**STATEMENT OF**
**JENNIFER S. LEE**
**DEPUTY UNDER SECRETARY FOR HEALTH**
**FOR POLICY AND SERVICES**
**VETERANS HEALTH ADMINISTRATION**
**DEPARTMENT OF VETERANS AFFAIRS**
**BEFORE THE**
**COMMITTEE ON VETERANS' AFFAIRS**
**U.S. HOUSE OF REPRESENTATIVES**
**SUBCOMMITTEE ON HEALTH**

**MARCH 29, 2017**

Good morning, Chairman Wenstrup, 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 the Department of Veterans Affairs' (VA) programs and services. Joining me today is Susan Blauert, Chief Counsel for the Health Care Law Group, Office of General Counsel.

## H.R. 91 Building Supportive Networks for Women Veterans Act

H.R. 91 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 currently is in the final year of a pilot program, authorized by Public Law 111-163 and reauthorized through several extensions of this authority, to determine the feasibility and advisability of such retreats. Under this program, a total of 12 retreats were provided to 272 women veterans between 2011 and 2016. Three more retreats are planned for calendar year 2017. These retreats focus on building trust and developing peer support for the participants in a therapeutic environment. Data have shown that those who participated in these retreats were able to increase their coping abilities and decrease their symptoms associated with posttraumatic stress disorder. Eighty-seven percent of participants are scoring higher on the Ryff Scale of Psychological Well Being immediately post-retreat, and 78 percent had higher scores two months later. Eighty-four percent showed a decrease in stress symptoms at two months post-retreat. VA is expecting similar results for those who participate in the 2017 retreats.

VA agrees that providing these retreats is beneficial to women veterans, other veteran and Service member cohorts could also benefit from this treatment modality. While VA appreciates the intent of this bill, we would request that the bill language be amended to allow VA the ability to conduct these retreats for all veteran or Service

member cohorts eligible for Vet Center services. Examples include those who have experienced military sexual trauma, veterans and their families, and families that experience the death of a loved one while on active duty. Also, rather than creating a separate biennial report, as would be required by the bill, VA recommends that this bill amend 38 U.S.C. § 7309 to include a report on this program as part of the annual report to Congress on the activities of the Readjustment Counseling Service.

VA estimates that this legislation would cost $467,347 to conduct six retreats in Fiscal Year (FY) 2018, $2.5 million over five years, and $5.6 million over 10 years. There retreats would serve an average of 138 woman veterans annually, for a total cost of $3,400 per person.

**H.R. 95 Veterans' Access to Child Care Act**

H.R. 95 would require VA to carry out a program to provide assistance to qualified Veterans to obtain child care so that the veterans can receive covered health care services. Such assistance may include stipends for payment of child care by licensed centers, direct provision of child care at VA facilities, payment to private child care agencies, and collaboration with other Federal facilities or programs. Covered health care services would include regular and intensive mental health care services and other intensive health care services access to which could be improved by provision of child care assistance. While VA is aware of the challenges faced by veterans with children in regard to access to medical appointments and other medical care, counseling, and care giving services, VA does not support this bill as written. In a 2015 Study of Barriers to Care for Women Veterans, when queried about the possibility of on-site child care, more than three out of five women (62 percent overall) indicated that they would find on-site child care very helpful. However, this was not shown to be a significant factor in whether they chose to utilize VA care.

VA believes it would be better to have permanent but discretionary authority to provide child care assistance for the children of eligible veterans while those veterans are accessing health care services at facilities. In addition, VA cannot responsibly support the creation of a new child care assistance program for veterans without a realistic consideration of the resources necessary, including an analysis of the future resources that must be available to fund other core direct-to-veteran health care services.

VA does not have cost estimates at this time but will be happy to follow up shortly with the Committee.

**H.R. 467 VA Scheduling Accountability Act**

H.R. 467 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 2(a) 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. If the director did not make a certification, section 2(b) would require the director to submit a report explaining why the director was unable to make such a certification and a description of the actions the director is taking to ensure full compliance. Section 2(c) of the bill would prohibit VA from awarding any award or bonus to certain covered officials if the director of a medical facility did not make a certification under subsection (a)(1) for any year. Section 3 of the bill would require VA to ensure that its policies apply uniformly to each office or facility of the Department.

VA supports the intent of this bill in terms of ensuring veterans are appropriately scheduled for the care they need and that scheduling processes are reliable and timely. Existing Departmental policies require VA directors to certify compliance with the scheduling directive and explain gaps in compliance based on scheduling data collected at the facility level.

