

**STATEMENT OF
MAUREEN MCCARTHY
ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH
FOR PATIENT CARE SERVICES
VETERANS HEALTH ADMINISTRATION (VHA)

DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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Good morning Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services. Joining me today is Susan Blauert, Chief Counsel for General Counsel's Health Care Law Group.

Draft Bill: To ensure that each VA medical facility complies with requirements relating to scheduling veterans for health care appointments and to improve the uniform application of VA directives

The proposed draft bill would require each VA medical facility to comply with requirements relating to scheduling Veterans for health care appointments and to ensure the uniform application of VA directives.

Section 1 would require the director of each VA medical facility to annually certify to the Secretary that the medical facility is in full compliance with all provisions of law, regulations, and VA directives relating to scheduling appointments for Veterans to receive hospital care and medical services. VA does not support section 1 of this bill

because it is unnecessary. Existing policies already require directors to certify compliance with the scheduling directive and explain gaps in compliance based on scheduling data collected at the facility level. This bill would not increase the amount or quality of information available regarding scheduling or meaningfully improve existing processes for certifying compliance.

The bill also over-prioritizes scheduling to a great extent. Scheduling, while important, is not the only way Veterans access care in VA. As a technical matter, we note this bill would provide that each VA medical facility Director must certify compliance with all laws and regulations relating to “scheduling appointments for Veterans to receive hospital care.” Veterans are not required to be scheduled for hospital care; they can walk in the door and be admitted through the emergency room, if clinically appropriate, or their primary care provider may admit them directly. Within VA, the term “scheduling” typically is used in the context of outpatient care.

The bill also prohibits the Secretary from waiving any provision of law or regulation relating to scheduling. This provision would not benefit Veterans. VA is actively working with Members of Congress on a consolidated care in the community program and other efforts to improve access to health care. In this dynamic environment, particularly with the increased use of community care, VA needs the flexibility to set scheduling standards that are clinically appropriate and can change and improve over time in step with other changes in the way Veterans access health care.

Section 2 of the bill would require VA to ensure that its policies apply uniformly to each office or facility of the Department. VA does not support section 2 of the bill because it is unnecessary and, if interpreted broadly, unduly rigid. VA national policies

already apply uniformly across the Department. At the same time, these policies provide some flexibility so that facilities can develop and pilot innovative ideas, or implement policies and procedures that are specific to the needs of the local Veteran community and consistent with the principles and procedures established in national policy. Section 2 could potentially limit VA facilities' ability to implement policies and procedures needed to tackle local challenges and address Veterans' needs.

We do not have costs for this bill at this time.

H.R. 2460: To Improve the provision of adult day health care services for veterans

H.R. 2460 would amend 38 United States Code (U.S.C.) § 1745 to require the Secretary to enter into an agreement under 38 U.S.C. § 1720(c)(1) or a contract with each State home for payment by VA for adult day health care (ADHC) provided to an eligible Veteran. Payments would be made at a rate that is 65 percent of the payment VA would make if the Veteran received nursing home care, and payment by VA would constitute payment in full for such care. Currently, under a grant mechanism, VA pays States not more than half the cost of care of providing ADHC. States may currently obtain reimbursement for this care from other sources in addition to VA's per diem payments.

VA does not support this bill for the following reasons. Substantively, we note that the bill would base payment rates for ADHC on nursing home care rates, even though these are two distinctly different levels of care and are furnished for different

periods of time. VA pays per diem for three levels of care at State Veterans Homes (SVH): nursing home care, domiciliary care, and adult day health care. The prevailing nursing home rate is calculated based on the cost of providing nursing home care. Nursing home residents live at the facility and receive 24-hour skilled nursing care. ADHC, however, is a much lower level of care where participants live at home and only use ADHC services for a portion of time during the day, normally about 8 hours, or one third of the length of time that skilled care is provided. A per diem payment is made only if the participant is under the care of the facility for at least 6 hours. Because the level of services for ADHC and nursing home care are different, and the period of time in which services are furnished are different, we believe the payment rate proposed in the bill is inappropriate. The bill, in essence, would pay two thirds of the rate that VA pays for a higher level of care for furnishing a lesser level of care for only one third of the time.

