STATEMENT OF

DR. MADHULIKA AGARWAL
DEPUTY UNDER SECRETARY FOR HEALTH
FOR POLICY AND SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)

JANET MURPHY
ACTING DEPUTY UNDERSECRETARY FOR HEALTH
FOR OPERATIONS AND MANAGEMENT
VETERANS HEALTH ADMINISTRATION (VHA)

DEPARTMENT OF VETERANS AFFAIRS (VA)
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COMMITTEE ON VETERANS' AFFAIRS
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Good morning Chairman Benishek, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services. Joining us today is Jessica Tanner, General Attorney, Office of General Counsel.

We are providing views on H.R. 353 and H.R. 2464. We are providing views and costs on H.R. 272, H.R. 359, H.R. 421, H.R. 423, H.R. 1688, H.R. 1862, and the draft bill to clarify the role of podiatrists. We do not have cleared views and costs on H.R. 2914, H.R. 2915, and for the draft bill on the Construction Reform Act.

H.R. 272 Medal of Honor Priority Care Act

H.R. 272 would place Medal of Honor (MOH) recipients in VA's health care system in enrollment priority group (PG) 1 under the Veteran health care enrollment

priorities established by Congress. Additionally, H.R. 272 would exempt MOH recipients from having to pay copayments for inpatient care, outpatient care, long-term care, and prescription drugs.

VA supports efforts to ensure responsive and appropriate health care for MOH recipients. The MOH recipients have been recognized as extraordinarily courageous Veterans who served their country without regard for their own safety. VA would support legislation designed to recognize their service and ensure that they can receive cost-free care to maintain their health and well-being.

There are currently 79 living recipients of the MOH. Sixty-five are currently enrolled in PG 1 and are not subject to copayments. Placing the remaining MOH recipients, who currently are in PG 2 or 3, in PG 1 will provide equity and further recognition for recipients of this nation's highest military honor.

A change to make MOH recipients copayment exempt would require some system changes to the Veterans Health Information Systems and Technology Architecture (VistA) and the enrollment system, but they would be relatively minor. Because these system changes would be combined with other funded projects, the cost would be insignificant. The MOH recipient population is extremely small and exempting them from copayments would not have any significant impact on our medical care collection fund.

H.R. 353 Veterans Access to Hearing Health Act of 2015

H.R. 353 would amend 38 U.S.C. § 7401(3) to specifically include Licensed Hearing Aid Specialists among the list of positions that the Secretary may appoint under title 38 of the United States Code. The bill would also allow the Secretary to set

standards for Licensed Hearing Aid Specialists under 38 U.S.C. § 7402(b)(14) and require VA to submit an annual report to Congress about Veterans' access to hearing health services at VA and VA's contracting policies with respect to providing hearing health services to Veterans in non-VA facilities.

Although VA supports the intent of this bill, it does not believe that this bill is necessary as the Secretary already has the authority under 38 U.S.C. § 7401(3) to appoint other specialists, such as Licensed Hearing Aid Specialists, as are needed by VA, and to prescribe standards for these specialists under 38 U.S.C. § 7402(b)(14).

VA provides comprehensive hearing health care services and employs both audiologists and audiology health care technicians who deliver high-quality and efficient hearing health care services to Veterans. VA audiologists are doctoral-level professionals trained to diagnose and treat hearing loss, acoustic trauma and ear injuries, tinnitus, auditory processing disorders, and patients with vestibular complaints.

VA audiology health technicians (commonly known as audiology assistants) perform under the supervision of audiologists. VA audiology health technicians have a broader scope of practice than the typical hearing aid specialist. Examples of the scope of practice for audiology health technicians include: cerumen management; aural rehabilitation; hearing conservation and prevention of noise induced hearing loss; tinnitus management; hearing aids and other amplification technologies including implantable auditory devices; and helping manage Veterans' hearing health care with other health care disciplines in the context of their overarching patient-centered needs.

