STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE SENATE COMMITTEE ON VETERANS' AFFAIRS

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Good afternoon, Chairman Isakson, Ranking Member Tester, and Members of the Committee. Joining me today are Dr. David Carroll, Executive Director of Mental Health and Suicide Prevention, Veterans Health Administration, and Ms. Beth Murphy, Director of Compensation Service, Veterans Benefits Administration (VBA).

I want to thank the Committee for putting forward legislation on critical issues such as suicide prevention, mental health care, and the needs of women Veterans, among other important topics. In this testimony we are providing background information on many of our ongoing efforts and strategies for addressing these important issues, so that we can provide context for our analysis of the proposals before us today. I am confident that we can, in partnership with Congress, ensure VA has the tools to deliver the state-of-the-art health care and other benefits that Veterans deserve.

VA was not able to address the draft Janey Ensminger Act of 2019. We are also still analyzing sections 101(a) and (b) and section 104 of S. 785, and will provide views soon in a follow-up letter

Legislation Concerning Mental Health and Suicide Prevention

Suicide is a national public health issue that affects all Americans, and the health and well-being of our Nation's Veterans is VA's top priority. On average, twenty Veterans, active-duty Servicemembers, and non-activated Guard or Reserve

members die by suicide each day, and of those twenty, fourteen have not been in our care. That is why we are implementing broad, community-based prevention strategies, driven by data, to connect Veterans outside our system with care and support. The Department's Fiscal Year (FY) 2020 budget requests $9.4 billion for mental health services, a $471 million increase over 2019. VA's budget specifically invests $221.7 million for suicide prevention programming, a $15.6 million increase over the 2019 enacted level. The budget request funds over $5.4 billion to support mental health outpatient visits, an increase of nearly 78,000 visits over the 2019 estimate. This builds on VA's current efforts. VA has hired more than 3,900 new mental health providers yielding a net increase in VA mental health staff of over 1,000 providers since July 2017. Nationally, in the first quarter of 2019, 90 percent of new patients completed an appointment in a mental health clinic within 30 days of scheduling an appointment, and 96.8 percent of established patients completed a mental health appointment within 30 days of the day they requested.

Preventing Veteran suicide requires closer collaboration between VA, the Department of Defense (DoD), and the Department of Homeland Security (DHS). On January 9, 2018, President Trump signed Executive Order (EO) 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life*. The EO directs DoD, VA, and DHS to develop a Joint Action Plan that describes concrete actions to provide access to mental health treatment and suicide prevention resources for transitioning uniformed Servicemembers in the year following their discharge, separation, or retirement. On March 5, 2019, President Trump signed Executive Order 13861, *National Roadmap to Empower Veterans and End Suicide*, which

creates a Veteran Wellness, Empowerment, and Suicide Prevention Task Force that is tasked with developing, within one year, a road map to empower Veterans to pursue an improved quality of life, prevent suicide, prioritize related research activities, and strengthen collaboration across the public and private sectors. This is an all-hands-on-deck approach to empower Veteran well-being with the goal of ending Veteran suicide.

For Servicemembers and Veterans alike, our collaboration with DoD and DHS is already increasing access to mental health and suicide prevention resources, due in large part to improved integration within VA, especially between VBA and VHA, which have worked in collaboration with DoD and DHS to engage Servicemembers earlier and more consistently than we have ever done in the past. This engagement includes support to members of the National Guard, Reserves, and Coast Guard.

VA's suicide prevention efforts are guided by our *National Strategy for Preventing Veteran Suicide*, a long-term plan published in the summer of 2018 that provides a framework for identifying priorities, organizing efforts, and focusing national attention and community resources to prevent suicide among Veterans. It also focuses on adopting a broad public health approach to prevention, with an emphasis on comprehensive, community-based engagement.

However, VA cannot do this alone, and suicide is not solely a mental health issue. As a national problem, Veteran suicide can only be reduced and mitigated through a nationwide community-level approach that begins to solve the problems Veterans face, such as loss of belonging, meaningful employment, and engagement with family, friends, and community.

The *National Strategy for Preventing Veteran Suicide* provides a blueprint for how the Nation can help to tackle the critical issue of Veteran suicide and outlines strategic directions and goals that involve implementation of programming across the public health spectrum, including, but not limited to:

- Integrating and coordinating Veteran Suicide Prevention across multiple sectors and settings;
- Developing public-private partnerships and enhancing collaborations across Federal agencies;
- Implementing research-informed communication efforts to prevent Veteran suicide by changing attitudes knowledge and behaviors;
- Promoting efforts to reduce access to lethal means;
- Implementation of clinical and professional practices for assessing and treating Veterans identified as being at risk for suicidal behaviors; and
- Improvement of the timeliness and usefulness of national surveillance systems relevant to preventing Veteran suicide.

Every day, more than 400 Suicide Prevention Coordinators and their teams—located at every VA medical center—connect Veterans with care and educate the community about suicide prevention programs and resources. Through innovative screening and assessment programs such as REACH VET (Recovery Engagement and Coordination for Health–Veterans Enhanced Treatment), VA identifies Veterans who may be at risk for suicide and who may benefit from enhanced care, which can include follow-ups for missed appointments, safety planning, and care plans.

