

**STATEMENT OF  
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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
OCTOBER 30, 2013**

Chairman Sanders, Ranking Member Burr and Members of the Committee:

Thank you for inviting the DAV (Disabled American Veterans) to testify at this legislative hearing of the Senate Veterans' Affairs Committee. As you know, DAV is a non-profit veterans service organization comprised of 1.2 million wartime service-disabled veterans dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to be here today to present our views on the bills under consideration by the Committee.

**S. 875, the Department of Veterans Affairs Disease Reporting and Oversight Act, and  
Draft Bill, to require the Secretary of Veterans Affairs to ensure the Department of  
Veterans Affairs has an up-to date policy on reporting of cases of infectious diseases, to  
require an independent assessment of the organizational structure of the Veterans  
Integrated Service Networks and Department medical centers.**

These measures seek to strengthen Department of Veterans Affairs (VA) policy in reporting nationally notifiable diseases published by the Council of State and Territorial Epidemiologists and the Centers for Disease Control and Prevention (CDC), or those infectious diseases required by a provision of law of a state.

Timely disease surveillance, identifying disease outbreaks, and recognizing disease trends in a community is critical to preventing infectious disease morbidity and mortality. Incomplete reporting, lack of consistent national standards, and a lack of timely reporting have created significant barriers to appropriate and effective disease-specific control measures since delays between the onset of illness and receipt of disease notification can allow for additional transmission to occur and additional people to become ill, thereby facilitating further spread of infection.

DAV believes the intent of these bills is laudable; lacking a national standard however, we urge the Committee ensure VA, CDC and Council of State and Territorial Epidemiologists work collaboratively to ensure the resulting VA policy address any barriers or ambiguities for timely and effective disease surveillance without placing undue burden on the Department and local VA facilities. Further, consideration of these measures and subsequent VA policy should be balanced with the requirements of sections 5701 and 7332 of title 38, United States Code, that protects the confidentiality of veterans health and personally identifiable information.

### **S. 1148, the Veterans Benefits Claims Faster Filing Act**

S. 1148 would direct the Secretary of Veterans Affairs to provide notice of average times for processing claims and percentage of claims approved. The goal of the legislation is to encourage veterans to seek the assistance of veterans service organizations (VSOs) and file claims for VA benefits using the Fully Developed Claim (FDC) process.

This legislation would make available to all current and potential veteran claimants information regarding the success or allowance rate of claims in each Department of Veterans Affairs (VA) Regional Office (RO) by requiring the Secretary of Veterans Affairs to publish this information on VA's website. Additionally, this information will be required to be conspicuously posted in every VARO and, when a claim is received, VA will notify the claimant of such information, including information about the benefit of filing a FDC, such as faster processing time and eligibility to receive up to an extra year of benefit payments.

The type of information this legislation is seeking to publicize to every claimant is the average processing time of claims and the percentage of allowed or granted claims for those with representation versus those without representation. Additionally, S. 1148 will require the information to be broken down into the percentage of claims that were FDC submitted electronically versus paper as compared to those who do not file their claims through the FDC program in electronic, standard paper or non-standard paper form.

DAV supports the principle of S. 1148, which is to bring better awareness and information to a claimant prior to filing a claim for benefits in the same manner as its companion bill, H.R. 1809, which was passed by the House. Both S. 1148 and H.R. 1809 are directed at providing more in-depth information to a claimant about representation in keeping with the primary goal of encouraging claimants to submit their claims for benefits through the FDC program.

DAV agrees with encouraging claimants to submit their claims through the FDC process, as is a standard practice for DAV. Nonetheless, DAV believes, in order to fully reach the goal of this legislation and, more importantly, to benefit the claimant in the best way possible, the posted information should provide a breakdown of the number of claims represented and the allowance rate for each VSO and for representatives other than VSOs. Otherwise, this information may not allow an individual to make an informed decision about representation. Moreover, when publishing this type of information, it should include the fact that DAV and other VSOs provide representation to virtually any claimant in the process, with the exception of frivolous or fraudulent claims. Conversely, others providing representation, including attorneys, tend to be much more selective in their representation; often choosing to represent only claims wherein the predicted outcome is favorable to the claimant. DAV believes this should also be made clear to a claimant in the published information.

While we do not have a specific resolution to support this matter, DAV does support the intent of S. 1148, which will require VA to make this information available to claimants; however, we are concerned about the possibility that this legislation, if enacted, may burden the

VA at a time when their primary focus is directed at reducing the backlog of disability claims and transforming the claims process.

### **S. 1155, the Rural Veterans Mental Health Care Improvement Act**

S. 1155, if enacted, would achieve four basic purposes. First, it would amend current law governing advance appropriations in VA health care by adding appropriations accounts and sub-accounts that provide funding for information technology (IT). Second, it would add two professional fields (marriage and family therapists, and mental health counselors) to existing career health fields that are participating in VA's academic health education programs, and would require the VA Secretary to apportion funding, from funds available, to these new professions. Third, the bill would require amendments to current authority for readjustment counseling and mental health counseling for family members of certain veterans; and, fourth, the bill would require VA to submit a report to Congress on telemedicine.

Based on DAV Resolution No. 180, DAV strongly supports Congress extending advance appropriations to all VA discretionary appropriations accounts. We believe the VA health care system's experience over the past three years, and particularly this year, protected by advance appropriations while most of the remainder of the federal government was forced to deal with continuing appropriations (and now a shutdown), produces a strong justification for protecting all of VA's discretionary accounts. While we support the provision in this bill that would bring IT accounts under the protection of advance appropriation, we ask the Committee rather to consider enacting S. 932, the Putting Veterans Funding First Act of 2013.

DAV has not received a specific resolution from our membership addressing the need to add the two new career fields of marriage and family therapists and mental health counselors to VA's academic responsibilities. VA already possesses authority to employ such providers, either in direct health care or in Readjustment Counseling Vet Centers. Absent a showing of shortage of available practitioners in these professions, mandating their inclusion within VA's responsibility in conducting its health care training programs may be ill advised. We defer to VA on balancing its academic programs across health professionals career fields and suggest the same to the bill's sponsor.

On the strength of resolutions from our membership we strongly support the existing VA family caregiver support program and VA's independent Vet Center readjustment counseling program; therefore, we support these provisions in this bill that would clarify and expand these efforts.

We have no objection to the report on telemedicine that the bill would require.

### **S. 1165, the Access to Appropriate Immunizations for Veterans Act of 2013**

This measure would require the Secretary of Veterans Affairs to make available periodic immunizations against certain infectious diseases as adjudged necessary by the Secretary of Health and Human Services through the recommended adult immunization schedule established by the Advisory Committee on Immunization Practices. The bill would include such

immunizations within the authorized preventative health services available for VA-enrolled veterans. The bill would establish publicly reported performance and quality measures consistent with the required program of immunizations authorized by the bill. The bill would require annual reports to Congress by the Secretary confirming the existence, compliance and performance of the immunization program authorized by the bill.

DAV Resolution No. 036 calls on VA to maintain a comprehensive, high-quality, and fully funded health care system for the nation's sick and disabled veterans, specifically including preventative health services. Preventative health services are an important component of the maintenance of general health, especially in elderly and disabled populations with compromised immune systems. If carried out sufficiently, the intent of this bill could also contribute to significant cost avoidance in health care by reducing the spread of infectious diseases and obviating the need for health interventions in acute illnesses of those without such immunizations.

