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***STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
NOVEMBER 17, 2015***

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the DAV (Disabled American Veterans) to testify at this legislative hearing of the House Veterans' Affairs Subcommittee on Health. As you know, DAV is a non-profit veterans service organization comprised of nearly 1.3 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

DAV is pleased to be here today to present our views on the bills under consideration by the Subcommittee.

H.R. 1319, the Ask Veterans Act

This bill would require the Department of Veterans Affairs (VA) to contract with an experienced non-government entity to conduct an annual survey, over a five-year period, to determine the experiences of veterans in obtaining hospital care and medical services at each VA medical facility. Survey questions would include but are not limited to those relating to a veteran's ability to obtain hospital care and medical services at the facility in a timely manner, the time between the date the veteran requests an appointment and the date the appointment is scheduled, the frequency with which scheduled appointments are cancelled, and the quality of hospital care or medical services received. Under the bill, the results of the surveys would be made publicly available on the VA's website.

We understand the intent of this legislation is to better describe the veterans experience in accessing and receiving VA medical care, as a standard of comparison to VA's reported data. Wounded, injured and ill members of DAV report they do experience delays in receiving timely access to medically necessary services from the VA health care system. Arguably, this kind of patient experience can be illustrated by various VA reports such as its access reports (<http://www.va.gov/health/access-audit.asp>) and the VHA Facility Quality and Safety Report (system level: www.va.gov/health/hospitalReportCard.asp, and for local facilities: www.va.gov/HEALTH/docs/QandS_Report_2013_data_tables_fy12_data.pdf).

If this legislation is to be favorably considered, we urge the Subcommittee to amend the legislation to require that surveys results be acted upon in consonance with the continuous improvement philosophy of the VA health care system. Perhaps also such information could be used to require analyzing and/or revising existing policy or used as a basis for developing new policy to ensure the VA health care system and all its points of care meet the goal of consistently providing high quality care that is safe, effective, efficient, timely, patient centered, and equitable.

H.R. 1603, the Military Sexual Assault Victims Empowerment Act

This bill would amend the Veterans Access, Choice, and Accountability Act of 2014 (VACAA) to make eligible a veteran who was the victim of a military sexual trauma (MST) which occurred on active duty, active duty for training, or inactive duty training, for treatment by a non-VA provider.

This bill would exempt such MST survivors from mileage and waiting-time standards otherwise applicable to veterans to receive contract care under the provisions of VACAA, and would remove the eligibility date of enrollment before August 1, 2014, for survivors of MST.

DAV has not received a resolution from our membership in support of the specific matter of contracting out counseling and care on demand for victims of MST; therefore, DAV takes no formal position on this bill. However, our resolution on treatment for MST recognizes VA as a provider of specialized residential and outpatient counseling programs and evidence-based treatments for MST survivors. Accordingly, enactment of this bill would engender a number of questions that we ask the Subcommittee to consider before advancing this measure.

This bill would provide access to the Veterans Choice Program for survivors of MST by exempting them from certain qualifying or eligibility aspects, but it leaves other patients with other disabilities to comply with VACAA. Moreover, current law and VA national mental health policy are positioned to honor the preferences of MST survivors, such as meeting their designated preferences for a female or male provider, or to be referred to private care and counseling services when necessary.

We do not believe the failure of one facility is justification for enacting this legislation – a bill that would do little to improve every VA facility's ability to care for MST survivors. To refer MST care and counseling to community providers would increase the risk of fragmenting the holistic approach employed by VA using all available resources, benefits and services across the Department that are critical to optimal treatment outcomes for these patients.

Over the past decade, given the growing incidence of MST, VA has made major strides to elevate this program, employ additional resources and personnel, and ensure that treatment staff in every locale are trained to deal with the sequelae of MST in the most effective manner. Nationally, VA is now treating over 100,000 veterans for their needs associated with MST. Over 800,000 annual outpatient visits are being made by these individuals, and we believe the vast majority are well satisfied with the services they are receiving.

We believe VA is the right choice for most if not all veterans who have experienced MST and need specialized counseling and care in its aftermath. Mental health is one of VA's most significant and successful programs, and VA offers integrated and coordinated care to millions of veterans. Accordingly, we urge this Subcommittee to exercise its oversight responsibilities, and for VA to take action when local facilities fail to comply with these policies to the detriment of veterans' health and well-being.

H.R. 1904, the Wounded Warrior Workforce Enhancement Act

This bill would establish two VA grant programs. One would be made to educational institutions to establish or enhance orthotic and prosthetic masters and doctoral education programs, with an appropriations limitation of \$15 million; and the other to establish a private "center of excellence in orthotic and prosthetic education," with an appropriations limitation of \$5 million.