With that background and foundation established, I will now turn to the suicide prevention and mental health-related bills on the agenda today.

S. 711

The CARE for Reservists Act of 2019 would authorize VA, in consultation with DoD, to furnish readjustment counseling, without a referral, to any member of the Reserve Components of the Armed Forces with a behavioral condition or psychological trauma; outpatient services and mental health services would also be available. The bill would further allow VA to include members of the Reserve Components in VA's comprehensive program for suicide prevention and would also allow VA to provide care and services to such members who served in classified missions. Finally, the bill would require VA to submit a report to Congress on the use of certain VA services by members of the Armed Forces and the Reserve Components of the Armed Forces.

Although we support the principle of providing suicide prevention services to members of the Reserve Components, we do not support the expansion of VA's Readjustment Counseling Service (RCS) eligibility to any member of the Reserve Components as this bill is currently written, for reasons tied to the special role of Vet Centers as distinguished from medical care. We would emphasize that we are looking for ways to provide suicide prevention services to members of the Reserve Components in VA's mental health programs. We welcome the opportunity to discuss section 4 of the bill with the Committee to explore those ideas.

The RCS was created to help Veterans who experienced traumatic events or served in combat and are facing readjustment issues as a result. While the bill would focus on members of the Reserve who have a behavioral health condition or

psychological trauma, Vet Center counselors are not prepared to treat serious mental illness because many cases of such care require prescription medications, and these Centers lack the infrastructure to support such care as this care is beyond the scope of what Vet Centers provide. While well-intentioned, we believe such an expansion could undermine this focus of the RCS and could compromise the quality of the services they provide to Veterans who are currently eligible. This would also blur the line to some extent between VA's Vet Centers and medical clinics. Concerning section 3 of the bill, which would permit VA to furnish mental health services to members of the Reserve Components, we are concerned this could have the unintended result of providing greater benefits to members of the Reserve Components than Veterans who meet statutory eligibility under other provisions of law. On a technical level, we are unsure whether the legislation is intended to permit DoD to reimburse VA for such care. We would appreciate the opportunity to discuss the intent of this provision with the Committee. Finally, we do not support section 5, which would require VA to submit an assessment to Congress on current and future utilization. We believe this would be redundant in some respects, as VA's RCS already submits an annual report on its workload, including services provided to members of the Armed Forces. We would like to work closely with the Committee on our efforts to augment the availability of VA services to those in Reserve Components.

S. 785

The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, is a sweeping bill that includes 35 different provisions. VA would like to discuss with the Committee in detail the abundance of ideas in the bill, so that any

legislation Congress enacts will ensure VA can maintain a strong focus on suicide prevention, and not create overlapping initiatives that pose the risk of confusing duplication of programs and undue complications in our efforts.

Title I of S. 785 would expand eligibility for mental health care for Veterans, amend VA's statutory authority regarding the enrollment system for VA health care, require the Department of Labor (DOL) to promote information on VA benefits and issue grants to support transition assistance, require VA to enter into an agreement to compile a list of community-based programs, and modify VA's authority to furnish care to Veterans with other than honorable discharges.

VA defers to DOL on sections 101(c) and 102. VA does not support section 103 as VA is already implementing a similar provision enacted as section 401 of Public Law 115-407.

Title II is focused on suicide prevention. Section 201 would require VA to provide grants to eligible community entities to provide or coordinate the provision of mental health supportive services for Veterans with mental health conditions. VA strongly supports this concept as it supports recently-issued Executive Order 13861, *National Roadmap to Empower Veterans and End Suicide*, which requires the establishment of a grant program and aligns with a similar proposal in VA's FY 2020 budget request. We do have concerns with some aspects of the language of the section 201 grant program, as it may be too limiting as far as the Veterans the grantee entities could assist. There are also other technical issues we'd like to work with the Committee to resolve. We are eager to partner with you on a grant program that could truly make a difference for at-risk Veterans.

Title II would also require VA to designate one week per year to organize outreach events and educate Veterans on how to conduct peer wellness checks, or "Buddy Checks." It would also direct VA, in consultation with DoD and DHS, to enter into partnerships with non-profit mental health organizations to facilitate posttraumatic growth among Veterans who have experienced trauma, as well as develop metrics to track progress on each of the 14 goals and 43 objectives outlined in the *National Strategy for Preventing Veteran Suicide*. There are several associated reports included within these provisions. Similarly, VA would further be required to complete a study on the feasibility and advisability of providing complementary and integrative health (CIH) treatments at all VA facilities and would also be required to begin a program to provide CIH services to Veterans for the treatment of posttraumatic stress disorder (PTSD), depression, anxiety, and other conditions. Finally, Title II would require the Comptroller General to report to the Committees on Veterans' Affairs on VA's efforts to manage Veterans at high risk of suicide.

