STATEMENT OF

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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

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Good morning Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA benefits programs and services. Joining us today is Maureen McCarthy, M.D., VHA's Deputy Chief Patient Care Services Officer and Susan Blauert, Deputy Assistant General Counsel in VA's Office of General Counsel.

We do not yet have cleared views on sections 2 and 4 of S. 297, S. 471, the draft bill on Joint VA-DoD formulary for pain and psychiatric medications, and the draft bill Veterans Health Act of 2015. We will forward the views to the Committee as soon as they are available.

S. 207 Veterans Access to Community Care Act of 2015

S. 207, the Veterans Access to Community Care Act of 2015, would require VA to use specified authorities to purchase non-VA hospital care and medical services for Veterans who reside more than 40 miles driving distance from the closest VA medical facility that can furnish the care sought by the Veteran. The specified authorities are section 1703 of title 38, United States Code (U.S.C.), the authority in section 101 of the recently enacted Veterans Access, Choice, and Accountability Act of 2014 (VACAA) (Public Law 113-146), and any other authority under the laws administered by VA relating to the purchase of hospital care and medical services at non-VA facilities.

We believe the intent of S. 207 is to expand eligibility for the Choice Program to Veterans who meet the threshold eligibility requirements for Choice and reside more than 40 miles driving distance from the closest VA medical facility that can furnish the care sought by the Veteran. However, it is not clear whether the bill as drafted would accomplish this objective. The language of section 2(b)(2), "relating to the furnishing of hospital care and medical services . . . if the veteran is unable to schedule an appointment . . . within the wait-time goals of the Veterans Health Administration,"

appears to limit the application of the bill's reference to VACAA to Veterans eligible for Choice based on section 101(b)(2)(A) of VACAA, i.e., only those Veterans unable to schedule an appointment within wait time goals.

We also note that S. 207 would not amend section 101 of VACAA. Consequently, it is not clear how the requirements of section 101 would apply to care provided under the authority in section 2(b)(2) of the bill. If enacted as drafted, we would interpret S. 207 in conjunction with section 101 by, for example, applying the provider eligibility requirements and payment rates set forth in VACAA. Similarly, sections 2(b)(1) and (3) do not amend section 1703 or VA's sharing agreement authorities, but we would apply the requirements of those existing authorities to care provided under S. 207. Because the bill does not actually alter distance-based eligibility under the Veterans Choice Program, it creates significant ambiguities, funding questions and legal issues which we would be glad to discuss with Committee staff.

When VA analyzed the cost impact of providing care under the Veterans Choice Program based on the distance between a Veteran's residence and the closest VA medical facility that provides the needed care, we concluded that this change would have a significant budgetary impact, leading to total Choice Program costs for those eligible Veterans more than 40 driving miles that could range from $5 billion to $34 billion annually; this estimate assumes that participation in the Veterans Choice Program is not limited to only those Veterans enrolled as of August 1, 2014, as is required under the current law. We have briefed your staff, as well as representatives from the Congressional Budget Office, on that range of estimates, including their underlying assumptions. VA cannot reconcile the resource requirements that would be posed by S. 207 with any realistic view regarding the resources that will be available to VA under the framework reached in the budget resolution recently approved by both the Senate and House. Therefore, VA does not support S. 207.

As VA testified on May 12 before this Committee, VA has taken steps to improve the Veterans Choice Program, including expanding access by publishing a second interim final rule changing the way we measure distance for purposes of determining eligibility based on residence from a straight-line measure to a driving distance measure. VA was glad to see this change also carried out in legislation, H.R. 2496, the Construction, Authorization and Choice Improvement Act, just signed into law by President Obama on May 22nd. This change has approximately doubled the number of Veterans eligible for the Veterans Choice Program based on the distance criteria, and we are glad to have eliminated one significant source of frustration and confusion for Veterans. H.R. 2496 also will provide VA greater flexibility within VACAA to consider factors unrelated to geographic challenges that impact a Veteran's ability to travel to access care. Enactment of this change allows us to mitigate the impact of distance and other

hardships, including the Veteran's medical condition, for many Veterans, and enable more Veterans to receive health care closer to home.

VA is committed to continuing to work with the Committee to improve Veterans' timely access to care, within the Veterans Choice Program and outside of it.

S. 297 Frontlines to Lifelines Act of 2015

Section 3(a) of the Frontlines to Lifelines Act of 2015 would direct the Secretary of Defense to transfer to the Secretary of Veterans Affairs the credentialing data of a covered health care provider who has been hired by VA, upon receiving a request from VA for the Department of Defense's (DoD) credentialing data related to such health care provider.