Apart from having a broader scope of practice than the typical hearing aid specialist, a number of VA audiology health technicians are also licensed hearing aid

specialists. VA currently employs 320 audiology health technicians and believes that with its current hiring authorities, it can successfully meet the demands of Veterans for timely access to hearing health services.

VA is unable to determine the costs of this bill without further consultation with other federal agencies that employ licensed hearing aid specialists (e.g., the Departments of Defense and Health and Human Services) and manage federal personnel, budget, and labor policies (e.g., Office of Personnel Management, Office of Management and Budget, and the Department of Labor).

H.R. 359 Veterans Dog Training Therapy Act

H.R. 359 would require the Secretary, within 120 days of enactment, to commence a 5-year pilot program under which the Secretary enters into a contract with one or more non-government entities for the purpose of assessing the effectiveness of addressing post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms through a program in which Veterans suffering from PTSD are educated in the training and handling of service dogs for other Veterans with disabilities. The bill would require the Secretary to enter into contracts with non-government entities located in close proximity to a minimum of three and not more than five VA medical centers. The bill requires that the non-government entities be certified in the training and handling of service dogs and have a training area that meets certain enumerated specifications.

The bill also includes provisions concerning the service dogs themselves and the personnel assigned to the program. The bill would require VA to ensure that each service dog in training have adequate temperament and health clearances. Dogs in

animal shelters or foster homes would be considered. The Secretary would be required to ensure that each service dog in training is taught all essential commands and behaviors required of service dogs. The bill would also require each pilot program site to have certified service dog training instructors with preference given to Veterans who have graduated from a residential treatment program and are adequately certified in service dog training. In addition, the bill would require VA to collect data to determine how effectively the program assists Veterans in various areas such as reducing stigma associated with PTSD, improving emotional regulation, and improving patience. Not later than one year after the date of commencement of the pilot program and annually thereafter, VA would be required to submit to Congress a report regarding the number of participating Veterans, a description of the services carried out by the pilot program, the effects of the pilot program in various areas, and recommendations with respect to extension or expansion of the pilot program.

VA supports the identification of effective treatment modalities to address PTSD and other post-deployment mental health symptoms; however, VA does not support the specific provisions in H.R. 359 because VA has significant concerns about the proposed legislation. Although anecdotal evidence has been offered to show the benefits of participating in such a dog training therapy program, there is no published scientific evidence to date that shows that such a program benefits PTSD patients specifically, or that such a resource-intensive program is any better other therapies known to be effective in alleviating PTSD symptoms. By propagating a yet unproven therapy, the bill may result in unintended and negative consequences for the Veterans who would be participating in this unsubstantiated treatment regime. Also, the pilot program would be

duplicative of the Department of Defense (DoD) study of this same therapy program at the Uniformed Services University of Health Sciences. In addition, the service dog training therapy program currently in place at the Palo Alto VA Medical Center (VAMC) is organized as part of an integrated set of services provided for their in-patient Trauma Recovery Program, and is not offered as a stand-alone program or as an out-patient service. VA has no prior experience in offering or managing such a program as an outpatient program.

VA notes that the bill would also make a number of restrictive stipulations regarding the structure and operation of the pilot program. For instance, contractor service dog trainers would be required to be certified, but there is currently no national certification program for service dog trainers. The bill would also require the contractor to preferentially hire Veterans who have graduated from a PTSD or other residential treatment program and received "adequate certification in service dog training." Such programs at the Palo Alto VAMC and other DoD sites do not provide adequate training to qualify a Veteran as a dog trainer, and they focus on basic commands rather than the advance tasks required by service dogs. The legislation would also require establishing a Director of Service Dog Training who is experienced both in teaching others to train service dogs and has a background in social services, with at least one year of experience working with Veterans or active duty military members with PTSD. These criteria would reduce the number of eligible candidates to almost none.