VA also has logistical concerns with the legislation. First, we note that the language in the bill directing VA to “enter into an agreement under § 1720(c)(1) of this title or a contract” with each State home is inadequate. VA does not have independent agreement authority under § 1720, and all agreements reached under this provision are contracts. The fact that these agreements are contracts places additional requirements on State homes that have proved burdensome and difficult to implement. To address this and similar situations, VA has requested congressional action to enact the Purchased Health Care Streamlining and Modernization Act that we submitted to Congress last year. This legislation would allow VA to enter into agreements that are not subject to certain provisions of law governing Federal contracts with providers on an

individual basis in the community. Already, we have seen certain private nursing homes not renew their contracts, requiring Veterans to find new facilities for residence. We recommend Congress enact this new authority before requiring VA to transition payments to States for some ADHC participants from a grant to a contract mechanism.

Additionally, in June 2015, VA published a proposed rule, “Per Diem Paid to States for Care of Eligible Veterans in State Homes,” RIN 2900-AO88, along with a clarifying and correcting rule one week later. VA proposed these amendments to its regulations regarding payments for ADHC care in SVHs so that States may establish diverse programs that better meet participants’ needs for socialization and maximize their independence. Currently, VA requires States to operate these programs using a medical supervision model exclusively. We expect that the proposed changes to our regulations will offer a socialized model that would result in an increase in the number of States that have ADHC programs. Currently, the SVH ADHC program is underutilized, as only three SVHs operate ADHC programs. We do not know at this time how many SVHs will adopt this new model, nor how the new model’s use will affect costs. Until we have such information, we recommend against codifying a payment rate, as such a limitation could result in VA overpaying or underpaying States in the future.

VA has other technical comments and recommendations we would be happy to provide at your request.

VA supports growing ADHC programs in general because they are a part of VA’s home and community-based programs included in the medical benefits package available to enrolled Veterans. VA operates ADHC programs, pays for ADHC in the community, and pays per diem to SVHs for ADHC. Those who are able to utilize the

ADHC program are able to avoid nursing home care, maximizing their independence to support their choices, while reducing costs to VA. Projections for the Long-Term Services and Supports Model demonstrate that VA utilization for ADHC in the community will increase. VA recommends forbearing any action at this time until we have clear authority to enter into agreements other than contracts for such services and until VA is able to finalize changes to its regulations allowing for the new social model of care.

VA estimates H.R. 2460 would cost \$1.7 million in the first year, \$2.1 million in the second year, and \$12.6 million over five years.

H.R. 3989: Support Our Military Caregivers Act

H.R. 3989 would add a new subsection (d) to 38 U.S.C. § 1720G that would set forth a process for external clinical reviews of certain determinations under VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) and Program of General Caregiver Support Services, as established in Public Law (P.L.) 111-163. Under the new subsection (d), "an individual may elect to have an independent contractor . . . perform an external clinical review" of: a denial of a caregiver's application for benefits under § 1720G, a determination or reconsideration of "the level or amount of personal care services that a veteran requires," or a revocation of benefits pursuant to § 1720G. The bill specifies that such reviews would be performed by an "independent contractor" as described in the bill, "[u]sing amounts otherwise appropriated" to carry out § 1720G."

VA does not support this bill because VA already has an existing mechanism in place to review eligibility determinations under § 1720G, including, where appropriate, consideration of recommendations from an external clinical review.

VA implemented Caregiver Support Programs under § 1720G in May 2011. Since then, more than 30,000 caregivers have received services and support through PCAFC. These additional services and support are essential aspects of a Veteran's treatment plan as VA provides Veteran-centered and family-centered care to Veterans.

As provided in 38 U.S.C. § 1720G(c), all decisions by the Secretary under § 1720G affecting the furnishing of assistance or support shall be considered medical determinations. Accordingly, when there are disagreements with or clinical disputes over a decision under § 1720G that are not resolved at the clinical team level, VHA follows the VHA Clinical Appeals policy and procedures that govern the appeals process for all VHA clinical programming (VHA Directive 2006-057, *VHA Clinical Appeals*). This policy sets forth the mechanism in VHA for both internal and external clinical appeals. As provided in VHA Directive 2006-057, “[i]t is VHA policy that patients or their representatives must have access to a fair and impartial review of disputes regarding clinical determinations or services that are not resolved at the facility level.”

