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CLAY HUNT SUICIDE PREVENTION FOR AMERICAN VETERANS ACT

MM/DD (LEGISLATIVE DAY), 2015.—Ordered to be printed

Mr. ISAKSON, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany H.R. 203]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (H.R. 203), to amend title 38, United States Code (hereinafter, "U.S.C."), to provide for the conduct of annual evaluations of mental health care and suicide prevention programs of the Department of Veterans Affairs (hereinafter, "VA" or "the Department"), to require a pilot program on loan repayment for psychiatrists who agree to serve in the Veterans Health Administration (hereinafter, "VHA") of the Department, and for other purposes, having considered the same, reports favorably thereon and recommends that the bill do pass.

INTRODUCTION

On January 7, 2015, Representative Timothy Walz introduced H.R. 203, to provide for the conduct of annual evaluations of mental health care and suicide prevention programs of the Department, to require a pilot program on loan repayment for psychiatrists who agree to serve in VHA of the Department, and for other purposes. Representatives Courtney, Duckworth, Esty, Kirkpatrick, Miller (FL), Murphy (PA), O'Rourke, Rush, Scott (GA), Slaughter, and Smith (NJ) were original cosponsors. Representatives Bonamici, Brown (FL), Bustos, Cicilline, Cleaver, Costello, Cramer, Fitzpatrick, Foster, Garamendi, Gibson, Israel, Kline, Kuster, Lujan, Lujan Grisham, Murphy (FL), Nolan, Paulsen, Peters, Peterson, Pingree, Quigley, Sinema, Walters, Welch, Wenstrup, and Young (IN) were later added as cosponsors.

On January 12, 2015, the House of Representatives suspended the rules and passed H.R. 203 by a vote of 403–0. On January 13,

2015, Senator McCain introduced S. 167, the Clay Hunt Suicide Prevention for American Veterans Act. Senators Blumenthal, Blunt, Boozman, Brown, Burr, Casey, Donnelly, Durbin, Flake, Gillibrand, Hirono, Klobuchar, Manchin, Menendez, Moran, Murkowski, Murray, Sanders, Sullivan, and Tester were original cosponsors. On January 13, 2015, the bill was referred to the Committee. Senators Ayotte, Baldwin, Bennet, Boxer, Cantwell, Capito, Cardin, Collins, Coons, Cornyn, Daines, Feinstein, Franken, Grassley, Heitkamp, Heller, Hoeven, Inhofe, Johnson, King, Kirk, Markey, Murphy, Nelson, Peters, Reed, Schumer, Sessions, Shaheen, Stabenow, Tillis, and Wyden were later added as cosponsors.

COMMITTEE MEETING

On January 21, 2015, the Committee met to consider H.R. 203. The bill was ordered to be reported favorably without amendment.

SUMMARY OF H.R. 203 AS REPORTED

H.R. 203, as reported (hereinafter, "the Committee bill"), would provide for the conduct of annual evaluations of mental health care and suicide prevention programs of VA, require a pilot program on loan repayment for psychiatrists who agree to serve in VHA, and serve other purposes.

Section 1 provides a short title of, the "Clay Hunt Suicide Prevention for American Veterans Act" or the "Clay Hunt SAV Act."

Section 2 would require VA to obtain an independent third party evaluation of VA's mental health care and suicide prevention programs to include: (1) use of metrics that are common and useful for mental health and suicide prevention practitioners; (2) identifying the most effective programs; (3) identifying the cost-effectiveness of each program; and (4) proposing best practices. The first report will be due no later than December 1, 2018, and subsequent reports will be required annually thereafter; two interim reports cataloging and reporting data on existing programs will be required.

Section 3 would require VA to publish an interactive Web site designed to serve as a centralized source of information regarding all VA mental health services.

Section 4 would require VA to establish a pilot program to repay education loans relating to psychiatric medicine for no less than ten individuals on the condition that they agree to serve no less than 2 years of obligated service within VA.

Section 5 would require VA to establish a pilot program in no less than five Veterans Integrated Service Networks (hereinafter, "VISNs") to assist veterans transitioning from active duty to veteran status and to improve veteran access to mental health services with community cooperation.

Section 6 would authorize VA to collaborate with non-profit mental health organizations to: (1) improve the efficiency and effectiveness of suicide prevention efforts; (2) assist non-profit mental health organizations through VA expertise; and (3) jointly carry out suicide prevention efforts.

Section 7 would extend an additional 1 year of eligibility for VA health care services for certain combat veterans who have not enrolled and whose 5-year combat eligibility period recently expired.

Section 8 stipulates that no additional funds are authorized to be appropriated to carry out this Act.

BACKGROUND AND DISCUSSION

Background. The number of veterans using VA mental health care treatment has risen from about 900,000 in 2006 to more than 1.4 million in 2013 and is expected to increase as servicemembers exit the military and enter the VA health care system. VA has attributed this increase to the improved screening, awareness, and understanding of post traumatic stress disorder (hereinafter, "PTSD") and other common mental health conditions. In testimony submitted for the Committee's November 19, 2014, hearing on Mental Health and Suicide Among Veterans, Dr. Harold Kudler, Chief Mental Health Consultant for VHA, noted the Department "anticipate(s) that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end."