VA also notes that the proposed legislation prompts the use of shelter or rescue dogs, when statistics indicate that an extremely low proportion of such dogs have the temperament and behavioral characteristics to be a good service dog candidate, and

VA's experience with shelter dogs as service dogs in the Tampa VAMC PTSD service dog pilot study suggests that such dogs should not be considered as service dog candidates. In addition, if any service dogs successfully trained through the program for Veterans with disabilities are to be eligible to participate in VA's service dog medical benefit program, the non-government entities chosen would have to be accredited by Assistance Dog International. Thus, the number of potential non-government entity partners who could produce dogs eligible for VA's service dog medical benefit program would be relatively limited.

VA estimates that this bill would cost $2,461,222 in fiscal year (FY) 2016 and $13.3M over five years.

H.R. 421 Classified Veterans Access to Care Act

H.R. 421 would require VA to establish standards and procedures to ensure that certain covered Veterans, as that term is defined in the bill, are able to access VA mental health care without having to improperly disclose classified information. Guidance on the standards and procedures would be disseminated to Veterans Health Administration employees, including mental health professionals. Lastly, VA would be required to ensure that a veteran would be able to self-identify as a covered veteran on an appropriate form.

VA supports H.R. 421. Veterans who served in classified missions can currently receive mental health services within VA medical treatment facilities safely and with minimal to no risk to national security.

VA mental health providers respect and work within the limits of the information that Veterans can share and within the confines of their clinical confidentiality

requirements and security clearance levels. When VA providers are examining Veterans or active duty personnel with security clearances and exposure to sensitive material, it generally does not prevent the Veteran from being able to discuss their experiences without revealing classified information. Veterans are generally able to engage in treatment irrespective of whether their health care provider has a comparable level (or any) security clearance. Even in exposure-based therapy for PTSD, it is not the case that every detail of the event has to be shared with the provider in order for treatment to be effective.

The Veterans who hold security clearances while receiving services and treatment are the first line of security for protecting classified information. However, VA recognizes the benefit of medical provider sensitivity to Veterans who may have had exposure to non-disclosable classified material. VA agrees that it would be beneficial to establish standards and procedures to ensure that Veterans have access to mental health care in a manner that accommodates the veteran's obligation to not improperly disclose classified information.

VA estimates that there would be minimal costs associated with H.R. 421. VA mental health professionals already deliver mental health services to Veterans and active duty personnel with little or no risk to national security resulting from improper disclosure of classified material. VA's review of current policies to identify improvements would not result in additional cost.

H.R. 423 Newborn Care Improvement Act

H.R. 423 would amend section 1786 of title 38, United States Code, to increase from seven to fourteen the number of days after the birth of a child for which VA may

furnish covered health care services to the newborn child of a woman veteran who is receiving maternity care furnished by the Department and who delivered the child in a facility of the Department or a another facility pursuant to a Department contract for services related to such delivery. Not later than October 31 of each year, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on such services provided during the preceding fiscal year, including the number of newborn children who received such services during that fiscal year.

Although VA supports this bill, VA would require additional appropriations to implement this legislation as written. If a full term newborn has fever or respiratory distress after delivery, they may need additional inpatient treatment to manage these complications. This treatment may extend beyond the current 7 days that are allowed in the VA medical benefits package. Additionally it is standard of care for further evaluations during the first two weeks of life to check infant weight; feeding; and newborn screening results. Pending these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may apply, including monitoring stability of the home environment, or providing clinical and other support if the newborn requires monitoring for neonatal abstinence syndrome (e.g. withdrawal for maternal drug use during pregnancy). However, VA must carefully consider the resources necessary to implement this bill, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. That consideration includes the budget levels included in the fiscal year 2016 budget resolution adopted by Congress, S. Con. Res 11, as well as the fiscal year 2016

Military Construction/VA appropriations measures passed in the House and awaiting action in the Senate (H.R. 2029). VA estimates that this bill would add additional costs of $2,300,000 in FY 2016; $12,700,000 over five years; and $28,200,000 over ten years.