Outreach, partnerships, studies and evaluation are a core part of the VA's current suicide prevention efforts. VA's current efforts address many of the elements of Title II, and as a result we believe those provisions are duplicative. For example, we believe the Buddy Check week provision is redundant, given other robust efforts to increase awareness and support. We do not believe it is advisable to pursue the posttraumatic growth (PTG) program required by this section, because currently there is little scientific evidence to support its effectiveness as a separate clinical intervention (Wagner et al, 2016; Zoellner et al, 2011). ch. VA currently has a range of effective treatment approaches that promotes recovery and is well-grounded in the academic literature.

Concerning CIH treatments, these treatments are already available at many VA facilities; we strongly support the use of CIH treatments within VA and are actively working to comply with the requirements of Subtitle C, Complementary and Integrative Health, from the Jason Simcakoski Memorial and Promise Act (Title IX of Public Law (P.L.) 114-198, the Comprehensive Addiction and Recovery Act of 2016). As a result, we do not believe further statutory requirements would be beneficial. We are also concerned that animal therapy, agritherapy, and outdoor sports therapy, as referenced in the bill, are not widely available, nor well studied as effective treatments (Strauss et al, 2011; Wehbeh et al., 2014). Further studies into these complementary therapies are underway and we hope to know more in coming years.

Title III of S. 785 would focus on programs, studies, and guidelines on mental health. Specifically, VA would be required to: (1) commence a program to assess the feasibility and advisability of using computerized cognitive behavioral therapy to treat eligible Veterans experiencing depression, anxiety, PTSD, military sexual trauma (MST), or substance use disorder (SUD) who are already receiving evidence-based therapy from VA; (2) conduct a study (which could be performed in part through a contract with academic institutions or other qualified entities) on the connection between living at high altitude and the risk of developing depression or dying by suicide among Veterans; (3) complete the development of clinical practice guidelines for the treatment of PTSD, MST, and traumatic brain injury (TBI) that is comorbid with SUD or chronic pain; (4) issue an update to the VA/DoD Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide; and (5) develop and implement an initiative to identify and validate brain and mental health biomarkers among Veterans,

with specific consideration for depression, anxiety, PTSD, TBI, and other mental health conditions.

In general, we do not believe these provisions are necessary, either because Veterans already have access to some services in the case of computerized cognitive behavioral therapy or because current efforts will satisfy these requirements, as in the case of the two provisions regarding clinical practice guidelines. For example, the topic of altitude related to hypoxia and suicide is already undergoing scientific investigation (see Reno et al, 2018; Riblet et al, 2019). Regarding the provision concerning biomarkers, the use of data collected must be specified in a research protocol and informed consent so that participating study enrollees may make an informed decision about what happens to their private health information. We generally do not believe the research studies that would be required by this Title are necessary either, given ongoing and completed work. VA has been actively engaged in biomarker research for numerous years, having highlighted numerous findings in precision medicine including blood tests that can predict which mental health patients will begin thinking about suicide or attempt it and apps developed to help patients monitor their mood and stressors (Le-Niculescu et al, 2013; Niculescu et al, 2015). In response to the provision on VA/DoD clinical practice guidelines for comorbid mental health conditions, we have concerns about the feasibility of implementing this section and believe it would be redundant to current efforts and there are other concerns regarding implementation. VA and DoD are also updating the clinical practice guidelines on the assessment and management of patients at risk for suicide, and we expect this work to be completed soon.

Title IV is focused on oversight of mental health care and related services. It would require a number of reports and studies from VA or others (including the Comptroller General) on the effectiveness of VA's suicide prevention and mental health outreach materials and campaigns and on VA's progress in meeting the goals and objectives of EO 13822. VA also would be required to establish goals for its mental health and suicide prevention media outreach campaigns in raising awareness about these topics. The Comptroller General would be required to submit to the Committees on Veterans' Affairs a management review of VA's mental health and suicide prevention services, as well as a report on VA's efforts to integrate mental health care into VA primary care clinics. Finally, VA and DoD would be required to submit to Congress a report on VA mental health programs, DoD mental health programs, and joint programs of the Departments.

Similar to Title III, we believe many of these provisions would impose significant reporting requirements that would be burdensome to meet, could divert employees' attention from patient care and program management, and in our view would not produce significant additional value. Moreover, similar reporting requirements already exist for several areas, particularly concerning VA and DoD programs.

Title V is focused on improving VA's medical workforce. Title V would modify VA's appointment authority for psychologists, require a staffing plan to address shortages of psychiatrists and psychologists, require VA to develop an occupational series for licensed professional mental health counselors and marriage and family therapists, require VA to assess the capacity of women peer specialists in VA, establish a readjustment counseling service scholarship program, and require VA to ensure that

each VA medical center is staffed with no less fewer than one suicide prevention coordinator. It would further direct the Comptroller General to submit to the Committees on Veterans' Affairs a report on VA's RCS, while also requiring VA to report on the resources required to meet unmet needs for VA's Vet Centers and to conduct a study on the attitudes of eligible Veterans toward VA offering appointments outside the usual operating hours of VA facilities. Title V would also establish direct hiring authority in Title 5 U.S.C. for certain VA health care positions.