Mental health diagnoses of veterans range from mild depression to severe PTSD, requiring an equally broad range of treatment options. According to statistics from VA, since 2002, more than 1.7 million servicemembers have left active duty and become eligible for VA care. Fifty-eight percent of those individuals have sought care from VA and, of those, 55 percent have been either diagnosed provisionally or confirmed with a mental health condition.

Additionally, different veterans with the same diagnosis may respond differently to the same treatment. The most severe cases of PTSD are frequently treated with intensive therapies at VA medical centers. Less severe cases can be treated at Vet Centers, which often appeal to veterans because of their welcoming, home-like nature. Certain veterans respond better to one-on-one therapies, while others respond well to group environments. Community Based Outpatient Clinics (hereinafter, "CBOC") play an important role in telehealth delivery by connecting rural veterans to psychiatry services from the medical center.

In an effort to meet the needs of veterans, VA began offering expanded access to mental health services through extended evening and weekend clinic hours at larger VA medical centers. Moreover, VA began offering same day appointments at some VA medical centers and services are available to veterans in an emergency situation. Another important change has been the inclusion of mental health professionals into primary care delivery through VA's Patient Aligned Care Teams. This improves the screening process to recognize and treat those veterans who present in their primary care location.

VA clinicians are now trained in—and utilizing—a variety of evidence-based therapies, including Cognitive Behavioral Therapy and Prolonged Exposure Therapy. The use of these therapies helps ensure veterans throughout the country are receiving the high-quality care most likely to assist them in the treatment and recovery of a broad spectrum of mental health diagnoses. However, VA must do a better job tracking utilization of these services to ensure clinicians are using them appropriately and to make sure they are being used across VHA.

Despite these changes to VA's mental health program, difficulties still exist. Over the last few years, the Committee has heard from

stakeholders about several ongoing concerns, which will be discussed below in further detail.

SUICIDE

Tragically, over the past year, it is estimated this nation has lost, on average, twenty-two veterans a day to suicide. While much of the attention has been focused on the youngest cohort of veterans returning from the wars in Iraq and Afghanistan, it is reported to be the older cohort of veterans who are committing suicide at higher rates. VA's Suicide Data Report 2012 found more than 69 percent of veteran suicides are among those age 50 years or older.

Among the youngest cohort of VHA users, the largest increase in suicide rates has been among males under 30, especially those between 18–25 years of age, according to VA's 2014 Suicide Data Report Update. This report also highlighted an increase in the suicide rate in female VHA users since the start of the wars in Iraq and Afghanistan. It is important to note, however, that the increase seen in this population is comparable to the increases among non-veteran women in the United States.

ACCESS AND SCOPE OF CARE

The events at the Phoenix VA Health Care System in 2014 underscored VA's inability to provide timely access to medical services, including mental health appointments. Concerns about the Department's scheduling practices had been raised by the VA's Office of Inspector General (hereinafter, "VAOIG") and the Government Accountability Office as early as the 1990s. In fact, in April 2012, the VAOIG released a report entitled Review of Veterans' Access to Mental Health Care, which showed VA was not meeting benchmarks for timely access to mental health care services. Some veterans were waiting as long as 60 days for an evaluation.

In her written testimony for the Committee hearing entitled VA Mental Health Care: Ensuring Timely Access to High-Quality Care on March 20, 2013, Kim Ruocco, National Director of Suicide Postvention Programs, Tragedy Assistance Program for Survivors, provided several examples of veterans who struggled to get timely access to treatment. She also discussed the challenges of navigating the system:

> At some point, the veteran may decide to go to the VA because he or she is struggling and needs help. Often this happens after a long battle and the servicemember's life is already falling apart and he or she is very sick. The servicemember then contacts the VA looking for help with his or her symptoms, whether it is addiction, anxiety, depression, uncontrollable outbursts of rage, etc. This is a critical time for the veteran . . . . Very often the veteran's suffering is complicated with combinations of physical and emotional pain including issues like traumatic brain injury, post-traumatic stress, depression, moral injury, and survivor guilt. These issues become the veteran's own personal barriers to care. In this population we see avoidance, anxiety and trouble concentrating. Symptoms like panic attacks, flashbacks and hyper-vigilance among

> this population of veterans are often described to us by our surviving families.
>
> These symptoms run counterintutitive to navigating a complex system of paperwork, crowded waiting rooms, extended wait times for appointments, referrals and disability ratings. The veteran enters the system tentatively with trepidation and some fear. The veteran is barely holding on. The veteran may feel like people do not understand him and that the public does not appreciate what he or she has sacrificed for this country . . . . When the veteran asks for help, he or she is desperate, and may be thinking of killing himself or herself because he or she is losing hope that things will get better. This is the composite profile of the veteran who dies by suicide, who initially approaches the VA for help.