Providing a separate process for external clinical reviews, as set forth in H.R. 3989, would significantly impact the current process for reviewing eligibility determinations under PCAFC, in particular, as the program is currently operated. For example, when a Veteran (or eligible Servicemember) applies for the PCAFC, the individual's primary care team makes a series of clinical eligibility determinations. Once

approved, the primary care team continues to remain involved by maintaining the individual's treatment plan and collaborating with clinical staff making home visits to monitor the individual's well-being, supporting both the Veteran (or eligible Servicemember) and family caregiver(s). The existing VHA Clinical Appeals policy ensures that, in the event of an appeal, decisions are made by VHA leadership with direct oversight of the clinical team involved with the individual's care.

In contrast, the external clinical review under H.R. 3989 would be conducted by an independent contractor who "employs a panel of physicians or other appropriate health care professionals" and who does not provide health care to the individual. The independent contractor would need to be educated about PCAFC, applicable eligibility requirements, existing assessment and revocation procedures, as well as required assessment tools. This new process would require management and quality assurance oversight and Veteran-facing customer service and satisfaction supports that would require additional staffing or contract support.

Moreover, using an "independent contractor" to perform external clinical reviews, as provided in H.R. 3989, could not be achieved with existing funding. Additional funding for this new requirement would be necessary, to include funding for education and customer service and satisfaction supports.

VA is unable to provide a cost estimate on this bill as data required to construct costing is not readily available.

H.R. 3974: The Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015

VA supports section 2 of H.R. 3974, subject to the availability of funds, which would require VA to carry out a pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as physician assistants (PA). Having a pilot program will help alleviate the health care workforce shortages in VA by requiring scholarship recipients to complete a service obligation at a VA health care facility after graduation and licensure/certification. Additionally, scholarships will enable students to gain academic credentials without additional debt burdens from student loans. Future benefits are gained in reduced recruitment costs as scholarship recipients will have obligated service agreements to fulfill. These service agreement obligations secure the graduates' services for up to 3 years, which reduces turnover, and costs typically associated with the first 2 years of employment.

While VA supports H.R. 3947, we believe that the Congress should provide more flexibility in implementation. The bill is very specific, including in areas such as directing new pay levels, and the exact criteria for participant eligibility. VA should be afforded the flexibility to implement such a program in a manner that can minimize any unintended consequences, such as consistency across Title 38 programs in other Federal agencies.

While VA supports section 2, we recommend removing language in paragraph (j) that would require these positions to be filled by a Veteran and a current employee. While requiring a position be filled by a Veteran could be challenging,

requiring that the individual be “employed by [VA] as of the date of enactment of the Act” would be legally problematic. In addition, the limitation of filling the proposed Deputy Director positions with Veterans only (as opposed to employing Veteran preference) would significantly limit the pool of applicants with the necessary experience and skill sets necessary to successfully carry out the responsibilities of the positions.

The total cost of section 2 of the Health Professional Scholarship Program (HPSP) with HPSP Stipend cost for 250 awards over 5 years would be \$19,812,531. This amount includes \$11,700,000 for scholarship assistance, \$7,652,584 for stipend costs, as well as additional costs for administration, information technology, and travel.

Section 3 would establish standards for the Department for using educational assistance programs to educate and hire PAs. VA does not support this section because Educational Debt Reduction Program (EDRP) assistance is targeted for specific positions that are designated as difficult to recruit and retain. In order to meet local Veteran population needs, local medical centers have the flexibility to determine the positions that have the most critical need for EDRP awards and advertise accordingly. Loan repayment awards are an attractive tool; however, EDRP is a limited resource and offering EDRP to an entire occupational series is contrary to the statutory mission of the program and sets a precedent for other occupations to seek similar authority.

The PA occupation is recognized as a top 5 mission-critical occupation within VA, ranking fourth and tied with physical therapy, according to the January 2015 VA Office of Inspector General (OIG) report after medical officer (physician), nurse, and psychologist.

Over the last several fiscal years (FY), the number of new PA hires has fluctuated between 250-350 annually. The number of EDRP awards made for newly hired PAs has gradually increased from 26 to 45 (62 percent increase) from FY 2014 to FY 2015, and currently comprises 13 percent of all new PA hires. In the FY 2015 EDRP award cycle, the average EDRP award for PAs was \$63,000. Current projections estimate similar awards for the PA occupation based on qualifying student loan debt. Overall, the OIG top 5 occupations represented 82 percent of all EDRP awards made in FY 2015.

