LEGISLATIVE HEARING ON H.R. 2818, H.R. 5554, H.R. 5595, H.R. 5622, H.R. 5729, AND H.R. 5730

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

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

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LEGISLATIVE HEARING ON H.R. 2818, H.R. 5554, H.R. 5595, H.R. 5622, H.R. 5729, AND H.R. 5730

TUESDAY, APRIL 15, 2008

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Hare, Berkley, Salazar, Miller, and Brown of South Carolina.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to thank everyone for coming this morning.

Today's hearing is an opportunity for Members of Congress, the Veterans Service Organizations (VSOs), and the U.S. Department of Veterans Affairs (VA), and other interested stakeholders and parties to provide their views and discuss recently introduced legislation within the purview of this Subcommittee.

The six bills before us today will cover a wide range of topics that are germane to veterans' healthcare issues. Issues addressed in today's hearing are bills that would address spina bifida, Epilepsy Research Centers, substance use disorder treatment and prevention, expansion of dental care, timely access to care, and a bill of rights.

I do not necessarily agree or disagree with all these bills, but I think it is a very important part of the legislative process to hear the legislation before us.

I want to thank our first panelists here today, and I would now like to ask Mr. Hare if he has any comments he wants to make.

[The prepared statement of Chairman Michaud appears on p. 32.]

Mr. HARE. No, Mr. Chairman.

Mr. MICHAUD. Thank you. We will start right off with the Honorable Chairman of the full Committee on Veterans' Affairs who has a long history of fighting for veterans issues.

Mr. Filner, I want to thank you for your leadership as it relates to Veterans' Affairs. And your tenacity in making sure that Congress does whatever we can do to help our veterans.

And you presented us today H.R. 5730. So without any further ado, Mr. Filner.

STATEMENTS OF HON. BOB FILNER, CHAIRMAN, COMMITTEE ON VETERANS' AFFAIRS, AND A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA; HON. ED PERLMUTTER, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO; HON. CHRISTOPHER P. CARNEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF PENNSYLVANIA; HON. BRAD ELLSWORTH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF INDIANA; AND HON. GINNY BROWN-WAITE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman and thank you for your leadership. We have passed, under your leadership as Chairman, a wide variety of bills on veterans' health care. And we will continue to do so. I think the veterans across the Nation will be better off because of the work of this Subcommittee.

As you said, I am speaking on H.R. 5730, the "Injured and Amputee Veterans Bill of Rights." As we see servicemembers returning from Iraq and Afghanistan with amputations and musculoskeletal injuries, many will require prosthetic and orthotic care and will be entering the VA healthcare system for that care.

In order to mitigate the impact of these potentially debilitating injuries, I believe the VA should establish a set of standards outlining the expectations and rights that returning veterans with musculoskeletal injuries have with respect to their prosthetic and orthotic needs.

H.R. 5730, which I introduced, requires that the Secretary of Veterans Affairs prominently display an "Injured and Amputee Bill of Rights" at every VA prosthetic and orthotic clinic.

This bill of rights outlines standards of care to ensure that injured and amputee veterans across the country have the same access to the highest quality of orthotics and prosthetics care in the most timely manner and using the most effective technology and treatments available.

For the most part, VA has provided quality orthotic and prosthetic care to injured veterans. But there are some areas where there are inconsistencies that require improvement.

Adoption of this bill of rights will establish a consistent set of standards that will form the basis of expectations of all veterans who have incurred an amputation or musculoskeletal injury requiring the prosthetic and orthotic care.

Our injured veterans deserve the assurance that they will receive the best care possible. And I believe this bill will provide a step in that direction.

Mr. Chairman, I thank you for taking up all these bills today. This bill was inspired by a wide variety of experiences. I have talked to both patients and healthcare professionals both with staff within and those outside the VA who provide the prosthetics that are necessary.

So I look forward to working with you to get this bill done.

Mr. MICHAUD. Thank you, Mr. Chairman, and I look forward to working with you as well as we move forward with this piece of legislation.

The next bill is H.R. 2818, the Epilepsy Centers for Excellence, by Mr. Perlmutter.

STATEMENT OF HON. ED PERLMUTTER

Mr. PERLMUTTER. Thank you Mr. Chairman, and Mr. Miller, and Mr. Hare. Good morning. I want to thank you for holding this hearing on H.R. 2818, the "Veterans' Epilepsy Treatment Act of 2008."

The VA Epilepsy Centers of Excellence Act, which I introduced on June 21, 2007, will create at least six VA Epilepsy Centers within the VA care system. A companion bill introduced by Senator Patty Murray passed the Senate VA Committee on December 12, 2007.

The Centers of Excellence will care for all veterans experiencing seizures and especially those we predict will develop epilepsy as a result of suffering a Traumatic Brain Injury (TBI) while serving in Operation Iraqi Freedom and Operation Enduring Freedom.

Epilepsy is defined as two or more seizures. During Vietnam, a number of men and women returned home with head wounds and head injuries. Of those who came home with these types of injuries, some 53 percent developed epilepsy within 15 years. And 15 percent of those who developed epilepsy did so 5 or more years after their combat injury.

Last year, I met with Dr. John Booss, the former Director of Neurology for the VA. He advised me that in 1972, the VA responded to the rise in veterans returning with seizures by creating VA Health Centers around the Nation that specialized in the treatment and research of epilepsy. The VA Centers partnered with medical schools to assist it in treating veterans with seizures and building a body of knowledge concerning epilepsy.

However, sometime in the 1980s or early 1990s, the increase in veterans developing epilepsy subsided, funding dissipated, and the centers were curtailed. At this time, the VA operates seven epilepsy monitoring sites. But these sites lack the resources and capacity to care for our current veterans with epilepsy.

Dr. Booss and a number of organizations such as the American Academy of Neurology, the Epilepsy Foundation of America, the Brain Injury Association, and the Citizens United for Research in Epilepsy have highlighted the need to rebuild the Epilepsy Centers of Excellence for the many men and women returning from the Middle East with head wounds and brain injuries.

Your Committee is only too aware of the injuries suffered by our servicemen and women in Iraq and Afghanistan. It is estimated that today some 89,000 veterans have epilepsy of which 42 percent of that number is service connected. If our country's experience in Vietnam is any indication of what to expect in the future, the number of veterans with epilepsy is surely bound to rise.

As an example, after I introduced this bill, I was contacted by one of my constituents, Naval Reserve Petty Officer Brian Johnson. He suffered a TBI while assigned to Navy Mobile Construction Battalion 7 just outside of Fallujah, Iraq.

And on November 7th, 2004, his position came under fire and he sustained a brain injury when he was blown against a wall when two mortars exploded nearby. After returning home, he resumed

his small plumbing business but eventually lost it due to the incidence of seizures.

Petty Officer Johnson's story is just one of many emerging from the experiences our servicemen and women are having after returning home.

H.R. 2818 establishes a process where VA Medical Centers partner with medical schools across the country to compete for the designation of a VA Epilepsy Center of Excellence. Six of these centers would be selected by the VA and would be disbursed across the country.

The VA's telemedicine capacity would also be expanded to track the neurological diagnostic tests of our rural veterans. And it is anticipated that each of these centers would cost about a million dollars for the first 4 years.

I want to thank the Disabled American Veterans, the Paralyzed Vets, the Blinded Veterans, and the Vietnam Veterans of America, and the other organizations I mentioned for their support of this bill.

I want to thank you for your time. And I look forward to answering any of your questions.

[The prepared statement of Congressman Perlmutter appears on p. 33.]

Mr. MICHAUD. Thank you very much, Mr. Perlmutter. The next piece of legislation is H.R. 5595, the "Make Our Veterans Smile Act of 2008," presented by Mr. Carney.

STATEMENT OF HON. CHRISTOPHER P. CARNEY

Mr. CARNEY. Good morning, Mr. Chairman, Mr. Michaud, and Ranking Member Miller, and our distinguished colleagues. I appreciate having this opportunity to discuss the bill I introduced with Congressman Mark Kirk, H.R. 5595, the "Make Our Veterans Smile Act of 2008."

The "Make our Veterans Smile Act" will expand dental care offered by the Department of Veterans Affairs to all service-connected disabled veterans. The VA has done an excellent job of providing dental services to those that are able to receive them and the VA should continue to provide these services.

However, the VA does not provide dental services to disabled veterans who are 90 percent or less disabled. The Make Our Veterans Smile Act will fix this problem by allowing all service-connected veterans to receive dental care through the VA. This will add another 2.4 million disabled veterans to the VA dental program.

I believe we have a moral obligation to care for these veterans. And I understand that the VA might have problems meeting the demand for dental services that will occur because of this legislation.

That is why this legislation allows service-connected disabled veterans to use contractor facilities for dental care. However, this legislation does not mandate contractor facilities be used. Instead it simply gives the VA greater authority to use these facilities.

The cost of this bill is a cost of the war. It is an investment in our way of life and our future. As every Member of this Subcommittee knows, to ensure a ready fighting force for tomorrow, we need to take care of our veterans today.

I would also like to point out that conditions such as missing teeth and cavities can be barriers in seeking employment. And I believe every effort must be made to ensure that there is a smooth transition for our military members who are entering the civilian workforce.

We must also ensure that disabled veterans from past wars are also given every tool to keep meaningful jobs and this includes dental care.

I would like to point out that numerous studies have shown that there is a clear correlation between dental health and someone's overall health.

I would like to thank the Enlisted Association of the National Guard of the United States, the Navy Reserve Association, the Air Force Association, the Military Order of the Purple Heart, and AMVETS for support of this bill.

I would also like to thank you again, Chairman Michaud, and Ranking Member Miller, and our distinguished colleagues, for holding this hearing and for allowing me to testify. I would be happy to answer any questions you might have.

[The prepared statement of Congressman Carney appears on p. 34.]

Mr. MICHAUD. Thank you very much, Mr. Carney. The next bill is H.R. 5729, the "Spina Bifida Health Care Program Expansion Act," presented by Mr. Ellsworth.

STATEMENT OF HON. BRAD ELLSWORTH

Mr. ELLSWORTH. Thank you, Chairman Michaud, Ranking Member Miller, and Members of this Subcommittee. I would like to thank you all for inviting me to testify in support of my bill, H.R. 5729, the "Spina Bifida Health Care Program Expansion Act."

Last year I testified in front of the Veterans' Affairs Subcommittee on Disability Assistance and Memorial Affairs on behalf of my constituents, Honey Sue Newby and the Nesler family of New Harmony, Indiana. I shared the heart-wrenching story of Honey Sue. This is a woman who lives with a complicated neurological disorder rooted in spina bifida and her parents Susan and Ron Nesler. They provide around-the-clock, 24-hour attendance and care.

Honey Sue's biological father served 8 years in the Marine Corps and completed three combat tours in Vietnam. The VA concedes and testifies that Honey Sue's condition is the direct result of her biological father's exposure to Agent Orange, a defoliant and herbicide used to protect our armed forces in Vietnam.

I introduced H.R. 5729 in an attempt to clear this seemingly insurmountable bureaucratic hurdles that continue to frustrate the Neslers. Each time the Neslers seek medical care for Honey Sue, they must provide a letter from a doctor from the VA stating that her condition is directly related to spina bifida. That is a given. It has been testified to and it is proven.

The Neslers must repeat this routine despite the fact that Honey Sue is recognized as a Level III child. And as you know, Level III children are eligible for the same full healthcare coverage as a military veteran with 100 percent service-connected disability.

It is my hope that H.R. 5729 will provide people facing the same challenges as Suzanne and Ron immediate relief from the paperwork and give them the piece of mind that their children will have unconditional access to attendant care when they are no longer capable of providing it themselves.

With the passage of this bill, Honey Sue and the estimated 1,200 children—I would like to emphasize, this is only 1,200 children with Levels I, II, and III spina bifida as caused by parents exposure to Agent Orange that we dropped on that country and dropped on our veterans. They will receive the same full healthcare coverage as the 100 percent service-connected military veterans.

I look forward to working closely with Dr. Gerald Cross at the Veterans Health Administration (VHA) and House VA Committee to ensure this legislation provides the Neslers and other families caring for children suffering from spina bifida with the much needed and long overdue relief from the tremendous bureaucratic hurdles that they currently face. I would also like to take just a moment to thank Cathy Wimblemo and Mark Heyman with the Subcommittee staff for being so helpful in this process.

I look forward to hearing the expert testimony from the witnesses on panel two and from Dr. Gerald Cross on panel three. Thank you and I yield back.

Mr. MICHAUD. Thank you very much, Mr. Ellsworth. The next piece of legislation is H.R. 5622, the "Veterans Timely Access to Health Care Act."

STATEMENT OF HON. GINNY BROWN-WAITE

Ms. BROWN-WAITE. Thank you, Mr. Chairman and Ranking Member Miller, for the opportunity to testify before this Subcommittee today.

I am pleased to have the opportunity to discuss this bill known as the "Veterans Timely Access to Health Care Act." This bill makes a responsible and reasonable commitment to veterans throughout the country by ensuring that veterans receive the care that they deserve.

Under H.R. 5622, if a veteran cannot get an appointment with a primary care physician within 30 days of a request, the veteran may see a private physician at no additional cost.

This bill contains provisions similar to those found in other bills that I have introduced in the past. However, this bill is unique in several ways. First, H.R. 5622 would create just a pilot program. It wouldn't go nationwide. It would be a pilot program that encompasses the Veteran Integrated Services Network (VISN) 8, which includes most of south Georgia, Florida, Puerto Rico, and the U.S. Virgin Islands.

The pilot program would give veterans receiving healthcare in VISN 8 the opportunity to seek healthcare from a primary care provider outside the VA if they have to wait more than 30 days for an appointment through the VA.

Mr. Chairman, it is more than reasonable for a veteran to expect to be seen by a primary care physician within 30 days. If the VA cannot provide this basic service to our veterans, then our veterans should have the option to look elsewhere.

My bill—and I would like to emphasize this does not force any veteran out of the VA healthcare system. It simply provides them another option to go outside the VA if they desire.

Should a veteran seek to see a physician outside the system, it is imperative that the VA be able to keep track of that veteran's medical records to ensure continuity of care. Therefore, this bill directs the Secretary to provide a form to veterans that would authorize the VA to obtain the records from these out-of-network visits. This provision is critical as the goal of H.R. 5622 is to ensure veterans not only receive access to timely healthcare, but to quality healthcare as well. This makes sure that there is a continuity of care and information sharing.

Mr. Chairman, as a Member of Congress from VISN 8, I would like to make this option available to the veterans in and around VISN 8 and certainly to expand it nationwide. There is no reason why any veteran should have to wait more than 30 days to receive basic care.

Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much, Ms. Brown-Waite. We have one more bill, which is actually my bill. So we will not hold up the rest. The panel will start taking questions. The first bill, H.R. 2818, Mr. Perlmutter's bill on Epilepsy Centers of Excellence. I will open it up for any questions or comments. Mr. Miller.

Mr. MILLER. The one thing on H.R. 2818, the "Veterans' Epilepsy Treatment Act of 2008," I think that I was—and I apologize, I was looking at another bill. I am trying to get my things together.

Last year in H.R. 2199, the "Traumatic Brain Injury Health Enhancement and Long-Term Support Act of 2007," we talked about establishing five TBI centers. We did address the epilepsy issue, albeit not to the extent that you have, and said that one of those five centers needed to focus on the issue, the epilepsy issue.

Do you think if we just expanded what is currently in place with those TBI centers to go from one to all five, that would assist in what you are trying to accomplish?

Mr. PERLMUTTER. I think—yes. I think the goal is to have geographically dispersed centers of excellence to study epilepsy, because when you start having seizures, it is different in many ways. And I should state, as full disclosure, I have a daughter with epilepsy. And so one of the things that clearly happens here is when the VA brings its force to bear and its knowledge is developed, it is—you know, that—there is a great spillover effect to society as a whole from the research that they develop.

But the goal here is to provide the men and women that are coming back, and then develop seizures, and develop epilepsy with the best lives possible and with the best treatments possible. And, you know, cures where, you know, the research centers and the VA hospitals can develop them.

And so under the bill, we couple a medical school with a VA hospital. They have to compete for it. If the TBI centers wish to do that, that is fine with me. The goal is to be able to provide the best service possible to the people having seizures that they—and we know that coming back from Iraq and Afghanistan, our servicemen and women who have had these head injuries are going to—some of them are going to start developing epilepsy.

Mr. MILLER. Thank you very much. Ms. Brown-Waite, my colleague from Florida, could you talk a little bit about the rationale requiring veterans to provide a written notification of his or her choice to receive care at a VA facility if available following care at a non-VA facility?

Ms. BROWN-WAITE. Well, certainly you want to have continuity of care. And if their preference and if their records—they want their records because of financial reasons or any other reasons, that they would want to have the non-VA information shared with the VA. I know that many of our veterans—and one year I had the highest number and one year you had the highest number of any Member of Congress. I know that they like having the services and the economy of going to the local Community-Based Outpatient Clinic (CBOC) and/or the local hospital.

But if they can't get that appointment within 30 days, it is almost like justice delayed is justice denied. Healthcare delayed is healthcare denied.

Mr. MILLER. Thank you very much for bringing this forward. I have no further questions, Mr. Chairman.

Mr. MICHAUD. Mr. Hare, any questions?

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Not really, Mr. Chairman. Just a couple of comments. Let me just say to all of you, first of all, thank you for being here. Each of these bills—it seems to me, you know, we sit on this Committee and we have talked a lot. We really have a moral obligation. I think that was mentioned by you Mr. Carney in terms of what we need to be doing here to assist our veterans.

And I was struck, Mr. Ellsworth, when you were talking about Agent Orange and the defoliant. My predecessor spent 8 years trying to get the VA to admit that Agent Orange caused more than severe acne in our veterans. And now we find out, because of, you know, spina bifida.

So I would just to all of you every—each one of these pieces of legislation is critical to our veterans. And the question isn't how can we afford to do this? The question is how can we afford not to do this?

Whether it is—as you said, Ms. Brown-Waite, on a trial basis and hopefully to expand this nationwide, because at the end of the day what I have—what I have said all the time since I have been on this Committee, and as you know I am new here, but if we make a promise to our veterans that we are going to take care of them and their families, we have to keep the promise or we have no business making that promise.

And, you know, with all due respect to the VA who I know might have some problems with some of these pieces of legislation, you know, lets fix the problem but lets enact the legislation. So at the end of the day those families, those veterans, the people that need help, have an opportunity.

And I just want to let you know that from my end, you have a very easy lobby, a lobby on me here today. If I am not on these bills, I will tell you I will be on them by the end of the day. But I commend you for standing up for our veterans. I appreciate the time and the effort that you have, you know, put into this. And

anything that I can do to help you and, you know, I stand ready to do it.

So, Mr. Chairman, I don't have any questions. I just really want to compliment all of you for standing up for the men and women and their families. Mr. Ellsworth, particularly with these kids with spina bifida who are so profoundly impacted.

And one last thing. You know, Mr. Carney, yours is on dental. And I will tell you, sometimes I think that is the last thing people really think about. And I have to tell you, I think that is one of the first things we should be looking at too. It is just as important in healthcare for our veterans as anything we can talk about. So I really appreciate your being here.

And with that, Mr. Chairman, I would yield back.

Mr. MICHAUD. Thank you very much, Mr. Hare. Ms. Berkley.

OPENING STATEMENT OF HON. SHELLEY BERKLEY

Ms. BERKLEY. Thank you, Mr. Chairman. And thank all of my colleagues for being here. I embrace everything that my colleague just said.

But for me, the cost of taking care of our veterans is the cost of going to war. And if you are not prepared to take care of our veterans when they come home from serving and sacrificing for their fellow citizens and our Nation, then you ought not send them in the first place.

But I am also agonizing over how we intend to pay for this. And you know there is a movement to make the President's tax cuts permanent. I think as a Nation and as a Congress we are going to have to figure out what our priorities are and fund them appropriately.

