XX, the Chair will postpone further proceedings today on motions to suspend the rules on which a recorded vote or the yeas and nays are ordered, or on which the vote incurs objection under clause 6 of rule XX.

Record votes on postponed questions will be taken later.

VETERAN ACCESS TO CARE ACT OF 2014

Mr. MILLER of Florida. Mr. Speaker, I move to suspend the rules and pass the bill (H.R. 4810) to direct the Secretary of Veterans Affairs to enter into contracts for the provision of hospital care and medical services at non-Department of Veterans Affairs facilities for Department of Veterans Affairs patients with extended waiting times for appointments at Department facilities, and for other purposes.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 4810

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Veteran Access to Care Act of 2014''.

SEC. 2. PROVISION OF HOSPITAL CARE AND MEDICAL SERVICES AT NON-DEPARTMENT OF VETERANS AFFAIRS FACILITIES FOR DEPARTMENT OF VETERANS AFFAIRS PATIENTS WITH EXTENDED WAITING TIMES FOR APPOINTMENTS AT DEPARTMENT FACILITIES.

(a) IN GENERAL.—As authorized by section 1710 of title 38, United States Code, the Secretary of Veterans Affairs (in this Act referred to as the ''Secretary'') shall enter into contracts with such non-Department facilities as may be necessary in order to furnish hospital care and medical services to covered veterans who are eligible for such care and services under chapter 17 of title 38, United States Code. To the greatest extent possible, the Secretary shall carry out this section using contracts entered into before the date of the enactment of this Act.

(b) COVERED VETERANS.—For purposes of this section, the term ''covered veteran'' means a veteran—

(1) who is enrolled in the patient enrollment system under section 1705 of title 38, United States Code;

(2) who—

(A) has waited longer than the wait-time goals of the Veterans Health Administration (as of June 1, 2014) for an appointment for hospital care or medical services in a facility of the Department;

(B) has been notified by a facility of the Department that an appointment for hospital care or medical services is not available within such wait-time goals; or

(C) resides more than 40 miles from the medical facility of the Department of Veterans Affairs, including a community-based outpatient clinic, that is closest to the residence of the veteran; and

(3) who makes an election to receive such care or services in a non-Department facility.

(c) FOLLOW-UP CARE.—In carrying out this section, the Secretary shall ensure that, at the election of a covered veteran who receives hospital care or medical services at a non-Department facility in an episode of care under this section, the veteran receives such hospital care and medical services at such non-Department facility through the completion of the episode of care (but for a period not exceeding 60 days), including all specialty and ancillary services deemed necessary as part of the treatment recommended in the course of such hospital care or medical services.

(d) REPORT.—The Secretary shall submit to Congress a quarterly report on hospital care and medical services furnished pursuant to this section. Such report shall include information, for the quarter covered by the report, regarding—

(1) the number of veterans who received care or services at non-Department facilities pursuant to this section;

(2) the number of veterans who were eligible to receive care or services pursuant to this section but who elected to continue waiting for an appointment at a Department facility;

(3) the purchase methods used to provide the care and services at non-Department facilities, including the rate of payment for individual authorizations for such care and services; and

(4) any other matters the Secretary determines appropriate.

(e) DEFINITIONS.—For purposes of this section, the terms ''facilities of the Department'', ''non-Department facilities'', ''hospital care'', and ''medical services'' have the meanings given such terms in section 1701 of title 38, United States Code.

(f) IMPLEMENTATION.—The Secretary shall begin implementing this section on the date of the enactment of this Act.

(e) CONSTRUCTION.—Nothing in this section shall be construed to authorize payment for care or services not otherwise covered under chapter 17 of title 38, United States Code.

(g) TERMINATION.—The authority of the Secretary under this section shall terminate with respect to any hospital care or medical services furnished after the end of the 2-year period beginning on the date of the enactment of this Act, except that in the case of an episode of care for which hospital care or medical services is furnished in a non-Department facility pursuant to this section before the end of such period, such termination shall not apply to such care and services furnished during the remainder of such episode of care but not to exceed a period of 60 days.

SEC. 3. EXPANDED ACCESS TO HOSPITAL CARE AND MEDICAL SERVICES.

(a) IN GENERAL.—To the extent that appropriations are available for the Veterans Health Administration of the Department of Veterans Affairs for medical services, to the extent that the Secretary of Veterans Affairs is unable to provide access, within the wait-time goals of the Veterans Health Administration (as of June 1, 2014), to hospital care or medical services to a covered veteran who is eligible for such care or services under chapter 17 of title 38, United States Code, under contracts described in section 2, the Secretary shall reimburse any non-Department facility with which the Secretary has not entered into a contract to furnish hospital care or medical services for furnishing such hospital care or medical services to such veteran, if the veteran elects to receive such care or services from the non-Department facility. The Secretary shall reimburse the facility for the care or services furnished to the veteran at the greatest of the following rates:

(1) VA PAYMENT RATE.—The rate of reimbursement for such care or services established by the Secretary of Veterans Affairs.

(2) MEDICARE PAYMENT RATE.—The payment rate for such care or services or comparable care or services under the Medicare program under title XVIII of the Social Security Act.