During the Committee's November 19, 2014, hearing, Susan Selke, Clay Hunt's mother, testified that her son exclusively used VA for his medical care after leaving the Marine Corps. She went on to note:

> Clay constantly voiced concerns about the care he was receiving, both in terms of the challenges he faced with scheduling appointments as well as the treatment he was receiving for PTS, which consisted primarily of medication . . . . Clay used to say, "I am a guinea pig for drugs."

Mrs. Selke also recalled a conversation she had with her son 2 weeks before his death:

> Clay had only two appointments in January and February 2011, and neither was with a psychiatrist. It was not until March 15 that Clay was finally able to see a psychiatrist at the Houston VA medical center. But after the appointment, Clay called me on his way home and said, "Mom, I can't go back there. The VA is way too stressful and not a place I can go. I will have to find a Vet Center or something."

Ensuring VA is providing veterans with the types of mental health care they want is paramount. In testimony before the House Committee on Veterans' Affairs on July 10, 2014, Warren Goldstein, Assistant Director for Traumatic Brain Injury and PTSD programs in the National Veterans Affairs and Rehabilitation Commission of The American Legion, discussed the findings of a survey conducted by the organization, which found more than half of the 3,100 veterans surveyed did not believe their symptoms improved as a result of psychotherapy or medication prescribed at VA. Furthermore, nearly a third of veterans actually terminated their treatment before it concluded. They cited reasons like stigma, travel burden, side effects, and frustration with the lack of progress that drove veterans to discontinue treatment before the end of the treatment cycle.

STAFFING SHORTAGES

Presenting testimony on behalf of the American Federation of Government Employees (hereinafter, "AFGE"), AFL-CIO, and the

AFGE National VA Council, Michelle Williams, Ph.D., a coordinator of PTSD Services and Evidence Based Psychotherapy at the Wilmington VA Medical Center, recounted numerous stories about staffing issues related to mental health providers during the November 30, 2011, hearing on VA Mental Health Care: Addressing Wait Times and Access to Care. In one instance, a psychiatrist in a general mental health clinic stated he felt like "staffing levels [would] 'never catch up' with the growing demand for services and that at his medical center, trying to keep up with patients' needs [is] like 'a finger in the dike'." Another psychologist at a CBOC noted she was overbooked every day, as she was the only mental health provider at that facility. She found herself handling individual and group appointments, walk-ins, and call-ins, as well as some compensation and pension examinations. This provider had a caseload of more than 200 patients, many of whom were considered high-risk patients.

In an effort to address staffing shortages, on August 31, 2012, President Obama signed an Executive Order directing VA to hire 1,600 more mental health professionals. Despite these additions, the Committee continued to hear concerns about shortages of mental health professionals across the country. As a result, recruitment and retention of medical professionals at VA became a focus during the 113th Congress as events at Phoenix and other VA facilities came to light during the summer of 2014. The Veterans Access, Choice, and Accountability Act of 2014 (hereinafter, "VACAA") sought to increase the number of graduate medical education residency slots by up to 1,500 over a 5-year period, with an emphasis on those pursuing primary care, mental health, and other specialties the Secretary deems appropriate; gave priority to the five medical occupations the VAOIG has identified as having the largest staffing shortages; and increased the maximum amount of money available to eligible VA health care professionals in their Education Debt Reduction Program.

However, given the extent of the national shortage of mental health care professionals across the United States, VA must continue to enhance its ability to recruit and retain staff. Rural and highly rural parts of the country face the largest burden.

In the months following VACAA's implementation, the Committee heard from Dr. Elspeth Cameron Ritchie, Chief Clinical Officer, District of Columbia Department of Mental Health and Member of the Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder, Institute Of Medicine, The National Academies, during the Committee's November 19, 2014, hearing on Mental Health and Suicide Among Veterans. She stated:

> [The Department of Defense] and VA have substantially increased their mental health staffing—both direct care and purchased care. However, staffing increases do not appear to have kept pace with the demand for PTSD services. Staffing shortages can result in clinicians not having sufficient time to provide evidence-based psychotherapies readily and with fidelity. The lack of time to deliver psychotherapy with fidelity is reflected in the fact that in 2013 only 53 percent of [Operation Enduring Freedom (hereinafter, "OEF")] and [Operation Iraqi Freedom (here-

inafter, "OIF")] veterans who had a primary diagnosis of PTSD and sought care in the VA received the recommended eight sessions within 14 weeks.

In an effort to better meet the needs of veterans with mental health conditions, as a part of the President's 2012 Executive Order to hire additional mental health staff, VA announced some of those slots would be used to hire peer support specialists. Within the last 2 years, VA has been able to hire 900 peer support specialists and apprentices to be incorporated into VA's mental health programs. These peer support specialists are uniquely positioned to relate to veterans and can serve on the front line of support for those veterans who are hesitant to seek care. VA has announced that it will start piloting the expansion of peer support to veterans in primary care settings. The pilot is expected to place one to two peer specialists in 25 primary care sites across the country.