And as far as the VA is concerned, and as you know I work very closely with the VA given the number of veterans in my district that you hear about quite often, but if we are going to continue to pile more responsibility on the VA and all of these pieces of legislation are very laudatory and important, but we better provide the VA with the necessary amount of money that they are going to need to carry out our will. And so far I haven't seen that happening.

As we all know for those of us who are veterans of this Committee, you know the last 7 years we just saw a very inattentive VA with an Administration that always underfunded the VA. We are playing catch-up now. But the needs are so dramatic, from everything from Post Traumatic Stress Disorder (PTSD) to making sure that our veterans get the care that they need in a timely manner, that I just think unless we have a national recognition that this is a major priority to take care of our veterans, and adequately fund them, and adequately fund the VA, and give them the necessary personnel to carry out the tasks that we are giving them, then we better just forget the whole thing.

And I think that is an important—that is important to me. And I thank you for listening to my soapbox.

Oh, and, Mr. Carney, may I call on you?

Mr. CARNEY. Yes.

Ms. BERKLEY. May I ask the Chair to call on him?

Mr. CARNEY. Well, however you guys do it here. That is fine. I just wanted to comment that I am a veteran myself. And if we don't live up to the promises that we make to our veterans, no one is going to enlist anymore. We are an all-volunteer force. And if we ignore the problems that are created by the service that young men and women provide to our country, we will not be able to have an all-volunteer force anymore. We will have to institute a draft again. And our sons and our daughters will feel that pain. And we don't want that.

Ms. BERKLEY. Mr. Carney, we are spending $4,000 a second. Let me be precise, $3,919 a second in Iraq. And if we are going to spend that kind of money, we better make sure that we spend a requisite amount of money when these veterans come home.

And when I hear the President and Administration officials talking about supporting the troops, the best way to support our troops is to support the veterans when they come home.

Mr. CARNEY. Well, Ms. Berkley, I agree 100 percent with that. You know, if we could just somehow figure out a way to siphon off even 20 or 25 percent of the graft and corruption going on in Iraq, we could fund all these programs and many, many more.

Ms. BERKLEY. And let me mention something else that we are working on. And let me give an effort to give full disclosure. My husband is a nephrologist. And they have a very, very busy practice. It is a kidney doctor. They have a very, very busy practice in Las Vegas. They also contract with the VA. They have not been paid in over a year. And talk about people not enlisting and volunteering to serve this Nation. If these doctors don't get paid, I mean I am not talking in a timely manner. I am talking about not getting paid. You are not going to get any doctors treating these veterans when they get home, especially those that are contracting with the VA.

So we have a ton of problems in the VA right now. And we are going to have to work through those. And, again, give the VA the necessary resources in order to provide the services that our veterans demand and we are obligated to provide.

Mr. CARNEY. I couldn't agree more.

Mr. MICHAUD. Ms. Berkley, if you didn't talk about Nevada and the VA system, I would think something was wrong.

Ms. BERKLEY. I would never disappoint you, Mr. Chairman.

Mr. MICHAUD. Thank you. Mr. Salazar.

Mr. SALAZAR. Thank you, Mr. Chairman. And I would like to take this opportunity to give a special welcome to my friend and colleague from Colorado, Mr. Perlmutter, who has been a champion on veterans' issues.

People on this Committee and people who work on veterans' issues don't do it because it is a glamorous job. They do it because they care. I just want to commend each and every one of you for the incredible work that you have done on veterans' issues.

I agree with everything that my colleagues have said this morning. Ms. Brown-Waite, I do not oppose your bill, I am very supportive of what you want to do.

Have you taken into account or do you have a cost estimate as to what your bill would do should we adopt it nationwide? The reason I am asking is not because I oppose it. I am very supportive.

We just need to start getting prepared for budget requests, in the future.

Ms. BROWN-WAITE. The bill was never heard before the full—even a Subcommittee before to take it nationwide. That is why I decided to truncate it. We did not—all we were told was it was too expensive. It would be too costly.

And, again, I want to reiterate, this doesn't—this gives the veteran the opportunity. It doesn't mandate that he has to go to a healthcare provider outside of the VA system. It is an option that I think we should be giving to our veterans.

But the answer is no. I do not—I never did—we never did get a full Congressional Budget Office scoring on taking it nationwide.

Mr. SALAZAR. I think what you have is a very important bill. In Craig, Colorado, with Secretary Nicholson before he left, we were able to establish a CBOC, which had been in place. Scott McInnis, my predecessor, had been working on it for 12 years.

An area where veterans had to drive 5 to 6 hours in order to get to a primary healthcare physician within the VA center. Mountainous areas can be very dangerous especially for veterans who are older. It was very difficult for them to get there and still in very remote and rural areas. Many of you know it is very difficult to get to a primary healthcare physician.

I had a friend in Colorado who was suffering from chest pains. He was a veteran who actually served at the same time I did. We couldn't get him an appointment at the VA health center in Colorado for almost 6 months. And we were able to get him an appointment to go to the VA hospital in Albuquerque. Two days after they saw him in Albuquerque, they gave him a quintuple bypass on his heart. That shows how critical this is.

There is a long waiting list of people waiting to get healthcare.

So I applaud each and every one of you, and thank you very much for being here today.

Mr. MICHAUD. Thank you, Mr. Salazar.

One question I have actually is for Mr. Carney dealing with dental care. As you probably noticed, the VA estimate that the cost for your bill is $817 million for fiscal year 2008 alone and almost $11.3 billion over the next 10 years, which is pretty costly.

Is your interest primarily in making sure that they get dental care? And if so, would you be amenable to working with the Armed Services Committee in opening up dental care? A good example is the Army National Guard. Even though they might have a dentist in the facility—in their State, all that they can do is look into your mouth and say you have a problem. They can't take care of it.

Would you be amenable in trying to change the rules and regulations so that maybe the U.S. Department of Defense (DoD) or Army National Guard might be able to take care of some of the dental care?

The other area you mentioned is contracting out. I know in Maine for instance, that some dentists they make their own right there on site. Other dentists actually contract out with a denturist. However, when they bill for the dentures, it is six-seven times higher than what they actually paid for it.

Would you be amenable to looking at having more denturists within the VA system and making them in-house versus contracting that out?

Mr. CARNEY. Of course. Anything that would help the dental health of our veterans I would support. And, of course, we are very sensitive to the costs of these things. The $11 billion number was much higher than the one that we had.

But whatever we can do to assure that we are taking care of our veterans and covering this 90 percent of the population of service disabled that don't have the dental coverage I think we should explore.

It is not about us. It is not about any particular bill. It is about doing the right thing by our veterans. And of course I will be able to do that.

Mr. MICHAUD. Okay. Thank you. Once again I would like to thank our four panelists for your testimony this morning. I look forward to working with you as we look at each one of these individual pieces of legislation. Thank you very much for coming here this morning. Thank you. We have one more piece of legislation this morning, which I am presenting. So I will turn the gavel over to Mr. Miller.

Mr. MILLER. Thank you, Mr. Michaud. Also, I would like to ask unanimous consent that my opening statement be placed into the record.

[The prepared statement of Congressman Miller appears on p. 32.]

Mr. MICHAUD. Without objection.

Mr. MILLER [presiding]. Thank you. I also might add there was a comment by a colleague earlier in regards to tax cuts and spending, and certainly we all understand we need to be prudent with our expenditures.

If we have $50 billion that this Congress can pass for AIDS in Africa, certainly we have the ability to spend the necessary dollars, and we all agree on veterans. The money is there. It is how this Congress decides to allocate that money.

Mr. Michaud, you are recognized.

STATEMENT OF HON. MICHAEL H. MICHAUD, CHAIRMAN, SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS, AND A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MAINE

Mr. MICHAUD. Thank you very much. I present H.R. 5554.

Nearly 300,000 veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) have been seen by the VA healthcare system. And over 40 percent of these individuals were diagnosed with mental health conditions.

Separating from military service can be a very difficult transition. Mental and physical wounds make it even more difficult for veterans to adjust.

According to the VA Office of Public Health and Environmental Hazard, 48,661 OEF and OIF veterans have met criteria for substance use disorder. This number only reflects—the veterans who have been seen by the VHA, which means that the total number of veterans with substance use disorder is likely higher than that

number. Also when you look at the lower income veterans they too have a higher prevalence of substance use disorder.

To address this issue, Ranking Member Miller and I introduced the Veterans Substance Use Disorder Prevention and Treatment Act of 2008.

Our legislation will require the VA to provide the full continuum of care for substance use disorder, and it will require this full spectrum of care to be available at every VA medical center.

Our legislation will also direct the VA to conduct a pilot program for internet-based substance use disorder treatment for OEF and OIF veterans. This will enable our newest generation of veterans to overcome the stigma associated with seeking treatment and receiving the necessary care—in a comfortable and secure setting.

We heard from individuals in the past that Internet-based substance abuse disorder treatment can be very beneficial and helpful. So I think that is definitely an option.

This bill is not a finished product. I appreciate the comments from the witnesses today.

Substance abuse can tear apart a family and individual lives. We have heard it over and over again from veterans, from their spouses, what effect it has on the family. I think it is very important that this Committee do whatever we can to provide service in this particular area.

With that, Mr. Miller, I will yield back the balance of my time and answer any questions that anyone might have.

[The prepared statement of Congressman Michaud appears on p. 35.]

Mr. MILLER. Ms. Berkley. Mr. Hare, excuse me. No, Ms. Berkley.

Ms. BERKLEY. Thank you very much. And I think this is an important piece of legislation. It dovetails nicely with my legislation.

And if I can refresh your memory, I had a constituent by the name of Justin Bailey who developed a substance abuse problem when he came back from Iraq. And his parents insisted that he check himself into a VA facility. It was very poorly run, very poorly administered, and even though Mr. Bailey was already taking five—was hooked on five medications, the VA treated him with yet another medication. And he OD'd in the facility. And he died under the care of the VA.

So we definitely need to get in front of this crisis, because it is nothing less than a crisis. But I would like to have more information about the Internet component. I mean, if you are somebody like Justin Bailey, going on the internet and getting information isn't going to do squat for you.

And I don't—I mean, given the fact that our resources are limited, how does that—if you can explain this to me I would appreciate it, because I think this is far more serious than going on the Internet and getting some practical advice on how to get yourself off of—wean yourself off of drugs.

Mr. MICHAUD. No. That is a very good question. It is something that I was kind of skeptical about at first, but having talked to those in the healthcare provider area, that is actually one area that has been very beneficial.

That is why I am recommending that they do a pilot project dealing with the internet-based substance use disorder treatment to see how it actually works.

That is not the primary focus of this legislation. It is only one component. The area we have heard about over and over again from our veterans is, the stigma that is attached to substance abuse and drug abuse. No matter what it is, there is a stigma attached to it. Quite frankly, some people actually feel more comfortable dealing with the Internet.

If you look at our troops today, they are very Internet savvy. This is one option. It is not the primary focus of this legislation. But I think it is very important that we provide whatever effective tools that we can for our servicemen and women.

That is why I thought it was important to set up a pilot project to actually see how it works.

Ms. BERKLEY. And thank you for that. And, again, my only admonishment is if we are going—I think this is very important. But we better make sure the VA has the tools, and they have personnel trained, and enough personnel trained to take—to address these issues.

When some kid like Justin Bailey checks himself into a VA facility, there should be an expectation by his or her family that someone there is going to know what they are doing and not—you know, like maybe read his medical records before they give him yet another medication.

And I am not sure that exists right now. So we better make sure that the medical personnel that we are paying, actually know what they are doing and can treat these kids that we are sending to the VA or we are—I mean, we are creating, not creating, we are no better than, you know, doing malpractice on these people. If we are telling them this is an opportunity and a treatment that is available to you, we better make sure it is available with expertise and knowledge, because I feel that we would be contributing to the death and mental instability of these kids if we are sending them there with the expectation that they are going to get treatment and they are not.

Mr. MICHAUD. Thank you.

Mr. MILLER. Any further questions? Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you.

Mr. MILLER. I yield back the gavel also.

Mr. MICHAUD [presiding]. Thank you. I would like to call up the second panel.

The second panel will include Joseph Wilson who is the Deputy Director of Veterans Affairs and Rehabilitation Commission of the American Legion; Joy Ilem, Disabled American Veterans (DAV); Christopher Needham who is with the Veterans of Foreign Wars (VFW) of the United States and Richard F. Weidman who is—it is Bernie Edelman from the Vietnam Veterans of America (VVA).

So I want to thank this panel for coming today. I look forward to your testimony. And I would now recognize Mr. Wilson for your testimony.

STATEMENTS OF JOSEPH L. WILSON, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; CHRISTOPHER NEEDHAM, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICES, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND BERNARD EDELMAN, DEPUTY DIRECTOR FOR POLICY AND GOVERNMENT AFFAIRS, VIETNAM VETERANS OF AMERICA

STATEMENT OF JOSEPH L. WILSON

Mr. WILSON. Thank you, Mr. Chairman. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present the American Legion's views on these pieces of legislation.

We will begin with H.R. 2818. This bill seeks to amend title 38 to provide for the establishment of Epilepsy Centers of Excellence within the VHA of the Department of Veterans Affairs.

According to VA research, approximately 53 percent of veterans who suffered a penetrating traumatic brain injury or TBI in Vietnam developed epilepsy within 15 years. The VA, in its effort to treat this condition, became the leader in epilepsy research. However, due to lack of funding, research resources eventually diminished.

According to the American Academy of Neurology or AAN, returning veterans with TBI injuries will eventually develop post traumatic epilepsy. Currently there is an increasing need for the presence of epilepsy centers throughout the Nation. This is due to the high count of Operation Iraqi Freedom/Operation Enduring Freedom or OIF/OEF troops returning with TBI.

The American Legion supports the efforts of H.R. 2818, which proposes to establish Centers of Excellence within the Department of Veterans Affairs for the various injuries related to blast trauma.

This would also ensure the best quality of care and treatment is accessible to current and future veterans suffering from the effects of blast injuries, to include epilepsy.

Next are H.R. 5554. This bill seeks to amend title 38 to expand and improve healthcare services available to veterans from the Department of Veterans Affairs for substance abuse disorders and for other purposes.

This bill also proposes that the medical center provides ready access to a full continuum of care for substance use disorders for veterans in need of such care.

The American Legion has no official position on this issue. However, when substance abuse disorders are secondary to service-connected conditions, it is our position that veterans should have full access to the quality and adequate healthcare in which they are entitled.

H.R. 5595, this bill seeks to amend title 38 to direct the Secretary of Veterans Affairs to provide dental care to veterans with service-connected disabilities and for other purposes.

The American Legion has no official position on this issue.

H.R. 5730, this bill seeks to direct the Secretary of Veterans Affairs to display in each prosthetic and orthotic clinic of the Depart-

ment of Veterans Affairs an Injured and Amputee Veterans Bill of Rights.

The American Legion has no official position on this issue.

H.R. 5729 seeks to direct the Secretary of Veterans Affairs to provide comprehensive healthcare to children of Vietnam veterans born with spina bifida.

The American Legion endorses the expansion of the spina bifida program provided by H.R. 5729. It will ensure that the child of any veteran who suffers from this crippling birth defect resulting from their parent's exposure to Agent Orange during military service receives complete medical care.

H.R. 5622 seeks to direct the Secretary of Veterans Affairs to carry out a pilot program to establish standards of access to care for veterans seeking healthcare from certain Department of Veterans Affairs facilities.

The American Legion agrees with H.R. 5622. However, in the event VA is unable to schedule the veteran for an appointment within 30 days and VA contracts with non-VA facilities, it must be ensured these facilities are in par with VA standards.

Mr. Chairman and Members of the Committee, the American Legion sincerely appreciates the opportunity to submit testimony on these pieces of legislation. Thank you.

[The prepared statement of Mr. Wilson appears on p. 36.]

Mr. MICHAUD. Thank you. Ms. Ilem.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Mr. Chairman and Members of the Subcommittee.

We appreciate the opportunity to present the views of the Disabled American Veterans on the healthcare measures before this Subcommittee today, which cover a range of issues important to DAV, veterans and their families.

The first measure under consideration, H.R. 2818, would require the VA Secretary to designate not less than six healthcare facilities as centers of excellence in research, education, and clinical care in the diagnosis and treatment of epilepsy to ensure improved access to state-of-the art treatment throughout the VA healthcare system.

While DAV has no adopted resolution from our membership on this matter, we have been concerned about literature emerging to suggest the incidence of co-morbid epilepsy in veterans with traumatic brain injury.

Therefore, we believe this legislation addresses a real need and DAV would have no objection to its passage.

H.R. 5554, the "Substance Use Disorders Prevention and Treatment Act of 2008," would mandate that VA provide system-wide access to a full continuum of care for substance use disorders with a special emphasis on outreach to veterans who served in Operations Enduring and Iraqi Freedom.

This measure would require an annual report on the availability of the substance use disorder treatment throughout the system, the number of veterans receiving such care, the barriers to accessing these services, and the quality of care provided.

Finally, the bill would require a pilot program specifically designated to offer web-based—designed to offer web-based options for

self-assessment, education, and specified treatment of substance use disorders.

DAV has a growing concern about the reported effects of combat deployments in Iraq and Afghanistan on our newest generation of war veterans and the converging evidence that substance abuse is a significant problem for many of these veterans.

For these reasons, DAV fully supports this comprehensive measure aimed at substance use disorder prevention, early intervention, outreach, education and training for veterans and their families to close the current gaps in VA's existing efforts.

H.R. 5595, the "Make Our Veterans Smile Act of 2008," would extend eligibility for outpatient dental services and treatment to all veterans with service-connected disabilities.

DAV recognizes that the oral health is integral to the general health and well being of a patient and is part of comprehensive healthcare. Consequently, DAV supports the passage of this bill.

H.R. 5622, the "Veterans Timely Access to Health Care Act," would establish a 5-year pilot program in VISN 8 to ensure a 30-day standard of access to primary care for enrolled veterans.

In the case where VA is unable to meet the 30-day access standard, the bill would require VA to contract for private healthcare.

DAV supports contract care options when needed services are unavailable in VA facilities and in other circumstances authorized by law.

However, we believe contract care should be used judiciously and that VA needs to better coordinate the contracted care it currently authorizes to ensure high quality, safety, and cost effectiveness.

While we appreciate the sponsor's intentions to improve access to care and acknowledge that enactment of this bill would be helpful for some veterans, it potentially could damage the VA system by eroding funding needed to sustain VA's viability to continue providing specialized services to service-disabled veterans.

For these reasons, we are unable to support this measure.

H.R. 5729, the "Spina Bifida Health Care Program Expansion Act," would amend the existing authority to provide a more comprehensive range of healthcare services for Vietnam veterans' children afflicted with spina bifida, including access to domiciliary care.

DAV believes the goals of the bill are in the best interest of the children involved. Therefore, we have no objection to enactment of this measure.

H.R. 5730 would require VA to establish and prominently display in each VA healthcare prosthetic and orthotic clinic a bill of rights for veterans who are injured or have amputations.

The bill of rights would include the right to timely, high-quality prosthetic and orthotic care, qualified parishioners, and continuity of these services throughout the VA healthcare system.

We believe this measure is consistent with providing comprehensive, high-quality, patient-centered healthcare services for our Nation's sick and disabled veterans, especially those with specialized needs. Thus, we would have no objection to its enactment.

Mr. Chairman, that concludes my testimony. And I would be pleased to answer any questions from you or other Members of the Subcommittee. Thank you.

[The prepared statement of Ms. Ilem appears on p. 37.]

Mr. MICHAUD. Thank you. Mr. Needham.

STATEMENT OF CHRISTOPHER NEEDHAM

Mr. NEEDHAM. Chairman Michaud, Ranking Member Miller, and Members of this Subcommittee, on behalf of the 2.3 million members of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I would like to thank you for the opportunity to testify at today's important legislative hearing.

There was a wide range of healthcare bills under consideration today. So I will limit my remarks. Our full comments on all may be found in my written statement.

The VFW is pleased to support H.R. 2818, which would create centers of excellence for the treatment of epilepsy within VA.