While DAV is pleased to support this bill, we urge the Committee to work with VA to address concerns the Department has raised with similar legislation. Those concerns included requiring that the quality metric, including targets for compliance, be established via notice and comment rulemaking would limit VA's ability to respond quickly to new research or medical findings regarding a vaccine. Moreover, because the clinical indications and population size for vaccines vary by vaccine, blanket monitoring of performance of all vaccines could be cost prohibitive and may not have a substantial positive clinical impact at the patient level.

**S. 1211, to prohibit the use of the phrases GI Bill and Post-9/11 GI Bill to give a false impression of approval or endorsement by the VA**

S. 1211 would amend title 38, United States Code, to prohibit the use of the phrases GI Bill and Post-9/11 GI Bill to give a false impression of approval or endorsement by the VA.

DAV does not have a resolution on this issue and takes no official position.

**S. 1216, the Improving Job Opportunities for Veterans Act of 2013**

S. 1216 would improve and increase the availability of on-job training and apprenticeship programs carried out by the Secretary of Veterans Affairs.

In accordance with DAV Resolution No. 001, DAV supports this legislation.

**S. 1262, the Veterans Conservation Corps Act of 2013**

S. 1262 would require the Secretary of Veterans Affairs to establish a veterans conservation corps.

DAV does not have a resolution on this issue and takes no official position on this legislation.

### **S. 1281, the Veterans and Servicemembers Employment Rights and Housing Act of 2013**

S. 1281 would prohibit employment practices that discriminate based on an individual's military service and amends the Fair Housing Act and the Civil Rights Act of 1968 to prohibit housing discrimination against members of the uniformed services.

DAV does not have a resolution on this issue and takes no official position on this bill.

### **S. 1295, to require the Secretary of Veterans Affairs to provide veterans with notice, when veterans electronically file claims for benefits under laws administered by the Secretary, that relevant services may be available from veterans service organizations**

S. 1295 would amend title 38, United States Code, to require the Secretary of Veterans Affairs to provide veterans with notice, when veterans electronically file claims for benefits under laws administered by the Secretary, that relevant services may be available from veterans service organizations.

While DAV does not have a specific resolution on this issue we support the intent of the legislation to make claimants fully aware of the vast, free services and assistance that are available from veterans service organizations. Navigating the VA system and the plethora of benefits available can be very complicated and paralyzing to any claimant and we appreciate the goal of S. 1295 to help ease this burden.

### **S. 1296, the Servicemember's Electronic Health Records Act of 2013**

This measure would amend Section 1635 "Wounded Warrior" and veterans provisions in the fiscal year 2008 National Defense Authorization Act (NDAA), to create a specific timeline and deadlines for a joint electronic health record to be implemented. This timeline would require, among other things, the Department of Defense (DOD) and VA to agree on and create standardized forms for data capture within 180 days of enactment. They would have one year to attain seamless integration and sharing of information and data downloading using the Blue Button Initiative.

The bill also would require the agencies to consider storage of patient data in a secure, remote, network-accessible computer storage system or a cloud storage system. This type of storage system would allow service members and veterans to upload their own information and allow their providers to have the ability to see the records at any time. The cloud storage system would increase interoperability and allow the patient to more easily share their information with their medical provider.

The development of an integrated DOD-VA electronic health record (EHR) has been beset with problems for years. Efforts to create a joint DOD/VA EHR scheduled to become operational in 2017 came to a halt in February 2013. The new plan includes both Departments to pursue separate systems and gain interoperability using existing commercial software.

The plan also assumes that in the summer of 2013, both Departments were to have launched pilot programs on the common interface at seven joint rehabilitation centers nationwide, initially, and eventually to nine sites, overall. All of the facilities were scheduled to exchange data that is computable and interoperable by the end of July.

Criticism of this decision resulted in an amendment to the House passed 2014 NDAA to increase oversight of the integrated electronic health record (iEHR). Notably, Section 734 of the National Defense Authorization Act of 2014 would require DOD and VA to give appropriate congressional committees a plan on an iEHR by January 31, 2014. This plan would include program objectives, organization, responsibilities of the departments, technical system requirements, milestones (including a schedule for industry competitions), system standards the program will use, metrics to assess the program's effectiveness, and funding levels needed for fiscal years 2014 to 2017 in order to execute the plan. It would also limit funding for development of an iEHR until the Government Accountability Office confirms the proposed system to be deployed by October 1, 2016, meets stated requirements.

We note that despite strong and consistent Congressional mandates and oversight over those years, efforts by both Departments remain fragmented and have proceeded at a glacial pace. As part of *The Independent Budget*, DAV remains firm that the DOD and VA must complete an electronic medical record process that is fully computable, interoperable, and that allows for two-way, real-time electronic exchange of health information and occupational and environmental exposure data for transitioning veterans. Effective record exchange could increase health care sharing between agencies and providers, laboratories, pharmacies, and patients; help patients transition between health care settings; reduce duplicative and unnecessary testing; improve patient safety by reducing medical errors; and increase our understanding of the clinical, safety, quality, financial, and organizational value of health IT.

DAV believes the intent of S. 1296 is laudable; however, we ask the Committee ensure the measure is consistent with the pertinent provisions in the 2014 NDAA awaiting consideration by the Senate. Moreover, we urge the Committee to consider the current capabilities of the Interagency Program Office (IPO), which would likely be responsible for meeting the requirements contained in S. 1296. The IPO was established by Congress in Section 1635 of Public Law 110-181, the 2008 National Defense Authorization Act as the office accountable for developing and implementing the health information sharing capabilities for DOD and VA. Staffing challenges within the IPO have been an issue. As of January 2013, the IPO was staffed at about 62 percent of the 236 employees assigned by both departments, according to a February 2013 Government Accountability Office report, which also noted hiring additional staff is one of the biggest challenges.<sup>1</sup>

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<sup>1</sup> *Long History of Management Challenges Raises Concerns about VA's and DOD's New Approach to Sharing Health Information*, Government Accountability Office, February 27, 2013. Washington, DC

**S. 1361, the World War II Merchant Mariner Service Act**

S. 1361 would direct the Secretary of Homeland Security to accept additional documentation when considering the application for veteran status of an individual who performed service as a coastwise merchant seaman during World War II.

DAV does not have a resolution on this issue and takes no position on S. 1361.

**S. 1399, to extend the interest rate limitation on debt entered into during military service to debt incurred during military service to consolidate or refinance students loans incurred before military service**

S. 1399 would amend the Servicemembers Civil Relief Act to extend the interest rate limitation on debt entered into during military service to debt incurred during military service to consolidate or refinance students loans incurred before military service.

DAV does not have a resolution on this issue and takes no official position on this legislation.

**S. 1411, the Rural Veterans Health Care Improvement Act of 2013**

S. 1411 would require the Office of Rural Health of the Veterans Health Administration to update its “Strategic Plan Refresh,” a document VA issued in 2012 that reviewed VA’s rural health expenditures, and laid out VA’s plans for rural health developments over the near term, and for other purposes. Our members have approved DAV Resolution No. 211, calling on Congress and VA to support sufficient resources for VA to improve health care services for veterans living in rural or remote areas; thus, we support this bill.

**S. 1434, to rename the Junction City, Kansas Community-Based Outpatient Clinic**

S. 1434 would designate the Junction City Community-Based Outpatient Clinic located at 715 Southwind Drive, Junction City, Kansas, as the Lieutenant General Richard J. Seitz Community-Based Outpatient Clinic.

As a local issue, DAV does not have a national position on the matter.

**S. 1471, the Alicia Dawn Koehl Respect for National Cemeteries Act**

S. 1471 would authorize the Secretary of Veterans Affairs and the Secretary of the Army to reconsider decisions to inter or honor the memory of a person in a national cemetery.