In addition, VA national policies already apply uniformly across the Department. At the same time, these policies provide some flexibility so that facilities may develop and pilot innovative ideas or implement policies and procedures that are specific to the needs of the local Veteran community, while remaining consistent with the principles and procedures established in national policy. Codifying activities that VA already does administratively could potentially limit VA facilities' ability to implement policies and procedures needed to tackle local challenges, adapt to changing conditions, and address veterans' needs in real time.

Finally, 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 that can change and improve over time in step with other changes in the way Veterans access health care.

VA estimates that there would be no costs associated with implementing the requirements in this bill.

**H.R. 907 Newborn Care Improvement Act**

H.R. 907 would amend section 1786 of title 38, United States Code, to increase from 7 to 42 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 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.

VA supports extending, from seven to 14 days, coverage of newborns of a woman veteran receiving delivery care. A newborn needing care for a medical condition may require treatment extending beyond the current 7 days that are authorized by law. Additionally, the standard of care is to have 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 a medical condition. Extending care to 14 days would provide time for further evaluations appropriate for the standard of care, as well as sufficient time to identify other health care coverage for the newborn. VA also notes the bill would not address travel benefits associated with the newborn's care. VA would support authorizing the provision of travel benefits under 38 U.S.C. § 1786.

VA estimates this bill would cost $25.9 million in FY 2018, $136.8 million over 5 years, and $293.6 million over 10 years.

**H.R. 918 Veteran Urgent Access to Mental Healthcare Act**

H.R. 918 would create a new section 1720I in title 38 that would direct VA to furnish to certain former members of the Armed Forces an initial mental health assessment and the mental health care services the Secretary determines are required to treat the urgent mental health needs of the former members, including risk of suicide or harming others. To be eligible for this care, an individual must be a former member of the Armed Forces, including the reserve components, who served in the active military, naval, or air service and was discharged or released therefrom under a condition that is not honorable but who did not receive a dishonorable or bad conduct discharge. The member would also have to have applied for a character of service determination that is still pending and otherwise be ineligible to enroll in the VA health care system established by section 1705 by reason of such discharge or otherwise not meeting the requirements for "veteran" status under section 101(2) of title 38. Furthermore, the former Servicemember must have been deployed in a theater of combat operations or an area at a time during which hostilities occurred in that area, participated in or experienced such combat operations or hostilities, or was the victim of a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment.

VA would be authorized to furnish such mental health care in a non-Department facility if treating the person in a VA facility would be clinically inadvisable or if VA facilities are not capable of furnishing such care economically because of geographic inaccessibility. The Secretary would be required to ensure that mental health services are furnished in a setting that is therapeutically appropriate and provide referral services to assist former Service members who are not eligible for services under this chapter to obtain services from outside VA. VA would also be required to provide information on

the availability of services and to coordinate with the Secretary of Defense to ensure that Service members who are being separated from active service are provided appropriate information about such services. VA would be required to submit an annual report on the provision of services under this authority and would be required, in consultation with the Secretary of Defense, to seek to enter into a contract with an independent nongovernmental entity to carry out a study on the effect combat service has had on suicide rates and serious mental health issues among veterans. VA would be required, within one year of enactment, to submit a report to Congress on this study.

VA supports this bill in principle. Veterans who were discharged or released with an other-than-honorable (OTH) administrative discharge or a punitive bad conduct discharge issued by a special court-martial may or may not be eligible for VA benefits. The determination is made based on the character of discharge standards in 38 C.F.R. § 3.12. An individual with an OTH administrative discharge that VA has determined to be disqualifying under 38 C.F.R. § 3.12 is eligible to receive health care for service-incurred or service-aggravated disabilities unless he or she is otherwise subject to one of the statutory bars to benefits set forth in 38 U.S.C. § 5303(a).

We note that requiring a study on the effect combat service has had on suicide rates and serious mental health issues would be largely duplicative of a number of recent research efforts in this area.

In addition, Secretary Shulkin recently announced his intention to expand access to mental health services for former Service members with OTH administrative discharges. It is estimated that there are slightly more than 500,000 former service members with OTH administrative discharges. As part of Secretary Shulkin's plan, former Service members with OTH administrative discharges would be able to seek treatment at a VA emergency department, Vet Center or contact the Veterans Crisis Line. Before finalizing the plan in early summer, Secretary Shulkin plans to meet with Congress, Veterans Service Organizations, and Department of Defense officials to determine the best way forward to get these former Service members the care they need.