(3) TRICARE PAYMENT RATE.—The reimbursement rate for such care or services furnished to a member of the Armed Forces under chapter 55 of title 10, United States Code.

(b) COVERED VETERANS.—For purposes of this section, the term ''covered veteran'' means a veteran—

(1) who is enrolled in the patient enrollment system under section 1705 of title 38, United States Code; and

(2) who—

(A) has waited longer than the wait-time goals of the Veterans Health Administration (as of June 1, 2014) for an appointment for hospital care or medical services in a facility of the Department;

(B) has been notified by a facility of the Department that an appointment for hospital care or medical services is not available within such wait-time goals after the date for which the veteran requests the appointment; or

(C) who resides more than 40 miles from the medical facility of the Department of Veterans Affairs, including a community-based outpatient clinic, that is closest to the residence of the veteran.

(c) DEFINITIONS.—For purposes of this section, the terms ''facilities of the Department'', ''non-Department facilities'', ''hospital care'', and ''medical services'' have the meanings given such terms in section 1701 of title 38, United States Code.

(d) IMPLEMENTATION.—The Secretary shall begin implementing this section on the date of the enactment of this Act.

(e) CONSTRUCTION.—Nothing in this section shall be construed to authorize payment for care or services not otherwise covered under chapter 17 of title 38, United States Code.

(f) TERMINATION.—The authority of the Secretary under this section shall terminate with respect to care or services furnished after the date that is 2 years after the date of the enactment of this Act.

SEC. 4. INDEPENDENT ASSESSMENT OF VETERANS HEALTH ADMINISTRATION PERFORMANCE.

(a) INDEPENDENT ASSESSMENT REQUIRED.—Not later than 120 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall enter into a contract or contracts with a private sector entity or entities with experience in the delivery systems of the Veterans Health Administration and the private sector and in health care management to conduct an independent assessment of hospital care and medical services furnished in medical facilities of the Department of Veterans Affairs. Such assessment shall address each of the following:

(1) The current and projected demographics and unique care needs of the patient population served by the Department of Veterans Affairs.

(2) The current and projected health care capabilities and resources of the Department, including hospital care and medical services furnished by non-Department facilities under contract with the Department, to provide timely and accessible care to eligible veterans.

(3) The authorities and mechanisms under which the Secretary may furnish hospital care and medical services at non-Department facilities, including an assessment of whether the Secretary should have the authority to furnish such care and services at such facilities through the completion of episodes of care.

(4) The appropriate system-wide access standard applicable to hospital care and medical services furnished by and through the Department of Veterans Affairs and recommendations relating to access standards specific to individual specialties and standards for post-care rehabilitation.

(5) The current organization, processes, and tools used to support clinical staffing and documentation.

(6) The staffing levels and productivity standards, including a comparison with industry performance percentiles.

(7) Information technology strategies of the Veterans Health Administration, including an identification of technology weaknesses and opportunities, especially as they apply to clinical documentation of hospital care and medical services provided in non-Department facilities.

(8) Business processes of the Veterans Health Administration, including non-Department care, insurance identification, third-party revenue collection, and vendor reimbursement.

(b) ASSESSMENT OUTCOMES.—The assessment conducted pursuant to subsection (a) shall include the following:

(1) An identification of improvement areas outlined both qualitatively and quantitatively, taking into consideration Department of Veterans Affairs directives and industry benchmarks from outside the Federal Government.

(2) Recommendations for how to address the improvement areas identified under paragraph (1) relating to structure, accountability, process changes, technology, and other relevant drivers of performance.

(3) The business case associated with making the improvements and recommendations identified in paragraphs (1) and (2).

(4) Findings and supporting analysis on how credible conclusions were established.

(c) PROGRAM INTEGRATOR.—If the Secretary enters into contracts with more than one private sector entity under subsection (a), the Secretary shall designate one such entity as the program integrator. The program integrator shall be responsible for coordinating the outcomes of the assessments conducted by the private entities pursuant to such contracts.

(d) SUBMITTAL OF REPORTS TO CONGRESS.—

(1) REPORT ON INDEPENDENT ASSESSMENT.—Not later than 10 months after entering into the contract under subsection (a), the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives the findings and recommendations of the independent assessment required by such subsection.

(2) REPORT ON VA ACTION PLAN TO IMPLEMENT RECOMMENDATIONS IN ASSESSMENT.—Not later than 120 days after the date of submission of the report under paragraph (1), the Secretary shall submit to such Committees on the Secretary's response to the findings of the assessment and shall include an action plan, including a timeline, for fully implementing the recommendations of the assessment.

SEC. 5. LIMITATION ON AWARDS AND BONUSES TO EMPLOYEES OF DEPARTMENT OF VETERANS AFFAIRS.

For each of fiscal years 2014 through 2016, the Secretary of Veterans Affairs may not pay awards or bonuses under chapter 45 or 53 of title 5, United States Code, or any other awards or bonuses authorized under such title.

SEC. 6. OMB ESTIMATE OF BUDGETARY EFFECTS AND NEEDED TRANSFER AUTHORITY.