DAV does not have a resolution on this issue and takes no official position on this bill.

**S. 1540, to remove a legal obstacle that effectively prevents state veterans homes from applying for federal grants to support homeless veterans programs**

S. 1540 was introduced in order to remove a legal obstacle that effectively prevents state veterans homes from applying for federal grants to support a homeless veterans program.

State veterans homes are a partnership between the federal government and the States, with the federal government providing construction grants that may cover up to 65 percent of the cost to build and maintain the homes, and states providing the balance. In addition, the federal government pays a per diem covering approximately one-third of the cost to care for qualified veterans under three authorized programs: nursing home care, domiciliary care and adult day health care.

Currently, some state veterans homes have underutilized bed capacity in their domiciliary program, a portion of which could be repurposed for homeless veterans programs. A few state homes that are well positioned to provide and coordinate the multitude of health care and supportive services required by homeless veterans have expressed an interest in applying for grants to operate such a program. However, under current law, state homes are authorized to use their federal support only for the three aforementioned programs and if a state home were to operate a homeless veterans program, the federal government could seek to recapture construction grant funding provided over the prior twenty years. Since no state home could afford to pay that high a financial penalty, this provision effectively prevents them from using excess capacity for operating a homeless veterans program.

S. 1540 seeks to resolve this problem by amending the recapture provisions of title 38, United States Code, section 8136, with an exemption for state homes that receive a contract or grant from VA for residential care programs, including homeless veterans programs. The change would remove the financial obstacle preventing some state homes from applying for federal grants to support homeless veterans, such as through VA's Health Care for Homeless Veterans program, but the decision to award the grant (or contract) would remain solely with VA as the grantor. It would be up to VA to determine whether the state home had sufficient excess capacity and was capable of operating a successful homeless veterans program.

By allowing state homes with excess bed capacity in their domiciliary programs to repurpose a portion of that existing space to support homeless veterans, this legislation would allow some additional options for homeless veterans in a cost-effective manner.

In line with DAV Resolution No. 165, which calls for sustained sufficient funding to improve services for homeless veterans, DAV supports the intent of this legislation; however, we urge the Committee to ensure the legislation allows for the recapture of the portion of grants to state homes if so provided for the costs of construction, renovation, or acquisition of a building for use as service centers or transitional housing for homeless veterans under VA's Homeless Providers Grant and Per Diem Program.



## **S. 1547, the Veterans Dialysis Pilot Program Review Act of 2013**

VA estimates show that in FY 2011, approximately 35,000 veterans enrolled in the VA health care system were diagnosed with end-stage renal disease (ESRD) reflecting a higher prevalence in the VA population than in the general U.S. population.<sup>2</sup> Initiated based on the rapidly rising cost of VA paid hemodialysis treatment in non-VA facilities and the high rates of morbidity and mortality of veteran patients with ESRD, several VA studies of this veteran patient population and paid for or directly provided dialysis therapy have been conducted.<sup>3</sup>

The May 23, 2012 Government Accountability Office (GAO) report on VA's Dialysis Pilot states VA had not fully developed performance measures for assessing the pilot locations<sup>4</sup> even though the Department has already begun planning for the expansion of the dialysis pilot. Further, GAO indicated that such an expansion "should not occur until after VA has defined clear performance measures for the existing pilot locations and evaluated their success."

This measure would limit the expansion of VA's dialysis pilot program beyond current locations, require an independent analysis of the pilot, and to submit a report to Congress based on the analysis.

While Congress has been focused on VA's actions to address the growing demand of dialysis therapies depicted in recent committee reports,<sup>5</sup> DAV is concerned that the discussion on VA's dialysis pilot and on the Department's purchased or provided dialysis therapy in general appears to be centered on cost and we find there is not sufficient emphasis on the veteran patient.

Certainly, ESRD patients are one of the most resource-intensive patient populations in the VA health care system. However, the burden of hemodialysis is extreme to veteran patients. It is a life-altering event that has implications for the veteran's health, lifestyle, and livelihood. Veterans diagnosed with ESRD are often prescribed and must receive dialysis treatments. These treatments are time intensive for veterans and typically require three outpatient treatments per week that each last about 4 hours for the rest of their lives unless they receive a kidney transplant.

As one of *The Independent Budget* veterans service organizations (IBVSOs), coordinating care among the veteran, dialysis clinic, VA nephrologists, and VA facilities and physicians is essential to improving clinical outcomes and reducing the total costs of care. The benefits of an integrated, collaborative approach for this population have been proven in several Centers for Medicare and Medicaid Services demonstration projects and within private-sector programs sponsored by health plans and the dialysis community. Such programs implement

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<sup>2</sup> *Comparison of outcomes for veterans receiving dialysis care from VA and non-VA providers*, Wang et al., BMC Health Services Research 2013, 13:26.

<sup>3</sup> *Comparing VA and private sector healthcare costs for end-stage renal disease*, Hynes et al., Medical care 2012, 50(2):161-170.

<sup>4</sup> Veterans Affairs (VA) medical centers (VAMC) in Durham and Fayetteville, North Carolina started June 2011; Philadelphia, Pennsylvania started October 2012; and Cleveland, Ohio started July 2013.

<sup>5</sup> House Appropriations Report 112-094 page 41, May 213, 2011 and House Appropriations Reports 112-491, pages 39-40, May 23, 2012.

specific interventions that are known to avoid unnecessary hospitalizations, which frequently cost more than the total cost of dialysis treatments. These interventions also focus on behavioral modification and motivational techniques. The potential return on investment in better clinical outcomes, higher quality of life, and lower costs could be substantial for VA and veteran patients.

We understand that some community dialysis providers are piloting the integrated care management concept among their veteran population. The IBVSOs believe that VA should provide integrated care management in this pilot program that can test and demonstrate the value of such an approach to VA and the veterans it serves.

### **S. 1556, to modify authorities relating to the collective bargaining of employees in the VHA**

S. 1556 would amend title 38, United States Code, to modify authorities relating to the collective bargaining of employees in the Veterans Health Administration.

This bill would restore some bargaining rights for clinical care employees of the VHA that were eroded by the former Administration and through subsequent federal court decisions. The bill would strike subsections (b), (c) and (d) of section 7422 of title 38, United States Code. Enactment of the bill would have the effect of authorizing employee representatives of recognized bargaining units to negotiate with VHA management over matters of employee compensation and conditions of employment other than their rates of basic pay. This feature is an important one in that locality pay elements and performance pay increments are subject only to VA's internal policy-making determinations. Recognized VA employee representatives have been subjectively excluded from participating in these decisions based on VA's interpretation that section 7422 broadly blocks any negotiation due to its potential negative impact on the quality of care of veterans.

We believe labor organizations that represent employees in recognized bargaining units within the VA health care system, including in its professional units, have an innate right to information and reasonable participation that result in making the VA health care system a workplace of choice, and in particular, to fully represent VA employees on issues impacting their conditions of employment.