We note generally that recruitment and retention of medical professionals are critical to ensuring that VA has the right doctors, nurses, clinicians, specialists and technicians to provide the care that Veterans need, and VA has placed a special focus on bringing the best mental health professionals into VA service. The FY 2020 budget strengthens VHA's workforce by providing funding for 342,647 full-time equivalent positions, an increase of 13,066 over 2019. VA is also actively implementing authorities enacted as part of P.L. 115-182, the Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act, which increased VA's ability to recruit and retain the best medical providers by expanding existing loan repayment and clinical scholarship programs; it also established the authority to create several new programs focused on medical school students and recent graduates. VA is also implementing additional initiatives to enhance VA's workforce, such as the expanded utilization of peer specialists and medical scribes.

With that background established, turning to the provisions of Title V, the Department does not object to section 509, requiring that the Secretary ensure that all VA Medical Centers have at least one suicide prevention coordinator. VA agrees with

that policy, and in fact that goal is already being met. VA defers to the Government Accountability Office (GAO) on section 506, which would require a Comptroller General report regarding VA's RCS, though it is important to note that RCS already has similar reporting criteria as a part of the annual congressionally mandated report currently outlined in 38 USC 1712a. As noted above, the remainder of Title V includes numerous changes in personnel authorities, a new specialized scholarship program, and multiple reports and plans. Especially with the enactment of significant VHA workforce provisions in the MISSION Act in June 2017, which VA is now implementing, VA would like to discuss these provisions in detail with the Committee. Some we believe would be duplicative of ongoing efforts and planning. VA wants to be careful that layering new requirements in light of the multitude of ongoing programs in the same area could distract personnel and resources from VA's current efforts. In addition, there are technical issues with some of the provisions we would like to discuss with the Committee.

Title VI would seek to improve VA's telehealth services, which are an important means of expanding access to high quality care, by requiring VA to enter into partnerships and expand existing partnerships between VA and community entities to expand telehealth capabilities and the provision of telehealth services to Veterans through grants. It would also require VA to assess current telehealth security protocols.

We are continuing to enhance our telehealth programs and appreciate the Committees' interest in bolstering VA's efforts. The first provision in Title VI includes provisions that are similar to VA's Advancing Telehealth Through Local Access

Stations initiative. The bill would go farther, though, in also creating a grant program to support these efforts. We welcome the Committee's support of these efforts and would appreciate the opportunity to discuss this further with the Committee to ensure that any legislative action does not limit our existing efforts. There are some details included in the legislation that could present problems that we believe could be avoided. For example, the inspection requirement would be difficult to scale and, we believe, impossible to fully maintain and enforce. Concerning the latter part of Title VI, we believe the language in this bill is ambiguous, and VA is uncertain what exactly the intended effect of this language is. We believe that elements of section 602, particularly in the networks, equipment, operators, and organizations involved, are outside the scope of VA's mission and authorities. We are also concerned that attempting to undertake the requirements of Title VI could affect other critical efforts of VA. We believe it would be advisable to have further discussions with the Committee, along with the Federal Communications Commission, to discuss this provision in more detail.

Legislation Concerning Women Veterans

On our ongoing efforts to ensure the needs of women Veterans are met, VA has made significant progress. We now provide full services to women Veterans, including comprehensive primary care, gynecology care, maternity care, specialty care, and mental health services. The FY 2020 budget requests $547 million for gender specific women Veterans' health care, a $51 million increase over 2019.

The number of women Veterans using VHA services has tripled since 2000, growing from nearly 160,000 to over 500,000 today. To accommodate the rapid

growth, VA has expanded services and sites of care across the country. VA now has at least two Women's Heath Primary Care Providers (WH-PCP) at all of VA's health care systems. In addition, 91 percent of community-based outpatient clinics have a WH-PCP in place. VA now has gynecologists on site at 133 sites and mammography on site at 65 locations. For severely injured Veterans, we also now offer in vitro fertilization services through care in the community and reimbursement of adoption costs.

VA is in the process of training additional providers, so every woman Veteran has an opportunity to receive primary care from a WH-PCP. Since 2008, 5,800 providers have been trained in women's health. In FY 2018, 968 Primary Care and Emergency Care Providers were trained in local and national trainings. VA has also developed a mobile women's health training for rural VA sites to better serve rural women Veterans, who make up 26 percent of women Veterans. This budget will also continue to support a full-time Women Veterans Program Manager at every VA health care system who is tasked with advocating for the health care needs of women Veterans.

VA is at the forefront of information technology for women's health and is redesigning its computerized patient record system to track breast and reproductive health care. Quality measures show that women Veterans who receive care from VA are more likely to receive breast cancer and cervical cancer screening than women in private sector health care. VA also tracks quality by gender and, unlike some other health care systems, has been able to reduce and eliminate gender disparities in important aspects of health screening, prevention, and chronic disease management.

We are also factoring care for women Veterans into the design of new VA facilities and using new technologies, including social media, to reach women Veterans and their families. We are proud of our care for women Veterans and are working to increase the trust and knowledge of VA services of women Veterans, so they choose VA for benefits and services.