Not later than 30 days after the date of the enactment of this Act, the Director of the Office of Management and Budget shall transmit to the Committees on Appropriations, the Budget, and Veterans' Affairs of the House of Representatives and of the Senate—

(1) an estimate of the budgetary effects of sections 2 and 3;

(2) any transfer authority needed to utilize the savings from section 5 to satisfy such budgetary effects; and

(3) if necessary, a request for any additional budgetary resources, or transfers or reprogramming of existing budgetary resources, necessary to provide funding for sections 2 and 3.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from Florida (Mr. MILLER) and the gentleman from Maine (Mr. MICHAUD) each will control 20 minutes.

The Chair recognizes the gentleman from Florida.

GENERAL LEAVE

Mr. MILLER of Florida. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days in which to revise and extend their remarks H.R. 4810.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

Mr. MILLER of Florida. Mr. Speaker, I yield myself such time as I may consume.

□ 1230

Mr. Speaker, I rise today amidst a growing crisis amongst America's veterans. Just over 2 months ago, at a committee oversight hearing, we disclosed that the committee investigation had in fact uncovered evidence suggesting that at least 40 veterans had died while waiting for care at the Phoenix Department of Veterans Affairs health care system. We now know, and VA has in fact confirmed, that almost 60 veterans have died while facing delays in care at Phoenix and other locations, and that the data manipulation efforts that the committee has uncovered are in fact systemic throughout the entire Department.

I cannot state it strongly enough, Mr. Speaker, this is a national disgrace. For our veterans, it is something more. It is a national emergency.

An internal audit that was released just yesterday found that more than 57,000 veterans had been waiting for care, for their first medical appointment, and an additional 64,000 veterans who have enrolled in the health care system over the last 10 years never received the appointment that they requested.

Now, correcting the many failures of the VA health care system is going to take diligent and focused work for a long time to come. This committee, both Republicans and Democrats, is committed to seeing this through. However, our first priority must be making sure that those 121,000 veterans—and the thousands more I fear that are out there that have yet to be identified—receive the long overdue care that they need without any further delay.

This is why we have introduced H.R. 4810, the Veteran Access to Care Act. This bill would require VA to provide non-VA care authorization to any enrolled veteran who resides more than 40 miles from a VA medical facility and has waited longer than VA's stated wait time goals for a medical appointment, or has been notified by the Department of Veterans Affairs that an appointment is not available within the stated wait time goals.

Now, to ensure continuity of care, the bill would require VA to utilize existing contracts to the greatest extent possible. It would also ensure that the non-VA care authorization encompasses the entire episode of care needed by the veteran during a 60-day period.

To ensure providers are willing to accept veteran patients, the bill requires the Department to reimburse non-VA providers at the greater of the following rates: the rate of reimbursement under VA, the rate of reimbursement under Medicare, or the rate of reimbursement under TRICARE. These authorities would remain in place for 2 years.

To ensure that we are addressing both the short-term access challenges facing our veterans as well as the long-term need for a proactive solution, H.R. 4810 would further require the VA to enter into a contract with an independent entity or entities to conduct an assessment of the health care provided by the VA medical facilities and to submit its findings and recommendations of the assessment as well as an action plan and a timeline for full implementation to the Congress.

Importantly, the bill would also eliminate bonuses and performance awards for all VA employees for fiscal years 2014 through 2016 and require the Office of Management and Budget to transmit to Congress an estimate of the authority's budgetary effects, to include any transfer authority needed to utilize savings and, if necessary, a request for additional budgetary resources. Our latest estimate suggests that a temporary elimination of bonuses and other incentives will free up roughly $400 million per year that can be immediately utilized for the expanded patient choice options under this bill.

VA has a well-established authority to send veterans outside of the VA health care system to receive care through non-VA providers. However, right now, the decision of if and when a veteran is sent to non-VA care lies with a VA bureaucrat.

H.R. 4810 would require that the VA use the authority the Department has been given to assure that veterans waiting for an appointment or residing far from VA medical facilities are left in the control of their own care and able to choose for themselves where, when, and how they receive the care that the veteran themselves need. This authority would ensure that no veteran waiting for an appointment today would receive what one veteran, during a recent committee hearing, determined ''a death sentence.''

Mr. Barry Coates is a gulf war era veteran who waited almost a year in increasing pain to receive a colonoscopy from the Dorn VA Medical Center in Columbia, South Carolina.

That colonoscopy revealed that Mr. Coates had stage IV colon cancer that had metastasized to his lungs and his liver. Members, he is terminally ill today. Mr. Coates called his experience attempting to access care through the Department long, painful, emotional, and unnecessary. He testified:

I am here to speak for those to come so that they might be spared the pain I have already endured and know that I have yet to face.

Mr. Speaker, the problems the Department of Veterans Affairs is now facing represents failure on at least two fronts: failure of accountability and failure of access. Over the last several weeks, the House has addressed VA's lack of accountability through the passage of two pieces of legislation: H.R. 4031, the Department of Veterans Affairs Management Accountability Act, and H.R. 2072, the Demanding Accountability for Veterans Act.

Today, with the passage of H.R. 4810, we will address the Department's access failures for Barry Coates and, as he so eloquently said, for all those veterans still yet to come.

Mr. Speaker, I urge all of my colleagues to join me in supporting this legislation, and I reserve the balance of my time.