The experience of today's servicemen and women leads us to believe that epilepsy will be a growing problem in the coming years. One of the main contributing factors for some forms of epilepsy is brain injury, an ailment that most consider the signature wound of this war.

While not much study has been done on these issues with respect to today's veterans, if the past is our guide, we could see a wave of epilepsy and other seizure disorders soon.

The VA/DoD research into Vietnam veterans with certain types of head injuries showed a rate of epilepsy that was 25 times higher than that of their non-veteran cohorts. Further, a large number of these disorders did not occur until at least 5 years after the initial injury. This means that we will not see the impact on today's veterans for a few years.

These centers would allow VA to better research, diagnose, treat, and educate about these conditions. And we urge this Subcommittee to take swift action to forestall what will be a growing problem.

The VFW is also happy to support H.R. 5554, the "Veterans Substance Use Disorders Prevention and Treatment Act." We are especially supportive of section 2 of the bill, which would expand the range of services the VA provides to veterans suffering from these disorders. It lists ten services that VA must provide, including peer to peer counseling, but also family and marital counseling. These expanded services are critical. Substance abuse often goes hand in hand with other mental health issues, such as depression and PTSD. VA's services for substance abuse have decreased over the last decade, and we need to ramp these services back up given the problems OEF/OIF veterans face. The VFW hopes that the Subcommittee favorably reports this bill.

VFW is also happy to support H.R. 5595, the Make Our Veterans Smile Act. We have long believed that dental care should be part of the standard healthcare benefits package that veterans receive. Poor dental healthcare can create bigger healthcare problems down the road, and the image of poor dental care can be a barrier to employment for some veterans.

On H.R. 5622 we have some concern. While we support the ultimate goal of this legislation, which is providing timely access to VA's high quality healthcare, we do have some concerns in the way in which this bill would achieve it. This bill would mandate VA to

provide contract care when they cannot see a veteran within 30 days of his or her scheduled appointment. Contracted care comes at a rate typically much higher than that of VA care, further draining resources from the system. If the cost of this contracted care were instead applied to VA we believe that VA would be better able to take care of more veterans, reducing the waiting times that we are seeing. VA needs a sufficient, timely, and predictable healthcare budget. With that in place, we believe that the problems that this bill aims to solve would likely go away.

I would note that we do strongly support the reporting requirements from the bill. Accurate information about the waiting times will better allow us to understand and fix some of these problems.

We also support H.R. 5622, which would require VA to display a Prosthetics Bill of Rights. And we support the draft bill, which would expand healthcare to those children of Vietnam veterans who are suffering from spina bifida. Given that these children are suffering from the debilitating and lifelong effects of this condition because of their parents' exposure during military service, it is only fair that we give them proper care and the full range of healthcare services. We would note, though, that these benefits should also be extended to the children of Korean war veterans, who are also eligible for certain types of healthcare.

Mr. Chairman, this concludes my statement and I would be happy to answer any questions you or the Members of the Subcommittee may have.

[The prepared statement of Mr. Needham appears on p. 40.]

Mr. MICHAUD. Thank you very much. Mr. Edelman.

STATEMENT OF BERNARD EDELMAN

Mr. EDELMAN. Good morning, Mr. Chairman, Mr. Miller and Mr. Hare. VVA thanks you for holding this hearing this morning. And I would like to focus our oral comments, though, on only four of the bills under consideration by the Subcommittee.

H.R. 2818, VVA generally supports this legislation but we would like to offer this caveat to you. We believe that the location of such centers of excellence must be in close proximity and closely associated and partnered with the Traumatic Brain Injury Centers of Excellence that are already in operation. We believe the reasons for this are clear. Within our veteran cohort, epilepsy is most often the result of Traumatic Brain Injury, which many consider to be the signature wound of the fighting in Iraq and Afghanistan. Epilepsy or seizure disorder caused by either a concussive or a contusive brain injury is never just an isolated incident. Over time, without proper diagnosis, treatment and care, this can impact a survivor's cognitive, motor, auditory, olfactory, and visual skills. It can also collapse a family. There is also one issue that needs to be considered. Although licensed clinical case managers number in the tens of thousands, licensed brain injury case managers number only in the tens of dozens, according to the Case Management Society of America. Of all the medically challenging injuries, brain injuries require the most involvement and cost over time. VVA believes H.R. 2818 is a good beginning for vitally needed legislation.

H.R. 5554, we believe is laudable. We believe it is doable. Too many—far too many—veterans self-medicate to assuage the de-

mons inside, demons that often derive from their experiences while in uniform. In order for them to lead complete and productive lives they need to get the monkey off their backs. Of course, VA is going to have to gear up to comply with the provisions if H.R. 5554 becomes law, they are going to need to find and hire enough experienced substance abuse counselors and clerical staff, something we believe the VA is quite adept at doing. We hope that they will do this as part of compliance with a new law.

H.R. 5622, VVA cannot endorse, unfortunately. We believe that this bill would likely cause more bureaucratic and clerical headaches than make the delivery of healthcare more efficient. Congress has sought to improve the very services this bill seeks to remedy by appropriating several billion additional dollars over the past 2 fiscal years for VA healthcare. We would advise the Subcommittee to take a very hard look at the potential for damaging the very system a bill like H.R. 5622 seeks to help. Congress, I believe, must demand accountability. If there are waiting lines in Florida or in Seattle, there has got to be a reason for it. Is it incompetent management? Do they need more funding? Offering veterans simply the option to go out of the VA healthcare system will cause, we believe, major problems and will undermine the very effective healthcare that the VA seeks to give.

"The Spina Bifida Health Care Program Expansion Act," H.R. 5729, we certainly support. We would advocate, however, that Congress consider either as part of this bill or in a new bill, mandating that the VA conduct research into other potential intergenerational effects of exposure to dioxin and other toxins while in military services. We are hearing far too many stories from far too many children, most of them women, of in-country Vietnam veterans who tell of the birth defects they have suffered as well as birth defects suffered by their offspring. And they wonder, "Could this be somehow related to my father's or my mother's exposure to Agent Orange?" We have no answer for them, unfortunately.

With this I conclude my oral remarks. And thank you for the opportunity to address you.

[The prepared statement of Mr. Edelman appears on p. 43.]

Mr. MICHAUD. Thank you very much, and once again I want to thank the panel for your testimony this morning. All of your organizations support the Epilepsy Centers for Excellence, either in whole or in part. The VA has stated in their testimony that the bill is unnecessary. How can it be that there is such a disconnect between the stakeholders and the users of the system such as yourself, and the VA's view that this bill is not necessary? I will start with Mr. Wilson.

Mr. WILSON. Mr. Chairman, I could only respond by stating that the disconnect is lack of information or lack of outreach. In my visits to the VA Medical Center, if I am responding correctly, I have spoken with veterans who have stated that they are driving 70, 80 miles still to receive care. And when I informed them that there is either a mobile clinic or a CBOC within that area, they basically know nothing about it. So there continues to be a disconnect.

I think I spoke on pilot programs being erected in certain parts of the country. Each VA Medical Center is pretty unique, to its respective community of course. So to establish consistency I think

we, when we are talking about programs, we really need to think about it geographically because you have certain areas where there are large catchment areas and it does not reach certain veterans. And I think as far as the disconnect, I think in certain VISNs, they are looking at their respective VISN as far as contacting every veteran, when you are talking about VISNs where in Nevada and Wyoming and such places, you would hear more of a disconnect, even within the VA Medical Center, or amongst the VA Medical Center Staff.

Mr. MICHAUD. Ms. Ilem.

Ms. ILEM. I would just note, I remember from the Senate testimony, we testified on the companion bill and remembering what VA, I think their indication was that they felt it was unnecessary because, that there should not be a specialized, you know, one disease. These Centers of Excellence should cover other, other diseases. It should not be so specified. So it will be interesting to hear if Dr. Cross has comments today, specifically from you, about the suggestions that have been made to perhaps combine it with the TBI Center, which, you know, could obviously make sense in terms of looking at these veterans who have a potential TBI with this rate that we expect to increase, and perhaps epilepsy associated with that as a co-morbid disorder.

Mr. NEEDHAM. Sort of the ultimate goal, the reason that we sort of support the Centers of Excellence, is that we need an emphasis on this. And as Ms. Ilem was saying, that if it were done sort of in concert with the TBI Centers that would certainly be an approach we would be happy to look at. The key is that this is going to be a growing problem. And VA needs to manage it, to get on top of it, but also to research it. And as long as it is a high priority that is probably something we can support.

Mr. EDELMAN. Why the VA opposes this we will find out from Dr. Cross, of course. But I think the reality is that very few medical facilities, even VA medical facilities, are capable of providing even the most minimal level of specialized care for brain injured patients. And I think that would extend to epilepsy. We see the idea of symbiosis, particularly if these are co-located, Epilepsy and Traumatic Brain Injury Centers of Excellence. We think that can do a lot in the form of research and in actually helping patients who come down with epilepsy. So we support it.

Mr. MICHAUD. Thank you. My next question is, if you had to pick two of the top healthcare issues that would require a legislative fix, what would they be? We will start with Mr. Wilson again. If you had to pick two top healthcare issues that we should focus our attention on that would require a legislative fix, what would the top two healthcare issues be?

Mr. WILSON. I would say the first being traumatic brain injury and the second, blind eye injury.

Ms. ILEM. I think the substance use disorder issue is one of the top issues that we have concern over right now. We have had a number of calls, veterans and their families that are seeking this care and a lot of problems that they have encountered with VA in terms of continuity of care, having access to a bed, having access to detoxification services. And then the continuation of that care and it relates to PTSD or some readjustment issues, and having

the combination of those services continue on without an interruption. So certainly the substance use disorder care would be high on the list. And I think that of the bills before us today as well I would think that, I mean, there is a number of them that I think would be certainly doable but they affect a small number of veterans and I think they are extremely important. The dental issue also would be, I think, critical as we are hearing more and more about that and the impact, and obviously for service-connected disabled veterans, you know, do not have that availability right now unless you are 100 percent service disabled or in unique circumstances. Thank you.

Mr. NEEDHAM. I would certainly agree with the substance abuse and sort of the mental health/PTSD issues. Sort of hand in hand with that, it is not purely a legislative fix although it does involve legislation, is funding for Vet Centers particularly in the staffing side. We have done a lot to expand the number of them but we need full staffing to ensure that there are no waiting times for veterans. You know, they are sort of a convenient access for care particularly for veterans in more rural areas who do not have access to a large, inpatient VA hospital or facility.

From the bills under current consideration we have a resolution with respect to the Epilepsy Centers of Excellence. So something in that direction would be good. But also, another one that is important came up at a hearing, I cannot remember when it was, earlier this year I believe, about the emergency care. And that would be certainly something we would hope to push for, where emergency care is paid for, for veterans who, I am trying to remember the particulars of the issue. I remember the bill number on that. But the emergency care——

Mr. MICHAUD. H.R. 3819?

Mr. NEEDHAM. Yeah, I believe that is it, yes, correct.

Mr. EDELMAN. You know, it is really hard to pick two out of a dozen, or two out of ten, or whatever it is. A lot of these health issues are interwoven—Traumatic Brain Injury, with PTSD, with stigma, a whole bunch of issues that all kind of come together. We believe one of the greatest problems faced by veterans, still from Vietnam as well as OEF/OIF, is stigma associated with seeking help. And there is a lot of reasons behind the stigma. And in some of the services it is still. You are a wuss if you go for mental health help. And I am not sure what legislation needs to be done on that but it is something that I would gather a bunch of the experts, who are the servicemen and servicewomen who are affected, and listen to what they have to say.

Also, I would suggest the issue that I brought up with Agent Orange, with dioxin. We are talking about spina bifida, which is recognized as being associated with exposure to this toxin. But there are a number of other childhood diseases, birth defects, that are also, we believe, associated with exposure to dioxin and there has been very little research. VA does not have any research projects going on now. When we asked if they have had any going on we were told, "Well, there may have been one a while ago." They do not know. We think legislation that would ask them these hard questions may be the way to go.

Mr. MICHAUD. Thank you. Mr. Miller.

Mr. MILLER. Thank you, Mr. Chairman. Your questions have covered quite a bit of the area that I was looking at. I do have one question for Mr. Edelman. How do you reconcile your opposition to Ms. Brown-Waite's bill, H.R. 5622, because it allows people to go outside of the system? Yet, you have full support for Chairman Filner's bill, H.R. 5730, which gives the right to the person to select their own practitioner outside of the system, so long as, I think it is, they are under contract with VA, or they are a private practitioner with specialized expertise? In one instance you are saying you do not want people going outside of the system, and in another instance you are saying that it is okay.

Mr. EDELMAN. Well, H.R. 5730, I believe, is the Prosthetic and Orthotic Clinic, which would mandate display of an Injured and Amputee Veterans Bill of Rights and I am not seeing any, any——

Mr. MILLER. Well, number three in that Bill of Rights says, "The right to select a practitioner that best meets the orthotic or prosthetic needs, whether or not that practitioner is an employee of the Department of Veterans Affairs, a private practitioner who has entered into a contract with the Secretary of the Department of Veterans Affairs to provide prosthetic or orthotic services, or a private practitioner with specialized expertise."

Mr. EDELMAN. We think that the prosthetics program in the VA has come an awful long way under Fred Downs over the past couple of decades. There are areas that, if you need repair, etcetera, you are not going to be able to travel to a VA Medical Center which will have the ability to do this. This can be contracted out. Right now the VA contracts out in fee-basis care something like one out of every ten healthcare dollars. We do not have any objection to this. We do believe, for a variety of reasons, you need physical therapy, you are 2½ hours away from the VA Medical Center, it can be done effectively locally, that is fine. The VA does have to get a better handle on this, and also get electronic health information, which we do not believe they may necessarily be getting now.

When Congress has given the VA as much additional funding over the past 2 fiscal years as it has, it seems to us that waiting times should be one of the first things that needs to be eliminated. And there is really no reason folks cannot be seen within a 30-day time period. And we believe if you open that up by putting a, "Well, if you cannot do it in 30 days you can go outside of the system," I think that is going to lead to chaos. And I do not think it is the way to go.

Mr. MILLER. So, you do not mind people going outside of the VA system for certain types of care?

Mr. EDELMAN. For certain types of care or for the——

Mr. MILLER. Because your testimony, if I recall, was that allowing them to go outside, if they could not get an appointment within 30 days, would degrade the quality of the care, it would degrade the VA system. I am just trying to figure out, I think you might need to at least go back and revisit your testimony. I understand your testimony, but I think they are conflicting. We have heard just this morning an enormous amount of projects that are going to require additional funding and resources, and this Committee will do everything that it can to authorize that. It may be that some people would sit here and say that the first thing that you

need to focus on with additional resources that the Congress provided is not shortening the wait time. If that is the case, then we should not trap the veteran in the system for whatever reason it may happen to be. You did, thank goodness, say that it could be for inappropriate management, or it could be for lack of dollars. I do not think anybody would want to say that the veteran would have to be trapped inside the system, and not be able to go outside to get the required care that is necessary.

Mr. EDELMAN. I would not disagree with that.

Mr. MILLER. That is all, Mr. Chairman. Thank you very much.

Mr. MICHAUD. Thank you. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. This question is for the entire panel regarding H.R. 5622, the "Veterans Timely Access to Health Care Act." You know, I understand the VSO's concerns about contracting out VA care to the private sector and lack of oversight cost issues, etcetera. But I represent a very rural area. And let me give you an example of, I got a call from a State senator who had a veteran sitting across her desk and he needed a chest x-ray. In order for him to get that he was going to have to go 2½ hours in a van to the nearest facility. He would probably end up waiting hours, be at the end of the line, for the chest x-ray, something that he could have 5 minutes from where he was sitting when he made the phone call to me. And it seemed to me, particularly in the rural communities where we do not have the CBOCs, we have some. And I am certainly trying to get a couple more, and hopefully get a chance to talk to Dr. Cross about one after the hearing. But my point is that for a lot of veterans who have to travel those types of miles, what we are finding, or what I am finding is, veterans are saying, "I am not getting in the van. I am not traveling that far. I am not going to sit there and wait for hours and hours and hours for something that I am 5 minutes away from." Is there not a way, or maybe there is, but is there not a way under this bill where things of that nature, a blood test, a simple blood test, and chest x-ray, blood pressure, whatever it is that could be done in a matter of minutes for this veteran literally minutes from his or her home can be done without having to put that person in the van.

A lot of, as I said, because what is happening is a lot of veterans, you know, they are elderly. The high price of gas, as you know, is getting expensive just for them to make the trip. Is there not a way that they could get that test and have that information transmitted to where it needs to be without having to put through that type of a wait? And, you know, it would just seem to me, I understand major things. But these type of procedures that we could do literally in the matter of minutes, we could save hours and tons of frustration and, as I said, I do not want to see a veteran say, "I am not going to go through this process again." Because to me this was just, it took an entire day and into the evening by the time that veteran got back.

So I am wondering if, you know, if you have any thoughts on that and how we can make this so that we can, you know, help veterans, particularly as I said, I have twenty-three counties and literally hundreds of miles in my district. I am just interested, you know, in your thoughts on that.

Mr. WILSON. Well, I think there is an inconsistency, that is, when speaking on issues of outreach and information being disseminated amongst veterans throughout this Nation; to add, there is a way to monitor veterans within the VA system through means of telemedicine and telehealth. The American Legion has visited various VA Medical Centers. Within these facilities are telehealth systems which are used to monitor the veteran's blood pressure as well as other vitals. While visiting in the State of Idaho, a veteran stated he had to travel 80 miles to seek medical care. He waited in the waiting room for approximately 2 hours, however, it took only a few minutes to treat this veteran. To obtain his medicine, the veteran had to go home again and wait. Conclusively, we found that the veteran was uninformed of the VA's accommodation of the veteran within his or her respective community. I think in this current era of technology, one would at least be aware that information could be disseminated to those veterans who are enrolled via the VA database. Overall, I think it is a matter of inadequate outreach, that is, effective outreach from VA to veterans throughout our Nation.

Ms. ILEM. I would just note that I think we are really looking forward to the Office of Rural Health to address some of these issues. Certainly, you know, Congress established that office, you know, it has been almost over a year now and there were a number of bandaids to look at these very specific issues. And I think these factors need to be taken into consideration with regard to travel and geographic barriers that veterans face that live in, you know, significantly rural areas. And our concern is, is that as far as I am aware there is still just one staff member at the Office of Rural Health. I think they are in the midst of hiring an additional person. But without I think oversight and attention from this Committee, you know, I am not sure where they are going to go in terms of really trying to address these tough rural issues. And it seems to be an important issue to the Subcommittee and the full Committee, in fact. A number of these, you know, rural healthcare questions have come up and, you know, what is in the best interest of the veteran and what is a reasonable expectation in terms of travel for these more, you know, primary care and more minor, you know, healthcare things that really are important to the maintenance of their health and preventing, you know, larger problems. So we are hoping that the oversight of this Committee will, you know, bring the Office of Rural Health in or for these types of questions and hold them to the mandate of the law. There is a number of reports that I know are due to try to look at these issues.

Mr. HARE. Yeah, and I would, let me just say and then my time is up. Mr. Chairman, I apologize for going over but for a veteran to have to spend 6 hours to get a chest x-ray and travel, and then the hospital that he lives in, if you live in Carlinville, Illinois, the hospital in Carlinville was 6 minutes from his home. It just seems to me for that veteran, to put that person in a van, transport him for a chest x-ray that took literally a few minutes and then bring him back after he waits with all of the other vets that had to be transported over, we can do a whole lot better than that. And I am hopeful at the end of the day that we can get to the point where we can make it easier. Because these people are starting to get up

in years. And this is a, this is difficult for them to be able to do, particularly in the Midwest, with the winters that we have, it makes it very difficult for them. So I am just hoping that at some point anything we can do to make it easier for them, and then transfer the data to the VA, you know, hospital, I do not think is going to hurt anybody. We are not asking them to do, we are just talking about basic, small, considered to be small, but basic things that do not take a whole lot of time. So I apologize for going over, Mr. Chairman.