With that background and foundation, we will turn now to related bills on today's agenda.

S. 514

We appreciate the intent and focus of S. 514, the Deborah Sampson Act, which seeks to improve the benefits and services provided by VA to women Veterans in a variety of ways. For example, subject to the Congress appropriating additional funding to support implementation, the Administration can support authorization for VA to furnish counseling in group retreat settings to persons eligible for RCS from VA including retreats specifically for women Veterans, as well as extending, from 7 to 14 days, coverage of newborns of a woman Veteran receiving delivery care. VA does not object to section 102, regarding Women Veterans Call Center, as we implemented the texting feature called for by the provision in April of this year. VA also agrees with the bill's intent to buttress the Women Veterans Health Care Mini-Residency Program by one million dollars annually, to provide more opportunities for participation by primary care and emergency care clinicians. We would like to discuss this provision with the Committee, however, as the ambiguous wording of the provision could have the unintended consequence of actually reducing the resources VA dedicates now to the program.

VA estimates the cost of these provisions to be:

- Approximately $505,000 to conduct six retreats in FY 2019, $2.7 million over 5 years, and $6.07 million over 10 years;
- $8.8 million in FY 2020, $46.6 million over 5 years, and $100.6 million over 10 years to provide extended coverage of newborns; and
- $1 million in FY 2019, $5 million over 5 years, and $10 million over 10 years to provide opportunities for participation in the Women Veterans Health Care Mini-Residency Program.

We also support, conditioned on the availability of additional appropriations, section 201 which would require VA to establish a partnership to provide legal service to women Veterans, and, again subject to the availability additional appropriations, section 202, which would authorize additional amounts for the Supportive Services for Veterans Families (SSVF) grant program to support organizations that have a focus on providing assistance to women Veterans and their families. Regarding section 201, we support this provision with modifications, specifically allowing such assistance to be available to male Veterans as well; we also have some further recommendations on improvements to this section as well. We do not believe the gap analysis required by section 203 is necessary. We estimate the authorization of additional amounts for the SSVF program would cost $60 million for FY 2020 through FY 2022.

Other provisions of the bill, though, present challenges that VA would appreciate the opportunity to discuss with the Committee. For example, we

appreciate the intent of section 401, which would require VA to retrofit existing VA medical facilities with fixtures, materials, and other outfitting measures to support the provision of care to women Veterans at such facilities. VA currently has the authority, and has made it a priority, to renovate or improve its facilities to protect the privacy, safety, and dignity of women Veterans. We are concerned that subsection (a), for example, would legislate specific requirements that are better addressed through current construction standards. Other provisions, such as section 402, are unnecessary because VA already has authority to employee women's health primary care providers, resources permitting.

We also do not support other provisions of the bill, particularly those in Title V dealing with data collection and reporting. In general, we believe these requirements are too onerous and will provide too little benefit to justify the time and expense involved in collecting this information.

S. 318

S. 318 would expand the scope of benefits for newborn children of women Veterans by authorizing VA to furnish transportation necessary to receive covered health care services. The bill also would allow VA to furnish more than 7 days of health care services to a newborn child and to provide transportation necessary to receive such services, if such care is based on medical necessity, including cases of readmission.

VA supports in principle providing medically necessary transportation benefits for newborns. The bill presents, however, a few technical concerns, such that we do not support the bill in its current form. For example, it would allow VA to "waive" a

debt that a beneficiary owes for medically necessary transportation provided for a newborn that was incurred prior to enactment of this Act. VA would generally have no ability to waive such a debt because the debt would not be owed to VA; further, VA would not have been a party to the transportation agreement or arrangement entered into by the beneficiary and a third party. In addition, the bill's exception to the otherwise applicable 7-day limitation on the duration of services is sweeping in scope. We would welcome the opportunity to discuss this to better understand the Committee's intent.

Legislation on Health Care Quality and Access

VA has been making a concerted effort to improve the quality of care we furnish and the ability of Veterans to access this care. Our efforts are paying dividends. Since 2014, the number of annual appointments for VA care has increased by 3.4 million, with over 58 million appointments in FY 2018. Simply put, more Veterans are choosing to receive their health care at VA. Patients' trust in VA care has risen steeply – currently at 87.7 percent – and a 2019 study in the Journal of the American Medical Association[1] shows that VA average wait times are shorter than those in the private sector in primary care and two of three specialty care areas reviewed. A 2018 Rand study[2] found that the VA health care system "generally delivers higher-quality care than other health providers," and a 2018 Dartmouth study[3]

[1] Penn, M. (2019, January 18). Comparison of Wait Times for New Patients Between the Private Sector and VA Medical Centers. Retrieved April 17, 2019, from https://jamanetwork.com/journals/jamanetworkopen/fullarticle/2720917

[2] Anhang Price, R., & Farmer, C. (2018, April 26). VA Health System Generally Delivers Higher-Quality Care Than Other Health Providers. Retrieved April 18, 2019, from https://www.rand.org/news/press/2018/04/26.html

[3] https://tdi.dartmouth.edu/news-events/veterans-health-administration-hospitals-outperform-non-vha-hospitals-most-healthcare-markets

found that “Veterans Health Administration hospitals outperform non-Veterans Health Administration hospitals in most health care markets.”