Mr. MICHAUD. Mr. Speaker, I yield myself as much time as I may consume.

I rise in support of H.R. 4810, the Veteran Access to Care Act of 2014. I want to thank the chairman for bringing this bill forward. I also want to thank the chairman and the staff on both the majority and minority side for all the work that they have been doing to get to the bottom of this crisis within the Department.

Access to timely, quality health care for veterans is a top priority for the Veterans' Affairs Committee. We often hear that the care that veterans receive at the VA facilities is second to none—that is, if you can get in. As we have recently learned, tens of thousands of veterans are not getting in, having to wait weeks and even months to access VA medical centers throughout the country.

The gravity of the delay in care that veterans from all areas are experiencing cannot be overstated and is totally unacceptable. This legislation would help to alleviate the backlog of veteran patients waiting to be seen at VA medical facilities both for specialty care and primary care appointments.

Specifically, it requires the VA to provide access to non-VA care to any enrolled veteran who lives more than 40 miles from a VA medical facility, has waited longer than the wait time goals for a medical appointment, or has been notified by the VA that an appointment is not available within the wait time goals. More importantly, it gives the veteran the option to elect to receive care at a non-VA facility or, if the veteran chooses, to wait to be seen at the VA medical center.

When our young men and women sign up to serve their country, we promise them quality, accessible health care. Thanks to many caring frontline clinicians, we have achieved the first, high-quality medical care. Now we must work on the second timely, and that is access issues. I encourage my colleagues to support this very important piece of legislation.

I reserve the balance of my time.

Mr. MILLER of Florida. Mr. Speaker, I yield 2 minutes to the gentleman from Colorado (Mr. LAMBORN), who has been at the forefront of the investigation on this scandal.

Mr. LAMBORN. Mr. Speaker, I rise today in support of the chairman's H.R. 4810, the Veteran Access to Care Act.

Recent reports from within the VA have confirmed that the manipulation of scheduling data and unacceptable wait times first highlighted in Phoenix are systemic throughout the VA system. Unfortunately, we have seen some of this in Colorado—at Colorado Springs, in particular. I am really upset about that.

These findings prompted me to author a letter last week that was signed by 35 of my colleagues urging Acting Secretary of the VA Gibson to expand the use of fee-based care in order to clear the current backlog and address any capacity shortfalls.

H.R. 4810 takes the next steps in addressing these shortfalls by mandating that the VA expand access to fee-based care and defines the parameters under which this care will be administered.

''Fee-based'' means that the veteran can get private health care providers to step in and take care of his health care needs when the VA doesn't have the capacity at that time to take care of him or her.

In order to ensure this timely delivery of quality care, H.R. 4810 also requires the VA to have an independent assessment conducted on the Veterans Health Administration to evaluate the Department's performance and to provide recommendations for improvement. Also, I would like to mention, bonuses will not be available to VA bureaucrats until 2016 under this bill, until this problem gets solved.

Mr. Speaker, I fully support H.R. 4810. I appreciate the chairman's leadership on this issue, and I ask my colleagues to support this important piece of legislation as well.

Mr. MICHAUD. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. BROWNLEY).

Ms. BROWNLEY of California. Mr. Speaker, I thank the ranking member for yielding, and I thank the chairman for introducing this bill.

I chose to join the House Veterans' Affairs Committee even knowing the many challenges that have plagued the VA for decades because I want to do all I can to make sure our veterans receive the care they have earned and deserve for the sacrifices they have made for our great Nation.

If the VA cannot see a veteran in a timely manner, then that veteran should be able to seek care outside of the VA. That is why I have cosponsored this bill and I intend to vote for it today.

This bill will not fix everything, but it will absolutely help and it is an important step forward. However, for those of us who represent urban areas like southern California, we all know that 40 miles can take the better part of a day to traverse back and forth. That is why I believe that we must take into account not only the distance traveled, but also the amount of time that it takes for veterans to travel to the VA so that the intention of this bill reaches all of our veterans. As a consequence, I ask the chairman and the ranking member to work with me to improve this bill and include time traveled as a factor as the bill continues to move forward.

I ask my colleagues to support this bill. I ask them to continue our work until we live up to the promise this country has made to our veterans and their families.

Mr. MILLER of Florida. Mr. Speaker, I understand Ms. BROWNLEY's concern, and I have heard that from Members on our side of the aisle as well.

At this point, I would like to yield 2 minutes to the gentleman from Florida (Mr. BILIRAKIS), the vice chairman of the House Committee on Veterans' Affairs, a stalwart supporter of our veterans.

Mr. BILIRAKIS. Thank you, Mr. Chairman, for your leadership on behalf of our true American heroes, and thank you for filing this bill. I also want to thank the ranking member. He does an outstanding job, as well, on behalf of our heroes.

Mr. Speaker, as a proud original cosponsor, I rise in strong support for H.R. 4810, the Veteran Access to Care Act. In upholding our promise to our Nation's heroes, this legislation will provide necessary relief for thousands of veterans who have waited far too long within the VA health system. Many of these veterans are forced to wait months, even years.

□ 1245

This is beyond unacceptable and represents a disservice for their sacrifice and service.