Congress passed section 7422, title 38, United States Code, in 1991, in order to grant specific bargaining rights to labor in VA professional units, and to promote effective interactions and negotiation between VA management, and its labor force recognized representatives concerned about the status and working conditions of VA physicians, nurses and other direct caregivers appointed under title 38, United States Code. In providing this authority, Congress granted to VA employees and their recognized representatives a right that already existed for all other federal employees appointed under title 5, United States Code. Nevertheless, federal labor organizations have reported that VA severely restricts the recognized federal bargaining unit representatives from participating in, or even being informed about, a number of human resources decisions and policies that directly impact conditions of employment of the VA professional staffs within these bargaining units. We are advised by labor organizations that when management actions are challenged, VA officials (many at the local level) have used

subsections (b), (c) and (d) of section 7422 as a statutory shield to obstruct any labor involvement to correct or ameliorate the negative impact of VA's management decisions on employees, even when management is allegedly not complying with clear statutory mandates (e.g., locality pay surveys and alternative work schedules for registered nurses, physician locality pay compensation panels, etc.).

We believe this bill, which would rescind VA's ability to refuse to bargain on matters of employment conditions and elements of compensation other than rates of basic pay embedded in law, is an appropriate remedy to address part of the bargaining problem in the VA's professional ranks. We understand recently VA has given federal labor organizations some indication of additional flexibility in negotiating labor-management issues such as some features of supplemental compensation, and we are hopeful that this change signals a new trend in these key relationships that directly affect sick and disabled veterans.

While DAV has not received a specific resolution from our membership related to the issues contained in this bill, we would not object to its enactment, while continuing to hope that VA and federal labor organizations can find a sustained basis for compromise.

**S. 1558, to carry out a program of outreach for veterans to increase their access and use of Federal, State, and local programs providing compensation for service in the Armed Forces**

S. 1558 would require the Secretary of Veterans Affairs to carry out a program of outreach for veterans to increase their access and use of Federal, State, and local programs providing compensation for service in the Armed Forces and the awareness of such programs by veterans and their eligibility for such programs.

Although DAV does not have a resolution on this particular matter, we currently provide such outreach to veterans and, therefore, we would not oppose passage of this legislation. The intent of this bill is to make veterans aware of the services and benefits from the VA that they have earned, which will increase the use of VA benefits and services. While we certainly agree and support the increased awareness, this will undoubtedly lead to increased demands placed upon the VA. Congress must ensure that VA has the adequate resources to handle the increase in demand.

If the enhanced outreach is successful and the demand too great, then this endeavor would cause a negative impact on VA and the veterans it serves.

**S. 1559, the Benefits Fairness for Filipino Veterans Act of 2013**

S. 1559 would amend title 38, United States Code, to modify the method of determining whether Filipino veterans are United States residents for purposes of eligibility for receipt of the full-dollar rate of compensation under the laws administered by the Secretary of Veterans Affairs.

DAV does not have a resolution on this issue and takes no position on S. 1559.

### **S. 1573, the Military Family Relief Act**

S. 1573 would amend section 1318 of title 38, United States Code, to provide for the payment of temporary compensation to a surviving spouse of a veteran upon the death of the veteran. Essentially this legislation is aimed at providing temporary death benefits to a surviving spouse for six months, without regard to whether that individual has submitted a claim for such compensation if, at the time of the veteran's death the veteran was in receipt or entitled to receive compensation for a service-connected disability continuously rated as total for not less than one year immediately preceding the veteran's death.

Specifically, if enacted, S. 1573 would allow a surviving spouse to receive payment of survivors benefits temporarily, for six months, with no lapse in time from the discontinuance of disability compensation upon the veteran's death. Given the current backlog of pending claims within the Veterans Benefits Administration (VBA), surviving spouses are left for months upon months with no income between the time of the veterans' death (and resultant loss of disability compensation) and the time dependency and indemnity compensation (DIC) benefits are awarded.

Under section 1318 of title 38, United States Code, certain surviving spouses may be entitled to DIC if at the time of the veteran's death, the veteran was continuously rated totally disabled for a period of five years within discharge or release from active duty; the veteran was continuously rated totally disabled for a period of 10 years or more; or the veteran was continuously rated totally disabled for a period of one year if the veteran was a former prisoner of war.

Generally, claims submitted for DIC that meet any of the aforementioned eligibility criteria can be processed by VBA very quickly because little to no development is required. However, because of the dire backlog of claims within VBA, qualified surviving spouses are left to languish for unacceptably long periods of time with no income. Even if the surviving spouse were to file a qualifying claim for DIC pursuant to Section 1318 of title 38, United States Code, under the more expedient FDC process, a lapse in payment and loss of vital income would still exist. S. 1573 is directed specifically at bridging the gap of benefits between the veteran's death and the time DIC is awarded. While this measure would provide DIC only temporarily for six months, it would ease the burden the veteran's death and immediate loss of vital income while VBA finally processes the claim.

In accordance with DAV Resolution No. 001, DAV supports enactment of S. 1573.

### **Draft Bill, to update the Service Disabled Insurance program to base premium rates on the Commissioner's 2001 Standard Ordinary Mortality table instead of the Commissioner's 1941 Standard Ordinary Table of Mortality**

This bill would amend title 38, United States Code, to update the Service Disabled Insurance program to base premium rates on the Commissioner's 2001 Standard Ordinary Mortality table instead of the Commissioner's 1941 Standard Ordinary Table of Mortality. DAV is pleased to see the introduction of this draft Senate bill.

It is strongly supported by our organization and has been adopted for decades as a formal resolution by DAV delegates. Also, the IBVSOs have encouraged Congress to adjust these premium rates rather than continue the practice of using an antiquated formula that has been disproportionate to industry standards. This premium inequity has persisted amongst disabled veterans for so many years with the monthly cost of this insurance negating the overall value of the benefit itself.

DAV strongly encourages this Committee to work with your colleagues and with the House of Representatives to ensure favorable consideration of this legislation. DAV also welcomes the opportunity to work with Congress to ensure the enactment of this measure, which will have a lasting and positive impact on our nation's disabled veterans and their families now and into the future.

**Draft Bill to provide replacement automobiles for certain disabled veterans and members of the Armed Forces**

This bill would amend title 38, United States Code, to provide replacement automobiles for certain disabled veterans and members of the Armed Forces. This measure, if enacted, would amend section 3903 allowing qualified disabled veterans the opportunity to utilize this vital program up to three times, rather than the currently allowed one time, and increase the current amount from \$18,900 to \$30,000. This measure will allow a qualified disabled veteran the ability to use the benefit up to two times beyond the initial use of the grant with an aggregate amount of \$30,000 available to the veteran.

Not only has the issue of increasing the amount of the automobile grant benefit been a long-standing issue for DAV, other veterans service organizations (VSOs) have also sought to have the amount of this vital benefit increased. DAV, joined with the other IBVSOs, have urged Congress to expand the automobile grant benefit by allowing previous recipients of a much lesser amount of \$11,000, \$8,000 or even less, to be able to receive a supplemental auto grant for the difference between what the original automobile grant and the current amount.

For example, the VA provides financial assistance in the form of grants to eligible veterans toward the purchase of a new or used automobile to accommodate a veteran or service member with certain disabilities that resulted from a disabling condition incurred or aggravated during active military service. In December 2011, this one-time auto grant was increased from \$11,000 to \$18,900, thus giving service-disabled veterans who need a modified vehicle increased purchasing power. While there are veterans who have not yet used the grant, veterans who have exhausted the grant are left to replace modified vehicles, once those vehicles have surpassed their useful life, at their own expense and at a higher cost than the first adapted vehicle due to inflation.

Additionally, last year the Department of Transportation reported the average life span of a vehicle is 12 years, or about 128,500 miles. The cost to replace modified vehicles can range from \$40,000 to \$65,000 new, and \$21,000 to \$35,000 used, on average. These tremendous costs, compounded by inflation, present a financial hardship for many service-disabled veterans

who need to replace their primary mode of transportation once it exceeds its expected life.