We appreciate Congress’ support of our efforts and its interest in further improving the quality and accessibility of VA care. In addition to the telehealth provisions of S. 785, numerous bills address the provision of health care to Veterans.

S. 123

The Ensuring Quality Care for Our Veterans Act would require VA to enter into a contract or agreement with a non-Federal organization to conduct a clinical review for quality management of hospital care or medical services furnished by certain VA providers. We do not support S. 123, as VA already closely monitors the quality of care provided and uses peer review to further ensure we are delivering safe and effective care. We also have a strong institutional disclosure process and policy.

S. 450

The Veterans Improved Access and Care Act of 2019 is intended to improve access by requiring VA to conduct a pilot program to assess the feasibility and advisability of expediting the onboarding process for new medical providers and to submit to Congress a strategy to reduce the duration of the hiring process by half for licensed professional medical providers. The pilot program would have VA seek to reduce the time to onboard medical providers to no more than 60 days. While we appreciate the intent of this bill, we do not support S. 450 because VA can achieve the goals of the proposed pilot program with currently available approaches and strategies. We are glad to brief the Committee regarding this initiative,

S. 850

The Highly Rural Veteran Transportation Program Extension Act would allow VA to continue operating the Highly Rural Veteran Transportation Program through FY 2021; this program helps provide grantees greater flexibility to employ new approaches to serving such Veterans, resulting in improved service and health care access for Veterans. VA strongly supports S. 850, but VA would like to extend this authority through 2029, as requested in our FY 2020 budget request.

Legislation Addressing Veteran Homelessness

S. 980

The Homeless Veterans Protection Act would make a number of improvements to VA's authorities that VA generally supports, on the condition of the availability of additional resources. In particular, we support section 3, which would require VA 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 the intent of section 3—this was a legislative proposal in VA's FY 2020 budget request. Legal services remain a crucial but largely unmet need for homeless and at-risk Veterans, but we respectfully recommend technical amendments to the bill language. We believe some additional changes could be made to other provisions to improve the bill and would welcome the opportunity to work with the Committee in this regard. We appreciate the intent of section 4, which would extend dental benefits to additional Veterans enrolled in the VA health care system.

However, because of likely very significant costs for section 4 we cannot support it absent a realistic prospect of future funding availability.

Legislation Regarding Other Health Care Matters

S. 221

This bill would require VA to report certain health care employees against whom a performance or conduct-based major adverse action was taken to the National Practitioner Data Bank (NPDB). VA would be prohibited from entering into settlement agreements with employees that conceal a serious medical error or purge a negative record from a VA employee's personnel file. While we certainly agree with the principles underlying this bill in terms of ensuring quality care, we do not support this legislation. NPDB reporting is for substandard care, professional misconduct, or professional incompetence. VA is in the process of rewriting policy and regulations related to reporting to NPDB to incorporate more comprehensive and stringent reporting requirements than those outlined in this bill. We also note that existing VA regulations and policy forbid any formal or implied agreement prohibiting the reporting of a licensed health care professional to a State licensing board or the NPDB.

S. 1154

S. 1154, the "Department of Veterans Affairs Electronic Health Record Advisory Committee Act," would establish an advisory committee to provide guidance to the Secretary and Congress on VA's implementation of and transition to an electronic health record system.

VA does not support S. 1154. We believe the Department, in concert with DoD, is already fulfilling the aims of the bill by its continuing collaboration with clinical,

business, and information technology stakeholders and Veterans Service Organizations, as well as our work in partnership with the Congress to advance the best possible technology to support the best possible care for Veterans. We also believe there are already multiple avenues for robust Congressional oversight, including regular briefings and Congressional hearings on the progress of the Electronic Health Record Modernization (EHRM) effort, engagement with GAO, regular statutory reporting requirements, and responses to Congressional inquiries. We believe the additional layers of review by an 11-member advisory committee would not only be unnecessary given the above but would also be unduly complicated and distract attention and resources from our core EHRM efforts and partnerships.

We also believe the requirement to have meetings no less frequently than monthly for an 11-member advisory committee would be excessive. Moreover, that requirement will present what we believe would be unworkable conflicts with the Federal Advisory Committee Act (FACA), which would be applicable to the new EHRM Advisory Committee. FACA requires a detailed meeting notice of a meeting be published in the Federal Register no later than 15 days before the date of the meeting. In addition, should the Advisory Committee wish to close all or part of a meeting to the public, the Department would need to be accorded 30 days to respond to the request. We believe these requirements are incompatible with a monthly meeting schedule.