The Committee has heard from multiple witnesses over the years about the value of peer support. For example, in his written testimony to the Committee on November 30, 2011, John Roberts, the Executive Vice President of Mental Health and Family Services for the Wounded Warrior Project (hereinafter, "WWP") drew attention to this when he discussed the findings of a survey of WWP alumni. He stated that "nearly 30 percent identified talking with another OEF/OIF veteran as the most effective resource in coping with stress—the highest response rate of all the resources cited, including VA care (24 percent), medication (15 percent) and talking with non-military family or friend (8 percent)."

OVERMEDICATION

The effect of combat does not end when veterans return from the battlefield. For many servicemembers returning home from war, chronic pain is part of daily life. VA's latest health care utilization report notes musculoskeletal ailments—like joint, neck, and back disorders—are the most frequent conditions diagnosed among post-9/11 veterans. A common symptom of these ailments is chronic pain. In fact, VA's own statistics from the Office of Health Service Research & Development show 50 percent of male veterans treated by VHA suffer from chronic pain and among female veterans the prevalence may be higher. As noted earlier in this report, 55 percent of the 58 percent of post-9/11 veterans seeking care at VA have a mental health diagnosis. Treating the invisible wounds of war can be challenging and often requires veterans to take multiple medications in order to help these individuals live fuller lives. However, these drugs come with significant risk if not properly monitored. In response to numerous stories in the media highlighting the problem of overmedication as it relates to servicemembers and veterans, especially in regards to opioids, the Committee held a hearing on the subject on April 30, 2014.

Recognizing both the need for these medications in order to properly treat veterans as well as the risks associated with their misuse, VA has taken steps to address this issue. One of the Department's most recent efforts is the Opioid Safety Initiative (hereinafter, "OSI"). Started in October 2013 in Minneapolis, Minnesota, with a goal of reducing dependency on opioid use, this initiative includes a team approach that educates veterans and provides pa-

tient monitoring with feedback. This program also helps ensure access to, and encourages the use of, Complementary and Alternative Medicine therapies for its participants. In written testimony to the Committee on April 30, 2014, Dr. Robert Petzel, Under Secretary for Health at VHA, noted that, as a result of implementing the OSI, "Minneapolis has seen a nearly 70 percent decrease in high-dose opioid prescribing for chronic non-cancer pain patients." Given the positive results seen in Minnesota, VA decided to implement this initiative nationwide.

VA has also begun a program known as the Academic Detailing Service to identify and disseminate best practices for evidence-based mental health treatments. It also seeks to improve treatment outcomes while reducing reliance on high-dose medications to treat chronic mental health conditions. This initiative was initially piloted in VISNs 21 and 22. Following its success, VISNs 3, 12, 17, 19, and 23 are preparing to implement the program as well.

While these efforts to reduce the use of opioids at VA are commendable, more remains to be done. A recent Administrative Closure by the VAOIG for alleged inappropriate prescribing practices of opioids at the VA Medical Center in Tomah, Wisconsin, has raised new concerns about the overuse of opioids at VA.

OUTREACH

The Committee has heard regularly from witnesses and constituents that VA's outreach efforts are inadequate. Many have discussed the difficulties of not only navigating the system but also knowing what services are available. In an effort to address some of these concerns, the Committee held a hearing entitled Call to Action: VA Outreach and Community Partnerships on April 23, 2013. During the hearing, it was highlighted that from fiscal year (hereinafter, "FY") 2009 through 2013, VA spent a total of $83.7 million on its outreach efforts, yet a 2010 survey found 60 percent of veterans knew "very little" or "nothing at all" about their VA benefits, including access to health care.

One of the main reasons a veteran may be reluctant to seek mental health treatment is the stigma surrounding such treatment. In his written testimony for the Committee on April 23, 2013, Eric Weingarter, the Managing Director of the Survival and Veterans program at the Robin Hood Foundation observed:

> Many individuals fear that seeking mental health services will jeopardize their career, community standing or both. Others are reluctant to expose their vulnerabilities to providers who may also be Armed Forces personnel themselves, given the military's emphasis on strength, confidence, and bravery. And some veterans have found the settings or providers they used especially bureaucratic or unsatisfactory in other ways, and would pursue a different option if available.

A similar sentiment was expressed by Lieutenant Colonel (hereinafter, "LTC") Kenny Allred, U.S. Army (Ret.), Chair of the Veterans and Military Council of the National Alliance on Mental Illness (hereinafter, "NAMI"), in written testimony provided to the Committee on March 20, 2013, for its hearing about mental health wait times. LTC Allred stated:

> "NAMI believes that the key to reducing stigma and strengthening suicide prevention is a change in the way we approach these problems. It is absolutely unacceptable to be applying the resources we have over the last 10 years and to see suicides grow at a rate of twenty-percent among veterans from eighteen to twenty-two a day. Many of these suicides are occurring among those who have never been in combat. In 2012, suicide deaths among soldiers were higher than combat deaths."

