

**STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH**

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Good Morning Mr. Chairman. Thank you for inviting me here today to present our views on several bills that would affect Department of Veterans Affairs (VA) benefits programs and services. Today we will be discussing legislation pertaining to Department of Veterans Affairs (VA) programs: H.R. 271, H.R. 627, H.R. 1369, H.R. 1575, H.R. 1769, draft bill to improve reproductive treatment provided to certain disabled Veterans, and a draft bill to direct VA to submit an annual report on the Veterans Health Administration (VHA). Joining me today is Janet Murphy, VHA's Acting Deputy Under Secretary for Health for Operations and Management, and Jennifer Gray, Attorney in the Office of General Counsel.

H.R. 271

H.R. 271 would establish a commission to examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental health illnesses of Veterans and the potential benefits of incorporating complementary alternative treatments available in non-VA medical facilities within the community.

More specifically, section 2 would establish a Veterans Expedited Recovery Commission (the “Commission”) that would be charged with:

- Examining the efficacy of VA’s evidence-based therapy model in the treatment of mental health illnesses and identifying areas to improve wellness-based outcomes;
- Conducting a patient-centered survey within each of the Veterans Integrated Service Networks (VISN) of Veterans seeking mental health services;
- Examining research on the benefits of complementary alternative treatment therapies for mental health issues, as specified by the bill; and
- Studying the potential increase of claims related to mental health issues submitted to VA by Veterans who served in Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn.

Section 3 would set forth the manner of appointing members. In general, it would require the Commission to be composed of 10 members, each of whom has recognized standing and distinction within the medical community, a background in treating mental health, experience working with the military and Veteran population, and no financial interest in any of the complementary alternative treatments reviewed by the

Commission. The President of the United States would be required to designate the chairman from among the members. Members would serve for the life of the Commission, and any vacancy would be required to be filled in the same manner as the original appointment. The measure would require these appointments to be made not later than 90 days after enactment.

Section 4 would require the Commission to hold its first meeting not later than 30 days after a majority of members are appointed and regular meetings thereafter. This measure would, among other things, authorize the Commission to take testimony and receive evidence; secure needed information directly from any Federal Department or Agency; and consult with private and public sector entities. It would also authorize a Federal department or agency, upon request, to detail personnel (on a reimbursable basis) to assist the Commission, but require the Administrator of General Services to provide (on a reimbursable basis) administrative support services requested and required by the Commission.

Section 5 would require submission of interim, periodic, and final reports to Congress, the President, and the Secretary of Veterans Affairs.

Section 6 would provide for the Commission's termination 30 days after the submission of its final report.

While VA supports the intent of H.R. 271 to examine the efficacy of VA treatment of mental disorders, we do not support the manner in which this bill would carry out that goal for the reasons discussed below. In addition, VA's current programs and reviews, as explained below, have substantial overlap with many elements of the work the Commission would do. Finally, the charge of the Commission to examine the efficacy of

VA's "evidence-based therapy model" in the treatment of mental health illnesses may be based on a flawed premise, as no single evidence-based therapy model exists by which to treat all mental health issues in Veterans who use VA health care.

Treatment is guided, in part, by the Post-traumatic Stress Disorder (PTSD) Practice Guideline (Guideline) that was jointly developed by VA and the Department of Defense (DoD) in 2010. The bill's charge to examine the efficacy of VA treatments would partially duplicate the Guideline as well as a report issued by the Institute of Medicine, entitled "Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment," in June of 2014. Creating such a Commission would also duplicate the efforts of the Institute of Medicine committee that is currently evaluating VA's mental health services. See "Evaluation of the Department of Veterans Affairs Mental Health Services."

<http://www.iom.edu/activities/Veterans/vamentalhealthservices.aspx>

As to the mandated patient-centered survey to be conducted by the Commission, such a charge would be unnecessarily burdensome to Veterans because some of the required information is already available in research programs and program evaluation studies. Other mandated information will be collected as part of VA data collection initiatives currently in development. Veterans should not be burdened by collection of information that is already available within VA or soon will be.