Section 3(b) would define a "covered health care provider" as a health care provider who is or was employed by the Secretary of Defense, provides or provided health care related services as part of such employment, and was credentialed by the Secretary of Defense.

Section 3(c) would require the Secretaries of Veterans Affairs and Defense to establish policies and promulgate regulations as may be necessary to carry out this section.

Section 3(d) would define the term "credentialing" to mean the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, and current competence and health status.

Credentialing is required to ensure a health care provider has the necessary clinical competence, professional experience, health status, education, training and licensure to provide specified medical or other patient care services. VA understands the goals of section 3, and the sharing of credentialing data between departments would facilitate VA's credentialing process and the appointment of only qualified, covered health care providers to the VA facility's medical staff. However, as this provision places requirements upon DoD, consultation with DoD is necessary before VA can present a position on this provision.

S. 425 Homeless Veterans' Reintegration Programs Reauthorization Act of 2015

S. 425 would extend the authorization of appropriations for the Department of Labor's Homeless Veteran Reintegration Programs (HVRP) and the Homeless Women Veterans and Homeless Veterans with Children Reintegration Grant Program from 2015 to 2020. The bill would further expand the population eligible to receive services under HVRP to include not only homeless Veterans but also Veterans who are participating in

the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program, receiving assistance under the Native American Housing Assistance and Self-Determination Act of 1996, or transitioning from incarceration.

VA defers to the Department of Labor for views and costs on S. 425; however, we offer that this bill would provide additional services for homeless and at-risk Veterans in the critical area of employment, which is a key factor in achieving and maintaining stability in permanent housing. Veterans transitioning from incarceration often face multiple barriers to successful reentry, and expanding HVRP eligibility to this population would help address the employment-related needs of a population of Veterans who are often at high risk of becoming homeless. It would also be especially helpful for Veterans transitioning from incarceration who may not be eligible for VA services.

S. 684 Homeless Veterans Prevention Act of 2015

Section 2 of S. 684 would amend 38 U.S.C. § 2012(a)(2) to increase the per diem payments for Veterans who are participating in the VA's Homeless Provider Grant and Per Diem (GPD) Program through a "transition in place" (TIP) grant. The per diem payments under GPD TIP would be increased to 150 percent of the VA State Home rate for domiciliary care, compared to the current payment *which is the lesser* of 100 percent of the VA State Home rate for domiciliary care *or the daily cost of care minus other sources of payments to the per diem recipient for furnishing services to homeless veterans*.

VA supports section 2. This new provision would facilitate and provide support for Veterans moving from transitional to permanent housing. Supporting Veterans' transition from homelessness to permanent housing is a strategy VA believes will be effective in our efforts to end homelessness among Veterans. By allowing Veterans to "transition in place" to permanent housing, the Department would provide a valuable alternative for Veterans who may not need or be interested in participating in the HUD-VASH program.

Section 3 would amend 38 U.S.C. § 2012(a) to permit a grantee receiving per diem payments under the GPD Program to use part of these payments for the care of a dependent of a homeless Veteran who is receiving services covered by the GPD grant. This authority would be limited to the time period during which the Veteran is receiving services under the grant.

VA supports the intent of section 3, conditioned on the availability of additional resources to implement this provision. We feel that this authority is needed to fully reach the entire homeless population. However, full implementation of the legislation would require additional funding to avoid diminished services in VA's full complement of programs for homeless Veterans.

Section 4 would authorize the Secretary to enter into partnerships with public or private entities to provide general legal services to Veterans who are homeless or at risk of homelessness. The language further specifies that VA is only authorized to fund a portion of the cost of legal services.

VA supports section 4 as legal services remain a crucial but largely unmet need for homeless and at-risk Veterans, but respectfully recommends technical amendments to the bill language. The Supportive Services for Veteran Families Program currently allows for grantees to enter into partnerships with legal service providers to address legal needs that pose barriers to housing stability. However, this is not a required service under the SSVF regulations and, therefore, is not provided to Veterans through all SSVF programs. Rather than authorizing VA to enter into "partnerships", section 4 should authorize VA to provide grants to ensure the language reflects a funding mechanism that VA could use to execute it. Furthermore, VA recommends removing the phrase “a portion of” from the proposed section 2022A(a). This change would allow VA to fund a portion or the entirety of the legal services provided under the partnership, thereby providing VA greater flexibility to support these efforts. Finally, VA would like to work with the Committee to make additional minor improvements to section 4.