As such, in accordance with DAV resolution No. 170, DAV supports enactment of this draft legislation as it will expand the vital automobile grant benefit by allowing multiple uses while increasing the current amount from \$18,900 to an aggregate amount of \$30,000.

### **Draft Bill, the Veterans Health Care Eligibility Expansion Act of 2013**

Section 2 of this measure would amend title 38, United States Code, section 1710 authorizing VA to provide health care to all veterans not currently enrolled in the VA health care system provided they meet other statutory requirements, including section 5303, availability of appropriations, agreeing to pay copayments, etc.

In amending section 1710 however, this new authority would require VA provide nursing home care to veterans described under the new paragraph (3) of subsection (a) while giving VA the discretion to provide nursing home care to veterans described under paragraph (2) of subsection (a).

(2) The Secretary (subject to paragraph (4)) shall furnish hospital care and medical services, and *may furnish nursing home care*, which the Secretary determines to be needed to any veteran-

(3) In the case of a veteran who is not described in paragraphs (1) and (2), the Secretary *shall* subject to the provisions of subsections (f) and (g), furnish hospital care, medical services, *and nursing home care* which the Secretary determines to be needed. [Emphasis added]

DAV National Resolution No. 186 supports top priority access for service-connected veterans within the VA health care system.

For purposes of equity, we recommend language amending paragraph (2) to state that the Secretary shall furnish hospital care, medical services, and nursing home care that the Secretary determines to be needed to any veteran under subparagraphs A through G.

Section 3 would amend title 38, United States Code, section 1705 requiring VA allow for the enrollment by December 31, 2014, of noncompensable service-connected veterans and nonservice-connected veterans not currently permitted to enroll in the VA health care system and who do not have access to health insurance except through state-based health insurance exchanges established according to the Patient Protection and Affordable Care Act.

DAV has no resolution to support this section and would not object to its favorable consideration as long as sufficient resources are in place at the time this enrollment takes effect.

Section 4 seeks to extend the eligibility for enrollment in the VA health care system from 5 to 10 years following discharge for a combat veteran discharged after January 27, 2003.

DAV has no specific resolution but the provision appears beneficial, thus we would not oppose favorable consideration of this section.

Section 5 intends to relocate section 1710(a)(4), which this measure proposes to eliminate, and by adding a new subsection (c) in section 1707.

DAV has no resolution and would not object to its favorable consideration. However, we note the requirements of VA in providing required nursing home care under section 1710A is due to expire December 31, 2013. We also note enactment of this provision would require technical changes in other sections of title 38 referencing subsection 1710(a)(4).

Section 6 would insert a new section (1729B) in title 38 to establish the “Medicare VA reimbursement program” for the purposes of recovering from the Department of Health and Human Services those costs to VA from providing treatment for a nonservice-connected condition to a Medicare-eligible veteran.

DAV has no resolution on this section and takes no formal position. However, notwithstanding the “Sense of Congress” provision, which is not enforceable on Congress or the Administration, that reimbursements received by VA from HHS<sup>6</sup> “should not be” used to reduce VA discretionary appropriations, history shows that third-party reimbursements have indeed been used to offset VA medical care discretionary appropriations despite the original intent.

History has also shown that VA does not have a good record of meeting projected amounts to be collected from reimbursements and must then operate a health care system with less funds than needed to meet the demand for care and services.

### **Draft Bill, the Enhanced Dental Care for Veterans Act of 2013**

This measure would authorize VA to establish a three-year pilot program in at least 16 locations to assess the feasibility and advisability of furnishing dental care to veterans enrolled in the VA health care system who are not eligible under current authorities for VA dental care. In addition, this bill would extend for an additional two years the VA Dental Insurance Program (VADIP) for veterans and survivors and dependents of veterans mandated under Section 510 of Public Law 111-163.

The legislation also requires VA to establish a mechanism to add any dental care treatment information provided by private providers under VADIP in VA’s Computerized Patient Record System (CPRS). Until recently, the discretionary nature of receiving any treatment information from a non-VA provider and electronically associating it with a veteran treatment file in CPRS has traditionally not been successful particularly if there is no requirement that submission of such records to VA was a condition to receive payment from the Department or that it is required by VA policy to include such records in CPRS. While we are

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<sup>6</sup> § 1729B (c)(5) “Any payment made to the Department under this subsection shall be deposited in the Department of Veterans Affairs Medical Care Collections Fund under section 1729A of this title.”

supportive of the intent in Section 5, we believe there will be limited success without an incentive or disincentive for the transmission or receiving end of such information.

DAV is pleased to support this measure based on DAV Resolution No. 072, supporting legislation to amend title 38, United States Code, section 1712, to provide outpatient dental care to all enrolled veterans. However, DAV opposes subsection (g), the copayment provision under the VA provided dental care pilot program in accordance with our Resolution No. 194, calling for the elimination or reduction of VA health care out-of-pocket costs for service-connected disabled veterans.

### **Draft Bill: Mental Health Support for Veterans Families and Caregivers Act of 2013**

The Mental Health Support for Veterans Families and Caregivers Act of 2013 would require the Secretary of Veterans Affairs to conduct an education program and peer support program for family members and caregivers of veterans with mental health disorders. The goal of the measure is to educate and train the family members and caregivers in how to cope with mental health disorders in veterans and would take place over a four-year period, with the Secretary being authorized to extend the duration of the education program for an additional four years. Eligible veterans are those who are enrolled in the VA health care system.

The bill would mandate VA to establish the education program in at least 10 VA Medical Centers (VAMCs), Community-Based Outpatient Clinics (CBOCs), and Vet Centers. Additionally, the Secretary must consider the feasibility of selecting locations in rural areas, areas not in close proximity to an active duty location and areas in different geographic locations. Two years after the start of the program, the Secretary would be required to expand locations to at least 10 more VAMCs, 10 more CBOCs, and 10 more Vet Centers.

In order to facilitate the program, the Secretary is required to enter into contracts with nonprofit entities with experience in mental health education and outreach to include work with children, teenagers and young adults. These groups must use high quality, relevant and age-appropriate information in their educational materials and coursework. The nonprofit entities must work with agencies, departments, nonprofit mental health organizations, early childhood educators and mental health providers to develop the educational programming, materials and coursework. The Secretary would give priority entering into contracts with entities that also use Internet technology for delivery of course content in order to expand the availability of support services, especially in rural areas.

The education component of the program would consist of at least 10 weeks of general education on different mental health disorders with information on understanding experiences of persons suffering from the disorders; techniques for handling crisis situations and administering mental health first aid; techniques for managing stress affiliated with living with a person with a mental health disorder; information on additional services available for family members and caregivers through VA or community organizations as well as mental health providers.

The instructors of the education program must be proficient in the course of education and able to prove their level of proficiency to the Secretary. Two years after the program has



begun, those who have successfully completed the course of education as well as any additional training that may be required, may act as an instructor in the education course. The Secretary will select mental health care providers to monitor the instruction of the education program along with primary care providers. The mental health providers will monitor instructors by meeting with them quarterly, and at a minimum of twice a year will submit a report on the progress of the instruction provided in the education program to the Secretary.

The peer support program will be conducted at the same locations the Secretary chooses for the education program and will consist of group meetings at least twice each calendar quarter between a peer support coordinator, family members and caregivers of eligible veterans on matters related to coping with mental health disorders in veterans. The medical facility director of each participating facility shall select an individual who has completed a course of education and maintains proficiency to serve as a peer support coordinator. A mental health care provider selected by the Secretary would be required to mentor each peer support coordinator and will meet with them quarterly to monitor progress of the program, and at a minimum of twice a year will submit a report on the progress of the peer support program to the Secretary.