Mr. MICHAUD. No problem. Thank you very much, Mr. Hare. Once again I want to thank the panel for your testimony this morning. We look forward to working with each of your organizations as we move forward to deal with the legislation before us today. So, thank you. The last panel that we have today is Dr. Cross, who is the Principal Deputy Under Secretary for Health. He is accompanied by Walter Hall, who is the Assistant General Counsel for the Department of Veterans Affairs. I would like to welcome you, Dr. Cross, once again before this Subcommittee. I want to thank both of you for your service to our country and taking care of our veterans, also, in this great Nation of ours. Without any further ado I recognize Dr. Cross for your statement.

STATEMENT OF GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY WALTER HALL, ASSISTANT GENERAL COUNSEL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. CROSS. Good morning Mr. Chairman and Members of the Subcommittee. Thank you for inviting me here today and joining me today is Walter Hall, Assistant General Counsel. I would like to request that my written statement be submitted for the record.

Mr. MICHAUD. Without objection, so ordered.

Dr. CROSS. Mr. Chairman, we have received H.R. 5730, which calls for a Veterans Bill of Rights for Injured and Amputee Veterans. However, we have not had time yet to review the bill and we will submit our views for the record.

[The Department of Veterans Affairs views for H.R. 5730 appear on p. 56.]

VA does not oppose H.R. 5729, which would authorize the Secretary to provide eligible children of Vietnam veterans or certain Korean conflict veterans who suffer from spina bifida with any needed healthcare. Providing a total healthcare management program to this beneficiary population would provide needed relief for families seeking a complete spectrum of fully integrated care. We offer one caveat, however. Providing such services in a VA domiciliary treatment setting could prove problematic since domiciliary care is unique to the VA healthcare system and is used mainly for veterans requiring intensive, rehabilitative outpatient care in a residential setting.

H.R. 2818 would require the Secretary to designate six Epilepsy Centers of Excellence. While we support the concept of expanding epilepsy care, we believe our current and planned efforts are effective and responsive to clinical needs. In fact, VA already has seven sites capable of meeting the full range of clinical and affiliation re-

quirements stated in the bill. And we will adjust our resources as needed in the future.

We support the intent of H.R. 5554, the "Veterans Substance Abuse Disorders Prevention and Treatment Act of 2008," and we have implemented many of its provisions already. We fully support the goals of enhancing substance abuse services for veterans and our comprehensive mental health strategic plan is making significant process to that end. We note, however, that the bill would institute certain requirements that we believe are inconsistent with scientific evidence and established best practices. For instance, it would be better to pursue targeted approaches to case identification rather than mandatory or universal screening for those conditions. We are also concerned universal screening, we are talking about for drugs, may deter some veterans from seeking VA care. Our providers are trained to assess signs of substance abuse disorders and pursue appropriate follow up as needed on an individual basis. VA is also undertaking significant outreach efforts and is increasing the number of sites of care, and we have plans for further and greater expansion.

H.R. 5595 would require VA to furnish outpatient dental services and treatment to any veteran who has a service connected disability. I believe I have a poster over here with our current dental wait time showing the remarkable progress that we have made. While we recognize that providing lifelong comprehensive dental services to veterans is laudable, enactment of this legislation would make an additional one million veterans immediately eligible for VA dental care, overwhelming VA's capacity to provide these services in-house. Expanding VA's contracting authority would result in a thirteenfold increase in fee basis expenses, and would cost the Department more than $11 billion, that was billion with a B, over the next 10 years.

Finally, H.R. 5622 would establish a 5 year pilot program to study the feasibility of setting a 30-day standard for scheduling primary care appointments in VISN 8. When unable to meet the 30-day standard the VA would be required to contract care and services. With the assistance and support of Congress, VA has already made remarkable progress in reducing wait times. We would ask the Committee to forego further action as we anticipate eliminating this list entirely by the end of fiscal year 2009 thereby making this legislation unnecessary. We also observe that many patients prefer to schedule appointments beyond 30 days of the time that they contact us, and the requirement in this bill that veterans submit a written request to be seen by a VA provider after receiving care from a non-VA facility would be burdensome on veterans and potentially disruptive to their care. Further, contracted care would not necessarily include the comprehensive screenings, case management services, documented quality, and expertise in veteran specific conditions that is available in the VA healthcare system.

Chairman Michaud and Ranking Member Miller, we sincerely appreciate your interest in and support of our veterans as reflected in the legislation you put forward. I believe these bills address important issues but some have technical issues that need to be addressed, and others duplicate existing efforts. Indeed, we have listened to Congress and have already implemented or begun develop-

ment on key aspects of these legislative proposals. My staff and I would be happy to help the Committee in any way we can, including providing details on our ongoing efforts and new initiatives. This concludes my prepared statement. I would be pleased to answer any questions for the Subcommittee at this time.

[The prepared statement of Dr. Cross appears on p. 44.]

Mr. MICHAUD. Thank you very much, Dr. Cross. I appreciate your testimony. Looking at your dental waiting list, that is an impressive reduction in the waiting list. During that timeframe from 2006, or 2008, has the eligibility of who qualifies for dental care changed at all? Or is that consistent?

Dr. CROSS. It changed recently and I think it was a very good change. It was done with the support of Congress—for the combat veterans returning from the conflict, from 90 days to 180 days. I was very concerned that they would get back and go on leave and the 90 day period would basically expire before they got around to applying. So we doubled it and I am hoping that will, you know, make it easier for some of them. That is the main thing that I think has changed.

Mr. MICHAUD. Okay. How much dental care, in terms of dollars, does the VA purchase now for all veterans? And how many veterans is that?

Dr. CROSS. If you can give me just a moment, sir?

Mr. MICHAUD. No problem.

Dr. CROSS. Currently VA dental services treat approximately 360,000 veterans in a fiscal year. And assuming about 40 percent of the newly eligible veterans take advantage of dental care, the percentage of classification IV veterans seeking dental care in a given year would increase by 430,000 patients per year, or 120 percent.

Mr. MICHAUD. So it is, what, 360,000?

Dr. CROSS. Three-hundred sixty thousand, I believe, is the current number.

Mr. MICHAUD. And that is what you contract out?

Dr. CROSS. That is what we are currently providing for dental services. I believe that is in-house and fee basis.

Mr. MICHAUD. What I am interested in is how much are your fee basis? How much are you contracting out in fee basis and how many veterans are attributed to that?

Dr. CROSS. Well, I have my dental consultant in the room. I will ask if he can pass me a note if he has that information. Otherwise, I will get it to you in writing.

Mr. MICHAUD. Okay, thank you. My next question, you mentioned H.R. 5554, the Substance Abuse Disorder legislation that the VA is currently implementing some provisions of that. What provisions are you implementing? How many veterans does that include?

Dr. CROSS. In fiscal year 2007, 33,000 OEF and OIF unique veterans were treated for substance abuse disorders and in fiscal year 2008 so far there have been about 25,488. I do not think those are necessarily exclusive numbers. Here are some of the things that we are doing, and I really appreciate the opportunity to mention a couple of these. Here are a couple of things I want to highlight. All VA Medical Centers now have specialized substance abuse dis-

orders service. We have a policy in place for mandatory screening for alcohol problems at the time the patients first contact with us, and annually thereafter. We have established 510 new substance abuse counselor positions and those have been authorized. We have added substance abuse counselors to 132 Homeless Outreach Teams. And we are integrating, you know, one of the speakers earlier talked about stigma. And the way that we are approaching that, because we recognize that that is very real, is we are integrating mental healthcare, mental healthcare providers, into our primary care clinics to a place where they are already comfortable in going, seeing, to make the first diagnosis and start the treatment program right there in the primary care setting. I think patients find that more acceptable than going and sitting for the first time in a clinic that says, "Mental Healthcare." Currently there are 19 substance use inpatient programs, 65 substance use residential rehab programs that are designed exclusively for veterans with substance abuse problems, and 123 additional residential rehab programs that include substance abuse treatment.

I wanted to talk about one other thing. One of the other speakers mentioned outreach. And we recognize this, and we have to learn new techniques for doing this. And I want to mention two things that we are getting ready to do or have already done. We have already been on Music Television Channel (MTV) to reach out to a different segment of the population than perhaps we have been used to doing in the past. I watched the segment just recently. It was very good. Second we are going to be announcing very shortly a remarkable outreach effort to 550,000 returning veterans who have not yet come to us for care. And Secretary Peake will be announcing that probably in a couple of weeks.

Mr. MICHAUD. Thank you very much. That is creative thinking. I never would have thought about MTV, primarily because I do not watch it, but, Mr. Miller? Do you watch the MTV?

Mr. MILLER. I have my MTV.

Mr. MICHAUD. Thank you.

Mr. MILLER. That probably goes way back, though. I have some questions to ask. Unfortunately, I have a time constraint so I would like to submit them for the record and thank the witnesses for the testimony.

[No questions were submitted.]

Mr. MICHAUD. Thank you, Mr. Miller. Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. Dr. Cross, I just have one. In your testimony on H.R. 5554 you said, and I am quoting it, "it fails to correctly target the veterans in need of residential care, those with substance abuse disorders who cannot be managed effectively in intensive outpatient programs." How then would you propose that we correctly target the veterans that are in need of residential care?

Dr. CROSS. The way the bill was constructed it appeared to us that based on severity would choose the residential approach or the outpatient approach. My scientists tell me that is not the best way to make that decision. You really make the decision based more on the social support and the ability of the individual to participate in an outpatient program. And for those individuals, perhaps some homeless individuals and others who cannot routinely arrange to

show up in an outpatient program, then sometimes an inpatient program, residential program, is better. But that is a different distinction from the severity of the illness. It is related to their social situation.

Mr. HARE. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. And I believe I saw that a note was handed to you. I assume it was on the dental?

Dr. CROSS. Sir, I am told the answer is $60 million in fee basis, about 40,000 veterans.

Mr. MICHAUD. Sixty million dollars in fee basis, 40,000 veterans? Have you looked at cost savings, particularly if some of those were in an area where it might be a lot cheaper to actually hire another dentist and hygienist? Have you looked at that to hold down costs?

Dr. CROSS. We have. And we have actually done as part of our expenditure last year in bringing this down, part of that was from in-house expansion. I do not know how much our total expansion was in dental in terms of patients. But yes, we are looking at that as well. Some of the limiting factors are, when our facilities were built we did not necessarily have room for so many chairs in place. And so you may reach a point where it becomes a construction issue. And so that is where we pretty much have gone out for contracted care at that point.

Mr. MICHAUD. Are you looking at also, I will use Maine as an example, I know the lease in the Bangor CBOC is coming due and the Veterans State Nursing Home is looking at building to suit whatever needs the VA has for a CBOC at cost. Here is a situation where you actually could take advantage of additional dental chairs and office space for dental. Are you looking at opportunities such as that to help move forward? Also, opportunities in working with the Department of Defense. One of the problems that our military is faced with today regarding readiness is actually dental. Are you looking at working closely with the Department of Defense, particularly in the area of the Guard and Reserves, where you can collaborate in those areas?

Dr. CROSS. On the first question in regard to looking for opportunities, yes we are doing that. And I will make sure that our staff are looking at the one you mentioned as well. In regard to working with DoD, I personally have been in probably half a dozen meetings specifically related to dental care. And, you know, the concerns were what aspect of it was done before they left and what aspect of it was done upon their return, before they were turned over to us. And I think we made progress. And I am not sure, I would not say there was not more to be done, but progress has been made in that area. I think we are much further along than we were 2 years ago.

Mr. MICHAUD. Great. And my last question actually deals with spina bifida. In your testimony you stated that beneficiaries of the Spina Bifida Health Care Program would benefit from services in VA's continuum of extended care services, such as home health, home telehealth, adult day health, et cetera. Would these services that you mentioned be covered under this legislation as it is currently written?

Dr. CROSS. These services would be comprehensive care as I understand it. But they would not necessarily, and probably not, be

coming from the VA. So as a rule they would not be using VA capabilities.

Mr. MICHAUD. But are they covered under the legislation as written? I see Mr. Hall shaking his head yes.

Mr. HALL. Yes, sir. They would be covered to the extent that VA provides those same benefits to veterans.

Mr. MICHAUD. Okay. Well, once again I know there will definitely be some additional questions for the record. I want to thank you, Dr. Cross, for your continuous service for the VA and your willingness to be very open with the Subcommittee as well. And also you, Mr. Hall, for your testimony today, your answering questions. Once again, I thank both of you. If there are no further questions we will adjourn the hearing. Thank you very much and thanks to the Subcommittee Members.

[Whereupon, at 11:50 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

I would like to thank everyone for coming.

Today's legislative hearing is an opportunity for Members of Congress, Veteran Service Organizations, the VA, and other interested stakeholders and parties to provide their views and discuss recently-introduced legislation within the purview of this Subcommittee.

The six bills before us cover a wide range of topics that are germane to veterans' health care. Issues addressed in today's bills include Spina Bifida, epilepsy research centers, substance use disorder treatment and prevention, expansion of dental care, timely access to care, and a bill of rights.

I do not necessarily agree or disagree with these bills, but I believe that this is an important part of the legislative process that will encourage frank discussions and new ideas.

I look forward to hearing the views of our witnesses on these bills.

I also look forward to working with everyone here to improve the quality of care available to our veterans.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

I appreciate your holding this legislative hearing. Today, we will examine six different legislative proposals that seek to improve the delivery of health care for our Nation's veterans.

This year our Subcommittee has placed renewed focus on the mental health concerns of veterans by holding a series of hearings aimed at better understanding the unique mental health needs of America's heroes. One of the bills we will consider today is H.R. 5554, the Veterans Substance Use Prevention and Treatment Act of 2008, which Chairman Michaud and I introduced in March in a true bipartisan effort.

H.R. 5554 would require each VA medical facility to provide ready access to comprehensive care for substance use disorders. This bill would also direct VA to conduct a pilot program for Internet-based substance use disorder treatment for veterans of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF).

This new generation of veterans is comfortable with computers and this program will allow VA to reach them by utilizing new and innovative technology. Hopefully, this will also help overcome the stigma that prevents many military personnel in need from seeking services.

It is important to remember that substance use disorders can be treated and recovery is possible. That is why it is critically important that we understand the nature of substance use disorder among our veterans and effectively break the barriers that prevent veterans from obtaining treatment services.

In addition to H.R. 5554, we will also be considering H.R. 5622, the Veterans Timely Access to Health Ccare Act. This legislation was introduced by my colleague and fellow Representative from Florida, Ms. Brown-Waite.

H.R. 5622 would create a pilot program aimed at making the standard access to care for a veteran seeking primary care 30 days from the date the veteran contacts the VA. If unable to meet this timeline, VA would be required to provide care at a non-VA facility. The veteran would then have a choice whether or not he or she would want to continue care at a VA facility.

Ensuring that veterans seeking health care receive the necessary services in a timely manner has long been a priority both of mine and this Subcommittee. As

such, I support Ms. Brown-Waite in her efforts to set appropriate standards for access to care to guarantee veterans needing help are not forced to wait unreasonable and lengthy periods of time before seeing a health care professional.

Finally, I would like to thank our esteemed Chairman and my other colleagues for bringing forward important legislative proposals that we will also consider today.

Additionally, I thank the representatives from the American Legion, the Disabled American Veterans, the Veterans of Foreign Wars, and Vietnam Veterans of America; and Dr. Cross from the VA for joining us this morning to discuss these and other legislative proposals.

Our Subcommittee has always worked in a bipartisan manner and I look forward to continuing to work with Chairman Michaud and the other Members of this Committee to ensure that our veterans receive the very best care possible.

Thank you Mr. Chairman, and I yield back.

Prepared Statement of Hon. John T. Salazar,
a Representative in Congress from the State of Colorado

Good morning, Chairman Michaud, Ranking Member Miller and distinguished members of this subcommittee.

I look forward to hearing the testimony from our colleagues and the experts here today.

Thank you for joining us and sharing your knowledge and experiences.

On behalf of my district, I am very interested to hear how these bills would affect our nation's rural veterans.

In the third district of Colorado, access to services is a major issue because we have so many vets spread out over a wide area.

I would also like to hear how the various services my colleagues propose will reach our veterans in rural areas.

I welcome my friend and fellow Coloradoan, Representative Ed Perlmutter.

I am a proud cosponsor of his bill that would direct the VA Secretary to designate, establish and operate at least six VA health-care facilities as locations for epilepsy centers of excellence.

I also look forward to discussing the need for improved dental care for our veterans, as well as the proposals to help our veterans deal with substance abuse.

Mr. Chairman, I thank you and the members of this sub-committee for the chance to sit with our colleagues and discuss legislation that will have a positive effect on the health and well-being of veterans across the country.

Prepared Statement of Hon. Ed Perlmutter,
a Representative in Congress from the State of Colorado

Good morning, Chairman Michaud, Ranking Member Miller and Members of the Subcommittee. I want to thank you for holding this hearing on H.R. 2818, the VA Epilepsy Centers of Excellence Act.

The VA Epilepsy Centers of Excellence Act, which I introduced on June 21, 2007, will create at least six VA Epilepsy Centers of Excellence within the VA Health Ccare system. A companion bill carried by Senator Patty Murray passed the Senate VA Committee on December 12, 2007. These Centers of Excellence will care for all veterans' experiencing seizures and especially those we predict will develop epilepsy as a result of suffering a Traumatic Brain Injury (TBI) while serving in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF).

Epilepsy is defined as two or more seizures. During Vietnam, a number of men and women returned home with head wounds and head injuries. Of those who came home with these types of injuries, some 53% developed epilepsy within 15 years. Fifteen percent of those who developed Epilepsy did so five or more years after their combat injury.

Last year, I met with Dr. John Booss, the former Director of Neurology for the VA. He advised me that in 1972, the VA responded to the rise in veterans returning with seizures by creating VA Health Centers around the nation that specialized in the treatment and research of epilepsy. The VA Centers partnered with medical schools to assist it in treating the veterans with seizures and building a body of knowledge concerning epilepsy. However, sometime in the 1980s or early 1990s the increase in veterans developing epilepsy subsided, funding dissipated and the Centers were curtailed. At this time the VA operates seven Epilepsy Monitoring sites.

These sites lack the resources and capacity to care for our current veterans with epilepsy.

Dr. Booss and a number of organizations such as the American Academy of Neurology, The Epilepsy Foundation of America, the Brain Injury Association, and the Citizens United for Research in Epilepsy (CURE) have highlighted the need to rebuild the Epilepsy Centers of Excellence for the many men and women returning from the Middle East with head wounds and brain injuries. Your committee is only too aware of the injuries suffered by our service men and women in Iraq and Afghanistan. It is estimated that today some 89,000 veterans have epilepsy of which 42% of that number is service connected. If our country's experience in Vietnam is any indication of what to expect in the future the number of veterans with epilepsy is bound to rise.

[As an example, after I introduced this Bill, I was contacted by one of my constituents, Naval Reserve Petty Officer Brian Johnson. He suffered a TBI while assigned to Navy Mobile Construction Battalion 7 just outside of Fallujah, Iraq. On November 7, 2004, his position came under fire and he sustained a brain injury when he was blown against a wall when two mortars exploded nearby. After returning home he resumed his small plumbing business, but eventually lost it due to the incidence of seizures. Petty Officer Johnson's story is just one of many emerging from the experiences our service men and women are having after returning home.]

H.R. 2818 establishes a process where VA Medical Centers partner with medical schools across the country to compete for the designation of a VA Epilepsy Center of Excellence. Six of these Centers would be selected by the VA and would be disbursed across the country. The VA's telemedicine capacity would also be expanded to track the neurological diagnostic tests of our rural veterans. It is anticipated that each of these centers would cost about $1 million for the first 4 years.

These Centers will develop and administer treatments and possibly cures for our veterans that will allow them to live the best lives possible. Moreover, the body of knowledge developed through the research conducted by the VA and the medical schools will help our society as a whole. (And as full disclosure I should mention that I have a daughter with epilepsy who might benefit by the body of knowledge generated through the research and treatment of our veterans with epilepsy.)