EDRP awards are typically 5-year awards. If EDRP was offered to every new PA hire, nearly \$4.6M would be needed each year for new awards, and additional funding would be required to sustain current participants. Furthermore, it can be expected that PAs currently employed within the VA network not receiving EDRP would expect to receive a similar award, or consider moving to a position elsewhere that authorized EDRP. Since EDRP may be awarded as a retention tool, additional funding would be required for current PAs as well.

Including EDRP in all announcements would also give interested candidates for hire the impression that EDRP would be available. EDRP awards are not made until after qualifying student loan debt can be confirmed with education institutions and lenders, which can take several months and occurs after employees are onboard. Without significantly increasing EDRP funding, including EDRP in all PA vacancy announcements will prevent facilities from offering the award to other positions that are more difficult for recruitment and retention locally. Advertising EDRP in all PA

announcements, without significantly increasing funding, is misleading and likely to disenfranchise new employees early in their VA career.

Advertising EDRP for an entire occupation sets a precedent that will likely encourage other occupations to seek the same. Such costs are not only unsustainable, but in conflict with the statutory mission. PAs are nationally ranked as a mission-critical occupation; however, certain facilities report no issues recruiting PAs (i.e., Michael E DeBakey VA Medical Center in Houston, TX, has a strong PA program with academic affiliates and reports no issues hiring PAs). Requiring all facilities to advertise EDRP for positions would deny the facility the ability to make awards for positions that are the most critical.

Alternative approaches may be better suited for strengthening the PA occupation within VA. If compensation of PAs is the primary driver, rather than include EDRP in all vacancy announcements, VA supports the legislation in Section 4, which seeks to eliminate the pay disparity between VA and the private sector.

The cost to include EDRP in all PA vacancy announcements for 5,350 new awards over 5 years would be \$45,500,000. Salary costs and development costs are estimated at an additional \$659,037, bringing the total cost of this proposal to \$46,159,037.

The PA occupation has been a difficult to recruit and retain occupation for several years. A major barrier to recruitment and retention of PAs is the significant pay disparity between private sector market pay and VA pay schedules for PAs. Special Pay rate authority exists at the medical center level to address these disparities. Salary surveys performed during FY 2015 by several VA medical facilities have resulted in

establishment or adjustment in local special salary rates for the PA occupation resulting in significant increases in salaries. This is an indication of the existing salary disparity overall. Including the PA occupation as a covered occupation under the nurse locality pay system in VA would be an important element in addressing recruitment and retention difficulties.

The total cost associated with this proposed legislation over 5 years would be \$135,149,625. This amount includes \$19,812,531 in Scholarship Support Costs, \$2,580,541 in Program Administration Costs, \$220,016 in Operational Costs, and \$112,536,537 associated with competitive pay for physician assistants.

H.R. 3956: The VA Health Center Management Stability and Improvement Act

Although the bill addresses the Department's challenges with recruiting and filling Medical Center Director positions, it does not offer any substantive solutions to address the challenges. Instead, it proposes legislation to develop and implement a hiring plan within 120 days of the legislation going into effect. By the time this draft language might become legislation, VA anticipates having significantly reduced the number of vacant Medical Center Director positions, such that the legislation would no longer be needed, but would impose another congressional reporting requirement on VA. Therefore, we do not support this bill. As an alternative to creating new reporting requirements, the Congress should consider options that would allow VA to achieve the same result through existing reports, such as the Agency's human capital plan. In fact, many of the

topics under consideration should already be covered in the succession management and recruitment sections of the existing human capital plan.

Since the beginning of FY 2016, VA has been working hard to shorten the time to hire for these executive positions. In October 2015, we began using nationwide announcements to identify and secure larger pools of qualified candidates, both internal and external to VA. This enterprise approach allows us to best match the candidate's skills and abilities with one of the vacant positions and do so in close to 120 days. Based on current recruitment efforts, we anticipate having nominees identified for approximately 20 of the more than 30 vacancies by the end of April 2016.

In addition, VA recently submitted a legislative proposal requesting the ability to transition all Medical Center Directors from Title 5 to Title 38, which will provide additional compensation and staffing flexibilities, thereby relieving some of the current challenges with attracting highly qualified candidates to serve in these leadership roles. Support of this proposal would be more beneficial to VA and ultimate resolution of the current staffing challenges rather than what is proposed in H.R. 3956.