VA research into the benefits of complementary and alternative medicine (CAM) is also already underway. VHA is also establishing the Integrative Health Coordinating Center (IHCC) within the Office of Patient-Centered Care and Cultural Transformation. Integrative Health reflects the practice of medicine that reaffirms the importance of the

relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, health care professionals, and disciplines to achieve optimal health and healing. Integrative Health is inclusive of CAM. The IHCC is charged to work with VHA Mental Health Services, Patient Care Services, the Office of Research and Development, and other VHA program offices to examine the evidence and potential benefits of incorporating complementary and alternative treatments. VHA is actively partnering with the National Institutes of Health, National Center for Complementary and Integrative Health to evaluate the evidence. Thus, VA is already engaged in robust CAM efforts.

The bill's requirement that the Committee conduct research on the benefits of CAM techniques is partially duplicative of the activity of the PTSD Practice Guideline Committee, which is currently preparing to update the Guideline. VHA continues to review the emerging literature in other ways too. For example, through its Evidence Synthesis Program, VHA issued a review of the evidence on CAM for PTSD. (See Efficacy of Complementary and Alternative Medicine Therapies for Posttraumatic Stress Disorder: Evidence-based Synthesis Program. Investigators: Jennifer L Strauss, PhD, Remy Coeytaux, MD, PhD, Jennifer McDuffie, PhD, Avishek Nagi, MS, and John W Williams, Jr., MD, MHSc. Evidence-based Synthesis Program (ESP) Center, Durham Veterans Affairs Healthcare System. Washington (DC): Department of Veterans Affairs; 2011 Aug.)

With respect to the requirement that the Secretary submit a plan to Congress in response to the Commission's final report, we believe the suggested timeframe

(90 days after the date the Commission submits its report) is not reasonable given the requirements of the legislation.

VA estimates the costs associated with enactment of H.R. 271 to be \$770,512 over Fiscal Years (FYs) 2015 through 2017, the period covered by the legislation. This estimate does not include, however, contract-related costs required for the Commission to discharge its duties. Clarification of certain terms in the legislation and development of a scope of work are needed before contract-related costs and other costs associated with the legislation could be estimated and included in our cost projections.

In addition to these views, the Department of Justice advises us that it would treat section 4(c) of H.R. 271, authorizing the Veterans Expedited Recovery Commission to “secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out the duties of the Commission,” consistently with executive privilege and the President’s authority to control the dissemination of privileged information within the Executive Branch.

H.R. 627

H.R. 627 would expand the definition of “homeless veteran” found in 38 United States Code (U.S.C.) § 2002(1) to include “any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual’s or family’s current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing.” H.R. 627 would expand the definition by inserting “or (b)” to the

current title 38 definition, which would incorporate an additional subsection of the general definition of “homeless individual” found in the McKinney-Vento Homeless Assistance Act, 42 U.S.C. § 11302.

VA supports H.R. 627; however, a technical correction is needed to the bill language. Specifically, "or (b)" also needs to be added after "42 U.S.C. 11302(a)" in 38 U.S.C. 2002(1).

Since Veterans fleeing from domestic violence and interpersonal violence (DV/IPV) are considered at high risk for homelessness, they are already served in VA’s homeless programs when it is clinically appropriate. Even when a VA homeless program is not a clinically appropriate placement for a Veteran affected by DV/IPV, VA works closely within the local community to identify resources best suited to the clinical needs of the Veteran.

VA’s homeless programs may help prevent future DV/IPV by providing Veterans with alternative housing options so they can safely exit abusive relationships. VA remains committed to serving these Veterans, and VA homeless programs will continue to ensure those fleeing DV/IPV get the care and support they need.

VA is not able to provide an accurate cost estimate for H.R. 627 since we currently lack detailed data regarding the size and characteristics of this population; however, we anticipate H.R. 627 will be cost neutral since VA Homeless Programs already serve Veterans fleeing domestic violence, due to their high risk for becoming homeless.