I want to thank the Disabled American Veterans, the Paralyzed Veterans, the Blinded Veterans, and the Vietnam Veterans of America and the other organizations I mentioned earlier for their support of this bill. Chairman Michaud, Ranking Member Miller and Members of the Subcommittee, thank you again for inviting me to testify. I look forward to answering any questions you may have.

Studies referenced:

Epilepsy after penetrating head injury. I. Clinical correlates: A report of the Vietnam Head Injury Study. Andres M. Salazar, Brahman Jabbari, Stephen C. Vance, Jordan Grafman, Dina Amin, and J.D. Dillion. Neurology 1985; 35; 1406.

Prepared Statement of Hon. Christopher P. Carney, a Representative in Congress from the State of Pennsylvania

Good morning, Chairman Michaud and Ranking Member Miller. Thank you for holding today's hearing. I appreciate having the opportunity to discuss a bill I introduced with Congressman Mark Kirk, H.R. 5595, the Make Our Veterans Smile Act.

The Make Our Veterans Smile Act will expand dental care offered by the Department of Veteran Affairs (VA) to all service connected disabled veterans. The VA has done an excellent job of providing dental services to those that are able to receive them and the VA should continue to provide these services. However, it is understandable that the VA will have problems meeting the demand for dental services that will occur because of this legislation. That is why this legislation allows service connected disabled veterans to use contractor facilities for dental care. However, this legislation does not mandate that contractor facilities be used. Instead it simply gives the VA greater authority to use these facilities.

While I am glad that the VA currently covers dental care for approximately 360,000 veterans, there are many disabled veterans who are not able to receive even basic dental care through the VA. I believe we have a moral obligation to care for these veterans.

In 2000, the Department of Health and Human Services released a report entitled *Oral Health in America: A Report by the Surgeon General.* This report states "the oral cavity is a portal of entry as well as the site of disease for microbial infections

that affect general health status.[1] Individuals such as immunocompromised and hospitalized patients are at greater risk for general morbidity due to oral infections." It goes on to say that, "Oral-facial pain, as a symptom of untreated dental and oral problems and as a condition in and of itself, is a major source of diminished quality of life. It is associated with sleep deprivation, depression, and multiple adverse psychosocial outcomes," and that "self-reported impacts of oral conditions on social function include limitations in verbal and nonverbal communication, social interaction, and intimacy." These are just a few of the ways poor oral health can affect a disabled veteran's life and their overall general health.

The cost of this bill is a cost of war; it is an investment in our way of life and our future. As every member of this subcommittee knows, to ensure a ready fighting force tomorrow we need to take care of our veterans today. I would also like to point out that conditions such as missing teeth and cavities can be barriers in seeking employment and I believe every effort must be made to ensure that there is a smooth transition for our military members who are entering the civilian workforce. We must also ensure that disabled veterans from wars past are also given every tool to keep a meaningful job and this includes dental care.

I would like to thank the Enlisted Association of the National Guard of the United States, the Navy Reserve Association, the Air Force Association, the Military Order of the Purple Heart and AMVETS for their support of this bill.

I would also like to thank again Chairman Michaud and Ranking Member Miller for holding this hearing and for allowing me to testify. I would be happy to answer any questions you may have.

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

Nearly 300,000 veterans of Operation Enduring Freedom or Operation Iraqi Freedom have been seen by the VA Health Care system, and over 40 percent of these individuals were diagnosed with mental health conditions.

Separating from military service can be a very difficult transition. Mental and physical wounds make it even more difficult for a veteran to adjust.

Unfortunately, many veterans turn to drugs or alcohol to self-medicate their mental and physical wounds.

According to the VA Health Care Utilization Among U.S. Global War on Terrorism (GWOT) Veterans, VA Office of Public Health and Environmental Hazards January 2008, 48,661 OEF/OIF veterans have met criteria for substance use disorder.

This number only reflects veterans who have been seen by the Veterans Health Administration, which means that the total number of veterans with substance use disorder is likely higher.

According to the November 2007 National Survey on Drug Use and Health, over 7 percent of veterans met the criteria for a past year substance use disorder, and approximately one-quarter of veterans age 18 to 25 met the criteria for a past year substance use disorder.

Lower income veterans also have a higher prevalence of substance use disorder.

To address this issue, Ranking Member Miller and I introduced the Veterans Substance Use Disorder Prevention and Treatment Act of 2008.

Our legislation will require the VA to provide the full continuum of care for substance use disorder, and it will require this full spectrum of care to be available at every VA medical center.

Our legislation will also direct the VA to conduct a pilot program for internet-based substance use disorder treatment for veterans of Operations Enduring Freedom and Iraqi Freedom. This will enable our newest generation of veterans to overcome the stigma associated with seeking treatment and receive the necessary care in a comfortable and secure setting.

This bill is not a finished product and I appreciate the comments from the witnesses today.

Substance abuse can tear apart families and ruin lives. I look forward to working with the VA, my colleagues and interested stakeholders to ensure that the appro-

[1] U.S. Department of Health and Human Services. *Oral Health in America: A Report of the Surgeon General—Executive Summary.* Rockville, MD: U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health, 2000: Part Three.

priate care and treatment is available throughout the VA system, and that we explore new ways to encourage our newest generation of heroes to seek help.

Prepared Statement of Joseph L. Wilson, Deputy Director, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion's views on the issues under consideration by this Subcommittee.

H.R. 2818

This bill seeks to amend title 38, United States Code, to provide for the establishment of Epilepsy Centers of Excellence within the Veterans Health Administration (VHA) of the Department of Veterans Affairs (VA). This bill would also ensure that the proposed Epilepsy Centers of Excellence function as such in research, education, and clinical care activities in the diagnosis and treatment of epilepsy.

According to VA research approximately 53 percent of veterans who suffered a penetrating Traumatic Brain Injury (TBI) in Vietnam developed epilepsy within 15 years. VA, in its effort to treat this condition, became the leader in epilepsy research. However, due to lack of funding, research resources eventually diminished.

According to the American Academy of Neurology (AAN), returning veterans with TBI injuries will eventually develop Post Traumatic Epilepsy (PTE). Currently, there is an increasing need for the presence of Epilepsy Centers throughout the nation. This is due to the high count of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) troops returning with TBI.

The American Legion supports the establishment of Centers of Excellence within VA for the various injuries related to blast trauma. This would also ensure the best quality of care and treatment is accessible to current and future veterans suffering from the effects of blast injuries, to include epilepsy.

H.R. 5554

This bill seeks to amend title 38, United States Code, to expand and improve health care services available to veterans from VA for substance abuse disorders, and for other purposes. This bill also proposes that the medical center provides ready access to a full continuum of care for substance use disorders for veterans in need of such care. H.R. 5554 also proposes a pilot program for internet-based substance use disorder treatment for OIF/OEF veterans.

If approved, these pilot programs will be located within those medical centers of the Department of Veterans Affairs that have established Centers of Excellence for Substance Abuse Treatment and Education or that have established a Substance Abuse Program Evaluation and Research Center.

The American Legion has no official position on this issue. However, when substance abuse disorders are secondary to service-connected conditions, it is our position that veterans should have full access to the quality and adequate health care in which they are entitled.

H.R. 5595

This bill seeks to amend title 38, United States Code, to direct the Secretary of Veterans Affairs to provide dental care to veterans with service-connected disabilities, and for other purposes.

The American Legion has no official position on this issue.

H.R. 5730

This bill seeks to direct the Secretary of Veterans Affairs to display in each prosthetic and orthotic clinic of the Department of Veterans Affairs an Injured and Amputee Veterans Bill of Rights.

The American Legion has no official position on this issue.

Mr. Chairman and members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues to resolve these critical issues. Thank you.

Prepared Statement of Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this hearing, and for the opportunity to present the views of our organization on health care legislation before the Subcommittee today. DAV is an organization of 1.3 million service-disabled veterans, and devotes its energies to rebuilding the lives of disabled veterans and their families.

The measures before the Subcommittee today cover a range of issues important to DAV, to veterans and their families. My testimony includes a synopsis of each of the bills being considered, along with DAV's position or other commentary. Our comments are expressed in numerical sequence of the bills.

H.R. 2818—To amend title 38, United States Code, to provide for the establishment of Epilepsy Centers of Excellence in the Veterans Health Administration of the Department of Veterans Affairs

This measure would require the Secretary to designate not less than six Department of Veterans Affairs (VA) health care facilities as epilepsy centers of excellence. The bill would intend these sites to function as centers of excellence in research, education, and clinical care in the diagnosis and treatment of epilepsy, and would include training of medical residents and other VA specialized providers to ensure improved access to state-of-the art treatment throughout the VA health care system.

The bill would establish a peer review panel, consisting of experts on epilepsy and complex multi-trauma associated with combat injuries, including post-traumatic epilepsy, to assess the scientific and clinical merit of proposals submitted by VA facilities for consideration to be designated as Epilepsy Centers of Excellence under this bill. The peer review panel would be required to report its assessment of such proposals to the Under Secretary for Health, presumably to strengthen the Secretary's decision to designate Centers on the basis of merit (but the bill does not specify this peer review as a precursor to the Secretary's designations). The Subcommittee may wish to make that minor modification to the bill to ensure the best proposals are considered by the Secretary as determined by the peer review panel.

Finally, the bill would require the Secretary to consider appropriate geographic distribution when making site selections, and would authorize $6 million for each of fiscal years 2008–2012 to establish and operate these Centers.

While DAV has no adopted resolution from our membership on this matter, we have been briefed by professional associations concerned about the decline of availability of epilepsy services in the VA, and we share their concerns. Also, literature is emerging to suggest the incidence of co-morbid epilepsy in veterans with traumatic brain injury. Therefore, we believe this timely legislation addresses a real need, and DAV would have no objection to its passage.

H.R. 5554—Veterans Substance Use Disorders Prevention and Treatment Act of 2008

This measure would amend section 1720A of title 38, United States Code, to mandate that VA provide eligible veterans system-wide access to a full continuum of care for substance use disorders. The bill would require substance use screening in all VA settings; detoxification and stabilization services; intensive outpatient care services; relapse prevention services; outpatient counseling services; residential substance abuse services for severe disorders; pharmacological treatments to reduce cravings, including opioid substitution therapy when needed; coordination with peer counselors; short term, early interventions when needed; and, marital and family counseling. Additionally, the bill would require the Secretary to provide outreach to veterans who served in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF), to increase awareness within that population about availability of these VA specialized services for substance use disorders.

H.R. 5554 would attempt to ensure more equitable access to VA substance use disorder treatment by allocating funding to assure that the full continuum of substance use disorder care was provided to all veterans in need, irrespective of their residences. Also, to that end it would require an annual report on the number of veterans who used care within the substance use disorder continuum as a proportion of all veterans who used care at the facility, the number of veterans who were screened and the number of veterans who were identified as having a substance use disorder, the number of veterans who were referred for substance use disorder treatment, and the number of veterans who received such care. The report would also address the availability of substance use disorder care at each VA facility. Under the terms of this bill, this report would be reviewed by the Committee on Care of

Severely Chronically Mentally Ill Veterans. That Committee would analyze and further report the availability of care along the continuum, the barriers to access such services and the quality of services provided.

Finally, the bill would require a pilot program specifically designed to offer worldwide web-based options for self-assessment, education and specified treatment of substance use disorders. The program would include, on a voluntary basis, any OEF/OIF veteran, and would be accessible from remote, particularly rural, areas. In designing the pilot program, the Secretary would be required to consider similar pilot programs of the Department of Defense for the early diagnosis and treatment of post traumatic stress disorder (PTSD) and other mental health conditions, and carry out such programs in VA medical centers that have established Centers of Excellence for Substance Abuse Treatment and Education, or that have established a Substance Abuse Program Evaluation and Research Center.

DAV fully supports the Veterans Substance Use Disorders Prevention and Treatment Act of 2008. As noted in prior testimony, DAV has a growing concern about the reported effects of combat deployments in Iraq and Afghanistan on our newest generation of war veterans, a steadily rising proportion of whom are serving multiple deployments and long separations from family. There is converging evidence that substance abuse is a significant problem for many OEF/OIF veterans—and that the incidence of this problem will likely continue to rise. Although substance abuse is a complex problem, there is clear evidence that treatment can be brought to bear to reduce some of the negative consequences of overuse of substances. This comprehensive measure would ensure the unique services necessary to address substance use disorders are provided consistently throughout the VA health care system. Untreated substance abuse can result in severe physical consequences for the veteran, additional stress on the veterans' families, and a marked increase in preventable health and social costs.

We owe our nation's disabled veterans access to timely and appropriate care, including specialized treatment programs for those suffering with post deployment mental health and related substance use disorders. We applaud the Chairman and cosponsors for advancing this timely bill that would aim effective VA substance use disorder programs at prevention, early intervention, outreach, education and training, for veterans and their families, to close the current gaps in VA's existing efforts. We support its passage and offer no recommendations for amendments.

H.R. 5595—Make Our Veterans Smile Act of 2008

H.R. 5595 would amend section 1712(a)(1)(G) of title 38, United States Code to extend eligibility for outpatient dental services and treatment, and related dental appliances, to all veterans with service-connected disabilities. Current law limits such services to veterans with a service-connected disability rated permanently and totally disabling; former prisoners of war; to a veteran who sustained a dental trauma during military service; and in other very limited circumstances related to necessary, ongoing or completion of VA treatment or care. It would further allow VA to provide these services through contract providers.

DAV recognizes that oral health is integral to the general health and well-being of a patient, and is part of comprehensive health care. For these reasons, we support this measure to provide dental services to all veterans with service-connected disabilities—a reasonable corollary to DAV Resolution No. 178, which supports legislation that would provide dental services to all veterans enrolled in VA health care. Consequently DAV would have no objection to the passage of this bill.

H.R. 5622—Veterans Timely Access to Health Care Act

This bill would establish a five-year pilot program in Veteran Integrated Services Network (VISN) 8 (primarily the State of Florida minus most of the Panhandle, but including several Georgia and Alabama counties) to ensure a standard of access to primary care for enrolled veterans in need of primary health care from VA. Under the bill the standard for access to care would be 30 days from the date the veteran contacted the VA facility seeking an appointment, until the date the primary care visit was actually completed. This measure would require VA to conduct periodic performance reviews of the access standards in all facilities within VISN 8 and provide Congress an annual report to outline the Department's performance in meeting the established standard of access to care.

In the case of any enrolled veteran for whom VA facilities were unable to meet the 30-day access standard, the bill would require VA to contract for private health care using its existing contracting authority (Section 1703(a), title 38, United States Code). Additionally, payment for contracted services under this procedure would not be permitted to exceed the Medicare reimbursement rate for similar services, and

under the bill the private provider involved could not require the veteran to defray any difference between the provider's invoiced charge and that paid by VA.

H.R. 5622 includes additional quarterly reports to identify the number of newly enrolled veterans in VISN 8 after enactment, versus the numbers of veterans enrolled in that VISN before October 1, 2001, who fall within specified waiting time ranges for primary and specialty care. The reports would also include the number of veterans who enroll in VA, but who had not sought care in a VA facility since enrollment.

Finally, the bill would require any veteran whose care were contracted out under the terms of this bill who wished to return to a VA facility's care to submit a written notice of intent to return, but only after expiration of a 30-day period receiving non-VA care. Such a veteran would then be authorized to return to VA-provided care, if capacity within the VA facility were available to accommodate that return.

DAV appreciates the bill's intent to ensure timely access to health care services for veterans in VISN 8. However, in our judgment contracting for care is not the best option for addressing this problem. DAV has maintained this principle in commenting on other bills, and we do so here. To guarantee access to care, VA must receive sufficient, timely and predicable funding. Over the past several budget cycles Congress has provided increased discretionary appropriations for veterans' medical care, but at the same time there have been even higher increases in demand for services. Additionally, the budget has been late arriving every year, and as a consequence, VA's ability to effectively plan and properly manage its resources was greatly hampered.

VA currently spends more than $2 billion annually on contract health care services. Unfortunately, VA does not routinely monitor this care, consider its relative costs, analyze patient care outcomes, or even establish patient satisfaction measures for most contract providers. VA has no established systematic process for contracted care services to ensure that:

- care is safely delivered by certified, licensed, credentialed providers;
- continuity of care is sufficiently monitored, and that patients are properly directed back to the VA health care system following private care;
- veterans' medical records accurately reflect the care provided and the associated pharmaceutical, laboratory, radiology and other key information relevant to the episode(s) of care; and
- the care received is consistent with a continuum of VA care.

Currently, VA is implementing a Congressionally authorized pilot project titled "Project HERO"—Health Care Effectiveness through Resource Optimization. The VISN 8 network is one of the demonstration sites participating in this project. According to VA, the purpose of Project HERO is to better manage private health care services VA purchases, and to ensure that community providers meet the quality standards of VA care in caring for participating veterans. As noted by VA, one expected benefit of Project HERO is improvement in access to specialty care services by veterans living in underserved areas. Given the early stages of this initiative, it is unclear what benefits Project HERO will yield in providing more timely access to VA health care services. In a similar vein, we question whether Congress should authorize two competing pilot projects in the same VISN purportedly aimed at solving the same problem. Thus, aside from our principled opposition to contracting as a primary means of solving access shortages in VA, we are concerned about the potential confusion enactment of this bill would spur in VISN 8 as it implements the Project HERO program.

DAV is a strong supporter of a robust, viable VA health care system, sustained to provide highly specialized health care resources—some of them unique—to wounded and ill war veterans. DAV supports contract care options when needed services are unavailable in VA facilities, and in other circumstances authorized by law; however, contract care should be used judiciously and VA coordination of outside care is essential to ensure high quality, safety and cost effectiveness. While we appreciate that enactment of this bill would seem to be helpful in the short run for some veterans, it potentially could damage the VA system by eroding funding needed to sustain VA's viability to continue providing specialized resources to service-disabled veterans. For these reasons we are unable to support this measure, but we appreciate the sponsor's intentions to improve access to care.

H.R. 5729—The Spina Bifida Health Care Program Expansion Act

This bill would amend the language of section 1803(a), title 38, United States Code. This section provides basic authority for health care services for Vietnam veterans' children afflicted with spina bifida. The current language states these individuals receive "such health care as the Secretary determines is needed by the child

for the spina bifida or any disability that is associated with such condition." Under the bill, this language would be stricken and replaced with "health care under this section." Such simplification of authority would ease determinations on eligibility to specific health care services, eliminate concerns that arise on the definition of "child", and moot the need for an association of a specific condition with spina bifida. Consequently this amended language would likely save administrative costs for VA and improve the quality of life for these children and their parents. Finally, this measure includes a provision to include domiciliary care as part of the health care services available to these individuals.

DAV does not have a resolution in support of the specific changes outlined in this bill; however, we believe the goals of the bill are in accord with the intent of the law to provide comprehensive health care services to Vietnam veterans' children with spina bifida. Thus, we have no objection to enactment of this measure.

H.R. 5730—To direct the Secretary of Veterans Affairs to display in each prosthetic and orthotic clinic of the Department an Injured and Amputee Veterans Bill of Rights.

This bill would require VA to establish and prominently display, in each VA health care prosthetic and orthotic clinic, a Bill of Rights for veterans who are injured or have amputations.

The Bill of Rights enumerated in the bill would include the right to:

- access the highest quality prosthetic and orthotic care including the most appropriate technology and qualified practitioners
- continuity of care in the transition from the Department of Defense to the VA health care system, including comparable benefits relating to prosthetic and orthotic services
- select a practitioner that best meets their needs
- consistent, portable and comparable health care services and technology across the VA system of care
- timely and efficient prosthetic and orthotic care
- patient-centered care with the option to request a second opinion regarding prosthetic and orthotic treatment options
- receive a primary and functional secondary prosthetic and orthotic devices
- respectful treatment and the ability to readjust to civilian life through access to VA vocational rehabilitation, employment programs and housing assistance

DAV does not have a specific resolution from our membership on this proposal; however, it is consistent with providing patient-centered, comprehensive, high quality health care services for our nation's sick and disabled veterans. Thus, DAV would have no objection to its enactment.