DAV has no resolution from our membership that would support the establishment of these specific activities. Nevertheless, prosthetic and orthotic aids and services are important to injured and ill veterans, and constitute a specialized medical program within the VA. However, absent a defined shortage of individuals who possess related skills and knowledge in these fields, justification for enactment of this bill seems questionable. Also, assuming the grant programs that would be established by this bill were to take form, graduating students who benefitted from them would not be required to provide obligated employment in VA to repay the government's investment in their education such as is required in VA's existing health professional scholarship programs under Chapters 75 and 76 of title 38, United States Code. We believe this existing and highly successful mandate for students in other health fields be considered in adopting the concept embedded in this bill, to ensure that VA regains at least some of the value of the work of these students following their VA-subsidized education and training.

Finally, assuming the establishment of a center of excellence in this particular field is warranted, DAV questions whether the center should be outside VA, rather than become a new VA in-house center of excellence along the lines of those centers already established in law in Chapter 73 of title 38. We ask that the sponsor of this bill reconsider and restructure this proposal in light of our testimony.

H.R. 2639, the Marriage and Family Therapists for Veterans Act

This bill would amend VA policy to require marriage and family therapist candidates to pass examination by the Association of Marital and Family Therapy, or pass an examination by a state board of behavioral sciences or an equivalent activity of a state, as a precondition to employment within the VA.

VA's various authorities under title 38, United States Code, section 7402 (which would be modified by this bill) generally require licensure in a state, or registration in the cases of nurses and pharmacists, as a condition of clinical professional employment in VA. Generally, any other requirements for VA employment of patient care professionals are left to the discretion of the VA Secretary. In the case of marriage and family therapists, current law requires a certain

level of educational achievement and a valid state license, unless the Under Secretary for Health recommends to the Secretary a waiver of licensure requirement for a reasonable period of time following initial appointment.

On this basis, we cannot identify a valid reason that this one particular category of patient care provider would need to undergo additional qualification testing as a pre-condition to employment in VA health care.

DAV has received no national resolution from our membership specific to the matters proposed in this bill, and thus takes no official position, but hopes the Subcommittee would take our views into consideration.

We also would take this opportunity to remind the Subcommittee of DAV's and VA's prior testimonies dealing with the topic of marriage and family counselors and licensed mental health counselors, and their potential employment in VA. DAV has long agreed with VA's position that these individuals from these professions could be employed in the Department's mental health programs without further acts of Congress. We maintain that view with respect to this bill.

H.R. 3234, the Failing VA Medical Center Recovery Act

If enacted this bill would establish within the VA a new Office of Failing Medical Center Recovery, led by an Under Secretary-level official.

Under this bill, the Secretary would be required to establish a set of key measurements against which to evaluate each VA medical center, and the bill would specify the measurements to be used. If a medical center were ranked and certified by the Secretary as "failing" under this measurement scheme, operational control of the medical center would be transferred to the new office. The office would be required to dispatch a "rapid deployment team" to each such failing medical center to examine and report on its resources, practices, health care programs. The Under Secretary for Failing Medical Center Recovery would be empowered to take a number of personnel actions, execute contracts, and carry out other actions to improve the performance of failing medical centers.

Both the VA Inspector General and the VA Office of Accountability Review would be required by the bill to give priority to whistleblower retaliation investigations emanating from failing medical centers.

The bill would define a number of terms associated with these new authorities, and would specify qualifications of the individual appointed to the position of Under Secretary for Failing Medical Center Recovery.

A number of the authorities this bill would prescribe to the new office are currently embedded in VA's existing organizational table, or are parts of the functions of existing staff offices, including the Office of Medical Inspector, the Office of Research Oversight and Compliance, the Office of the Inspector General, as well as the Governmental Accountability

Office in its continuing reviews of VA health care, most of which are directed by Congress. Numerous offices within the Veterans Health Administration are responsible for ensuring medical centers do not fail in their work. In our view, collectivizing these responsibilities into one new office, while attractive on its face, could create a number of unintended consequences and conflicts with similar and preexisting VA functions. Also, we believe establishing a single set of measurements to apply to every medical center in the system could be very challenging, given the wide variety of missions and histories of individual centers, producing distorted results. Some are clearly academic health centers with major affiliations with educational institutions; others are secondary-level facilities, many in rural areas or small cities; and still others are primarily long-term care oriented.

Finally, it should be noted that the bill is silent on addressing the disposition of a failing medical center once it improves its performance such that it is no longer “failing.”

DAV has received no national resolution from our membership that could be applied to this legislative proposal; therefore, DAV takes no position on this bill.

H.R. 3471, the Veterans Mobility Safety Act of 2015

The intent of this legislation would be to ensure disabled veterans receive the best quality, performance, and safety by establishing a set of minimum standards for vendors who want to participate in the VA Automobile and Adaptive Equipment (AAE) program. Specifically, under the bill an AAE vendor would need to be certified by a qualified organization or by the equipment’s manufacturer. The vendor could also be licensed or certified by the state where the modification services are performed.