He also stressed the need for "addressing the health and mental health care needs of National Guard and Reservists who are not considered 'veterans' despite their service. These individuals have frequently experienced the same challenges and trauma as those in the more traditional branches of the military."

EXPANDED ACCESS

Under current law, section 1710(e) of title 38, U.S.C., combat veterans are eligible to enroll in the VA health care system up to 5 years post discharge. During such time, veterans are eligible for enrollment in Priority Group 6. Those who receive a service-connected disability rating are reassigned to the highest applicable health care priority group. At the end of the 5-year period, all others are moved to Priority Group 7 or 8, depending on income level. Veterans in health care Priority Groups 7 and 8 generally pay copayments for treatments and medications.

VA reports nearly 1 million of the 1.6 million veterans, discharged from active duty since 2002, have received VA health care services. Furthermore, OEF/OIF/Operation New Dawn veterans constitute 9 percent of the 6.3 million individuals who received VA health care during FY 2012.[1]

Based on anecdotes and research, it has been suggested the 5-year period under current law may be inadequate. A 2012 study found the median time for initiation of mental health outpatient care was 4.1 years for veterans. The time between first mental health outpatient clinic care and initiation of minimally adequate care was 2 years longer for male veterans than for female veterans (8.02 and 5.98 years, respectively, $p<.001$), thus supporting the need for a 1-year extension of combat veterans health care.[2]

In his testimony before the Committee on November 19, 2014, to support an earlier version of the Clay Hunt SAV Act, Senator Walsh reiterated this sentiment when he discussed delayed onset PTSD. He noted:

> According to the National Comorbidity Survey, only 7 percent of people with PTSD seek treatment within 1 year of their initial trauma event. The average time it takes to seek treatment is well beyond the current 5-year combat eligibility period. Several major studies have also shown that between 16 and 20 percent of combat troops with

[1] Epidemiology Program, Veterans Health Administration, Dep't of Veterans Affairs, Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) Veterans 5 (2013).

[2] Maguen, S., Madden, E., Cohen, B. E., Bertenthal, D., & Seal, K. H. "Time to Treatment Among Veterans of Conflicts in Iraq and Afghanistan with Psychiatric Diagnosis" *Psychiatric Services* 63 (12) 1206–1212.

mental illness suffered from delayed onset PTSD, the symptoms of which may not appear for several years.

Committee Bill. The Committee bill would provide for annual evaluations of mental health care and suicide prevention programs of VA. The Committee bill would direct VA to publish on their Web site the mental health services available at VA. The Committee bill would establish a pilot program on loan repayment for psychiatrists who agree to serve in VHA. The Committee bill would improve access to mental health services of transitioning servicemembers. The Committee bill would provide for collaboration between VHA and non-profit mental health providers. The Committee bill would extend for 1 additional year the period of eligibility of certain combat veterans for enrollment in VHA for health care. Specifically, the changes made by each section of the bill are outlined below.

Section 2(a) of the bill would amend chapter 17 of title 38, U.S.C., to provide for annual independent third-party evaluations of VA's mental health and suicide prevention programs. This section would also provide for VA to submit to the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs the most recent evaluation and any recommendations VA considers appropriate.

The Committee intends that the required "evaluation[s] of the mental health care and suicide prevention programs" described in this provision will include a review of opioid prescription trends by doctors in the VA system. The review of opioid prescription practices shall include, but not be limited to: (1) an evaluation of VA opioid prescription patterns of take-home opioids, including frequency of written prescriptions for opioids, amount of opioids prescribed, and medications (type and amount) that are concurrently prescribed with opioids to patients; (2) an evaluation of VA dispensing patterns, including data on early refill requests and how often those early refill requests are granted; (3) a description of both the prevalence of VA patients who filled any take-home opioid prescriptions at a VA facility in the given fiscal year and those patients' baseline characteristics; (4) an assessment on whether VA facilities are adequately following VA/Department of Defense Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain screening and monitoring guidelines for patients prescribed opioids; and (5) an assessment of VA patterns for prescribing opioid treatment for patients suffering from mental health disorders.

Section 2(b) of the bill would direct VA to submit interim reports on VA's mental health and suicide prevention programs to the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs.

Section 3(a) of the bill would direct VA to publish on the Internet information regarding all of the mental health services provided by VA.

Section 3(b) of the bill describes the elements VA must include on the Web site directed to be built under section 3(a), which includes the mental health care services available to veterans, contact information of each social work office and mental health clinic, and a list of mental health staff supporting these offices.

Section 3(c) of the bill would direct VA to update the information on the Web site directed to be built under section 3(a) at least every 90 days.

Section 3(d) of the bill would direct VA to ensure that outreach directed under section 1720F(i) of title 38, U.S.C., regarding VA's outreach of the comprehensive suicide prevention program includes information about the Web site directed to be built under section 3(a).