H.R. 4810 empowers the veterans with choice. It will address an immediate problem, allowing veterans to access non-VA care or stay within the VA system if they desire.

Our colleagues in the Senate have introduced similar legislation, which includes, again, a very similar provision. Mr. Speaker, I hope that this needed solution to care for our veterans will move quickly and be presented before the President without delay.

Long term, the VA's systemic failures that promote a culture of mediocrity and discourage transparency and accountability must be addressed.

However, our first priority is to ensure veterans are receiving timely quality care, but we must also continue our oversight to root out this culture of corruption.

I want to thank again the chairman for filing this bill, and I urge my colleagues to support it.

Mr. MICHAUD. Mr. Speaker, at this time, I yield 2 minutes to the gentlewoman from Nevada (Ms. TITUS).

Ms. TITUS. Mr. Speaker, I thank the ranking member for yielding to me.

As a member of the House Veterans' Affairs Committee, I rise in support of H.R. 4810. This important legislation will allow our Nation's heroes to access health care outside the VA for the next 2 years.

If even one veteran who has been waiting a long time for an appointment through the VA is able to receive care more quickly in the private sector, then we should give him or her that opportunity.

But this alone won't solve the problem. More must be done. We have known for a while that the VA facilities across the United States do not have enough doctors and nurses on staff to meet the growing demand for care. This is not a problem that is just isolated to the VA.

As I discussed in our hearing last night, allowing veterans to access care in the private sector will help in some areas of the United States, but in many cities and rural areas across the country there is also a shortage of care in the private sector.

In Nevada, for example, we have for a long time had a chronic shortage of doctors, both in primary care and among specialists. When comparing the number of health care workers relative to State population, Nevada ranks 46th in the Nation for general and family practitioners, 50th for psychiatrists, and 51st for general surgeons. So, as a result, veterans aren't the only ones who are waiting for health care. Everyone is affected.

Adding more patients to an already burdened system will not be a panacea.

That is why I am working with members of the committee on legislation that will shore up our VA health care system by increasing the number of medical residency programs at VA hospitals in areas that are facing a physician shortage. By increasing our investment in physician training, we will not only help our veterans in the short run, but we will be taking a step toward addressing the long-term nationwide physician shortage.

I hope that I will find support for that as we move forward, and I thank the chairman for his work on this important issue.

Mr. MILLER of Florida. Mr. Speaker, I yield 2 minutes to the gentleman from the First District of Tennessee, Dr. ROE, a veteran himself.

Mr. ROE of Tennessee. Mr. Speaker I thank the chairman.

I rise in support of H.R. 4810, the Veteran Access to Care Act.

As a physician, veteran, and member of the House Veterans' Affairs Committee, words cannot express my outrage over the VA's blatant disregard for the lives of those who served their country honorably and earned timely access to quality care.

I have helped run a hospital and am fully aware of how wait times and performance goals work. When the VA set a 14-day goal for scheduling appointments, it should have become immediately apparent that this was unattainable and could only be realized by cooking the books. Even in the private sector, a 14-day wait time is quite ambitious.

This bipartisan legislation offers a simple solution to a deadly problem. The needs of the vast majority of VA patients across the country can and will continue to be met through the existing VA system. But it is outrageous that veterans could die awaiting for care that is readily available in the private sector, so this is a commonsense solution and, frankly, the least we should do to help our veterans.

As I said last night in the committee hearing, there is something the VA could do today to change the culture of the VA. If you asked someone who works on a VA campus where do they work, Mr. Speaker, they will say I work for the VA. They should say, the answer to that question should be, I work and serve veterans.

I applaud the work that Chairman MILLER, Ranking Member MICHAUD, and the committee staff have undertaken to hold the VA accountable.

Mr. MICHAUD. Mr. Speaker, at this time, I yield 2 minutes to the gentleman from Georgia (Mr. BARROW), a former member of the Veterans' Affairs Committee.

Mr. BARROW of Georgia. Mr. Speaker, I thank the chairman for yielding and for his leadership on this issue.

I am proud to be an original cosponsor of this bill because it offers a way out for so many veterans who are stuck in the VA bureaucracy.

Over a year ago, I joined Chairman MILLER at the VA in Atlanta when this problem first arose. Just this year, he was gracious enough to come to my district in Georgia, where we are encountering similar problems. The audit released yesterday underscores the necessity of this legislation.

In my district alone, 130 veterans who requested appointments have never been seen. Sadly, they are only a small portion of the 57,000 who have waited more than 90 days to see a physician. We can do better.

This bill addresses the immediate critical needs of our veterans, but for too long veterans have been denied access to the care we promised them, too often because of simple inefficiency and incompetence at the VA.

I urge my colleagues to support this bill. I look forward to continuing to work together toward comprehensive reform of the VA services that our veterans have earned.

Mr. MILLER of Florida. Mr. Speaker, many Members have been very involved in this issue. Certainly the chairman of the Subcommittee on Health has been at the forefront. I yield 2 minutes to the gentleman from Michigan, Dr. BENISHEK.

Mr. BENISHEK. Thank you, Mr. Chairman.

Mr. Speaker, today I rise in support of H.R. 4810, the Veteran Access to Care Act.