H.R. 1369

Section 2 of HR 1369 would amend 38 U.S.C. § 1720(c)(1), to clarify that agreements for extended care services under that section shall not be treated as contracts for the acquisition of goods and services and are not subject to any provision of law governing federal contracts for the acquisition of goods or services. It would also require that any agreement with a provider specified in the section 1720 include provisions to ensure the safety and quality of care furnished to Veterans under those agreements. Specifically, agreements would have to include requirements as to the licensing and credentialing of the provider's medical professionals, site visits by VA, and review by VA of the medical records maintained by the provider as well as staffing levels for the provider's medical professionals and support personnel.

Section 3 of the bill would amend 41 U.S.C. § 6702(b) to exempt agreements under 38 U.S.C. § 1720 from certain labor laws.

VA appreciates the Committee's interest in updating our authority to purchase extended care services from community providers. As noted in VA's budget request, we are currently developing a legislative proposal to address our authority to purchase hospital care, medical services, and extended care services. We look forward to working with the Committee on this vital legislation.

H.R. 1575

HR 1575 would direct VA to provide reintegration and readjustment counseling services, in a retreat setting, to women Veterans who are recently separated from service in the Armed Forces after prolonged deployments.

VA is currently in the final year of a pilot program, authorized by Public Law 111-163 and subsequent laws (extensions), to determine the feasibility and advisability of such retreats. Under this program, six retreats were provided to women Veterans from 2011-2012, and three more are planned for calendar year 2015. These retreats focus on building trust and developing peer support for the participants in a therapeutic environment. Data has shown that those who participated in these retreats were able to increase their coping abilities and decrease their symptoms associated with PTSD. VA is expecting similar results for those who participate in the retreats in 2015. We will be happy to provide the Committee with a copy of the final report.

While VA agrees that providing these retreats is beneficial to women Veterans and authorization to provide them should be made permanent, other Veteran and Servicemember cohorts could also benefit from this treatment modality, conditioned on the availability of the additional resources needed to implement these provisions. VA recommends legislation to allow VA to provide these retreats to all Veteran or Servicemember cohorts eligible for Vet Center services. Examples could include those who have experienced a military sexual trauma, Veterans and their families, and families that experience a death of a loved one while on active duty.

VA estimates that this legislation would cost \$456,000 to conduct six retreats in FY 2016, \$2.5 million over five years, and \$5.5 million over 10 years.

HR 1769

In general, this draft bill would require the Secretary to establish a National Center ("Center") charged with researching the diagnosis and treatment of health

conditions of descendants of individuals who were exposed to toxic substances while serving in the Armed Forces. It would also establish an Advisory Board (the “Board”) to oversee and assess the Center and advise the Secretary as to the Center’s work. The term “toxic substance” would be defined as any substance determined by the Environmental Protection Agency to be harmful to the environment or hazardous to the health of an individual if inhaled or ingested by or absorbed through the skin of the individual.

VA is committed to working with other Federal departments and agencies to ensure that Veterans exposed to toxic substances receive the best possible care we can provide and the benefits for which they are eligible. With respect to military exposures, VA is working closely with DoD to ensure that those who have transitioned to Veteran status are identified and provided information about their exposures. VA will also ensure their records document their exposures and they are provided access to the health care and benefits for which they are eligible.

Section 3 would require VA, in consultation with the Board, to select, not later than one year after the date of enactment, a VA medical center to serve as the Center for research on the diagnosis and treatment of health conditions of descendants of individuals exposed to toxic substances while serving in the Armed Forces that are related to such exposure. It would also establish selection criteria for the site and authorize the Center to conduct research on the diagnosis and treatment of health conditions of such descendants. In conducting such research, the Center would be required, at the election of the individual, to study individuals for whom the Secretary has made one of the following determinations:

- The individual is a descendant of an individual who served as a member of the Armed Forces; such member was exposed to a toxic substance while serving as a member of the Armed Forces; and such descendant is afflicted with a health condition that is related to the exposure of such member to such toxic substance.
- The individual was exposed to a toxic substance while serving as a member of the Armed Forces, and such individual is afflicted with a health condition that is related to the exposure of such individual to such toxic substance.