DAV recognizes that the intent of this legislation could be beneficial to wounded, injured and ill veterans, but we urge the Subcommittee consider addressing certain possible unintended consequences. For example, a new provision may need to be added to this bill in cases where a veteran who requires AAE repair, maintenance, or replacement services resides beyond a reasonable distance from a certified AAE provider or requires emergency repairs when the closest provider is not certified as required by the bill. A strict requirement without flexibility, such as a waiver or approved exception, could be particularly troublesome for veterans residing in rural areas or when traveling across a vast distance when the need for these services arises.

H.R. 3549, the VA Billing Accountability Act

This bill would provide VA the authority to waive an otherwise required co-payment if the veteran received a VA notification more than 120 days after the date the veteran received services or medication from the VA, or more than 18 months later for services from a non-Department facility, and that the notification delay was caused by an error on the part of the agency. VA would also need to provide information to veterans on arranging payment plans and applying for waivers.

Based on Resolution Nos. 114 and 231, passed by our membership regarding VA copayments, we support this legislation.

Draft Bill – the Promoting Responsible Opioid Management and Incorporating Scientific Expertise “PROMISE” Act

Title I of this bill would establish a far-reaching and ambitious new program to deal with, protect against, control, and report any over-prescribing of benzodiazepines and opioid substances in the care of veterans enrolled in health programs of VA. While VA has made recent efforts to address overprescribing, its existing pain management program is not well organized, and is insufficiently staffed in our view, so enactment of this bill would call attention to the need for VA to better manage and staff this function at both the national and local levels.

DAV strongly supports Title II of the bill, which would establish a formalized national patient advocacy program in VA. As a co-author of the *Independent Budget*, DAV has called for improvements in patient advocacy and ombudsman programs in VA for several years. We believe this bill would give this program the weight and importance it deserves to help veterans to better navigate the VA health care system.

Title III of the bill would enhance complementary and alternative health care programs in VA. We support the advent of complementary and alternative care, both in substitute to VA’s use of pharmacological agents, and to better respond to the needs and demands of a younger generation of veterans, who often do not want traditional medical management – especially if it involves the prescribing of pain and psychotropic medications.

Title IV of this bill would require VA to strengthen its scrutiny in hiring practices for physicians and other providers by validating that such candidates for employment in VA carry no blemishes on their state licenses. If a VA provider were to violate a requirement of medical licensure, VA would be required by the bill to report such violation to the state medical board(s) of the state(s) that had granted licensure. Also, if the VA provider were to resign from VA, or transfer from one VA facility to another, your bill would require VA to determine whether there were any “concerns, complaints, or allegations related to the medical practice” of the individual during VA employment, and to take appropriate action in response. In respect to these requirements, the sponsor or the Subcommittee staff may wish to consider amending the bill to more clearly define the term “provider,” and whether the intention is to include all or only some of the individuals identified as direct care providers in section 7401 of title 38, United States Code.

Title V of the bill would require the establishment and reporting to Congress of a series of internal audits of VA administrations and key offices.

In summary, based on Resolution Nos. 103, 116, 228, and 126 adopted by our membership in our most recent National Convention, DAV supports this bill. We appreciate the sponsor’s introducing this omnibus proposal, and we urge Congress to proceed with its enactment this year.

A VA legislative proposal to establish certain agreements for purchasing medical care for veterans when care within VA facilities or through contracts or sharing agreements is not feasibly available.

This draft bill would establish authority for VA to execute purchase agreements for medical care for veterans when the VA and contracts or sharing agreements are not feasibly available. According to VA, this proposed language will streamline and speed the business process for purchasing care for an individual veteran when necessary care cannot be purchased through existing contracts or sharing agreements.

The continuing problem harming disabled veterans and their families was discussed in prior testimony from DAV on H.R. 1369, the Veterans Access to Extended Care Act of 2015. Like VA's draft bill, which would give VA the authority to enter into provider agreements, H.R. 1369 focuses on selected extended care facilities.

We support the intent of this draft legislation based on DAV Resolution 217. However, as with H.R. 1369, we recommend this measure be amended under subsection (e) to add federally recognized providers of service—Aging and Disability Resource Centers, area agencies on aging, State agencies (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)), and centers for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)). These entities serve on the front lines of a partnership between the VA and the Department of Health and Human Services that has served over 3,400 Veterans across 31 States and the District of Columbia and Puerto Rico. These agencies provide severely ill and injured veterans of all ages the opportunity to determine their own supports and services to live independently at home.

This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Subcommittee Members concerning our views on these bills.