The measure would also require the Secretary to conduct a comprehensive and statistically significant survey of individuals who have participated in the education and peer support programs to include their level of satisfaction, perceived effectiveness and applicability of the programs. This information is to be included in a mandated annual report due no later than one year after the start of the education program, and no later than September 30 of every following year until 2017. In addition to the survey results, the report must include the number of participants in each program, analysis of the surveys, summary of feedback from the mentors and monitors, and the degree to which the veterans and family members and caregivers are aware of the eligibility requirements for enrollment in both programs. The report must also note any plans for expansion of the programs and interim findings and conclusions of the Secretary with respect to the success of the programs. The bill requires the mandated report to be submitted to the Committees on Veterans' Affairs of the Senate and House.

The final report would be due to the Committees on Veterans' Affairs of the Senate and House no later than one year after the completion of the education program regarding the feasibility and advisability of the education and peer support programs to include analysis of the surveys, viability of continuing the education program without entering into contracts and instead using peer support coordinators selected as instructors of the education course as well as comments on expanding both programs.

In accordance with DAV Resolution No. 166, DAV is pleased to support the Mental Health Support for Veterans Families and Caregivers Act of 2013. DAV Resolution 166 calls on the Secretary of Veterans Affairs to establish appropriate and effective programs to ensure that veterans who are enrolled in VA health care receive adequate care for their wounds and illnesses, including mental health-related illnesses, and, when appropriate, family members—whether family caregivers, spouses or other family dependents—receive necessary counseling, including psychological counseling, training and other mental health support services authorized by law to aid in the recovery of veterans.

VA treats a large patient population of veterans suffering from chronic effects of PTSD, depression and other serious mental illnesses. Many of these veterans suffer marriage and relationship breakdown, under-employment or loss of employment, financial hardship, social alienation and even homelessness. When a veteran experiences emotional distress and or mental decompensation, the consequences of that behavioral health event often fall directly on the veteran's family members and caregivers. Experts argue that support of family members and caregivers is often vital to a veteran's gaining and maintaining emotional stability and eventual recovery from mental illness.

Currently, title 38, United States Code, subsection 1712A(b)2 authorizes the VA Readjustment Counseling Service, through its Vet Center program, to provide psychological counseling and other necessary mental health services to family members of war veterans under care in such Vet Centers, irrespective of service connected disability status. Section 301 of Public Law 110-387 authorizes marriage and family counseling in VA facilities to address the needs of veterans' families, including spouses and other dependent family members of veterans who are experiencing mental health challenges with attendant marital or family difficulties. Public Law 111-163 authorizes a wide array of support, care and counseling services for personal caregivers of severely injured or ill veterans from all eras of military service.

Additionally, title 38, United States Code, section 1782 authorizes a program of counseling, training, and mental health services, including psychological support, for immediate family members of disabled veterans who need care for service-connected disabilities; who have service-connected disabilities rated at 50 percent or more disabling; who were discharged or retired from the armed forces for injuries or illnesses incurred in line of duty; who are World War I or Mexican Border Period veterans; who were awarded the Purple Heart; who are former prisoners of war; who were exposed to radiation or toxic substances; or, who are unable to defray the expenses of their care.

This measure would expand education, training and psychological support, for family members and caregivers of enrolled veterans with mental health disorders.

### **Draft Bill, the Medical Foster Home Act of 2013**

This bill would authorize the Secretary of Veterans Affairs to cover the costs associated with the care of veterans at medical foster homes.

VA inspects and approves Medical Foster Homes, which are private homes with a trained caregiver providing needed services to a few individual residents. A Medical Foster Home may be appropriate for veterans who would otherwise be placed in a nursing home because they lack the support network necessary to remain in their own home.

VA ensures the caregiver is both well trained to deliver VA's planned care for the veteran and is on duty 24 hours a day, 7 days a week. While living in a Medical Foster Home, veteran residents are enrolled in the VA Home Based Primary Care program and care is provided by an interdisciplinary team that offers a broad array of supportive services.

DAV is pleased with VA's innovation by offering medical foster homes as part of its long-term care program. While patient participation in this program is voluntary, it yields exceedingly high satisfaction among veteran residents. In addition, because of its low cost, many VA facilities perceive this program as a cost-effective alternative to nursing home placement and it is gaining popularity based on the expansion of this program over the last several years.

However, based on DAV Resolution No. 198, supporting legislation to expand the comprehensive program of long-term services and supports (LTSS) for service-connected disabled veterans, and as part of the IB, DAV is greatly concerned that veterans living in medical foster homes are required to use personal funds, include VA disability compensation, as payment.

Because this program operates under VA's community residential care authority, veterans in medical foster home programs have to pay for their care, which range from about \$50 to as much as \$150 a day. Even veterans who are otherwise entitled to nursing home care fully paid for by VA, whether it is under the law or by VA's policy must pay to reside in a Medical Foster Home. Moreover, service-connected veterans who do not have the resources to pay a medical foster home caregiver may not avail themselves of such an important benefit.

We thank the Chairman for introducing this measure, which would give VA the authority to pay for those costs service-connected veterans must currently pay out-of-pocket to reside in a VA approved medical foster home.

DAV is pleased to support the intent of this bill; however, because current statutory authority prohibits VA from meeting its mandatory obligations in providing long-term services and supports to service-connected disabled veterans, we believe the intent of this legislation should be codified.

#### **Draft Bill, the SCRA Enhancement and Improvement Act of 2013**

The SCRA Enhancement and Improvement Act of 2013 would amend the Servicemembers Civil Relief Act to extend the interest rate limitation on debt entered into during military service to debt incurred during military service to consolidate or refinance students loans incurred before military service.

DAV does not have a resolution on this issue and takes no official position, but would not oppose enactment of such legislation.

#### **Draft Bill, the Improved Compensation for Hearing Loss Act of 2013**

The Improved Compensation for Hearing Loss Act of 2013 would require the Secretary of Veterans Affairs to submit reports on the provision of services by the VA to veterans with hearing loss and other auditory system injuries and the measures that can be taken jointly by the VA and the DOD with respect to hearing loss and other auditory system injuries.

Specifically, if enacted, this proposed legislation would allow the Secretary one year from the date of such enactment to report to Congress on the actions taken to implement the directives in Public Law 107-330, the Veterans Benefits Act of 2002, with respect to a longitudinal study of hearing loss and tinnitus since World War II, and the implementation of findings and recommendations of the pursuant comprehensive 2006 report by the Institute of Medicine titled, “Noise and Military Service: Implications for Hearing Loss and Tinnitus.”

This measure requires the Secretary’s report to include an evaluation as to the number of veterans who had a military occupational specialty (MOS) not included in the Duty Military Occupational Specialty Noise Exposure Listing (MOS List) that are precluded from receiving hearing loss benefits from VA. This measure also requires the Secretary to report the number of veterans who had an MOS listed on the MOS List that were granted and denied benefits for hearing loss; and of those veterans with an MOS not listed on the MOS List, the number that were granted and denied entitlement to hearing loss benefits, as well as the number of those denied that were successfully granted on appeal.

While this proposed legislation is one of reporting requirement in nature, of particular interest to DAV is the requirement for the Secretary to provide an explanation of the rationale for the practice of not issuing a compensable rating for hearing loss that is severe enough to necessitate the use of hearing aids. This particular provision in the proposed legislation is directly in line with a long-standing DAV resolution, as well as in consensus with the other *Independent Budget* VSOs, as it has been recognized that certain veterans may suffer from hearing loss to the degree of requiring a prescribed hearing aid, but are not able to receive compensation.