VA Benefits Measures

S. 857

S. 857 would amend 38 U.S.C. § 1562(a) to increase the amount of special pension for Medal of Honor recipients to $3000, effective 180 days after the date of enactment, but if this date is not the first day of a month, the first day of the first month beginning after the date that is 180 days after enactment. If the effective day is prior to December 1, 2019, the monthly rate of the pension would not be increased by the cost of living adjustment (COLA) for FY 2020, and the annual COLA would resume effective December 1, 2019. VA supports an increase in the pension for these heroes provided Congress can identify an offset for the mandatory benefit costs. Benefit costs are estimated to be $693,000 in the first year, $6.6 million over 5 years, and $14.7 million over 10 years. There are no additional full-time equivalent or general operating expense costs associated with the proposed legislation.

S. 1101

S. 1101, the "Better Examiner Standards and Transparency for Veterans Act of 2019" ("BEST for Vets Act of 2019"), would amend section 504(a) of the Veterans' Benefits Improvements Act of 1996 to authorize VA to contract with non-physician healthcare providers to conduct disability examinations. VA would have to report to Congress no later than one year after the date of enactment of this Act and not less frequently than once each year thereafter, on the conduct of the program.

VA supports this bill with the clarification that VA will contract with licensed non-physician providers to perform medical disability examinations. Along with licensed physicians, VA has historically utilized VA physician assistants, audiologists, and nurse

practitioners to perform disability examinations. These individuals have been medically trained and have demonstrated their competence to conduct examinations. Enabling licensed non-physicians to perform contract examinations would greatly increase the number of examiners available for this important segment of the disability claims process.

We believe that section 2(a)(2) of S. 1101 is not in fact a "prohibition" because section 2(d) of the bill expands the medical professionals authorized to provide exams from licensed contract physicians to licensed contract health care providers. VA would appreciate the opportunity to provide technical assistance to the Committee to streamline this bill.

There are no costs associated with this bill.

Draft bill regarding continuance of educational assistance for temporary closure of educational institutions

The draft bill would extend the authority of the Secretary of Veterans Affairs to continue payments of educational assistance and subsistence allowances to eligible persons when educational institutions are temporarily closed until 8 weeks after the temporary closure. VA supports this bill because it would ensure that beneficiaries are not disadvantaged during emergency situations that are due to no fault of their own. Benefit costs associated with this bill are insignificant.

Legislation on Other Matters

S. 805

The Veteran Debt Fairness Act would (1) require VA to improve notice about debts that is provided to VA beneficiaries, (2) limit the authority of the Secretary of Veterans Affairs to recover overpayments made by the Department and other amounts owed by Veterans to the United States, and (3) makes changes regarding the adjudication of disputes over collections.

With respect to improving the processing of Veteran's benefits, VA continues to make progress in centrally tracking debts incurred by Veterans, to include providing more standardized electronic and standard mail notifications that would, to the fullest extent possible, and considering the limitations, consolidate the full scope of each Veteran's debt into one notification. The Office of Enterprise Integration is working with all internal VA stakeholders (i.e., Office of Management (OM), Veterans Experience Office, Office of Information Technology, VHA, and VBA) to establish an integrated program management plan and identify a lead office for implementation of our Veteran debt management efforts from an enterprise level.

While VA appreciates the intent of this bill and is continuing to work with Committee staff to address VA debt management, VA does not support the bill in its current form. We believe some provisions are duplicative of current efforts, while others present technical and implementation issues as detailed below. We pledge to continue to work with the Committee to improve our debt collection program.

Regarding the requirement in section 2(a) of the legislation that VA develop a method by which individuals may elect to receive notice of debt by electronic means in

addition to standard mail, VHA is currently developing an electronic option to permit viewing of monthly Patient Medical Statements via the “My Healthevet” portal (https://www.myhealth.va.gov/mhv-portal-web/home). By July 2019, Veterans will be able to view or print their statements electronically via the portal. These statements are currently delivered by standard mail to Veterans who are required to make co-payments; the statements advise Veteran patients of their medical copayment debts, provide a description of those debts, and present all payment options available to them. VBA and OM are in the initial scoping and planning phases for electronic notification of VBA-related debts.

Some of the proposed amendments to 38 USC § 5314, set forth in section 3 of the legislation, are not consistent with other statutes outside of Title 38. For example, 31 U.S.C. § 3711, entitled “Collection and Compromise,” provides that, “The head of an executive, judicial, or legislative agency shall try to collect a claim of the United States Government for money or property arising out of the activities of, or referred to, the agency.” Pursuant to existing law and regulation, VA returned to our respective programs over $1.6 billion through debt collection in FY 2018, thereby allowing recovered funds to be reused for Veterans programs. Failure to collect any portion of these funds would therefore increase the mandatory benefit budget request by that amount.

With respect to the due process notice periods set forth in the legislation, VA notes that in cases where a debt dispute is not submitted within 30 days from VA’s initial notification of indebtedness, the Department will still have to comply with P.L. 104-134 and the Debt Collection Improvement Act (DCIA) of 1996 to refer the debt to the

Department of the Treasury Offset Program (TOP) when the debt reaches 120 days. Not referring the debt to TOP timely would be a violation of the DCIA.