Section 3 would further require the Secretary of Defense or the head of a Federal agency to make available for review records held by DoD, an Armed Force, or the Federal agency, as appropriate, that might assist the Secretary in making the determinations described above. Moreover, the Center would need to employ not less than one licensed clinical social worker to coordinate access of individuals to appropriate Federal, State, and local social and healthcare programs and to handle case management; plus it would need to reimburse the reasonable costs of travel and lodging of any individual participating in a study at the Center (and those of any parent, guardian, spouse, or sibling who accompanies the individual). This section would also require the Center to submit an annual report to Congress and to the Board that summarizes, for the preceding year, all completed research efforts and identifies ongoing research efforts. A copy of such report would also have to be released to an organization that requests it, if the organization has tax exempt status as an organization of past or present members of the Armed Forces or an auxiliary unit under

section 501(c)(19) of the Internal Revenue Service Code of 1986. The Center would also be required to submit quarterly reports to the Board.

Section 4 would require the Secretary to establish, not later than 180 days after the date of enactment of this legislation, a Board that would be tasked with overseeing and assessing the Center and also advising the Secretary with respect to the Center's work. Among its duties, the Board would advise the Secretary on issues related to the research conducted at the Center; health conditions of descendants of individuals exposed to toxic substances while serving as members of the Armed Forces that are related to the exposure of such individual to such toxic substance; health care services that are needed by the descendants of individuals exposed to toxic substances while serving as members of the Armed Forces for health conditions that are related to the exposure of such individual to such toxic substance; and, any determinations or recommendations that the Board may have with respect to the feasibility and advisability of VA providing such health care services to those descendants, including a description of changes to existing policy.

Section 5 would require the Secretary of Defense, unless excepted for reasons of national security, to declassify documents related to any known incident in which not fewer than 100 members of the Armed Forces were exposed to a toxic substance that resulted in a least one case of a disability that a member of the medical profession has determined to be associated with that toxic substance. It would limit such declassification to information needed to determine whether an individual was exposed to the toxic substance, the potential severity of the exposure, and any potential health conditions that may have resulted from the exposure.

Section 6 would require the Secretary, in consultation with the Secretaries of Health and Human Services and Defense, to conduct a national outreach and education campaign directed toward members of the Armed Forces, Veterans, and their family members.

Section 7 of the bill would provide that no additional funds are authorized to be appropriated for the conduct of this program.

However, VA does not support the draft bill. Other Federal departments and agencies are better poised to support research on multi-generational health effects of toxic exposures. Large populations are needed to study rare multi-generational effects appropriately. Focusing solely on military exposures – which can often be similar to many civilian exposures – will likely result in inconclusive research. VA's approach is to monitor Veterans' health, conduct surveillance studies, and remain abreast of findings from well-conducted studies in other populations. New Veteran-centric studies are conducted when indicated by clinical care findings or surveillance, or when the clinical or scientific community indicates a need exists for the conduct of such studies, or when such research is likely to yield new insights. None of those reasons applies here.

Moreover, the proposed Center would duplicate work done by the National Institute of Environmental Health Sciences, the Centers for Disease Control and Prevention, the Agency for Toxic Substances and Disease Registry, VHA (the War Related Illness and Injury Study Center, the Office of Research and Development, and the Office of Public Health), as well as other governmental and non-governmental scientific organizations. For many years, these existing organizations have conducted research on the health effects of a myriad of environmental exposures. Despite these

efforts, few diseases have been shown to be caused solely by exposure to environmental toxicants, and far fewer studies have demonstrated adverse health effects among the descendants of the exposed populations or adverse health effects specific to military service. Establishing a Center dedicated primarily to the study of adverse health effects on descendants, as proposed, would have little scientific-knowledge base and so would be premature. Existing agencies and research organizations should undertake preliminary research, as indicated by clinical findings, before a new Center for multigenerational research is created. We are also concerned that the draft bill's provisions related to the Board are impracticable, as the amount of work expected of the Board would be excessive for what is essentially a volunteer group of (at least) 13 members. We also note it is unclear what is contemplated by the provision in the draft bill that would require the licensed clinical social worker(s) at the Center to "coordinate access of individuals to appropriate Federal, State, and local social and healthcare programs and to handle case management."