In fact, the *VA Schedule for Rating Disabilities* (VASRD) contained in title 38, Code of Federal Regulations, part 4 does not provide a compensable rating for hearing loss at certain levels severe enough to require the use of hearing aids. The minimum disability rating for any hearing loss severe enough to require use of a hearing aid should be 10 percent, and the VASRD should be amended accordingly.

A disability severe enough to require use of a prosthetic device should be compensable. Beyond the functional impairment and the disadvantages of artificial hearing restoration, hearing aids negatively affect the wearer’s physical appearance, similar to scars or deformities that result in cosmetic defects. Also, it is a general principle of VA disability compensation that ratings are not offset by the function artificially restored by a prosthetic device.

For example, a veteran receives full compensation for amputation of a lower extremity although he or she may be able to ambulate with a prosthetic limb. Additionally, a review of title 38, Code of Federal Regulations, Part 4 [VASRD] shows that all disabilities for which treatment warrants an appliance, device, implant, or prosthetic, other than hearing loss with hearing aids, receive a compensable rating.

Assigning a compensable rating for medically prescribed hearing aids would be consistent with minimum ratings provided throughout the VASRD. Such a change would be equitable and fair.

While DAV appreciates the proposed legislation requiring the Secretary to provide an explanation, we believe this provision would merely allow VA the opportunity to prolong this inequitable issue. In accordance with DAV Resolution No. 111, DAV recommends this provision of the proposed legislation be changed from requiring the Secretary to provide an explanation to that of amending the VASRD to provide a minimum 10 percent disability rating for any service-related hearing loss medically requiring a hearing aid.

Although we do not have a resolution to support the other reporting requirements of this proposed legislation, DAV is not opposed enactment of those provisions, provided they do not overburden VA at a time where transformation of the claims process and reducing the backlog of pending disability claims is paramount.

### **Draft Bill the Survivors of Military Sexual Assault and Domestic Abuse Act of 2013**

The Survivors of Military Sexual Assault and Domestic Abuse Act of 2013 would expand subsection (a) of section 1720D of title 38, United States Code, and authorize the VA to provide counseling and treatment for sexual trauma to members of the Armed Forces including the National Guard and Reserves to aid in their overcoming psychological trauma. A referral will not be required before an individual receives counseling and care. Some technical aspects of the measure include amending the law to be gender neutral.

Section 3 of the bill would require the VA Secretary, no later than 540 days after enactment of the Act, to develop and implement a screening mechanism to be used when veterans seek health care services from VA to identify if the veteran has been a victim of domestic abuse. The purpose of this provision is to improve treatment of the veteran and assess prevalence of domestic abuse in the veteran population. Domestic abuse, in part, is defined as behavior that constitutes a pattern of physical or emotional abuse, economic control or interference with personal liberty, or a violation of federal or state law involving the attempted, threatened, or actual use of force or violence against the person, in addition to a violation of a protective order. In order to qualify as domestic abuse, the behavior is committed by a current or former spouse or domestic partner, or a person that shares a child with the individual, is a current or former intimate partner that shares or has shared a common residence or is a caregiver of the individual as defined in section 1720G(d) of title 38, United States Code, or in any other type of relationship with the individual that the Secretary may specify for this purpose.

Section 4 of the legislation would require the VA Secretary, within a year after enactment of the Act, to submit a report to the Committees on Veterans' Affairs of the Senate and House and detail the treatment and services available from VA for male veterans who experience military sexual trauma (MST) compared to the treatment and services available to women veterans who experience MST. The Secretary would also be required to include a report on domestic abuse among veterans that specifies the types, outcomes, and circumstances of domestic abuse incidents reported by veterans over the two-year period preceding the submission of the report as well as a summary of the treatments available from VA for sufferers of domestic abuse and whether an incident of MST experienced after the age of 18 may increase the risk for domestic abuse along with any other issues the Secretary deems appropriate.

Additionally, within a year after enactment of this Act and annually thereafter for five years, the VA-DOD Joint Executive Committee would be required to submit a report on MST and domestic abuse that details the processes and procedures utilized by VA and DOD to facilitate transition of treatment of those who have experienced either of one these to include treatment provided by both Departments. The report must also include a description and assessment of VA-DOD collaboration assisting veterans in filing claims for disabilities related to MST or domestic abuse, including permitting veterans access to information and evidence necessary to develop or support such claims.

The continued prevalence of sexual assault in the military is alarming and often results in lingering physical, emotional or chronic psychological symptoms in assault survivors. The DOD's Office of Sexual Assault Prevention and Response (SAPRO) reports that over 3,000 sexual assaults are reported each year across the military services and estimates that approximately 87 percent of all sexual assaults go unreported, therefore approximating more than 26,000 sexual assaults occur each year in the military services. Likewise, more than 20 percent of women and over one percent of men enrolled in the VA health care system report they had experienced military sexual trauma (MST). MST-related outpatient treatment encounters total nearly 800,000 clinic visits each year in the VA.

For these reasons, DAV is pleased to support the Survivors of Military Sexual Assault and Domestic Abuse Act of 2013. DAV Resolution No. 125, in part, urges VA to continually improve its MST treatment programs. DAV wants to ensure all MST survivors, male and female, gain open access to the specialized treatment programs and services they need to fully recover from sexual trauma that occurred in military service. We appreciate the intent of the bill to improve better collaboration between DOD and VA, specifically related to transition from military service to veteran status, as it is essential in achieving this goal. Due to the stigma and sensitive and personal nature of sexual assault, coupled with the unique and complex military hierarchy, rules and regulations that service members are subjected to, it appears it would be extremely beneficial for active duty service members, including National Guard and Reserve troops, to have access to MST counseling and care from VA. Although DAV does not have a specific resolution related to domestic abuse screening or required reports, we have no objection to those provisions in the bill.

DAV also suggests the Committee consider adding a provision in the bill related to MST care and beneficiary travel reimbursement. As a result of VA clinical determinations, some veterans are referred to VA medical facilities other than their local facilities or closest Veterans Integrated Service Network to receive the specialized MST care they need. The VA Office Inspector General (IG) conducted a healthcare inspection of inpatient and residential programs for female veterans with mental health conditions related to MST. The IG found that obtaining authorization for travel funding was frequently cited as a problem for patients and staff.

According to the IG, the VA's current policy in beneficiary travel indicates that only selected categories of veterans are eligible for travel benefits and payment is only authorized to the closest facility providing comparable service. The IG points out that this Directive is not aligned with the MST policy that states that patients with MST should be referred to programs

that are clinically indicated regardless of geographic location. If a VA clinician determines an MST survivor needs specialized care from a VA MST inpatient facility, VA's beneficiary travel policy may serve to obstruct access to that unique resource, or force an MST survivor to self-pay all travel costs in order to gain access to these specialized services. For these reasons, DAV supports legislation to change beneficiary travel policies to meet the specialized clinical needs of veterans receiving MST-related treatment in accordance with DAV Resolution 125.

**Draft Bill, to expand and facilitate compensation of veterans for illnesses associated with exposure to toxic substance during service on active duty in the Armed Forces**

This bill would amend title 38, United States Code, to expand and facilitate compensation of veterans for illnesses associated with exposure to toxic substance during service on active duty in the Armed Forces. Although DAV has two resolutions on providing health care and benefits for veterans exposed to toxic substances while on active duty, we have not had sufficient time to review this bill thoroughly. We ask the Committee to allow DAV to submit supplemental comments on this legislation for the record, after we have had time to fully analyze this draft legislation.