H.R. 1356 Women Veterans Access to Quality Care Act of 2015

Section 2 of H.R. 1356 would require VA to establish standards to ensure that all VA medical facilities have the structural characteristics necessary to adequately meet the gender-specific health care needs, including privacy, safety, and dignity, of Veterans at these facilities. VA would be required to promulgate regulations within 180 days of the date of enactment to carry out this section. Within 270 days of the date of the enactment of the Act, VA would be required to integrate these standards into the prioritization methodology used by VA with respect to requests for funding of major medical facility projects and major medical facility leases. Not later than 450 days after the date of the enactment of the Act, VA would be required to report to the Committees on Veterans' Affairs of the House and Senate on the standards established under this section, including a list of VA medical facilities that fail to meet the standards; the minimum total cost to ensure that all VA medical facilities meet such standards; the number of projects or leases that qualify as a major medical facility project or major medical facility lease; and where each such project or lease is located in VA's current project prioritization.

VA appreciates the intent of section 2 of H.R. 1356, but we do not believe it is necessary given other actions we are already taking. For example, in 2012, VA developed and published a Space Planning Criteria Chapter for Women Veterans

Clinical Service, which provides standards for Women Veterans Clinical services within VA. A standard examination room plan for Women Veterans Clinics was developed including access to bathroom facilities directly connected to the examination room. VA's Medical/Surgical Inpatient Units and Intensive Care Nursing Units Design Guide, developed in 2011 and 2012, addresses the gender-specific needs of women Veterans. These standards are available online at: www.cfm.va.gov/TIL. Moreover, it is unclear why VA would need to promulgate regulations for this section. Absent the requirement in the bill, VA would not need to promulgate regulations. VA's construction standards have been established through policy for years, and revising our standards through this process is less resource intensive and faster than formal regulations.

Section 3 of H.R. 1356 would require the Secretary to use health outcomes for women Veterans furnished hospital care, medical services, and other health care by VA in evaluating the performance of VA medical center directors. It would also require VA to publish on an Internet Web site information on the performance of directors of medical centers with respect to health outcomes for women Veterans, including data on health outcomes pursuant to key health outcome metrics, a comparison of how such data compares to data on health outcomes for male Veterans, and explanations of this data to help the public understand this information.

We do not support section 3 of H.R. 1356. Many important health outcomes, such as mortality and readmission, are normally not reported by gender in hospitals. The inherent problem relates to the difficulty of measurement at individual facilities where numbers of outcome events for women Veterans may be few, which would mean that any findings would not be statistically significant or reliable. VA could report

outpatient experience by gender, but to obtain valid results at the facility level, we would need to implement over-sampling of women Veterans for the Survey of Healthcare Experiences of Patients (SHEP). This would be costly and is likely to be perceived as burdensome on women Veterans.

Furthermore, the Institute of Medicine (IOM), in its report "Vital Signs: Core Metrics for Health and Health Care Progress" (2015), has raised concerns about the increasing burden on providers posed by the proliferation of performance measures. Valid and actionable metrics are difficult and costly to develop and implement. Flawed measures, however well-intentioned, can produce programmatic distortions such as an overly narrow focus on measured activities rather than what is most important to the patient (IOM, p 19). VA already monitors gender-specific performance system wide and has other mechanisms in place, such as site surveys, to ensure equitable provision of care. For these reasons, we do not support inclusion of gender-based outcome measures for evaluating the performance of medical center directors.

Section 4 of H.R. 1356 would seek to increase the number of obstetricians and gynecologists employed by VA. Paragraph (a) of this section would require, not later than 540 days after the date of the enactment of this Act, that VA ensure that every VA medical center have a full-time obstetrician or gynecologist.