With respect to researching the diagnosis and treatment of adverse health effects related to exposure from toxic agents, we underscore that the scientific approach generally does not differ whether the exposure occurred while performing in a military occupation or in a civilian occupation. It is also unclear whether the focus of such a Center would be to determine additional unknown health outcomes from exposure or translate known health outcomes of exposure – typically best determined by research in non-military populations – to the Veteran population. As to the field of research, the draft bill would require VA to determine whether an eligible descendant of an individual who served in the Armed Forces has a health condition that is related to the individual's

exposure to a toxic substance while serving in the Armed Forces. It is unclear what role the Center would have in researching potential exposures that have not been determined to be related to military service. However, a more fundamental problem is that exposure research typically looks at populations and does not provide the level of information necessary to determine causation at the individual level. As a result, many of the apparent goals of the draft bill could not be achieved.

In addition, the Department of Justice advises us that it opposes the inclusion of section 5 in the HR 1769 on the ground that it interferes with the President's exclusive authority to "classify and control access to information bearing on national security." *Dep't of Navy v. Egan*, 484 U.S. 518, 527 (1988).

Without authorization for additional appropriations to carry out the program established by the draft bill, resources would have to be taken from existing programs for Veterans should the draft legislation be enacted. VA estimates the costs associated with enactment of the draft bill to be \$7.2 million for FY 2015; \$96 million over a 5-year period; and \$222 million over a 10-year period.

Draft Bill on Annual Report Requirement

This draft bill would require VA to submit an annual report to the Senate and House Committees on Veterans' Affairs on the furnishing of hospital care, medical services, and nursing home care that VHA provides. The report would contain an evaluation of the effectiveness of VHA's program to increase access of eligible Veterans, an evaluation of effectiveness of VHA in improving the quality of health care services to Veterans, and information about VHA employee workload, patient

demographics and utilization rates, physician compensation, VHA employee productivity, the percentage of care provided in VA facilities compared to non-VA facilities, and pharmaceutical prices.

The Department appreciates the intent of this bill but notes that the bill may be unnecessary, as the data and related measures contemplated by the bill are already compiled as part of an ongoing and automated process for data that are available publicly and also in response to the requirements of the Veterans Choice Act. Additionally, VA currently provides reports and data on an annual, bi-annual or quarterly basis on programs and subjects such as homelessness, mental health, nursing education, and contracted care to name a few. Furthermore, pharmaceutical pricing information is already compiled and available on VA's Internet site. VA would be happy to brief the Committee on the various types of information currently compiled and disseminated on VHA programs and organization structure including the 32 Congressionally Mandated Reports and the 62 Congressional Tracking Reports that are required under law.

VA estimates that there would be negligible costs associated with this bill.

Draft Bill to Improve the Reproductive Treatment Provided to Certain Disabled Veterans

The draft bill would add a new section 1720H to title 38 of the U.S.C., to require the Secretary to furnish assisted reproduction technology to covered individuals. "covered individuals" would mean: 1) a Veteran, regardless of sex, who is enrolled in VA's health care system and who has a service-connected disability that includes an

injury to the reproductive organs, or to the Veteran's spinal cord, and such injury directly results in the Veteran being unable to procreate without assisted reproductive technology; and 2) the spouse of such a Veteran. Notably, such medical services would be in addition to any other fertility treatment otherwise furnished by VA.