**H.R. 1005 Improving the Provision of Adult Day Health Care Services for Veterans**

H.R. 1005 would amend 38 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 Veterans Home (SVH) for payment by VA for adult day health care (ADHC) provided to an eligible Veteran. Eligible veterans would be those in need of nursing home care for a service-connected disability or who have a service-connected disability rated at 70 percent or more and are in need of nursing home care. 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 providing

ADHC. States may currently obtain reimbursement for this care from other sources in addition to VA's per diem payments.

VA supports growing ADHC programs in general as they are a part of VA's home- and community-based programs that have been demonstrated to benefit the health and well-being of older veterans. However, VA does not support this bill as written for several reasons.

First, VA notes that the bill would base payment rates for ADHC on nursing home care rates, though these are two distinctly different levels of care and are furnished for different periods of time. Nursing home residents live at the facility and receive 24-hour skilled nursing care, including services after normal business hours with registered nurses involved in care at all times. ADHC is a distinctly different level of care that provides health maintenance and rehabilitative services to eligible Veterans in a group setting during daytime hours only. The nursing home rates that would be used to compute the ADHC rates under this bill are based on a formula that was developed in partnership with VA's State home partners and is specific to nursing home care. VA would like the opportunity to thoroughly review the cost of providing ADHC and, as was accomplished for nursing home care, establish a mutually agreeable ADHC rate with our SVH partners. VA believes revising the language to allow for VA to propose a formula for computing ADHC rates and for SVHs to provide comments on the formula would be consistent with the way the nursing home care rates were developed under 38 U.S.C. § 1745.

Second, VA has technical concerns with the legislation. We note that the bill directs VA to "enter into an agreement under section 1720(c)(1) of this title or a contract" with each SVH. VA does not have the authority to enter into individual agreements, and thus this provision would need to be implemented through contracts. VA has requested this specific authority.

Third, this legislation would impact VA's anticipated implementation of a proposed regulation that would allow SVHs to offer ADHC using either a medical supervision model or a socialized model. Currently, VA requires states to operate ADHC programs exclusively using a medical supervision model. In June 2015, VA published a proposed rule, "Per Diem Paid to States for Care of Eligible Veterans in State Homes," RIN 2900-AO88. VA proposed these regulations in part so that states may also establish ADHC programs using only a socialized model. A medical supervision model would include physician services, dental services, and administration of drugs, whereas these would not be required for a socialized model. Although the intent of the legislation may be to limit a higher per diem to medical supervision model programs, VA is concerned that H.R. 1005 does not make this distinction, which would result in VA being required to pay the same rate for a socialized model as for a medical supervision model.

Additionally, VA expects the numbers of both socialized and medical supervision model ADHCs to increase after publication of the proposed regulation. VA is not able to predict how many SVHs will adopt the new socialized model, nor how the new model's

use will affect costs. Until VA has such information, VA recommends against codifying a payment rate, as such a limitation could result in VA overpaying or underpaying States in the future.

VA estimates H.R. 1005 would cost an additional $492,972 in FY 2018, $3.8 million over 5 years, and $11.6 million over 10 years.

**H.R. 1162 No Hero Left Untreated Act**

H.R. 1162 would require VA, within 90 days of enactment, to begin a one-year pilot program in no more than two VA facilities by providing access to magnetic EEG/EKG-guided resonance therapy (Magnetic eResonance Therapy or MeRT) to treat veterans suffering from post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), chronic pain, or opiate addiction. The bill would not authorize additional amounts to be appropriated to carry out the requirements of this bill.

While preliminary experience with this technology is promising, a study by the Newport Brain Research Laboratory to establish the efficacy of MeRT in treating PTSD in veterans is still in progress. VA offers repetitive transcranial magnetic stimulation (rTMS), which is a treatment related to MeRT that has FDA approval for treatment-resistant depression, a common comorbid condition in PTSD, TBI, MST, and chronic pain and opioid addiction. There is no existing evidence that MeRT is superior to rTMS for treating any disorder. To date, no medical device using MeRT technology has been cleared or approved by the Food and Drug Administration for the uses described in the legislation. While VA research continuously examines new treatment methods and modalities, independently collected evidence of the safety and efficacy of this technology has yet to be obtained. The additional pilot data that would be obtained under the proposed legislation would not address the critical issues of determining MerT's efficacy against a placebo or against rTMS. For these reasons, VA does not support the legislation.

VA estimates the bill have a one-time $1.83 million cost to implement.

**H.R. 1545 Disclosure of Patient Information to State Controlled Substance Monitoring Programs**

H.R. 1545 would amend 38 U.S.C. § 5701(l) to direct the Secretary to disclose information about covered individuals to a State controlled substance monitoring program, including a program approved by the Secretary of Health and Human Services under section 399O of the Public Health Service Act (42 U.S.C. 280g-3), to the extent necessary to prevent misuse and diversion of prescription medications. Covered individuals would include an individual who is dispensed medication prescribed by a VA employee or a non-Department provider authorized to provide such medication by VA.