This bill simply says to our veterans, you will receive the care you earned in a timely manner, whether it is at a VA facility or at your local hospital. I am proud to be an original cosponsor.

By passing this legislation, we give a helping hand to those veterans stuck in a broken bureaucracy. We will not allow them to sit and wait for an appointment that they should have gotten immediately. They fought to defend our right to freedom. Today we defend their right to the care they were promised.

The 2-year authorization for private care in this bill will give Congress time to work with the VA to overhaul the system. As a former VA doctor, I pledge to you that the VA that emerges from this process will be leaner, smarter, and far more responsive to the needs of our veterans.

We know 35 veterans have died while awaiting care in the Phoenix area alone. We know the recent deaths of at least 23 veterans have been linked to delayed VA medical care. The time for excuses is over. The time for action is now.

I support, and I urge all my colleagues to support, H.R. 4810.

Mr. MICHAUD. Mr. Speaker, at this time, I yield 2 minutes to the gentleman from Texas, Dr. CUELLAR.

Mr. CUELLAR. Mr. Speaker, I first want to thank my good friend, the chairman, for the great work that he and his staff have been doing, and certainly the ranking member and his staff, who have worked so hard, along with the Members, to get this piece of legislation.

I have always said, as my fellow colleagues have said, that when one of our men and women go out and fight on a foreign battlefield, they should not come back and fight the bureaucracy of the VA. This is why this legislation is very, very important, that we address some of the issues.

As one of the original cosponsors, I think providing an alternative with this emergency bill, H.R. 4810, which is at the top of an emergency, will provide an alternative to those veterans.

I represent part of San Antonio, go through a lot of rural areas, go down to Laredo, then go through a lot of rural areas, and then go into the McAllen area, the Valley area. In that area, I think this legislation will be very, very useful in the sense that if somebody has to wait or somebody lives more than 40 miles away from the VA facility, then they should be able to go to one of the local providers in their home area to get that assistance. I think this will save the veterans a lot of trouble, time, and provide them care in their home area.

I believe also when they are provided services at a non-VA facility where

they can be reimbursed at the rate of the VA, TRICARE, Medicare, whatever is greater, that is, again, another good alternative. The only thing I would caution my friends on is, let's be careful, because I have been pushing the alternative to work with the local providers, and there has been a problem with the VA where they don't provide the reimbursement to those providers on a timely basis, and we have got to make sure that we provide the oversight that if a provider comes in, a private provider, that they are reimbursed and paid promptly. Otherwise we are going to lose those providers.

Again, I certainly want to thank the chairman for the great work that he has been doing, the ranking member, the staff, and the other Members. This is a good piece of legislation, a good step forward, and I urge my colleagues to support H.R. 4810.

Mr. MILLER of Florida. Mr. Speaker, I yield 2 minutes to the gentleman from Kansas (Mr. HUELSKAMP).

Mr. HUELSKAMP. Mr. Speaker, I rise in strong support of the Veteran Access to Care Act of 2014.

I want to thank the chairman for his leadership not only on this bill, but investigating the current situation at the VA. This is a long overdue, proactive, multipronged solution I have been advocating for since coming to Congress.

On the committee in the last 3 years, we have been investigating lavish conference spending at the VA, millions of dollars of outrageous bonuses, billions of dollars of cost overruns. These are all significant scandals in and of themselves.

But what we are discussing here today is much bigger. It is about life and death. It is about dozens of veterans who lost their lives because of what happened at the VA; a systemic, nationwide problem, along with coverups, corruption, and, yes, criminality. It is shameful.

Instead of fighting to preserve the status quo, it is time to ensure that veterans receive quality health care closer to home. H.R. 4810 is a proactive solution. It involves veterans choice, independent review of VA performance, eliminating those outrageous bonuses, and holding the administration and holding the VA accountable.

Whether it is the veteran I met in Syracuse, Kansas, who was told he had to drive 10 hours round-trip three times in 10 days for care he could have gotten down the street at his local hospital, and he was told to drive to a facility that had a secret waiting list in Wichita, or the veteran Jack in Liberal, Kansas, who has waited 2 years for a doctor that was promised by the VA, or Larry in Oberlin, who I just learned a few weeks ago was told again to drive 10 hours to get a shingles vaccination that was just down the road, these are veterans who have been denied access to quality care.

H.R. 4810 deserves to be passed. These veterans deserve quality care close to home. The answer is pretty simple, Mr. Speaker. I do not believe there will be a rush to the exits of VA, but it will meet the needs of Larry, it will need the needs of Jack, it will meet the needs of Joe, and hopefully millions of other veterans that deserve quality access to care.

Mr. MILLER of Florida. Mr. Speaker, we have no further speakers at this time so we are prepared to close.

Mr. MICHAUD. Mr. Speaker, I have a couple of speakers, but they are not here so I will close.

Once again, Mr. Speaker, I urge my colleagues to support H.R. 4810, the Veteran Access to Care Act of 2014.

I want to thank the chairman once again for bringing this bill before the Chamber so we can vote on it.

Good quality health care is important for our veterans, but it doesn't do any good unless they can have access to that quality care. This legislation will definitely provide that access through non-VA care that our veterans need in certain areas.