Section 4(a) of the bill would require VA to establish a pilot program to provide for the repayment of educational loans of certain psychiatrists.

Section 4(b) of the bill would establish those eligible for the pilot program would be psychiatrists licensed or eligible to practice medicine at VA or in their final year of a residency program leading to a specialty in psychiatry, if they demonstrate a commitment to a long-term career at VHA. Section 4(b) would also prohibit an individual who is participating in any other Federal government educational loan repayment program from participating in this pilot program.

Section 4(c) of the bill would limit the participation of this program to not less than ten individuals.

Section 4(d) of the bill would create, for those participating in the pilot program, an obligatory period of service of 2 or more years at VA.

Section 4(e) of the bill outlines that the loan repayment may consist of the principal, interest, and related expenses and limits the amount paid to $30,000 for each year of obligated service.

Section 4(f) of the bill would provide that an individual who does not satisfy the period of obligatory service under section 4(d) would be liable to repay to the United States the amount that had been paid on behalf of the individual, reduced proportionally based on the service completed.

Section 4(g) of the bill directs VA to submit to the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs an initial report 2 years after the pilot program commences and a final report 90 days after it ends.

Section 4(h) of the bill directs VA to prescribe regulations to carry out this section.

Section 4(i) of the bill would terminate the pilot program 3 years after the date on which it commences.

Section 5(a) of the bill would require VA to create a pilot program to improve access to mental health services for transitioning servicemembers with mental health conditions.

Section 5(b) of the bill would limit the locations of the pilot program created under section 5(a) to not less than five Veterans Integrated Service Networks with a large population of veterans who have served in the National Guard or reserves or with a large population of veterans transitioning back to Veterans Integrated Service Networks with large established veterans' populations.

Section 5(c) of the bill describes the functions of the pilot program established by section 5(a). The program would include a community oriented veteran peer support program and a community outreach team for one VA medical center in each of the participating VISNs.

Section 5(d) of the bill directs VA to submit to the Senate Committee on Veterans' Affairs and the House Committee on Veterans' Affairs an initial report 18 months after the pilot program starts and a final report not later than 90 days before the pilot program ends.

Section 5(e) of the bill stipulates that section 5 will not be construed as authorizing VA to hire additional employees to carry out this section.

Section 5(f) of the bill would terminate this pilot program 3 years after it commences.

Section 6(a) of the bill authorizes VA to collaborate with non-profit mental health organizations to improve efficiency and effectiveness of VA's suicide prevention programs; assist the non-profits through the use of the expertise of VA employees; and jointly carry out suicide prevention efforts.

Section 6(b) of the bill directs VA, if VA engages any non-profits for that purpose, to collaborate with those non-profit mental health organizations to share best practices and exchange training sessions.

Section 6(c) of the bill directs VA to designate a Director of Suicide Prevention Coordination to implement this section.

Section 7 of the bill would, for certain combat veterans whose period of eligibility under section 1710(e)(3) of title 38, U.S.C., has expired, extend for 1 additional year eligibility for health care at VHA.

Section 8 of the bill stipulates that no new appropriations shall be used to carry out this Act. It is the Committee's intent that VA use funding otherwise made available for mental health and suicide prevention programs.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (hereinafter, "CBO"), estimates that enactment of the Committee bill would, relative to current law, cost $24 million over the 2015–2020 period, subject to appropriation of the necessary amounts, but would not affect direct spending or revenues. Enactment of the Committee bill would not affect the budget of state, local, or tribal governments.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, January 28, 2015.

Hon. JOHNNY ISAKSON,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 203, the Clay Hunt Suicide Prevention for American Veterans Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ann E. Futrell.

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Enclosure.

H.R. 203—Clay Hunt Suicide Prevention for American Veterans Act

Summary: H.R. 203 would require the Department of Veterans Affairs (VA) to have programs for mental health care and suicide prevention evaluated annually. The bill also would extend the period of eligibility for health care for combat veterans and establish pilot programs for community outreach and repayment of education loans. In total, CBO estimates that implementing the bill would cost $24 million over the 2015–2020 period, subject to appropriation of the necessary amounts.

Pay-as-you-go procedures do not apply to this legislation because it would not affect direct spending or revenues.

H.R. 203 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would not affect the budgets of state, local, or tribal governments.

Estimated cost to the Federal Government: The estimated budgetary effect of H.R. 203 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted early in calendar year 2015, that the necessary amounts will be appropriated for each year, and that outlays will follow historical spending patterns for similar and existing programs.