Section 5 would extend dental benefits under 38 U.S.C. § 2062 to a Veteran enrolled in the VA health care system who is also receiving for a period of 60 consecutive days assistance under the HUD-VASH program, or care under title 38 authority in one of the following settings: a domiciliary, therapeutic residence, community residential care, or a GPD program. For purposes of the 60-day requirement, it would permit breaks in the continuity of assistance or care for which the Veteran is not responsible.

VA appreciates the intent of section 5 to expand eligibility for VA dental care, but cannot support it under a realistic assumption of future funding availability. VA believes these services would be especially valuable for this group of Veterans, and we welcome further discussion with the Committee.

VA supports section 6, which would provide permanent authority for VA’s Veterans Justice Outreach (VJO) and Healthcare for Reentry Veterans (HCRV) Programs. VJO’s goal is to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible Veterans involved with the criminal justice system have timely access to VA’s mental health and substance use services when clinically indicated, and other VA services and benefits as appropriate. Similarly, designed to address the community reentry needs of incarcerated Veterans, HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment, and decrease the likelihood of re-incarceration for those leaving prison. This permanent authority would

recognize the crucial role these programs play in preventing and ending Veteran homelessness.

Section 7 would amend 38 U.S.C. § 2044(e) to authorize the use of $500 million from VA's FY 2016 Medical Services appropriation for the Supportive Services for Veteran Families (SSVF) Program, and to extend the existing $1 million appropriation authority for training and technical assistance to SSVF grantees through FY 2015.

While the $500 million level of this authorization is above the level proposed in VA's budget, we nevertheless support an authorization level that provides flexibility should VA determine that additional funding is necessary and the Department is in a position to dedicate higher amounts to the program. VA thus supports the intent of section 7, but believes that in order to ensure the provision of quality services to Veteran families and the efficient execution of such additional funds; this increased flexibility should be accompanied by an increased proportional authorization in technical assistance for SSVF providers.

Section 8 would require the Secretary to assess and measure the capacity of programs receiving grants under 38 U.S.C. § 2011, or per diem payments under 38 U.S.C. § 2012 or 2061.

VA believes the intent of section 8 is satisfied by existing VA's Homeless Providers Grant and Per Diem Program monitoring practices. VA's GPD Program regularly monitors capacity and performance in grantees' programs, so section 8 would impose a new and potentially duplicative reporting requirement. Although VA expects that compliance with section 8 would require time and effort from VA employees, the reporting requirements are not unduly burdensome and would result in minimal costs to VA. Therefore, VA does not object to section 8.

Section 9 would require the U.S. Comptroller General to conduct an assessment of VA programs serving homeless Veterans to determine whether these programs are meeting Veterans' needs, and recent efforts to improve the privacy, safety, and security of female Veterans receiving assistance under these programs. VA supports the intent of section 9, but believes its goals have been accomplished by recent reviews of VA homeless programs conducted by the Government Accountability Office and by VA's annual assessment of homeless Veterans' service needs and the availability of responsive VA and community services. Since its inception in 1994, VA's Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) has surveyed participants (homeless and formerly homeless Veterans, as well as VA and community service providers) on the needs of homeless Veterans in their local communities, and the extent to which these are addressed by existing VA and community services. The results not only drive the development of new local

partnerships, but also generate a national picture of male and female homeless Veterans' met and unmet service needs, as identified by homeless Veterans themselves and the service providers who work with them directly.

Section 10 would remove the requirement that VA report to the Senate and House of Representatives Committees on Veterans' Affairs on the activities of the Department during the calendar year preceding the report under programs of the Department for the provision of assistance to homeless veterans.

VA supports section 10. Removing this time consuming reporting function would free up VA resources that could be better used to internally asses the programs and implement changes to enhance the benefits and services provided to homeless Veterans. Furthermore, VA remains committed to providing timely data reporting to the Committees upon request. Removing this annual reporting requirement would recognize that VA, on its own initiative, conducts ongoing data analysis of VA homeless programs.

Draft Bill Department of Veteran Affairs Purchased Health Care Streamlining and Modernization Act

This draft bill is similar to legislation requested by the Administration to reform the authorities VA uses to purchase hospital care, medical services, and extended care when that care is not feasibly available at a VA facility, or through contracts or sharing agreements entered into under other authorities. We sincerely appreciate the Committee placing it on the agenda today, and look forward to working with you on this critical aspect of ensuring Veterans' timely access to health care.