VA supports this bill. Currently, VA is required to provide information on veterans and their dependents, but this bill would expand that authority to include any person

who is dispensed medication prescribed by a VA employee or a non-VA provider authorized to prescribe such medication by the Department. Under our current authority, VA does not disclose information for other persons who receive care, such as in humanitarian cases or family members or caregivers who are eligible to receive care. This bill would provide an important authority to ensure that VA is able to fulfill its public health role in sharing vital clinical information to help guide treatment decisions. However, we note that there are information technology challenges relating to variations in State prescription drug monitoring program requirements that would prevent immediate implementation of this provision.

We estimate there would be negligible costs associated with this bill.

**H.R. 1662 To Prohibit Smoking in Any Veterans Health Administration (VHA) Facility**

H.R. 1662 would repeal section 526 of Public Law (P.L.) 102-585 and amend section 1715 of title 38, United States Code, to prohibit any person from smoking indoors in any VHA facility. It would also prohibit, beginning October 1, 2022, any person from smoking outdoors at any VHA facility. The bill would prohibit the use of cigarettes, e-cigarettes, cigars, pipes, and any other combustion of tobacco. The prohibition would apply to any land or building that is under VA's jurisdiction, under the control of VHA, and not under the control of the General Services Administration. The amendments made by the bill would take effect 90 days after the date of enactment.

VA strongly supports H.R. 1662. For several years, VA has proposed legislation to reverse the requirement in P.L. 102-585, section 526 for designated smoking areas at VA facilities. Currently P.L. 102-585, section 526, enacted in 1992, requires VHA to provide suitable smoking areas, either an indoor area or detached building, for patients or residents who desire to smoke tobacco products. As of January 2, 2017, there were over 4,000 local and/or state/territory/commonwealth hospitals, health care systems and clinics, and four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation) in the United States that have adopted 100 percent smoke-free policies that extend to all their facilities, grounds, and office buildings. Numerous Department of Defense (DoD) medical treatment facilities have become tobacco free as well. VHA health care providers and visitors do not have the same level of protection from the hazardous effects of second-hand smoke exposure as do patients and employees in these other systems. Currently, approximately 20 percent of veterans enrolled in VA health care are smokers. Many of the non-smokers are also older veterans who may be at higher risk for cardiac or other conditions that may make them even more vulnerable to the cardiovascular events associated with secondhand smoke. As with patients of other health care systems, VA believes veteran patients have a right to be protected from secondhand smoke exposure when seeking health care at a VA facility. For veteran smokers who are inpatients, nicotine replacement therapy is available.

VA estimates that it would see no savings in FY 2018, as the substantive changes made by this bill would not become effective until the beginning of FY 2023. VA estimates it would save approximately $8.2 million in FY 2023.

**Draft Bill Veterans Affairs Medical Scribe Pilot Act of 2017**

Section 2 of the draft bill would require VA to carry out a 2-year pilot program under which VA would increase the use of medical scribes at VA medical centers (VAMCs). The pilot program would be carried out at 10 VAMCs, with four located in rural areas, four in urban areas, and two in areas with need for increased access or efficiency. Under the pilot program, VA would hire 20 new medical scribes and would seek to enter into contracts with appropriate entities for the employment of 20 additional medical scribes. Two scribes would be assigned to each of two physicians, 30 percent of the scribes would be employed in the provision of emergency care, and the rest would be employed in the provision of specialty care. Every 180 days, VA would be required to report on the pilot program, and 90 days after completion, the Comptroller General would submit a report to Congress on the pilot program. No additional funding would be authorized to be appropriated to carry out the program.

While VA is exploring the use of medical scribes, VA does not support this draft bill as written. In the first quarter of FY 2017, VA began a demonstration project that includes the use of scribes (contracted or hired) and transcription, as well as a health advocate. There are eight sites in varying implementation stages, and VA has developed an evaluation plan for all methods of provider documentation support. VA also has an Enterprise Wide Front End Speech Recognition contract that includes unlimited licenses for clinical end users for the Nuance Dragon Medical 360 Network Edition (DMNE) Version 2.3, which is the current version. DMNE provides advanced, secure, speech recognition solutions that allow clinicians to document the complete patient story using voice while allowing healthcare organizations to deploy and administer medical speech recognition across the enterprise. VA does not have a cost estimate for this bill at this time, but will continue to work to provide this to the Committee shortly.

Members of the Committee, this concludes my statement. I would be happy to answer any questions you may have.