**Draft Bill, to provide a limited exception to the 24-month requirement in order for veterans enrolled in the VA health care system to be eligible for payments or reimbursement for non-VA emergency treatment**

This bill proposes a limited exception to the 24-month requirement in order for veterans enrolled in the VA health care system to be eligible for payment or reimbursement for non-VA emergency treatment under title 38, United States Code, section 1725.

DAV Resolution No. 212 supports legislation to amend title 38, United States Code, to eliminate the provision that requires enrolled veterans to have received care from VA within the 24-month period prior to date of the emergency care. DAV believes a health care benefit package is incomplete without a provision for emergency care. Accordingly, the 24-month requirement under § 1725 discriminates against otherwise healthy veterans who need not seek care at least once every 24 months, yet is required to make an otherwise unnecessary medical appointment in order to be eligible for payment or reimbursement for non-VA emergency treatment.

While DAV supports the concept of the legislation, which is to address the restrictive nature of the 24-month requirement included in §1725(b)(2)(B). We are concerned with the measures approach, which further fragments an already poorly constructed eligibility criterion, by providing relief to only "new veteran patients" with the "safety net" of non-VA emergency coverage.

Notably, "established patients" represent approximately 90 percent of VHA's total outpatient appointments. Currently, the VHA defined "established patients" as those who have received care from a qualifying provider in a specific clinic in the previous 2 years; "new patients" represent all others.

VA examines wait times for completed appointments with the ultimate goal of delivering high quality service at the time wanted and needed by each veteran. In 2014, VA will measure wait times for primary care, specialty care, and mental health appointments for new and established patients. In 2013, VA updated the methodologies to measure wait times for “new” and “established patient” appointments to improve reliability and consistency. Appointments for “new patients” will use the create date, defined as when the appointment was made and automatically captured by the scheduling system. Appointments for “established patients” will use the desired date, defined as the agreed upon date determined together by provider and patient. Desired date is measured prospectively to better represent patient satisfaction. Therefore, no targets are set in 2013 and 2014 so that baseline performance can be established.

We also note the ill-defined legislative text “a waiting period imposed by the Department” pertaining to wait times associated with a newly enrolled veteran’s initial appointment at a VA medical facility is especially problematic. In determining “a waiting period,” this Committee is aware of continuing reliability issues of VA reported outpatient medical appointment wait times and the need for improving appointment scheduling oversight.<sup>7</sup>

**Draft Bill, to require entities that receive per diem payments through VA, for the provision of services to homeless veterans, to submit an annual certification to the Secretary of Veterans Affairs proving that the building where the entity provides housing or services is in compliance with codes relevant to the operations and level of care provided**

This draft bill would amend title 38, United States Code, to require entities that receive per diem payments through VA, for the provision of services to homeless veterans, to submit an annual certification to the Secretary of Veterans Affairs proving that the building where the entity provides housing or services is in compliance with codes relevant to the operations and level of care provided.

The certification would include compliance with requirements outlined in the recently published version of the Life Safety Code or such other comparable fire and safety requirements as the Secretary may specify. Additionally, all licensing requirements regarding the condition of the structure and the operation of supportive housing or service center, including fire and safety requirements, must be provided.

DAV previously testified on a similar bill, H.R. 2065, introduced in the 113th Congress. While we did not have a National Resolution from our membership specifically covering the state of the housing provided to veterans or the safety of the facilities where homeless services are provided, we did not oppose favorable consideration of the legislation. However, we testified that H.R. 2065 may adversely impact Grant and Per Diem providers, which could leave many homeless veterans and their families without the services they need.

For entities that receive per diem payments during the year in which the legislation is enacted, the recipient must submit all certifications required to the Secretary no later than two

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<sup>7</sup> *Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement*, Government Accountability Office, December 21, 2012. Washington, DC



years after the date of enactment, or additional per diem payments will be halted until certification is received. Both the Senate and House versions contain similar language; leaving the question unanswered as to what would become of the homeless veterans in these programs where their facilities fail to produce the mandated documentation?

While DAV agrees with the intent of the measure to provide safe shelters for our homeless veterans, we urge the Senate to work with the House to mitigate any detrimental effects this bill may have while meeting the needs of homeless veterans in a safe environment. Both bills contain sound components. They can be modified slightly to produce a comprehensive piece of legislation that takes into consideration the potential impact on homeless veterans that are serviced by grant recipients that fail to meet the criteria set forth in the legislation.

#### **Draft Bill, to rename the Bay Pines VA Healthcare System**

This bill would redesignate the Department of Veterans Affairs Healthcare System located at 10000 Bay Pines Boulevard in Bay Pines, Florida, as the “C.W. Bill Young Department of Veterans Affairs Medical Center.”

This is a local issue. DAV does not have a national position on the matter.

#### **Draft Bill, the Servicemember Housing Protection Act of 2013**

This bill would amend the Servicemembers Civil Relief Act to enhance the protections accorded to service members and their spouses with respect to mortgages.

DAV does not have a resolution on this issue and takes no official position, but would not oppose enactment of such legislation.

#### **Draft Bill, the Support of Joint Federal Facilities Act of 2013**

This measure would provide VA the authority to enter into agreements with the Department of Health and Human Services (HHS) to share medical facilities with the goal of improving access to, and quality and cost effectiveness of, health care furnished by HHS. Funds transferred from the Department’s accounts for medical care, and major and minor construction would be used in conjunction with HHS funds.

DAV has no resolution on sharing medical facilities with HHS; however, National Resolution No. 188 calls on Congress to carefully monitor any intended changes in VA infrastructure that could jeopardize VA’s ability to meet veterans’ needs for primary and specialized VA medical care and rehabilitative services.

Although DOD and VA have shared resources at some level since the 1980s, shared facilities with DOD have raised DAV’s concerns over VA’s ability under such sharing to ensure its resources are used in a cost-effective manner for the care and rehabilitation of ill and injured

veterans. Through their reports, the Government Accountability Office appears to validate our concerns in sharing facilities and resources.<sup>8</sup>

Like the original authorization provided to VA and DOD for a five-year demonstration project to integrate VA and DOD medical care into a first-of-its-kind Federal Health Care Center in North Chicago, Illinois, we ask the Committee to first consider a demonstration project for this new authority. Moreover, we ask the Committee consider additional provisions on VA and HHS to develop performance measures to show the extent of progress for effective management and strategic planning, and to assess the effectiveness and efficiencies in the provision of care and operations.

Mr. Chairman, this concludes my testimony and I would be happy to answer any questions from you or members of the Subcommittee.

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<sup>8</sup> *VA Health Care: Additional Efforts to Better Assess Joint Ventures Needed*, GAO-08-399 (Washington, D.C.: Mar. 28, 2008); *VA and DOD Health Care: First Federal Health Care Center Established, but Implementation Concerns Need to Be Addressed*, GAO-11-570 (Washington, D.C.: July 19, 2011); *Electronic Health Records: DOD and VA Should Remove Barriers and Improve Efforts to Meet Their Common System Needs*, GAO-11-265 (Washington, D.C.: Feb. 2, 2011); *Costly Information Technology Delays Continue and Evaluation Plan Lacking*, GAO-12-669 (Washington, D.C.: June 26, 2012); *Department-Level Actions Needed to Assess Collaboration Performance, Address Barriers, and Identify Opportunities*, GAO 12-992 (Washington, D.C.: Sept. 28, 2012)