Mr. Chairman, thank you for requesting the views and recommendations of DAV on these bills. This concludes my testimony and I would be pleased to address your questions and those from other Members of the Subcommittee.

Prepared Statement of Christopher Needham,
Senior Legislative Associate, National Legislative Services,
Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THIS SUBCOMMITTEE:

On behalf of the 2.3 million men and women of the Veterans of Foreign Wars of the U.S. and our Auxiliaries, I would like to express our appreciation for the opportunity to testify at today's legislative hearing. The issues under consideration today are of great importance to our members, and the entire veteran population.

H.R. 2818

This legislation would establish Centers of Excellence for the study of and treatment of epilepsy within the Department of Veterans Affairs (VA). The voting delegates to the 109th VFW National Convention approved Resolution 669, which calls for the creation of these centers, and we strongly support this legislation.

One of the contributing factors of epilepsy is brain injury. As many as 20 to 25% of individuals who suffer closed-head brain injuries eventually suffer from a form of epilepsy known as post-traumatic epilepsy (PTE). With the prevalence of Traumatic Brain Injuries (TBI) among OEF/OIF veterans, it stands to reason that VA will see an increase in the number of veterans suffering from PTE or other seizure disorders.

In May 2007, Dr. John Boos of the American Academy of Neurology testified before the Senate Committee on Veterans' Affairs with respect to research into these conditions and what we can expect from the present conflicts.

> "Although we do not have data on post-traumatic epilepsy from the current conflicts, the statistics from the Vietnam era are alarming. VA-funded research conducted in collaboration with the Department of Defense found that 53 percent of veterans who suffered a penetrating TBI in Vietnam developed epilepsy within 15 years. For these service-connected veterans, the relative risk for developing epilepsy more than 10 to 15 years after their injury was 25 times higher than their age-related civilian cohorts. Indeed, 15 percent did not manifest epilepsy until five or more years after their combat injury. As neurologists, we believe that the rate of epilepsy from blast TBI will also be high."

Given the lack of research, and the outstanding questions concerning the condition, as well as what is likely to be a dramatic increase in the patients seeking treatment through VA, we clearly need these centers of excellence for epilepsy. Their creation would improve research, clinical care, diagnosis and education and outreach efforts throughout the entire Department and veteran community.

We thank Representative Perlmutter for introducing this important legislation, and we would urge the Subcommittee to take action to ensure this bill's passage.

H.R. 5554

The VFW is pleased to support the "Veterans Substance Use Disorders Prevention and Treatment Act." This legislation would create a pilot program to expand and improve VA's ability to treat veterans suffering from substance use disorders.

Section 2 of the bill enumerates ten types of care for the treatment of these disorders, including inpatient and outpatient counseling. We are especially pleased to see peer to peer counseling, interventions and marital and family counseling included among the types of services this bill would mandate. This bill takes it a step further, requiring VA to conduct outreach about the range of services the department provides to OEF/OIF veterans, which will help those affected by these disorders get the treatment they need to overcome these conditions.

Section 3 of the bill requires VA to allocate funding for these programs fairly based upon the number of veterans seeking these types of care, not just based upon the demand for all services within an area. This is important since substance use disorders are quite common in rural areas, places where access to the full range of VA's services is not always easy. Improving outreach, but also the types of services VA can provide can only help these veterans receive proper care.

We support section 4 of the legislation, which would expand VA's outreach efforts for these conditions, by creating a pilot program for Internet-based self-assessments. Since the majority of OEF/OIF veterans are computer literate, and a great number of them use the Internet as a daily part of their lives, a convenient web-based resource, where they can receive information about the range of options for treatment, can only help. We feel that this could also be an important resource for families of veterans who are concerned about their loved one's condition, and who desire more information about the services available to the veteran. When younger generations are looking for information, they often first turn to the Internet. This can only help get them the answers they are seeking.

This issue is important because substance abuse often comes hand-in-hand with other mental health issues, all of which are on the rise among OEF/OIF veterans. Substance abuse is linked to depression, PTSD, and many other mental health conditions. A 2007 study of the Post-Deployment Health Reassessments from the Maine Army National Guard showed that about 12 percent of returning soldiers reported alcohol misuse. Despite this, less than half a percent were referred to treatment. VA's services for these conditions have gone down over the last decade or so, and it is clear that they must be restored to meet this growing demand. Treating these conditions early and managing problems before they worsen is the right thing to do for these brave men and women, giving them a hand up as they make the sometimes difficult transition back into civilian life.

To alleviate the problems, we urge swift action to restore, expand, and improve VA's ability to treat substance abuse disorders among veterans.

H.R. 5595

The VFW is happy to support the "Make Our Veterans Smile Act." This legislation would require VA to provide outpatient dental care to all service-connected veterans. Under current law, only certain types of veterans are eligible for dental care, including veterans who have a service connection of 100%, or veterans who have a

direct service connection for dental-related issues. The majority of disabled veterans are not eligible for care.

We believe that VA should provide dental care as part of the uniform benefits package It is an essential part of health care and should be provided as part of the full continuum of health care for which we have long advocated.

Poor dental care can create larger health problems down the road, and for some veterans, poor dental health can create image problems, which make finding a job difficult. VA does provide dental care for certain veterans enrolled in the vocational rehabilitation program, but not every veteran is, and although we would like more veterans to utilize the service if they need it, it should not be a prerequisite for dental treatment.

H.R. 5622

The VFW supports the intent of this bill, the "Veterans Timely Access to Health Care Act," but we cannot support it. This legislation would create a 5-year pilot program to provide contract care for any veteran who would have to wait thirty days or more for primary care in VISN 8.

The VFW shares the desire to see all veterans have timely access to high-quality VA health care. It has been and continues to be our highest legislative priority. We feel, however, that this legislation would create more problems with the availability of health care across the system than it would fix for those veterans in the pilot program.

Contract care is at a much higher rate than the cost of care that VA provides. The problems with access to care are a function of VA not having enough resources. This bill would take away even more resources—at an inefficient price compared to VA care—from the system, lessening the number of patients VA can treat with limited healthcare dollars even further. We must be mindful of these unintended consequences of the legislation.

The fix for this problem this bill aims to solve is to increase the resources available to VA so that they do not have to ration care. With proper funding, there should not be a problem. It is also important that VA receive funding on time, to ensure that it can properly plan for and manage these dollars efficiently. Additionally, on-time funding would allow VA to recruit, hire and train doctors, nurses and other health care providers, ensuring that VA has sufficient staff to keep up with demand. Congress has made great strides in improving the amount of funding—for which the VFW applauds your efforts—but a greater effort in delivering an on-time budget would help VA to plan properly for the year.

We strongly support the reporting requirements of the bill. Accurate information about the waiting times across the system has been hard to come by, and hard numbers are always more informative than anecdote. Better numbers would allow us to understand the problem, if any, as well as to see what areas are having difficulties, aiding attempts to fix the problems

H.R. 5730

The VFW supports this legislation, which would require the display of an injured and amputee veterans bill of rights. The display simply reaffirms the rights of these injured service men and women, letting them know what is expected of them, and what they can expect from VA.

Draft Bill, the "Spina Bifida Health Care Program Expansion Act"

The VFW supports this legislation, which would mandate health care for children suffering from spina bifida of Vietnam Veterans. It would fulfill VFW Resolution 640, which the voting delegates to our 109th National Convention approved.

Under current law, the Secretary has a lot of discretion about which care and services VA provides to these children. Although the direct care of their condition is typically covered, given the range of complicated health care problems they face, and its probable link to exposures of their veteran parent, it is only fair that the range of services provided to them be opened up fully. Were it not for their parent's military service, these children of those veterans would likely not be suffering from this life-long and debilitating condition. Expanding care to them—including the provision of the bill that would give VA the authority to provide domiciliary care—is clearly the correct thing to do.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions you or the Subcommittee may have.

Prepared Statement of Bernard Edelman, Deputy Director for Policy and Government Affairs, Vietnam Veterans of America

On behalf of the members of Vietnam Veterans of America (VVA) and their families, we appreciate being afforded the opportunity to offer testimony on the health-related legislation up for consideration before the distinguished members of the Subcommittee on Health.

H.R. 2818: This bill would provide for the establishment of Epilepsy Centers of Excellence in the Veterans Health Administration of the Department of Veterans Affairs.

While VVA generally supports the intent of this legislation, particularly section (e)(3) as it calls for the inclusion of veterans on the center facilities' advisory boards, we are obligated to voice our concerns with other parts of the bill as written.

VVA considers that the location of such centers must be in close proximity to and closely partnered with the Traumatic Brain Injury Centers of Excellence which are already in operation. The reasons for this are clear: Within our veteran cohort, epilepsy is most often the result of traumatic brain injury, what many consider to be the "signature wound" of the fighting in Iraq and Afghanistan. Thanks to antiquated legislation and budgetary cutbacks, very few medical facilities in the U.S. are capable of providing even the most minimal level of specialized care for brain-injured patients, forcing most survivors to find treatment hundreds of miles from home, if they can find it at all. And keep this in mind: more than 40 percent of our military deployed in Afghanistan and Iraq hail from rural America.

In addition, the most utilized current treatment modality for epilepsy/seizure disorder is medication. However, epilepsy/seizure disorder caused by either a concussive or contusive brain injury is never just an isolated incident. Over time, without proper diagnosis, treatment and care, this can impact a survivor's cognitive, motor, auditory, olfactory, and visual skills. Treatment and recovery services and programs can also collapse a family and its finances.

Furthermore, establishment of the epilepsy centers in partnership with the TBI Centers will necessitate the hiring of additional clinical staff to coordinate treatment and recovery plans. It should also be noted, however, that brain injuries cannot be managed any more than a thunderstorm can be managed. Although licensed clinical case managers number in the tens of thousands, licensed brain injury case managers number only in the tens of dozens, according to the Case Management Society of America. Of all the medically challenging injuries, brain injuries require the most involvement and cost over time.

So, yes, H.R. 2818, as currently drafted, represents a good beginning of vitally needed legislation.

H.R. 5730: This bill directs the Secretary of Veterans Affairs to display in each prosthetic and orthotic clinic of the Department of Veterans Affairs an Injured and Amputee Veterans Bill of Rights.

VVA endorses H.R. 5730

H.R. 5554: The goal of the "Veterans Substance Use Disorders Prevention and Treatment Act of 2008" is to "expand and improve" healthcare services available to veterans from the VA for substance use disorders. This is laudable and doable. H.R. 5554 ought to be enacted and action taken by the VA to immediately adapt to its provisions. And we applaud the provision in this bill that "report(s) an assessment of the feasibility and advisability of the pilot program, of any cost savings or other benefits associated with the pilot program, and recommendations for the continuation or expansion of the pilot program."

Far too many veterans self-medicate to assuage the demons inside, demons that often derive from their experiences while in uniform. In order for them to lead complete and productive lives, they need to get the monkey off their backs.

Of course, the VA will have to gear up in order to comply with the provisions of the bill if H.R. 5554 becomes law. A key aspect of this gearing up will be to find and hire enough experienced substance use counselors and clerical staff, something we believe the VA is quite adept at doing.

VVA endorses H.R. 5554.

H.R. 5595: The sweetly titled "Make Our Veterans Smile Act of 2008" would direct the Secretary of Veterans Affairs to provide dental care to veterans with service-connected disabilities.

VVA endorses this bill, even though it will mean that VAMCs will have to pump up their dental departments. This they ought to be able to accomplish, considering the boosts to VA coffers in the current fiscal year.

H.R. 5622: The "Veterans Timely Access to Health Care Act" would, if enacted, set in motion a pilot program "to establish standards of access to care for veterans seeking health care from certain Department of Veterans Affairs medical facilities."

This bill, however, will likely cause more bureaucratic and clerical headaches than make the delivery of health care more efficient. Also, this bill, like H.R. 4915, seemingly does not take into account the fact that one out of every ten healthcare dollars spent by the VA is spent outside the VA system.

We fear that a bill such as this will only serve to erode the VA system, which has been built up since the advent of the Eligibility Reform Act in 1996. Congress has sought to improve the very services this bill seeks to remedy by appropriating several billion additional dollars over the past two fiscal years for VA health care. We would advise the subcommittee to take a very hard look at the potential for damaging the very system a bill like H.R. 5622 seeks to help.

With this in mind, VVA cannot endorse H.R. 5622.

"Spina Bifida Health Care Program Expansion Act": This bill is a sensible update, taking into account that a child afflicted with spina bifida is no longer a child and hence may need a variety of additional medical interventions and healthcare services.

VVA would advocate, however, that Congress consider, either as part of this bill or in a new bill, mandating that the VA conduct research into other potential intergenerational effects of exposure to Agent Orange and other toxins in military services. We are hearing too many stories from too many children of in-country Vietnam veterans who tell of the birth defects suffered by their offspring and who wonder: Could this be somehow related to my father's—or mother's—exposure to Agent Orange?

I thank you for affording VVA the opportunity to present our views, and thank you for what you are doing to assist veterans and their families. I will be pleased to answer any questions you may have.

Prepared Statement of Gerald M. Cross, M.D., FAAFP,
Principal Deputy Under Secretary for Health,
Veterans Health Administration, U.S. Department of Veterans Affairs

Good Morning Mr. Chairman and Members of the Subcommittee:

Thank you for inviting me here today to present the Administration's views on five bills that would affect Department of Veterans Affairs (VA) programs that provide veteran health care benefits and services. With me today is Walter Hall, Assistant General Counsel.

H.R. 5729. "Spina Bifida Health Care Program Expansion Act"

H.R. 5729 would authorize the Secretary to provide an eligible child of a Vietnam veteran who suffers from spina bifida with any needed health care. It would also authorize the Secretary to provide these beneficiaries with domiciliary care. As you know, the law currently limits the provision of health care services to those needed to treat the condition of spina bifida or an associated disability.

VA has no objection to H.R. 5729. Providing a total health management program to this needy beneficiary population would provide needed relief for the families seeking a complete spectrum of fully integrated care. Spina bifida is a devastating birth defect resulting from the failure of the spine to close. Depending on the extent of spinal damage, problems resulting from spina bifida may include: permanent paralysis, orthopedic deformities, cognitive disabilities, breathing problems, or impaired basic bodily functions. Even with appropriate medical treatment, these children will have numerous secondary health conditions, such as decubitus ulcers (bed sores), lung infections, depression, and fractured bones. Due to the wide range of neurological damage and mobility impairments that can be caused by spina bifida, it can be difficult to identify the secondary disabilities that are either directly or indirectly associated with the condition.

We offer one caveat, however. Providing such services in a VA domiciliary treatment setting could prove problematic. Services provided under the spina bifida program are currently furnished under contract. Domiciliary care is unique to the VA health care system and is used mainly for veteran-populations needing intensive rehabilitative outpatient care in a residential setting, such as veterans receiving treat-

ment for substance use disorders, seriously mentally ill veterans, and homeless veterans. The domiciliary program is managed by Mental Health Services and is intended as a transitional program to return veterans to the community, not as a long-term residential care arrangement. Given the nature of the distinct clinical needs of the spina bifida beneficiary population and the traditional users of domiciliary services, we do not believe VA's domiciliaries would be suitable residential treatment settings for spina bifida beneficiaries. Instead, those beneficiaries would benefit from the services in VA's continuum of extended care services, e.g. home telehealth, homemaker/home health aide, adult day health care, and nursing home care.

As a technical matter, we note that this bill amends only 38 U.S.C. § 1803 [related to children of Vietnam veterans]. However, a separate authority (38 U.S.C. § 1821(a)) authorizes VA to furnish certain Korean conflict veterans' children born with spina bifida the same health care benefits that are available and furnished to Vietnam veterans' children born with spina bifida. Thus, by operation of law, the amendments included in H.R. 5729 would extend to those other beneficiaries as well.

We estimate that enactment of this bill will result cost $8.4 million in FY 2010 and $142 million from FY 2010–2019.

H.R. 2818. Epilepsy Centers of Excellence

H.R. 2818 would require the Secretary, not later than 120 days after the date of the bill's enactment, to designate not less than six VA facilities as Epilepsy Centers of Excellence ("Centers"). Subject to the availability of appropriations for this specific purpose, the Secretary would be required to establish and operate these Centers. H.R. 2818 includes general procedures to be followed by the Secretary when designating a facility as a Center as well as qualification criteria for facilities seeking such designation. For instance, one criterion would require a facility to have (or develop in the foreseeable future) an affiliation with an accredited medical school that provides education and training in neurology, plus have an arrangement under which medical residents would receive education and training in the diagnosis and treatment of epilepsy. Other criteria would require a facility to be able to attract the participation of scientists who are capable of ingenuity and creativity in healthcare research efforts and to also possess the capability to evaluate effectively the Center's activities in the areas of education, clinical care, and research.

H.R. 2818 would also establish a national coordinator for epilepsy programs, who would report to the official responsible for neurology within the Veterans Health Administration (VHA). This individual would be responsible for supervising the operation of the Centers, coordinating and supporting the national consortium of providers with interest in treating epilepsy at VA medical facilities without a Center, and regularly evaluating the Centers to ensure their compliance with the bill's requirements.

VA does not support H.R. 2818, because it is unnecessary. VA already has seven sites that have the following capabilities: 1) an epilepsy monitoring unit; 2) capacity to perform invasive monitoring; 3) ability to implant vagus nerve stimulators; and 4) ability to perform resection of epileptic foci. Five additional sites have the capacity to perform epilepsy surgery but not all of the other components listed above.

Moreover, it is increasingly VA's goal to have each of its medical facilities capable of providing state-of-the-art epilepsy care. Thus, the trend is to establish expertise and capacity on a system-wide basis, as opposed to creating a few centers of excellence across the country.

We estimate the cost for FY 2008 to be $6.4 million and $64.7 million over a ten-year period.

H.R. 5554. "Veterans Substance Use Disorders Prevention and Treatment Act of 2008"

Currently, VA is required to develop and carry out individual treatment plans for veterans receiving treatment for substance use disorders. H.R. 5554 would further require that these treatment plans ensure VA medical centers provide a "full continuum of care" for substance use disorders. The bill would define a "full continuum of care" as all of the following:

- screening for substance use disorders in all settings;
- detoxification and stabilization services;
- intensive outpatient care services;
- relapse prevention services;
- outpatient counseling services;
- residential substance use disorder treatment in the case of veterans with severe recurring substance abuse or substance dependence;

- pharmacological treatment to reduce cravings and opioid substitution therapy;
- coordination with groups providing peer-to-peer counseling;
- short-term, early interventions for substance use disorders, such as motivation counseling, that are readily available and provided in a manner to overcome the stigma associated with the provision of such interventions and related care; and
- marital and family counseling.

H.R. 5554 would also require the Secretary to provide outreach to veterans who served in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF) to increase awareness of the availability of VA care, treatment, and services for substance use disorders.

This measure would further compel the Secretary to ensure that amounts available for care, treatment, and services for substance use disorders are allocated in such a manner that a full continuum of care is available to every veteran seeking such services without regard to the location of the veteran's residence. The Secretary would also have to submit a detailed report on the services furnished under this authority as part of the budget documents submitted annually to the Congress, and each such report would need to be reviewed and addressed by VA's own Committee on Care of Severely Chronically Mentally Ill Veterans. The amendments concerning the allocation of funding would be effective October 1, 2009.

H.R. 5554 would also require, not later than one year after the date of the bill's enactment, that the Secretary carry out a two-year pilot program to test the feasibility and advisability of providing veterans who seek treatment for substance use disorders with access to a computer-based self-assessment, education, and specified treatment program through a secure Internet website operated by the Secretary. Participation in the pilot would be voluntary and limited to veterans who served in OEF/OIF. The bill specifies a number of requirements to be followed by the Secretary in establishing the pilot program. For example, the Secretary would be required to ensure that access to the Internet website and the online treatment program does not involuntarily generate an identifiable medical record of that access in any medical database maintained by VA. The Internet website would also need to be accessible from remote locations, including rural areas, as well as include a self-assessment tool for substance use disorders, self-guided treatment, and educational materials. Plus, appropriate information for the veteran's family members would need to be available on the website. H.R. 5554 would limit pilot program sites to VA medical centers that have a Center for Excellence for Substance Abuse Treatment and Education or a Substance Abuse Program Evaluation and Research Center.