Draft Bill: To direct the Secretary of Veterans Affairs to establish a list of drugs that require an increased level of informed consent

The draft bill would add new section 7335 to Title 38, U.S.C., to require VA to establish, within VHA's Office of Specialty Care Services, a panel to create and maintain a list of drugs (including psychotropic drugs) that may only be furnished with the "increased informed consent" of the patient or, in appropriate cases, a

representative thereof. Such term would refer to full and informed consent that provides the patient with a meaningful understanding of the treatment to be provided based on such consent, an opportunity to ask questions and receive information regarding such treatment, and is acknowledged in written form.

The Secretary would be responsible for determining the composition, membership, and functions of the panel. VA medical professionals who then prescribe any drug on this list would need to prepare and present to the patient (or patient representative) a written form that meets a number of detailed criteria specified in the bill, (e.g., the names of any drugs being offered to the patient) including any other trade or the generic name for such drug, each side effect, alternative methods of treatment or therapy not involving that drug, etc. Before such form is used, however, the provider, except in emergency situations, would first need to: (1) ensure that the patient signs an initial form acknowledging that the patient has received information regarding the recommended treatment and any other possible treatments; (2) refer the patient to an appropriate pharmacy of the Department if the patient has additional questions about the drug in question; and (3) provide the patient with the opportunity to review the information.

Thereafter, the patient would have the opportunity to sign the form reflecting the mandated requirements, to call or email the medical professional to provide consent, or to schedule a follow-up appointment with the medical professional to discuss the recommended treatment during the 3-day period beginning on the date on which the patient requests the appointment. The form would also need to provide for acknowledgement by the patient that he or she has received the required information,

as described in brief above, and has had adequate time to understand the information and consider alternative treatments, including, as appropriate, the opportunity to leave the medical facility.

VA does not support the draft bill. The terms of 38 U.S.C. § 7331, as implemented by 38 CFR § 17.32, VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*; VHA Handbook 1004.05, *iMedConsent*, and VHA Directive 1005, *Informed Consent for Long-Term Opioid Therapy for Pain*, already meet the objectives of the proposed measure and are aligned with professional best practice standards.

No medical treatment or procedure can be provided in VHA to any patient without the patient's full and informed consent first having been obtained and documented. Providers are required to appropriately document the informed consent in the patients' electronic health records. In addition, through its implementing regulations and policies, VA has already identified classes of treatment and procedures that, because of their inherent risk for significant pain, discomfort, complication, or morbidity, require signed informed consent, that is, a patient's (or surrogate's) and practitioner's signature on a VA-authorized consent form. These forms are developed by an established clinical expert process to include information about the treatment's risks, benefits, and alternatives at the appropriate reading level for the VA population. VA also provides written information about prescribed drugs each time the drug is dispensed to the patient. VA care is Veteran-centered, and the discussions described in the bill are already available to our patients.

Experts in law, ethics, and clinical implementation of informed consent in VA have also implemented appropriate means for seeking and documenting informed consent by patients and surrogates, including situations where the individual providing consent on behalf of the patient is not physically present, for example mechanisms for asynchronous signature. However, VA does not allow signed consent forms to be transmitted through commercial e-mail services. Until secure email is available, this prohibition in policy helps to ensure patient privacy and the security of patient information, and it also ensures the authenticity of the signed informed consent form confirming the identity of the sender.

The steps described in the proposed measure could significantly impede VA's ability to provide prompt care. The proposed legislation would add an undue time burden on Veterans and their care providers, by introducing unnecessary steps and delays in what is standard informed consent practice for high-risk medications. Of particular concern, the bill would apply the "increased informed consent" requirements to involuntarily committed inpatients in need of psychotropic drugs (because they have been found by the appropriate officials to be a danger to themselves or others). VA regulation and policy currently afford due process protections in these situations, while balancing the need for prompt medical intervention as defined by generally accepted standards of medical practice. Waiting on the completion of all the actions required by "increased informed consent" could well result in these clinical cases becoming exacerbated, with greater safety risks being posed, as a result, to the patients themselves, their surrogates, other patients, and/or VA staff.

Finally, it is unclear what problem this draft legislation purports to correct or remedy. For this reason, we request the Committee forbear in its consideration of this draft bill until we have a chance to meet with the Committee to ascertain the Members' concerns and together consider less formal and more flexible ways of satisfactorily addressing them.

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.