VA supports the intent of section 4(a) and is already taking steps to expand access to gynecological care throughout VA. Currently, approximately 78 percent of VA medical centers have a gynecologist on staff, and we plan to add this service at roughly another 20 facilities. This will ensure that all facilities with a surgical complexity of intermediate or complex will have a gynecologist on staff. At facilities with a surgical

complexity designation of standard or less, we do not believe that there is sufficient patient demand to support a full-time gynecologist or obstetrician. For Veterans needing gynecological or obstetric services at these facilities, VA uses its non-VA care authorities to ensure these Veterans are able to access care. Moreover, in some areas of the country, particularly in smaller or more rural areas, VA faces recruitment challenges in hiring new staff, and we anticipate we would face similar challenges if this legislation were enacted.

Paragraph (b) of section 4 of H.R. 1356 would require VA, within 2 years of the enactment of this Act, to carry out a pilot program in not less than three Veterans Integrated Service Networks (VISN) to increase the number of residency program positions and graduate medical education positions for obstetricians and gynecologists (OB-GYN) at VA medical facilities.

VA supports the intent of paragraph (b) of section 4, and is already using authority Congress has previously provided to recruit residents in these fields. Currently, VA funds over 25 OB-GYN residency positions across 32 sites. While gynecologic services are widely available throughout VA, the limited patient population and scope of services at some sites makes broad-based national increases in these residency positions difficult. Additionally, section 301(b) of the Veterans Access, Choice, and Accountability Act of 2014 ("the Choice Act," Public Law 113-146) allows the Secretary to support primary care, mental health, and other specialty residency positions as appropriate. VA is using the authority and resources from the Choice Act to increase OB-GYN residency positions in locations demonstrating significant access issues for Women Veterans, as long as these sites can also demonstrate sufficient

educational infrastructure such as faculty supervision and space, and willing educational program partners. We do not have costs at this time.

H.R. 1688 To amend the Veterans Access, Choice, and Accountability Act of 2014 to designate 20 graduate medical education residency positions specifically for the study of optometry

H.R. 1688 would amend section 301(b)(2)(A) of the Veterans Access, Choice, and Accountability Act of 2014 (Choice Act), which requires VA to increase the number of graduate medical education residency positions at its facilities by up to 1,500 positions, to include up to 20 positions designated for residencies in optometry.

We appreciate the intent but VA already has the authority to create additional optometry positions and does not require additional legislation. The VACAA educational expansion is already in year two of a five-year expansion. Shifting its focus to include optometrists will significantly complicate processes that are well underway.

VA anticipates that the total cost for including optometry residents as part of the Choice Act's expansion of graduate medical education residency positions would be approximately $1,928,195. This cost excludes the current cost of the Choice Act's expansion of graduate medical education residency positions currently being undertaken by VA.

H.R. 1862 Veterans' Credit Protection Act

Section 2(a) of H.R. 1862, the Veterans' Credit Protection Act, would require VA to conduct outreach to Veterans regarding how to resolve credit issues caused by delayed payment for emergency health care furnished through non-VA providers. This would include establishing a toll-free number for Veterans to report such issues to the

Veterans Health Administration's Chief Business Office (CBO). The bill, in sections 2(b) and (c), would also require VA to submit to Congress reports on the effectiveness of CBO in providing timely payment for non-VA emergency care (annually) and the number of pending claims for reimbursement (quarterly). Finally, section 2(d) of the bill would require the Comptroller General of the United States to conduct a study of the effectiveness of CBO in providing timely payments for emergency health care furnished through non-VA providers. VA supports this proposed legislation as written.

In some instances, Veterans' credit histories have been negatively impacted as a result of VA's late payments to providers for emergency hospital care, medical services, or other emergency health care furnished through non-VA providers. Several strategies and actions are already underway to improve claims processing timeliness including expediting the filling of vacancies, utilizing claims processing support teams, and employing overtime for existing staff to process backlog claims and address growing claims volume. In addition to these short term solutions, VHA is deploying several longer-term improvement strategies. This legislation would provide for consistent reporting regarding the timeliness of claims processing, number of claims reimbursed or denied, interest penalties paid, and Veterans' adverse credit actions reported to VA, as well as comments regarding delayed payments made by medical providers. Establishing this reporting would result in improved relationships with Veterans and providers, by decreasing negative reporting of financial information on a Veteran's credit history as a result of delayed payment by VA; improving timeliness of payments to providers; decreasing interest payments by VA; and protecting Veterans' credit.