	By fiscal year, in millions of dollars—						
	2015	2016	2017	2018	2019	2020	2015–2020
CHANGES IN SPENDING SUBJECT TO APPROPRIATION							
Evaluations of Mental Health Care and Suicide Prevention Programs							
Estimated Authorization Level	0	0	0	2	2	2	6
Estimated Outlays	0	0	0	2	2	2	6
Web site on Mental Health Care Services							
Estimated Authorization Level	*	*	*	*	*	*	1
Estimated Outlays	*	*	*	*	*	*	1
Pilot Program for Repayment of Education Loans for Certain Psychiatrists							
Estimated Authorization Level	*	1	1	1	0	0	3
Estimated Outlays	*	1	1	1	*	0	3
Pilot Program on Community Outreach							
Estimated Authorization Level	1	2	2	2	0	0	7
Estimated Outlays	1	2	2	2	*	0	7
Collaborative Efforts to Prevent Suicide							
Estimated Authorization Level	*	*	*	*	*	*	1
Estimated Outlays	*	*	*	*	*	*	1
Extension of Enhanced Eligibility for Certain Veterans							
Estimated Authorization Level	1	1	1	1	1	1	7
Estimated Outlays	1	1	1	1	1	1	7
Total Changes							
Estimated Authorization Level	3	4	5	6	3	3	24

	By fiscal year, in millions of dollars—						
	2015	2016	2017	2018	2019	2020	2015–2020
Estimated Outlays	3	4	5	6	3	3	24

Note: Components may not sum to totals because of rounding; * = less than $500,000.

CBO estimates that implementing H.R. 203 would have a discretionary cost of $24 million over the 2015–2020 period, assuming appropriation of the estimated amounts.

Evaluations of Mental Health Care and Suicide Prevention Programs

Section 2 would require VA to have an independent entity conduct annual evaluations of the mental health care and suicide prevention programs at the department. In 2013, VA entered into a 4-year contract with an independent entity for $7.7 million to perform a comprehensive assessment of VA's mental health care system. That study will be completed at the end of fiscal year 2017. CBO assumes that assessment will address the requirements of this provision through 2017. As a result, we assume no additional cost from 2015 through 2017. Based on the costs of that assessment and adjusting for inflation, CBO estimates that section 2 would cost $6 million over the 2018–2020 period for ongoing evaluations, assuming appropriation of the necessary amounts.

Web site on Mental Health Care Services

Section 3 would require VA to publish, at a centralized location on the Internet, up-to-date information for each Veteran Integrated Service Network (a regional VA health care system). That information would have to include the following items:

- Name and contact information of VA social work offices,
- Locations of VA mental health clinics, and
- Contact information of VA practitioners of mental health care.

We assume that VA would provide this information on their existing mental health care Web site. Based on previous efforts by VA to compile and publish information online, we estimate upfront costs in 2015 for information technology to revise the mental health care Web site and compile the data would total less than $500,000. Thereafter, VA would be required to update the online material at least four times each year. Over the 2015–2020 period, CBO estimates the total cost of this provision would be $1 million, assuming availability of discretionary funds.

Pilot Program for Repayment of Education Loans for Certain Psychiatrists

Section 4 would require VA to carry out a 3-year pilot program to repay the education loans of certain psychiatrists. Eligible psychiatrists would include those who are licensed as well as those in their last year of residency who agree to work at VA for a certain period of time. The department would be required to select at least 10 individuals each year for this pilot program, and to repay up to $30,000 per individual for every year of obligated service.

For this estimate, CBO assumes that VA would completely repay the loans of 10 individuals in each year of the pilot program, and that half of the participants would be newly licensed psychiatrists

and half would be established psychiatrists. Based on information from the National Center for Education Statistics and the Association of American Medical Colleges, we estimate that newly licensed and established psychiatrists would have average education loan debts of $120,000 and $50,000, respectively, in 2015. After factoring in the growth in costs for higher education, CBO estimates that implementing the pilot program would cost $3 million over the 2015–2020 period, assuming appropriation of the necessary amounts.

Pilot Program on Community Outreach

Section 5 would require VA to conduct a 3-year pilot program to assist veterans who recently left active-duty service in accessing mental health services offered by the department. The program would operate peer support networks and outreach programs at the local level in five regions of the VA health care system. To carry out this program, we estimate that VA would hire five peer support specialists at an annual salary of $60,000 each, five clinical support staff (certified mental health professionals) at a salary of $120,000 each, and a total of 10 support staff for the community outreach teams at a salary of $60,000 each. After including benefits and taking account of inflation, CBO estimates that implementing this provision would increase costs for salary and benefits by $6 million over the 2015–2020 period.

Section 5 also would require VA to hold an annual mental health summit during the 3-year period of the pilot program. After factoring in costs for transportation, hotel accommodations, food, and conference space, CBO estimates discretionary costs of roughly $200,000 each year for the annual summit. In total, CBO estimates that implementing section 5 would cost $7 million over the 2015–2020 period, assuming appropriation of the necessary amounts.

Collaborative Efforts to Prevent Suicide

Section 6 would authorize VA to collaborate with nonprofit organizations that provide mental health services. This section also would require VA to appoint a Director of Suicide Prevention Coordination to manage the collaborative efforts. According to VA, such collaboration is already ongoing. As a result, we estimate that the only additional cost would be for hiring a new director. Assuming a salary level of GS–15, CBO estimates those costs would total $1 million over the 2015–2020 period.