We support the goals of enhancing substance use services for veterans as described in H.R. 5554, but we cannot support the bill as written. First, many of the bill's provisions are unnecessary because those enhancements have been included in VHA's Comprehensive Mental Health Strategic Plan, which is being funded under the Mental Health Enhancement Initiative.

Second, the bill would provide for residential substance use disorder treatment only "in the case of veterans with severe recurring substance abuse or substance dependence." This implies that the choice between an outpatient and a residential treatment program should be based upon the severity and persistence of a substance use disorder. There is no evidence that treatment-outcomes for persons with severe substance use disorder vary as a function of the setting in which the services are delivered. Rather, the important factor is that patients be able to consistently attend treatment services. Thus, availability of residential treatment is important for patients who could not reliably attend outpatient treatment programs because of their distance to care, unstable housing arrangements, or health or psychosocial factors that prevent consistent treatment attendance. Simply put, the bill fails to correctly target the veterans in need of residential care: those with substance use disorders who cannot be managed effectively in intensive outpatient programs.

For these reasons, we recommend the Committee forbear in its consideration of this bill, and we would welcome the opportunity to work with the Committee and to brief the Committee on the Department's on-going efforts in this area.

We estimate the total cost of H.R. 5554 to be $72 million in FY 2009 and $725 million over a ten-year period.

H.R. 5595. "Make Our Veterans Smile Act of 2008"

Mr. Chairman, H.R. 5595 would make two significant changes to VA's current authority to furnish outpatient dental services. First, the bill would require VA to furnish needed outpatient dental services and treatment to any veteran who has a service-connected disability. Second, it would authorize the Secretary to invoke our fee-basis authority to contract with a private provider for outpatient dental treatment and services for any veteran eligible to receive dental treatment and services

through Department facilities. Both of the amendments would be effective on or after January 1, 2009.

VA does not support H.R. 5595. Although the concept of providing life-long comprehensive dental services to veterans with a service-connected disability is laudable and in concert with our general mission of improving the oral health of all veterans, it is not feasible. Enactment of this legislation would make an additional 1,075,000 veterans eligible for VA dental care. This increased workload would overwhelm VA's capacity to provide these services in-house (both in terms of staffing and the number of physical dental clinics and labs). In fact, VA is already operating at full capacity and must now purchase dental services for those veterans we cannot treat.

Of chief concern to us is the estimated cost of this bill. Expanding VA's contracting authority would result in a thirteenfold increase in the amount VA expends for fee-basis dental care, i.e., over $817 million in FY 2008 alone. The total cost for the next ten years would be almost $11.3 billion.

H.R. 5622 "Veterans Timely Access to Health Care Act"

Mr. Chairman, the last bill on the agenda is H.R. 5622, which would establish a five-year pilot program under which the Secretary would be required to ensure that a veteran seeking primary care from a VA medical facility in Veteran Integrated Services Network 8 is given access to care in 30 days. The standard would be measured from the date on which the veteran contacts VA seeking an appointment until the date on which a visit with a primary-care provider is completed. H.R. 5622 would also require the Secretary to periodically review the performance of covered medical facilities in meeting the 30-day standard. When unable to meet the 30-day standard, the bill would require VA to contract for the needed care and services.

When purchasing those services, H.R. 5622 would prohibit the Secretary from paying the non-VA provider more than the rate that would be applicable under part B of the Medicare Program. It would also prohibit the non-VA provider from billing the veteran for any difference between the billed charges and the amount paid by VA. The Secretary would also be required to develop a form to be used by veterans to authorize VA to obtain any records created in connection with the veterans' receipt of care from a non-VA facility.

Once a veteran has received care for 30 days from a non-VA provider under this section, the veteran could choose to receive his or her primary care at a VA facility, if available. The veteran would need to notify VA in writing of this choice.

VA does not support H.R. 5622, because it is overly prescriptive and to a large degree unnecessary. Although we agree with the imposition of a 30-day standard for the scheduling of patients, such a standard should only apply to new patients. New patients need to be tracked to determine if there are difficulties accessing the VA system of care.

VA already complies with and exceeds the 30-day standard. Almost all VA facilities currently comply with the 30-day standard 90 percent or more of the time and improvement continues. In FY 2007, the percent of primary care appointments provided within 30 days of the patient's desired date for new patients was 83 percent and 98 percent for established patients (established patients are those already being seen; the majority of their appointments are for follow-up care in the future and they do not need to be seen within 30 days).

VA is making significant strides to eliminate the waiting list for primary care and believes based upon our recent progress and planned future efforts that we will reduce the list of primary care patients waiting more than 30 days of the desired appointment date to zero by the end of FY 2009.

In those situations where VA would be required by H.R. 5622 to contract for care, restricting payment to no more than the Medicare rate could make it difficult for VA to obtain that care in the private sector. The bill would not require contractors, even if they are Medicare providers, to agree to accept the Medicare rate from VA. The result could be that VA may not be able to purchase needed services in the community, and VA would have to limit the contract services available to veterans participating in the pilot program.

Another fundamental problem with H.R. 5622 is its requirement to contract for care for certain veterans. This essentially sends these veterans outside the VA system for a 30-day period before they can choose to resume care at a VA facility. This would result in their care being interrupted and fragmented, lessening the quality of care they receive. Also, requiring the veterans to request in writing their desire to return to care in a VA facility places an undue responsibility on the patients. Lastly, this contracting-requirement assumes that all private care providers in the community can meet the 30-day standard, but there are no measures available to support this assumption.

Finally, contracted care would not necessarily include the comprehensive screenings, case management services, documented quality, and expertise in veteran-specific conditions that are available in the VA health care system.

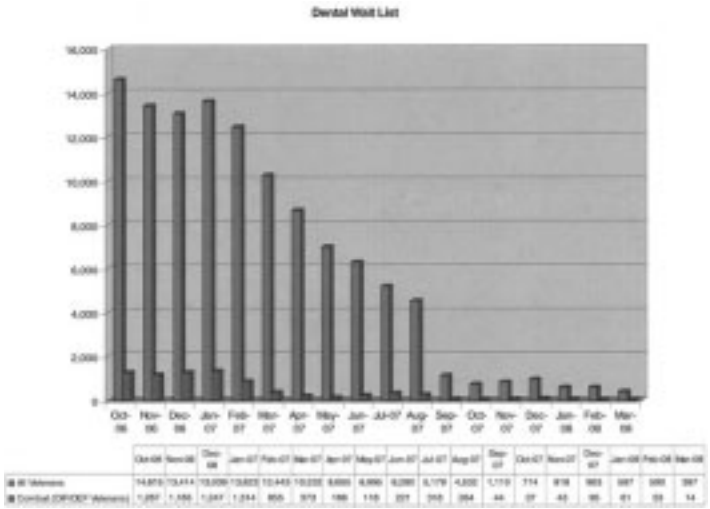
We estimate that H.R. 5622, if enacted, would cost $26.2 million for the remainder of FY 2008. We are still developing out-year projections based on anticipated changes in the demographics of VISN 8, but we will supply those for the record as soon as they are available.

H.R. 5730. Injured and Amputee Veterans Bill of Rights

Mr. Chairman, H.R. 5730, which would direct the Secretary to display in each VA prosthetic and orthotic clinic an Injured and Amputee Veterans Bill of Rights, was only recently added to today's agenda. We are still in the process of developing views on the bill. Once completed, we will forward it to the Committee.

This concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Subcommittee may have.

[A second handout from the Department of Veterans Affairs entitled, "Risk Adjustment Mortality as an Indicator of Outcomes: Comparison of the Medicare Advantage Program with the Veterans Health Administration," will be retained in the Committee files.]



Statement of Raymond C. Kelly, National Legislative Director, American Veterans (AMVETS)

Chairman Michaud, Ranking Member Miller and members of the Subcommittee:

On behalf of AMVETS (American Veterans) I want to thank you for providing me the opportunity to testify before this Subcommittee concerning pending legislation.

AMVETS supports H.R. 2818 which will amend Chapter 73, title 38, U.S.C., to provide for the establishment of Epilepsy Centers of Excellence. AMVETS believes that with the number of servicemembers who have been exposed to Improvised Explosive Devices (IEDs), VA must take every action possible to develop Epilepsy Centers of Excellence to conduct research, education, and the highest quality clinical care for our veterans who will undoubtedly become epileptic. Research has shown that more than 50% of service related TBI from the Vietnam War became epilepsy within 1–15 years from the date of the trauma. More recent studies have shown that mild to moderate TBI victims, even those who did not lose consciousness, are at risk of having cognitive deficits. When the brain is working to repair the damage caused by TBI, excessive neuroexcitation occurs. When these neuroexcitations misfire it can cause, among other symptoms, seizures. Data from a 2003 report found that 61% of returning servicemembers were exposed to IED blasts. It is unrealistic to predict the number of veterans from current conflicts who will become epileptic

from TBI, but it is very realistic to predict from past evidence and the IED exposure rate that thousands of veterans are susceptible to epileptic seizures. It would be irresponsible for Congress to wait until there is an epileptic crisis to provide VA with the means to research and treat this condition.

Although AMVETS understands the benefits of being able to be near one's home when recovering, we historically oppose contract for care when there is timely access to a VA facility. Therefore, AMVETS opposes H.R. 4915, the "Veterans' Access to Local Options for Recovery Act of 2007" (VALOR Act).

H.R. 5554, the "Veterans Substance Use Disorders Prevention and Treatment Act" expands and improves health care services available to veterans from the Department of Veterans Affairs for substance use disorders. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), one fifth of veterans of wars in Iraq and Afghanistan who received care from the Department of Veterans Affairs between 2001 and 2005 were diagnosed with substance use disorder (SUD). In November of 2007 SAMHSA published the National Survey on Drug Use and Health (NSDUH) which stated that an annual average of 7.1 percent of veterans (an estimated 1.8 million persons) met the criteria for SUD. From 2004 to 2006 approximately 1.5 percent of veterans aged 18 or older (an estimated 395,000 persons) had co-occurring serious psychological stress (SPD) and SUD. AMVETS recognizes the importance of ensuring veterans have access to a full continuum of care and for this reason support the expansion of veterans substance use disorder programs.

AMVETS is concerned, however, with section 4 of this bill which provides $1.5 million dollars in 2009 and 2010 for a pilot program for Internet-based substance use disorder treatment for veterans of Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). AMVETS does not believe the Internet is an appropriate medium for substance use disorder treatment. It is impossible to provide the continuum of care outlined in section 2 of the bill without inpatient or intensive outpatient treatment. AMVETS would support appropriating those funds to ensure veterans access to more traditional and proven treatment options.

AMVETS wholly supports H.R. 5595 the "Make Our Veterans Smile Act of 2008." This will ensure dental service for those who have sacrificed so much. Currently, section 1712, Title 38 U.S.C., provides dental care for certain eligible veterans. This legislation will provide dental services to all disabled veterans. It is well documented that poor oral health can attribute to poor physical health. Therefore, VA should view dental care as an important aspect of overall health of veterans. This legislation would be most beneficial to veterans who are rated 100% disabled and have begun dental care through VA, and due to reevaluation the disability rating is reduced, leaving the veteran with partially completed dental care with no means to complete the care. This was the case for one veteran, who has requested to stay anonymous, who was rated 100% disabled with PTSD and upon reevaluation his rating was reduced to 90%, leaving him with partially completed bridge work that was initiated by VA, but because of the rating reduction was no longer eligible for dental care. If Congress truly wants to provide a full continuum of care for our veterans, then dental health should be a part of that care.

AMVETS views section 2, Subsection (b) of H.R. 5595 as an administrative amendment of contract for care and not new authority for the Secretary to enter into contracts. Additionally, AMVETS would prefer H.R. 5595 be enacted as written, but would consider supporting an amendment, based on cost estimates, that would reduce coverage to those already receiving care under section 1712, title 38 U.S.C., and Priority Group 1 veterans who are not currently covered by that same section.

H.R. 5622 the "Veterans Timely Access to Health Care Act," provides a five-year pilot program to evaluate the standard for access to care for veterans. AMVETS opposes this legislation. VBA currently tracks primary care standard for access; therefore, AMVETS believes this program would build unnecessary redundancy in tracking. Current tracking should be used to trend VA's need for primary care FTE. Also, AMVETS is opposed to contracting primary care. Even though VA can be billed by non-department care providers at no cost to the veteran, under current VA regulation VA is not allowed to honor non-department prescriptions, so the veteran would be obligated to pay for any medications the non-department physician would write. Again, AMVETS supports tracking of standard of access to care, but only for the purpose of evaluating hiring needs.

Mr. Chairman, this concludes my testimony. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Statement of Lewis E. Gallant, Ph.D., Executive Director,
National Association of State Alcohol and Drug Abuse Directors, Inc.

Chairman Michaud, Ranking Member Miller, and members of the Subcommittee, on behalf of the National Association of State Alcohol and Drug Abuse Directors (NASADAD), and our component organizations, the National Prevention Network (NPN) and the National Treatment Network (NTN), thank you for your leadership on issues related to veterans suffering from substance use disorders. We are pleased to offer comments on H.R. 5554, the Veterans Substance Use Disorder Prevention and Treatment Act of 2008.

Who We Are: NASADAD members include the State Substance Abuse Directors from the 50 States and five U.S. territories. These State Directors, also known as Single State Authorities (SSAs), have the frontline responsibility for managing the nation's publicly funded substance abuse prevention, treatment and recovery systems. SSAs have a long history of providing effective and efficient services—with the Substance Abuse Prevention and Treatment (SAPT) Block Grant being the backbone of the system. SSAs also provide leadership to continually improve quality of care, expand access to services, improve client outcomes, increase accountability and nurture new and effective service initiatives.

Scope of the Problem: According to the Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH), approximately 23.6 million Americans aged 12 or older needed treatment for an alcohol or illicit drug problem in 2006. During the same year, approximately 4 million received some kind of treatment for an alcohol or illicit drug problem. As a result, approximately 19.6 million people needed but did not receive services in 2006.

Scope of the Problem Among Veterans: According to the NSDUH, in 2003, there were an estimated 25 million veterans in the United States. One quarter of veterans aged 18 to 25 met the criteria for a substance use disorder in the past year compared to 11.3 percent of veterans aged 26 to 54 and 4.4 percent of veterans aged 55 or older. Heavy use of alcohol was most prevalent among veterans compared to nonveterans: an annual average of 7.1 percent of veterans aged 18 or older or an estimated 1.8 million veterans met the criteria for a substance use disorder in 2006.

Addiction is a Brain Disease: According to research by the National Institute on Drug Abuse (NIDA), substance use disorders or addictive disorders are defined as chronic, relapsing brain diseases that are characterized by compulsive drug seeking and use, despite harmful consequences. Substance use disorders literally change the brain's structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs. Not only do genetics play a large role in one's vulnerability to suffer from substance use disorders, but environmental factors, such as trauma, also play a role in one's vulnerability to suffer from substance use disorders.

Trauma and Stress are Risk Factors for Substance Use Problems: Research shows that a very stressful event or trauma such as military combat may lead to the development of Post Traumatic Stress Disorder (PTSD) or another form of psychological distress. A NIDA Special Report on Stress and Substance Abuse found ". . . studies have reported that individuals exposed to stress are more likely to abuse alcohol and other drugs or undergo relapse." The NIDA Special Report also found that ". . . high rates of co-occurring substance use disorders and PTSD are reported in studies of combat veterans, with as many as 75% of combat veterans with PTSD meeting the criteria for alcohol abuse or dependence (NIDA: 2005)."

Services for Substance Use Disorders are Effective: Research shows that substance use disorder prevention and treatment services are effective. Discoveries in the science of addiction have led to advances in treatment that help people stop using alcohol and other drugs and resume their productive lives. Research and experience also have found that successful treatment approaches are those that are tailored to address each person's individual circumstances.

Publicly-funded State System Yields Results: The Substance Abuse Prevention and Treatment (SAPT) Block Grant, which is managed by SSAs, represents approximately 40 percent of State substance abuse agency expenditures. The SAPT Block Grant is an effective and efficient program that provides vital prevention and treatment services for the nation's most vulnerable populations. According to SAMHSA, the SAPT Block Grant has been successful in expanding capacity to treatment and achieving positive results. In particular, outcomes data from the SAPT Block Grant found, at discharge, 68.3 percent of clients were abstinent from illegal drugs and 73.7 percent of clients were abstinent from alcohol. SAPT Block Grant funded programs help people find or regain employment; stay away from criminal

activity; reunite with families; and find stable housing. Some State-specific examples of outcomes made possible by the SAPT Block Grant are included below:

- *Maine's Office of Substance Abuse (OSA)* reported 12,976 admissions to treatment and provided prevention services to 18,551 in State Fiscal Year 2007. In State Fiscal Year 2007, the following client outcomes were reported at discharge: 77 percent of clients were abstinent from alcohol or other drugs; employment increased by 20 percent at discharge; and homelessness decreased at discharge.
- *Florida's Department of Children and Families* reported 89,716 new treatment admissions and provided prevention services to 133,024 adults and children received in State Fiscal Year 2006. In SFY 2006, the Department reported the following client outcomes: 81 percent of adult clients were abstinent one year after discharge; 67 percent of child clients were abstinent one year after discharge; a 28 percent decrease in homelessness for clients receiving treatment; and employment rates increased by 20 percent for clients receiving treatment.
- *South Carolina's Department of Alcohol and Other Drug Abuse Services (DAODAS)* reported 48,299 admissions to treatment and provided prevention services to approximately 208,000 people in State Fiscal Year 2006. In SFY 2006, the Department reported the following client outcomes from a sample survey comparing admission to 90 days after discharge: 80.1 percent of clients reported no alcohol use; 71.6 percent of clients reported that they were employed; and 98 percent of students reported a reduction in suspensions, expulsions or detention.

Current State Initiatives: A number of States are implementing various programs and initiatives to help veterans/military personnel and their families. NASADAD would like to call attention to a report issued on July 30, 2007 by the National Governors' Association (NGA), with the support of the Office of the Deputy Under Secretary of Defense, titled *State and Territorial Support for Members of the National Guard, the Reserves and their Families* (see http://www.nga.org/Files/pdf/07GUARDREPORT.PDF). The report notes that Governors are moving above and beyond federal requirements related to support for the National Guard and Reserves as many return from overseas assignments. The NGA report places the benefits States are offering into six categories, including State Employee Benefits and Family Support benefits.

NASADAD is also aware of current activities that include the involvement of the State substance abuse agency to address the needs of military personnel returning from countries impacted by war. A sample of these activities is included below:

- *Vermont's Division of Alcohol and Drug Abuse Programs* reports the development of a State interagency team; training for providers on veterans issues; and training for professionals working with children and families.
- *California's Department of Alcohol and Drug Programs (ADP)* is working to infuse veterans issues into the statewide needs assessment and planning effort. ADP participated in a veterans conference in January 2008 to discuss and prepare for the needs of OIF/OEF veterans.
- *Washington State's Division of Alcohol and Substance Abuse (DASA)* reports working with the U.S. Army at Ft. Lewis, the Washington State National Guard, and the State Office of Veterans Affairs to engage returning veterans.
- *Indiana's Division of Mental Health and Addiction (DMHA),* in cooperation with the DMHA Advisory Council, convened a forum that included the VA Veteran Integrated Services Network (VISN) 11, Indiana Department of Veterans Affairs, VA Roudebush Medical Center, VA Northern Indiana Medical Center, and the Indiana National Guard to discuss the needs of returning veterans and to explore opportunities for collaboration. DMHA's Advisory Council, State Planning Council, and Transformation Working Group include VA representatives. The Division has also designated a liaison to VISN 11.
- Since 2005, ODADAS has participated in a multi-agency collaborative, spearheaded by Ohio's Adjutant General, to develop a network of specially trained community-based alcohol and other drug and mental health providers to address the unique behavioral health needs of soldiers returning from Iraq and Afghanistan and their families. This initiative, referred to as OHIOCARES, has trained over 400 community-based providers including Veterans Administration and state mental health institution personnel. The OHIOCARES collaborative has convened two statewide conferences, published a brochure for military personnel and their families on how to access services, a resource guide to assist returning service members during their transition from active duty and a 1–800 number (1–800–761–0868) and website (www.ohiocares.ohio.gov). A marketing/

branding Committee was formed in 2007 and is currently finalizing materials for a statewide public awareness campaign. Included in this effort are the development of a radio and television PSA, posters, Info Cards, refrigerator magnets and web banners. These materials will be finalized and made available in May 2008.