The prohibition in section 3 on recoupment of debt by offset more than 5 years after the date the debt was incurred is contrary to 31 USC § 3716, which does not place a time limit on VA's ability to collect via offset. Further, the prohibition on recoupment of debt by offset more than 5 years after the date the debt was incurred is also contrary to 28 U.S.C. § 2415(i), which does not impose any limitation on the time period for agencies of the United States to collect claims by means of administrative offset. Additionally, disputing and appealing a debt sometimes takes years, delaying collections significantly. Considering such appeals delays, particularly in cases where a debt is discovered after the fact and established retroactively, VA may end up not being able to collect some debts.

With respect to reforms intended to improve due process, VA appreciates the bill's recognition that different notice periods are appropriate for different benefit programs. For example, the 45-day notice period for debts incurred as a result of a person's participation in a program of educational assistance administered by the Secretary recognizes that, with education debts, there was a risk in extending the notice timeline to 90 days before a deduction may be made as there may not be an education benefit to offset after 90 days.

Another concern is that limiting VA's ability to recover debts through offset could impact agreements VA has with the Defense Finance and Accounting Service, which acts on behalf of DoD, to collect such debts. For example: VBA awards Dependent and Indemnity Compensation benefits to a surviving spouse, which results in an offset

of DoD Survivor Benefit Plan benefits and a potential debt to DoD. VA would collect any potential debt by withholding it from any retroactive benefits and then reimburse DoD. However, this debt is not a result of any of the five elements of the proposed legislation and may go back more than 5 years.

Additionally, VA routinely creates debts in excess of $2,500. For example, VA's compensation program has over 150,000 such debts. All VA benefit debts currently have a dispute process in place for validation. A secondary review would impose a significant additional burden which would further delay the collection process, potentially causing non-compliance with the DCIA, which requires debt referral within 120 days.

Finally, with respect to the issue of correcting erroneous information submitted to consumer reporting agencies (CRA), it is important to note that VHA does not submit debt information to CRAs. However, pursuant to 31 U.S.C. 3711(g)(1), VHA is required to refer delinquent accounts to the Treasury Cross Servicing program. Notwithstanding the fact that VHA does not submit debt information directly to CRAs, the VA's Debt Management Center (DMC) does refer delinquencies to them for VBA debts. However, the DMC also corrects CRA reports when needed, either through the Online Solution for Complete and Accurate Reporting or when internal processing determines a negative remark needs to be corrected. An internal processing example would include if the DMC sent debt notification letters to a deployed reservist; DMC would remove the negative remark when the reservist advised DMC of the situation. VA also provides written notice to a debtor when a CRA referral is changed.

As noted above, VA has been working with the Committee staff on these and numerous other Veteran debt management issues and looks forward to continuing such work for the benefit of Veterans.

S. 524

S. 524, the "Department of Veterans Affairs Tribal Advisory Committee Act of 2019," would establish an advisory committee to provide advice and guidance to VA on matters relating to Indian tribes, tribal organizations, and Native American Veterans and to annually report to Congress on the committee's recommendations.

VA supports this bill as an opportunity to strengthen and potentially expand opportunities for partnerships between the Department and tribal governments, provided Congress appropriates additional funds to support implementation. VA also supports this bill because it would provide a forum in which the Secretary and senior VA leadership could engage with tribal leadership on a scheduled, recurring basis. Native American Veterans may sometimes be viewed as members of a minority group rather than citizens of political entities which should be consulted with and engaged on a government to government basis in regular discussion and partnership. However, many issues involving Native American Veterans are not related to Native American Veterans' minority status, and thus do not fall within the purview of the Advisory Committee on Minority Veterans. The committee proposed by this bill would provide a forum for consideration of issues related to the relationship tribal governments have with the United States, such as opportunities for VA collaboration with the Indian Health Service and Tribal health programs and land tenure issues.

Costs for S. 524 would range between $45,000 and $60,000 annually for committee member travel reimbursement and compilation and distribution of an annual report.

S. 746

S. 746, the "Department of Veterans Affairs Website Accessibility Act of 2019," would require VA, within 180 days after enactment, to conduct a study on the accessibility of VA websites to individuals with disabilities in accordance with section 508 of the Rehabilitation Act of 1973 and to report to Congress within 90 days after completion of the study on the websites that are not accessible and a plan to bring such websites into compliance.

While VA agrees with the purpose of the bill, we believe it is unnecessary as system owners scan and remediate their websites as needed. Moreover, we have some concerns with the mandated schedule regarding conducting a review and developing a remediation plan. VA's Section 508 Office currently scans VA websites to identify non-compliant websites, files, and web-based applications. The results of these scans are shared with the Administrations and staff offices responsible for maintaining the Web sites. Furthermore, the inclusion of kiosks and file attachments in the definition of "Web site" significantly expands the scope of what are considered Web sites for VA's section-508 compliance regime. As an example, a file attachment could include any number of items that are not covered under section 508. Finally, we believe that, in practical terms, it would be unrealistic to conduct a universal review within 180 days. While VA does not support S. 746 in its current form, we wish to emphasize that

VA system owners are scanning their systems and implementing remediation when necessary in accordance with section 508.

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