The draft legislation would further define assisted reproductive technology to include in vitro fertilization or any other specific technology used to assist reproduction that the Secretary determines is appropriate. It would also provide that when the type of assisted reproductive technology provided under this new section consists of in vitro fertilization, the Secretary would be limited to providing no more than three in vitro fertilization cycles that result in a total of not more than six implantation attempts. The draft bill would also authorize the Secretary to provide for cryogenic storage of genetic material for individuals receiving services under this section for a period not exceeding three years, after which time the individual would be required to pay for any costs relating to such storage. The Secretary would be prohibited from possessing or making any determination regarding the disposition of a covered individual's genetic material and would be required to carry out any activities relating to the custody or disposition of genetic material of a covered individual in accordance with the laws of the State in which the genetic material is located. Finally, the draft bill would further prohibit the Secretary, when providing services under this section, to provide any benefits relating to surrogacy or third-party genetic material donation.

VA supports this draft legislation, conditioned on the availability of the additional resources needed to implement this provision. The provision of assisted reproductive technologies (including any existing or future reproductive technology that involves the

handling of eggs or sperm) is consistent with VA's goal to restore, to the greatest extent possible, the physical and mental capabilities of our enrolled Veterans. From a clinical perspective, this is particularly important given that the inability to be a biological parent can lead some to develop depression or other mental health conditions.¹ We note, however, that enrolled Veterans who have lost reproductive function for clinical reasons not covered by the draft legislation, for example, Veterans who have lost reproductive function due to some disease process or as a result of treatment for some other service-connected disability, could feel they were being treated inequitably by the Department based on their exclusion under this bill.

VA estimates costs associated with enactment of the draft bill to be as follows: \$177 million (consisting of approximately \$64 million for Veterans and \$113 million for eligible spouses). Expenditures are expected to decline to approximately \$80 million in FY 2017, gradually increasing to \$154 million by FY 2025. Total expenditures from FY 2016 to FY 2025 are expected to be approximately \$1,207 million (approximately \$437 million for disabled Veterans and \$769 million for eligible spouses). Expenditures for pregnancies resulting from fertility services are estimated to be \$28.9 million from FY 2016 through FY 2025.

Please note that the chart below summarizes what is currently available through VA in the field of reproductive care.

¹ 1. Chachamovich JR, Chachamovich E, Ezer H, Fleck MP, Knauth D, Passos EP. Investigating quality of life and health-related quality of life in infertility: A systematic review. *J Psychosom Obstet Gynaecol* 2010;31:101–110.
2. Fisher JR, Hammarberg K. Psychological and social aspects of infertility in men: An overview of the evidence and implications for psychologically informed clinical care and future research. *Asian J Androl* 2012;14:121–129.
3. Klemetti R, Raitanen J, Sihvo S, Saarni S, Koponen P. Infertility, mental disorders and well-being—a nationwide survey. *Acta Obstet Gynecol Scand* 2010;89:677–682.
4. Smith JF, Walsh TJ, Shindel AW, et al. Sexual, marital, and social impact of a man's perceived infertility diagnosis. *J Sex Med* 2009;6:2505–2515.

Current Infertility Services offered through VA

Female Veterans	Male Veterans
<ul style="list-style-type: none">•Laboratory blood testing•Genetic counseling and testing•Pelvic and/or transvaginal ultrasound•Hysterosalpingogram (HSG)•Saline infused Sonohysterogram•Surgical correction of structural pathology including operative laparoscopy, operative hysteroscopy and reversal of tubal ligation•Intrauterine Insemination (IUI) and Hormonal Therapies•Hormonal therapies for ovulation induction for IUI	<ul style="list-style-type: none">•Laboratory blood testing•Genetic counseling and testing•Semen analysis•Evaluation and treatment of erectile dysfunction (e.g., in spinal cord injury)•Surgical correction of structural pathology•Vasectomy reversal•Hormonal therapies•Sperm retrieval techniques•Post-Ejaculatory urinalysis•Transrectal and/or scrotal ultrasonography•Sperm cryopreservation

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. I would be pleased to respond to questions you or the other Members of the Subcommittee may have regarding our views as presented.