At this time, the cost of establishing a toll-free number as required by section 2(a) is not known. We do not have costs at this time.

H.R. 2464 Demanding Accountability for Veterans Act of 2015

H.R. 2464 would add a new section 712 to title 38 of the United States Code. Under section 712(a), as proposed by the bill, a report issued by VA's Office of Inspector General (OIG) would be accompanied by two lists: (1) a list of changes that were made to the report at the recommendation of the Secretary and (2) a list of names of managers responsible for issues addressed in the OIG report. Section 712(a) would require that the OIG send a copy of the report, including both lists, to the Committees on Veterans' Affairs of the Senate and House of Representatives at the same time that the OIG transmits the report to the Secretary.

Section 712(b)(1) would require that the Secretary: (1) notify a manager within seven days after the Secretary receives an OIG report, about the issues for which the manager is responsible; (2) direct the manger to resolve the issues identified in the OIG report; and (3) provide the manager with appropriate counseling and a mitigation plan with respect to resolving the issues identified in the OIG report.

Section 712(b)(2) would require the Secretary to evaluate actions taken by a manager in response to issues raised in an OIG report when reviewing the manager's performance. Section 712(b)(3) prohibits the Secretary from granting a performance award to any manager, identified by the OIG as being responsible for an issue in an OIG report, if an issue raised by the OIG is unresolved.

H.R. 2464 would curtail the Secretary's authority to properly manage VA and its employees, negatively affect employee morale, and adversely impact the collaborative

process between the Inspector General and the Secretary. Consequently, VA does not support this bill.

With regard to section 712(a), views on this section may be best addressed by the OIG. VA is extremely concerned that this section would have an adverse effect on the relationship between the Secretary and the OIG and would contravene the deliberative process component of executive privilege by requiring the disclosure of pre-decisional intra-Executive Branch deliberations. Requiring the OIG to explain changes that were made to a draft report at the recommendation of the Secretary would impede the deliberative process that occurs prior to the OIG finalizing its report. The deliberative process allows an agency, of which the OIG is a component, to talk freely within itself prior to reaching a decision or conclusion. Section 712(a) also presents other practical challenges, such as identifying responsible managers when issues are more systematic rather than related to the misconduct or performance failure of a manager.

Sections 712(b)(1), (b)(2), and (b)(3), raise a number of shared practical concerns. For example, the sections do not take into account OIG reports where the Secretary disagrees with the findings of the OIG or only partially concurs with the OIG's findings. Requiring an employee to take an action in accordance with the OIG's findings in these circumstances is tantamount to the Inspector General managing VA rather than the Secretary. The sections also do not take into account OIG reports that require actions involving multiple federal agencies (e.g., the Department of Defense). In these cases, VA managers may not be given performance awards until the matter has been resolved. This leads VA into an accountability problem, which is that a manager is now

being held accountable for actions above and beyond his or her control. This would not only penalize the manager for actions that he or she cannot control it would also have a negative impact on employee morale.

For the foregoing reasons, VA is unable to support the bill. VA is also unable to determine the costs for this bill.

H.R. XXXX To amend title 38 to clarify the role of podiatrists in VA

This bill would amend the term "physician" under chapter 74 of title 38, United States Code, to include podiatrists. Under this bill, VA would treat podiatrists in a similar fashion to VA physicians for the purposes of pay, recruitment, and retention.

VA supports this bill as a way of improving its ability to recruit and retain podiatrists at its facilities. VA anticipates that the salaries and benefits for podiatrists under this bill would go up from $69,646,104 to $74,096,352 in FY 2016 and from $392,264,620 to $417,330,788 over five years.

This concludes out statement, Mr. Chairman. We would be happy now to entertain any questions you or the other members of the Subcommittee may have.