- *Iowa's Division of Behavioral Health* reports working with Traumatic Brain Injury advocates and service providers. The Division is also working to link with VA systems and participating in training through a suicide prevention grant.
- *Oklahoma's Department of Mental Health* is providing briefings to families impacted by deployment.
- *Pennsylvania's Bureau of Drug and Alcohol Programs (BDAP)* participates on the Returning Pennsylvania Military Task Force, along with the Pennsylvania National Guard, Social Security Administration, State Civil Service Commission, U.S. Department of Veterans Affairs, Pennsylvania Department of Education, Pennsylvania Department of Labor and Industry, and others. BDAP also sponsored a regional training event in September 2007—Serving Those Who Serve: Veterans and their Families. The event attracted 170 individuals and provided five specific courses designed for counselors and therapists.
- *New Hampshire's Office of Alcohol and Drug Abuse Policy* reports work with the New Hampshire National Guard to augment alcohol and other drug intervention service and treatment services with current services for those returning home from war.
- *New York's Office on Alcoholism and Substance Abuse Services (OASAS)* reports funding Samaritan Village since 1996 which offers a 48 bed treatment facility for veterans in Manhattan; a new 50-bed residential facility will be placed in Queens; $280,000 was allocated for prevention counseling in the Fort Drum impacted schools; and a program model is being developed to bring 100 new residential beds for veterans into the system that will be responsive to the needs and characteristics of veterans, including Traumatic Brain Injury, PTSD and other issues.
- *New Jersey's Division of Addiction Services (DAS)* reports participation on the Veterans Subcommittee of the Governor's Council on Alcoholism and Drug Abuse, which is developing a directory of resources to be distributed to veterans affiliated government and private agencies. DAS is working with military officials at Fort Dix, New Jersey, in an effort to provide them with training opportunities for evidence-based Strengthening Families prevention program which could then be implemented on base.
- *Kentucky's Division of Mental Health and Substance Abuse* is working with the State provider network to determine the impact of returning veterans and others seeking services in the public sector. The State reports that a number of providers have reported increases in the number of veterans in the publicly funded system and report an increased need for family and children's services.

Barriers to Service Delivery at the VA: The Department of Veterans Affairs (VA) has identified substance use disorders as a significant problem among veterans. In 2004, Dr. Richard Suchinsky, Department of Veterans Affairs Associate Chief for Addictive Disorders, ranked substance use disorders among the three most common diagnoses made by the Veterans Health Administration (VHA). The January 2008 VA Healthcare Utilization Among U.S. Global War on Terrorism (GWOT) Veterans, VA Office of Public Health and Environmental Hazards, found that of the approximately 300,000 veterans from Operations Enduring and Iraqi Freedom who have accessed VA healthcare, nearly 50,000 have been diagnosed with a substance use disorder. Furthermore, data from the NSDUH found that an estimated 0.8 percent of veterans received specialty treatment for a substance use disorder in the past year, yet an estimated 7.1 percent of veterans met the criteria for a substance use disorder in the past year, leaving close to 6.3 percent of veterans going without treatment. NASADAD recognizes the capacity problems across the whole system and applauds the VA for recognizing that substance use disorders are a problem among veterans and for making efforts to expand capacity to treatment for returning veterans. The stigma associated with substance use disorders also presents a barrier to veterans seeking treatment for substance use disorders.

Recommendations: As the Subcommittee engages in discussions about substance use disorder services in general, and H.R. 5554 in particular, NASADAD offers the following recommendations for consideration:

Coordination with State Substance Abuse Directors: NASADAD recommends provisions that foster and enhance coordination and communication between SSAs and the VA. As previously mentioned, SSAs plan, implement, oversee and evaluate comprehensive statewide systems of clinically appropriate care. SSAs already work with

a variety of public and private stakeholders given the impact substance use disorders have on issues such as housing, education, employment, family and much more. As mentioned earlier, a number of SSAs are already engaged in initiatives regarding services for veterans. The inclusion of provisions in H.R. 5554 that foster or enhance coordination with the State substance abuse agency would ensure a thoughtful planning process and promote a more effective and effective approach to service delivery, as well ensure a referral network of competent providers.

Federal Agency Collaboration: NASADAD recommends continued work to encourage coordination among federal agencies that have a role in helping veterans receive appropriate services. We recommend continued and consistent collaboration between the VA and the Substance Abuse and Mental Health Services Administration (SAMHSA) on issues related to substance abuse and mental health. This collaboration ensures that efforts are made to maximize and leverage the financial resources and expertise available on these important issues. One specific example relates to the benefit of coordinating the efforts of SAMHSA's regional Addiction Technology Transfer Centers (ATTCs) and Centers for the Application for Prevention Technologies (CAPTs) with proposals to establish within the VA system centers of excellence that would include substance abuse as a specific component. The ATTCs and CAPTs serve as centers that help take the latest research and infuse the knowledge into the publicly funded system through practice improvement initiatives, training, workforce development and other mechanisms. Federal agency coordination specific to substance use disorders would also include work with the National Institute on Drug Abuse (NIDA), National Institute on Alcohol Abuse and Alcoholism (NIAAA). Finally, NASADAD supports additional federal agency coordination with other agencies as well, including Department of Housing and Urban Development (HUD), Department of Labor (DoL), Department of Education (Ed), and others.

Adequate Resources: NASADAD wishes to applaud the VA for its work and commitment to veterans in States across the country. There is no doubt that excellent work is moving forward. We also know that many challenges remain. For example, the core funding stream that represents the backbone of the State publicly funded system—SAMHSA's Substance Abuse Prevention and Treatment (SAPT) Block Grant—has been reduced by $20 million since FY 2004. In addition, resources within SAMHSA's Center for Substance Abuse Prevention (CSAP) and Center for Substance Abuse Treatment (CSAT) remain stagnant. In addition, decreases in capacity across the whole system make it difficult to address the needs of returning military personnel, such as the returning National Guard members.

NASADAD strongly agrees with the Veterans Affairs Policy Position of the NGA (HHS–05) that notes "Governors recommend that more resources be provided to address the impact of completed suicides, PTSD, TBI, and substance/alcohol abuse through the VA." Additional resources are needed for the VA in order to enable the agency to attain our common goal of improving access to, and quality of, services for substance use disorders. NASADAD would like to recognize recent investments made by Congress in support of substance use disorder services within the VA and Department of Defense (DoD) over the past few years.

Workforce: As previously noted, treatment for substance use disorders is effective and efficient. NASADAD supports the delivery of substance use disorder services by practitioners that adhere to standards of care set by the State. We believe this approach ensures that healthcare professionals have the clinical expertise needed to provide the best care possible to returning veterans suffering from substance use disorders. NASADAD applauds the VA for efforts to expand their addiction-specific workforce in the last couple years. NASADAD is committed to partnering with the VA and others to continue this expansion given the acute problem of recruiting and retaining a qualified health workforce.

Flexibility: NASADAD encourages initiatives to include the benefits of flexibility. As previously mentioned, States across the country are implementing a number of initiatives to assist veterans and their families. The Association encourages federal initiatives to include flexible approaches to policy decisions in order to maximize State participation. In addition, NASADAD recognizes that individuals present with many circumstances that in turn determine an individual's treatment plan. As a result, the Association believes that legislation should encourage clinically appropriate care that is based on accepted standards set within the State.

Data Reporting and Management: One of NASADAD's top policy priories is the implementation of an outcome and performance measurement data system. With this goal in mind, NASADAD and the members have successfully partnered with SAMHSA to implement the National Outcome Measures (NOMs) initiative. The goal of NOMs is to improve service delivery within publicly funded systems using a common set of indicators of accountability and performance. States across the country are reporting data on the impact treatment services have on abstinence from alcohol

and other drugs; employment; criminal justice involvement; housing; social connectedness and more. States are also reporting data on the impact prevention services have on the youth alcohol and other drug use; age of initiation; perceived risk/harm of use; drug related crime and other measures.

NASADAD recommends widespread awareness of the NOMs initiative across all agencies. The Association also recommends cross-agency discussions regarding the benefits of this performance and outcome system that is being utilized in every State in the country. Synchronized data collection efforts will improve the accuracy of the information we have on the number of Americans impacted by alcohol and other drugs and enhance our understanding of service delivery.

Thank You: We applaud you for introducing legislation that seeks to expand access to high quality substance use disorder services for our nation's veterans. We stand ready to partner with you on this initiative and others to ensure that our nation's veterans receive the care they need and deserve.

Statement of Paralyzed Veterans of America

Mr. Chairman and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit a statement for the record on H.R. 2818; H.R. 4915, the "Veterans Access to Local Options for Recovery Act;" H.R. 5554, the "Veterans Substance Use Disorders Prevention and Treatment Act;" H.R. 5595, the "Make Our Veterans Smile Act;" H.R. 5622, the "Veterans Timely Access to Health Care Act;" and the "Spina Bifida Health Care Program Expansion Act." PVA appreciates the emphasis this Subcommittee has placed on critical issues facing all generations of veterans, such as substance abuse disorders. We hope that addressing the issues outlined in this legislation will better benefit today's veterans and the veterans of tomorrow.

H.R. 2818, Epilepsy Centers of Excellence

PVA principally supports H.R. 2818, a bill that would create six Epilepsy Centers of Excellence within the VA health care system. Much like the Multiple Sclerosis (MS) and Parkinson's disease Centers of Excellence permanently authorized during the 109th Congress, this proposal recognizes the successful strategy of the Veterans Health Administration (VHA) to focus its system-wide service and research expertise on a critical care segment of the veteran population. The designation of these six Centers of Excellence will provide open access to centers engaged in marshaling VA expertise in diagnosis, service delivery, research and education. Furthermore, these programs will be available across the country through the "hub and spokes" approach.

We also hope that this legislation will sow the seeds for broader based research and development into Traumatic Brain Injury (TBI), as we believe the same concept could be crucial for better treatment for veterans in the future. This is particularly important in light of the number of veterans returning from service in Iraq and Afghanistan who have incurred a Traumatic Brain Injury.

H.R. 4915, the "Veterans Access to Local Options for Recovery Act"

PVA strongly opposes the proposed legislation which would essentially allow the VA to expand contract health care opportunities. This legislation would give the VA additional leverage to contract out any type of medical services. If you review the early stages of VA's Project HERO, it is apparent that this is a direction that some VA senior leadership would like to go. We believe that this legislation would set a dangerous precedent, encouraging those who would like to see the VA privatized. Privatization is ultimately a means for the federal government to shift its responsibility of caring for the men and women who served.

As we have stated in the past, we believe legislation such as this is wholly unnecessary. In fact, we would like to point out that current law allows VA to contract for care with private health care providers in instances where VA facilities are incapable of providing necessary care to a veteran; when VA facilities are geographically inaccessible to a veteran for necessary care; when medical emergency prevents a veteran from receiving care in a VA facility; to complete an episode of VA care; and, for certain specialty examinations to assist VA in adjudicating disability claims. With this in mind, this legislation serves no real purpose other than to encourage contract health care.

H.R. 5554, the "Veterans Substance Use Disorders Prevention and Treatment Act"

PVA fully supports H.R. 5554, a bill that would expand health care services to veterans dealing with substance use disorders. The stress and pressure associated with military service, and by extension combat service, place veterans at much greater risk for alcohol abuse and dependence. In fact, surveys have demonstrated that veterans report higher rates of alcohol abuse and dependence.

We are pleased that the Subcommittee has chosen to address this critical need among the veteran population. In fact, the legislation would mandate that the VA provide services as recommended in *The Independent Budget* for FY 2009:

> We urge VA to provide a full continuum of care for substance-use disorders, including more consistent and universal periodic screening of OEF/OIF combat veterans in all its health facilities and programs—especially primary care. Outpatient counseling and pharmacotherapy should be available at all larger VA community-based outpatient clinics, and short-term outpatient counseling, including motivational interventions, intensive outpatient treatment, residential care for those most severely disabled, detoxification services, ongoing aftercare and relapse prevention, self-help groups, opiate substitution therapies, and newer drugs to reduce craving, should be included in VA's overall program for substance abuse and prevention.

PVA also particularly appreciates the Subcommittee considering innovative new techniques to address the needs of today's newest generation of veterans by instituting an Internet-based pilot program. These new veterans are very technology savvy and drawn to non-traditional methods for treatment. We believe that this pilot program could be a positive first step in better addressing the needs of these veterans who are battling substance use problems.

H.R. 5595, the "Make Our Veterans Smile Act"

PVA supports H.R. 5595, a bill that would allow veterans with a service-connected disability to receive dental care through the VA. Current law limits this service to veterans whose dental issues are either service-connected or aggravated by another service-connected condition. The VA is also authorized to provide dental care to veterans who are rated as totally disabled. We have no problem with providing dental care to any service-connected veteran as it will enhance the full continuum of care available to these individuals.

H.R. 5622, the "Veterans Timely Access to Health Care Act"

H.R. 5622, the "Veterans Timely Access to Health Care Act," would require the VA to carry out a pilot program to establish standards of access to care within the VA health system. Under the requirements of the pilot program, the VA will be required to provide a primary care appointment to veterans seeking health care within 30 days of a request for an appointment. If a VA facility is unable to meet the 30-day standard for a veteran, then the VA must make an appointment for that veteran with a non-VA provider, thereby contracting out the health care service. The legislation also requires the Secretary of the VA to report to Congress each quarter of a fiscal year on the efforts of the VA health system to meet this 30-day access standard. The concepts of this legislation are not unlike similar legislation—H.R. 92—that was considered by this Subcommittee last year.

Access is indeed a critical concern of PVA. The number of veterans enrolled in the VA is approaching 8 million and the number of unique users is nearly 6 million. Despite the ongoing policy to deny enrollment to Category 8 veterans, the numbers of enrolled veterans continues to increase, particularly as more and more veterans of the Global War on Terror take advantage of the services in VA.

PVA is concerned that contracting health care services to private facilities when access standards are not met is not an appropriate enforcement mechanism for ensuring access to care. In fact, it may actually serve as a disincentive to achieve timely access for veterans seeking care. Contracting out to private providers will leave the VA with the difficult task of ensuring that veterans seeking treatment at non-VA facilities are receiving quality health care. We do think that access standards are important. We believe that the answer to providing timely access to quality care in the VA is sufficient, predictable, and timely funding coordinated with sufficient staff and capacity. For these reasons, PVA cannot support H.R. 5622.

H.R. 5729, the "Spina Bifida Health Care Program Expansion Act"

PVA supports the proposed legislation that would allow for more comprehensive health care services to the children of Vietnam veterans who suffer from spina bifida and related conditions. We have heard anecdotally that some of these individuals have experienced difficulties in receiving proper care due to the burden of trying to prove that the health issue that they are dealing with is in fact related to the spina bifida. This legislation would eliminate that concern by ensuring that they can get a full continuum of health care services, regardless if a connection to spinal bifida can be proved. As an aside, we would like to know if the VA has a record of how many individuals it is providing for under the current spina bifida statute and if it would be willing to share that information.

H.R. 5730, Injured and Amputee Veterans Bill of Rights

PVA generally supports the intent of the proposed legislation. This bill would ensure that VA prosthetics clinics around the country prominently display the "Injured and Amputee Veterans Bill of Rights." This reaffirms the idea that a veteran in need of an assistive device or prosthetic gets the highest quality item available and in a timely manner. The only concern that we have about this legislation is that the language seems to ignore veterans who may be in need of special equipment who suffer from a specific disease and not a physical injury.

Mr. Chairman and members of the Subcommittee, PVA would once again like to thank you for the opportunity to provide our views on this important legislation. We look forward to working with you to continue to improve the health care services available to veterans.

Thank you again. We would be happy to answer any questions that you might have.

U.S. Department of Veterans Affairs
Washington, DC.
August 28, 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This letter transmits the views of the Department of Veterans Affairs (VA) on H.R. 5730. The bill would require the Secretary to establish a "Bill of Rights" for injured and amputee veterans that would be displayed prominently in each VA prosthetic and orthotic clinic. Although we appreciate the intent of H.R. 5730, the Department cannot support the bill as drafted.

As a general matter, H.R. 5730 would seek to give unique rights to a limited group of veterans. Patient care should not, however, vary based either on the condition or injury experienced by a veteran or the type of medical services a veteran receives. Giving special benefits to amputee patients that are not available to other enrolled veterans would result in inconsistent and inequitable treatment among our veteran-patients. Patient treatment should be applied uniformly to every veteran-patient. VA regulations already require that a comprehensive list of patients' rights be posted prominently in all VA facilities.

If tailored for all the different patient-populations, the Department would support the majority of "rights" that are included in this "Bill of Rights," e.g., the right to receive appropriate treatment, the right to participate meaningfully in treatment decisions, etc. However, a few of the "rights" raise serious concerns. Specifically, the veteran's "right" to select the practitioner that best meets his or her orthotic and prosthetic needs, including a private practitioner with specialized expertise, is not sound from a medical perspective. VA's practitioners are highly qualified, and VA is able to continually monitor their performance through its rigorous quality management programs. As part of those programs, VA has an extensive credentialing and privileging program, which surpasses those found in the private sector. VA, generally, does not have ready and efficient access to veterans' non-NA medical records, as few private providers, if any, employ an electronic medical record. Were these veterans permitted to choose their own private providers, VA could not oversee the quality of their care, ensure their private provider possesses adequate quali-

fications, and ensure they receive a continuum of services. One must also bear in mind that VA's legal privacy and confidentiality requirements exceed those applicable to the private sector.

In short, VA has the needed expertise in managing veterans' unique issues, including unparalleled expertise in managing and caring for amputee patients, particularly those wounded in combat. What we cannot provide through our own clinics and labs, we readily purchase through contractual arrangements with vendors and providers who are approved by the Department. Although our Prosthetics and Orthotics Service labs are top-notch and very successful in timely meeting veterans' needs, we actively evaluate our programs to identify any areas in need of improvement. With respect to our contractor-prosthetists, we conduct quality management programs to oversee their performance, thereby protecting our veterans and assuring they receive good services. These efforts would be significantly hindered were veterans permitted to self-refer to private prosthetists and practitioners. Veterans could become a vulnerable marketing target by those holding themselves out as having special expertise in this field.

Moreover, including that "right" in a "bill of rights" would be misleading. Congress has very carefully limited our authority to pay for non-VA care and services. Stating that a veteran has the "right" to choose one's own provider would still not make the veteran eligible for private care at VA expense if he or she does not otherwise meet the eligibility terms of 38 U.S.C. § 1703. This "right" could mislead veterans into believing they are entitled to seek prosthetic or orthotic care or services from a non-VA provider at VA expense. As a result, some could incur private medical expenses for which they would be personally liable,

Another concern is raised by the "right" to receive comparable services and technology at any VA medical facility. Veterans may believe this means they can receive the same services and prosthetic equipment anywhere they go in the system. However, our facilities must meet the demands of their local veteran population and establish lines of service that meet those demands. Not all facilities serve significant amputee populations. A cookie-cutter approach to VA services is not appropriate. It is also more consistent with the principles of patient-centered medicine, as well as more efficient, to focus on making these services and technologies available to patients who require them, as opposed to requiring every VA facility to provide them.

There would be no additional costs associated with enactment of H.R. 5730. The Office of Management and Budget advises there is no objection to the transmission of this letter from the standpoint of the President's program.

Sincerely yours,

James B. Peake, M.D.
Secretary

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