Section 2 would amend chapter 17 of title 38, U.S.C., by adding a new section, "1703A. Veterans Care Agreements with certain health care providers".

Subsection (a) of 1703A would provide that if VA is not feasibly able to furnish hospital care, medical services, or extended care within the Department or through the exercise of other authority to enter into contracts or sharing agreements, VA may enter into "Veterans Care Agreements" (VCA) with eligible providers who are certified under subsection (c) of the new 1703A. Eligibility for care would be determined in the same manner as if the care or services were furnished directly by a VA facility.

Subsection (b) would define eligible providers to include Medicare and Medicaid providers; an Aging or Disability Resource Center, an area agency on aging, or a State agency as defined in section 102 of the Older Americans Act; a center for independent living as defined in section 702 of the Rehabilitation Act; and other providers the Secretary determines to be appropriate.

Subsection (c) would require the Secretary to establish a process for the certification and re-certification of eligible providers. This process must include procedures for screening providers according the risk of fraud, waste, and abuse and must require the denial of applications from providers excluded from certain federal programs. VA notes that this provision would require VA to certify all eligible providers, including those participating in Medicare or Medicaid. In VA's legislative proposal, VA would establish a separate certification process for those eligible providers that are not under the certification regimes of Medicare and Medicaid. VA suggests this approach to avoid subjecting providers to duplicative certification processes, which could dissuade providers from entering VCAs.

Subsection (d) would require the inclusion of specific terms in VCAs, including payment rates that are, to the extent practicable, in accordance with the rates paid by the United States in the Medicare program. Other requirements of VCAs would include restricting care to that authorized by VA, prohibiting third-party billing by providers, and submitting medical records to the Department.

Subsection (e) would specify the terms and conditions under which VA or the provider may terminate a VCA.

Subsection (f) would require the Secretary to review VCAs of material size every two years to determine whether it is feasible or advisable to provide the necessary care at facilities of the Department or through contract or sharing agreements entered into under other authorities.

Subsection (g) would specify that VCAs under section 1703A are exempt from certain provisions of law governing federal contracting. Specifically, VCAs would be awarded without regard to competitive procedures and would not subject an eligible provider to certain laws that providers and suppliers of health care services through the Medicare program are not subject to. Providers entering into VCAs would be subject to all laws regarding integrity, ethics, fraud, or that subject a person to civil or criminal penalties, as well as all laws prohibiting employment discrimination on the basis of race, color, national origin, religion, gender, sexual orientation, gender identity, disability, or status as a Veteran.

Subsection (h) would require the Secretary to establish a system or systems to monitor the quality of care and services provided to Veterans under section 1703A and to assess the quality of care and services for purposes determining whether to renew a VCA.

Subsection (i) would require the Secretary to establish administrative procedures for providers to present disputes arising under or related to VCAs. It would further require

that providers exhaust these administrative procedures before seeking judicial review under the Contract Disputes Act.

Subsection (j) would direct the Secretary to prescribe regulations to carry out section 1703A.

Section 3 of the draft bill would amend 38 U.S.C. § 1745 to permit VA to enter into agreements with State Veterans Homes that are exempt from certain provisions of law governing federal contracting. Specifically, an agreement could be awarded without regard to competitive procedures and would not subject a State Home to certain laws that providers and suppliers of health care services through the Medicare program are not subject to. An agreement would be subject to all laws regarding integrity, ethics, fraud, or that subject a person to civil or criminal penalties, as well as all laws prohibiting employment discrimination on the basis of race, color, national origin, religion, gender, sexual orientation, gender identity, disability, or status as a Veteran. In addition, subsection (c) would establish a separate effective date for the amendments made by section 3 based on the effective date of implementing VA regulations.

Although section 3 would eliminate the word “contract” in section 1745, it would authorize VA to enter into “agreements” which VA believes would include contracts based on the Federal Acquisition Regulation (FAR) contracts. VA thus does not interpret this amendment to prohibit VA from using FAR-based contracts if a State home requests it.

Similar to the legislation proposed by the Administration, the draft bill would not result in additional costs and thus would be budget neutral.

This bill is a critical reform that will address deficiencies in current law, as well as provide a comprehensive framework and foundation for the purchase of non-VA care in those circumstances where it is not feasibly available from VA or through contracts or sharing agreements. We strongly support its enactment, which we believe is essential to maintaining Veterans’ access to care in every part of the country.

Mr. Chairman, thank for the opportunity to present the Department’s views on these bills and we will be glad to respond to the Committee’s questions.