I encourage my colleagues to support it. I once again want to thank you, Mr. Chairman, for working in a bipartisan manner to bring this bill before us today for a vote.

With that, I yield back the balance of my time.

Mr. MILLER of Florida. Mr. Speaker, without a doubt there are thousands of veterans across this country that are waiting for care that VA should be providing for them today. That is a national disgrace.

It is a national crisis when veterans die, as VA has already admitted: 23 preventable deaths due to delayed care, and maybe more on the way.

Let me assure the Members of this body, this will not end here. There are problems, systemic problems, throughout the entire Department of Veterans Affairs. We will work day and night, as we did last night, going until 11:30 p.m., making sure that VA tells this Congress, a coequal branch of this Federal Government, the truth.

With that, I urge my colleagues to vote in favor of H.R. 4810, and I yield back the balance of my time.

Mr. RYAN of Wisconsin. Mr. Speaker, the Veteran Access to Care Act of 2014 is critical to ensuring that our nation's veterans have timely access to quality health care. Recent reports from the VA's internal audits have revealed that thousands of veterans are still waiting for their first medical appointments at VA medical centers after waiting for at least 90 days. This is much longer than the agency's wait-time policy of 14 days or less. And it is simply unacceptable.

Further, the VA inspector general has confirmed that VA medical centers were deliberately hiding treatment delays and waiting times to make it seem that they were meeting the agency's wait-time goals. The Veteran Access to Care Act would address the wait-time issue by allowing veterans to receive private-sector health care if they have waited longer than the Veterans Health Administration's wait-time targets or if they reside more than 40 miles from the nearest VA medical facility or community-based outpatient clinic. The Access to Care Act gives the secretary authority to enter into contracts with non-Department medical facilities to provide health care to veterans and, if the secretary is unable to provide timely health-care access using contracted care, the act provides authority for the secretary to reimburse any non-Department medical facility for health care provided to a veteran.

Funding for implementing this act will come from funds that have already been appropriated, or will in the future be appropriated, to the Veterans Health Administration for medical services in the normal course of the discretionary appropriations process. This bill provides no new budget authority to the Department of Veterans Affairs and does not violate the budget enforcement regime.

Mrs. KIRKPATRICK. Mr. Speaker, I rise today in support of H.R. 4810, the Veterans Access to Care Act. This common-sense bill will help the veterans in my district get access to the care they deserve.

As many of you may know, my district is mostly rural. Many of the veterans in Arizona's district one wait too long to receive care, and they drive over 200 miles one way for an appointment.

This is difficult not only for the veterans, but for their families—and it's unrealistic for veterans requiring frequent treatment for things like mental health services or post-traumatic stress.

This bill helps our rural veterans by giving them a choice. Veterans will now be able to see a healthcare provider outside of the VA system if they live at least 40 miles from the closest VA medical facility and cannot get an appointment with a VA provider within a reasonable period of time.

This choice works for the veterans in my district. On the Navajo Nation, we realized that it was too difficult for our veterans to travel great distances to VA providers—and we pushed for a partnership with the Indian Health Service.

Now veterans on the Navajo Nation have the option of seeing a provider at the Indian Health Service without having to wait an unreasonable amount of time or travel great distances.

Mr. Speaker, I urge my colleagues to support H.R. 4810 so that veterans in rural communities in Arizona and across the country can go to a local doctor, clinic or hospital when the VA wait time is just too long.

Our veterans deserve timely care, and this will address one part of the VA access problem.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from Florida (Mr. MILLER) that the House suspend the rules and pass the bill, H.R. 4810.

The question was taken.

The SPEAKER pro tempore. In the opinion of the Chair, two-thirds being in the affirmative, the ayes have it.

Mr. MILLER of Florida. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this motion will be postponed.

□ 1300

CONDEMNING THE MASS SHOOTING IN ISLA VISTA, CALIFORNIA

Mr. ISSA. Mr. Speaker, I move to suspend the rules and agree to the resolution (H. Res. 608) condemning the senseless rampage and mass shooting that took place in Isla Vista, California, on Friday, May 23, 2014, as amended.

The Clerk read the title of the resolution.

The text of the resolution is as follows:

H. RES. 608

Whereas on May 23, 2014, a rampage and mass shooting took place in Isla Vista, California, a community adjacent to the University of California at Santa Barbara;

Whereas the people of the United States mourn the 6 innocent lives lost in this senseless tragedy, George Chen, 19, Katherine Breann Cooper, 22, Cheng ''James'' Yuan Hong, 20, Christopher Ross Michaels-Martinez, 20, Weihan ''David'' Wang, 20, Veronika Weiss, 19, all of whom were students at the University of California, Santa Barbara;

Whereas the people of the United States offer support to all the victims and their families, and wish the 13 injured full and speedy recoveries;

Whereas the brave response of law enforcement officials and other first responders prevented additional losses of life and further injury; and

Whereas the people of the United States call for a reduction of violence, deplore mass shootings, and stand with the survivors: Now, therefore, be it

Resolved, That the House of Representatives—

(1) condemns the senseless rampage and mass shooting that took place in Isla Vista, California, on May 23, 2014;

(2) offers condolences to the entire Isla Vista community and the University of California, Santa Barbara community, as well as their families;

(3) recognizes that the healing process will be long and difficult for the Isla Vista and Santa Barbara communities;

(4) encourages a productive and thoughtful dialogue on all aspects of this senseless tragedy;

(5) honors the selfless, dedicated service of the law enforcement officials and emergency response personnel who responded to the attack, preventing further loss of life and injury, and who continue to investigate the attack; and

(6) remains committed to working to help prevent tragedies like this from happening again.

The SPEAKER pro tempore. Pursuant to the rule, the gentleman from California (Mr. ISSA) and the gentlewoman from California (Ms. SPEIER) each will control 20 minutes.

The Chair recognizes the gentleman from California.

GENERAL LEAVE

Mr. ISSA. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks and include extraneous material on the bill under consideration.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. ISSA. Mr. Speaker, I yield myself such time as I may consume.

As many of us know, on May 23, 2014, a mass shooting took place in Isla Vista, California, a community adjacent to the University of California, Santa Barbara campus.

The people of the United States will continue to mourn the loss of six innocent victims and students of the University of California, Santa Barbara. Each of these students excelled in school and were looking forward to bright futures.

We will continue to remember the victims: George Chen, 19; Katherine Breann Cooper, 22; Cheng ''James'' Yuan Hong, 20; Christopher Ross Michaels-Martinez, 20; Weihan ''David'' Wang, 20; and Veronika Weiss, 19.

Americans everywhere continue to extend their support and sympathy to the victims, their families, and loved ones, and we wish each of the 13 people injured in the shooting a full and speedy recovery.

I would also like to commend the law enforcement officers and other first responders for their courage, bravery, and dedication to service. Their efforts helped to prevent further fatalities and injuries, and we remain extremely grateful to each of them.

I urge support of this measure, and I reserve the balance of my time.

Ms. SPEIER. Mr. Speaker, I yield myself such time as I may consume.

I rise in support of H. Res. 608, introduced by Congresswoman LOIS CAPPS, which is a bipartisan resolution to offer condolences to the Isla Vista and University of California, Santa Barbara communities, to mourn the victims and offer support to their families.

It condemns the senseless rampage and urges a dialogue on ''the Nation's mental health care system, anger, firearms laws, harmful attitudes towards women.''

The resolution honors law enforcement and emergency personnel for their response to the attack and continues the commitment of ''working to help prevent tragedies like this from happening again.''

The rampage and mass shooting that left six UC Santa Barbara students dead and 13 others injured in Isla Vista on May 23 was perpetrated by a deeply troubled man, with violent tendencies, who planned for months to kill as many as he could before the tragic day unfolded.

Despite warnings from his parents to police and a subsequent law enforcement check a few weeks before the murders, Elliot Rodger was able to cleverly ward off police by passing off the warnings as a ''misunderstanding.''

Police said, later, that Rodger did not meet the criteria for an involuntary hold. He legally purchased more than 400 rounds of ammunition and three semiautomatic pistols over the course of months before his rampage.

In the months leading up to the shooting, Elliot Rodger posted numerous videos and comments on social media sites detailing his frustrations with women and his hatred of them.

He made such comments as:

My orchestration of the day of retribution is my attempt to do everything in my power to destroy everything I cannot have. All of those beautiful girls I've desired so much in my life, but can never have because they despise and loathe me, I will destroy.

He said he would also eliminate the men who had better luck with women than he did.

Rodger, distressingly, joins a long list of mass killers that have haunted this country in recent years at grim scenes, including Sandy Hook, Virginia Tech, Aurora, Tucson, a Walmart in Las Vegas, and now in Oregon, just minutes ago.

Rodger shares three common denominators with these other mass murderers: easy access to guns, a history of mental illness, and clear warning signs that he wanted to carry out violent acts. Together, the five lone killers left a staggering 82 people dead and 114 others injured and scarred.

The Sandy Hook killer had serious mental health issues. The man who shot Representative Gabby Giffords had dropped out of school after his college required a mental health evaluation.

The Virginia Tech killer had been investigated by the university for stalking and had been declared mentally ill by a Virginia special justice. The Isla Vista shooter also had a long history of mental illness.

What it is going to take, colleagues?

Like many other mass shooters, he showed clear signs that he was extremely dangerous and planned to kill, but these five massacres are only a fraction of the mass shootings Americans have endured in a short span.

Between January 2009 and September 2013, there were 93 mass shootings—almost two per month—that occurred in 35 States, in a nearly 5-year period.

Is the problem too many guns? Is it mental health? Is it guns in the wrong hands?

The answer to all these questions is yes. We know what needs to be done. We may not agree on every solution to reduce gun violence, but Americans, outraged by our inability to get anything done on this issue, are waiting for us to come to our senses and to act.

The threshold for taking someone against their will for psychiatric evaluation needs to be reviewed. Police need better mental health training. It must become easier to intervene when there are risks.

The prevailing majority of individuals with a mental health problem aren't violent, but we should have the tools to respond to the smaller number who show clear violent tendencies and evidence that they are preparing to act on it.

Richard Martinez, the father of slain 20-year-old Christopher Michaels-Martinez, tearfully pleaded for people to