Extension of Enhanced Eligibility for Certain Veterans

Section 7 would extend—for 1 year after the date of enactment of H.R. 203—the period of enhanced enrollment in the VA health care system for certain veterans. Under current law, veterans who served after 2003 have up to 5 years after being discharged from the military to enroll in the VA health care system with enhanced priority (priority group 6).[1] This section would extend that window

[1] Enrollment in the VA health care system is based on eight priority groups. The highest priority group consists of veterans who have the most severe service-connected disabilities (priority groups 1–3); the lowest priority group consists of higher-income veterans who have no compensable service-connected disabilities (priority groups 7–8). Section 7 would allow certain veterans to enroll under priority group 6, which makes veterans eligible for lower copayments when they receive services.

by 1 year for veterans who separated from active-duty service between January 1, 2009, and January 1, 2011.

Based on data from VA on historical participation rates, CBO estimates that about 4,600 veterans would take advantage of the extended period of enhanced enrollment. This number does not include veterans who would qualify for higher priority groups (1 through 5). Using income data from the U.S. Census Bureau, we estimate that 3,200 of those veterans (or 70 percent) would have qualified and enrolled for VA health benefits under the income criteria of the lowest priority groups (priority groups 7 and 8). For those veterans, during the 1-year period of enhanced eligibility, we estimate an annual difference in VA health care costs per enrollee of $200. After the enhanced eligibility expires, we assume VA would shift those veterans to the lower priority groups that they would have otherwise enrolled in—therefore resulting in no additional costs in those years.

We expect that the remaining 1,400 veterans would not be eligible to enroll in the VA health care system under current law. For those veterans we estimate average annual costs of $1,000 per enrollee, during the 1-year period of enhanced eligibility. After that period, we assume VA would shift those veterans to the lower priority groups—with average annual costs of about $800 per enrollee.

In total, CBO estimates that implementing this section would cost $7 million over the 2015–2019 period, assuming appropriation of the necessary amounts.

Pay-As-You-Go Considerations: None.

Intergovernmental and private-sector impact: H.R. 203 contains no intergovernmental or private-sector mandates as defined in UMRA and would not affect the budgets of state, local, or tribal governments.

Estimate prepared by: Federal Costs: Ann E. Futrell; Impact on State, Local, and Tribal Governments: Jon Sperl; Impact on the Private Sector: Paige Piper-Bach.

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by Members of the Committee on Veterans' Affairs at its January 21, 2015, meeting.

Yeas	Senator	Nays
X	Mr. Moran	
X	Mr. Boozman	
X	Mr. Heller	
X	Mr. Cassidy	
X	Mr. Rounds	
X	Mr. Tillis	
X	Mr. Sullivan	
X	Mr. Blumenthal	
X (by proxy)	Mrs. Murray	
X (by proxy)	Mr. Sanders	
X	Mr. Brown	
X (by proxy)	Mr. Tester	
X	Mr. Hirono	
X	Mr. Manchin	
X	Mr. Isakson, Chairman	
15	TALLY	0

AGENCY REPORT

On March 23, 2015, Robert A. McDonald, Secretary, U.S. Department of Veterans Affairs, provided views on H.R. 203, among other issues. An excerpt from the Department views is reprinted below:

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, March 23, 2015.

Hon. JOHNNY ISAKSON,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: I am pleased to provide the Department of Veteran Affairs views on H.R. 203, the Clay Hunt Suicide Prevention for American Veterans Act, also referred to as the Clay Hunt SAV Act. As you know, the President signed the bill into law on February 12, 2015, and in his remarks at the signing expressed in detail the Administration's support for the bill and the critical importance of the areas touched on by H.R. 203.

Mental health care and suicide prevention are among VA's highest priorities. Veterans who need help must receive that help when and where they need it. VA supports the Clay Hunt SAV Act and believes this bill complements VA's on-going multi-faceted efforts to improving mental health care for our Nation's Veterans. These efforts include our implementation of the President's Executive Actions announced this summer, which focused on improving the transition from Department of Defense to VA for servicemembers with mental health needs, improving mental health peer support, and promoting mental health awareness and training.

We are committed to excellence in mental health treatment through regular program monitoring and working with staff to make program improvements. VA's mental health program not only addresses medical treatment, but also encompasses training, research, support services for Veterans and their families, partnerships with community organizations, expanded eligibility, hiring efforts, technology advances, and innovative communications strategies to reduce negative perceptions of seeking mental health care.

VA has seen improvements in our mental health program, but we know that there is more work to be done so that Veterans can reach out for help and connect with services. We appreciate the steps Congress has taken to support this goal through the passage of the Clay Hunt SAV Act.

In the 113th Congress, VA testified before the House Veterans' Affairs Health Subcommittee on November 19, 2014 regarding the introduced version of the Clay Hunt SAV Act, H.R. 5059. H.R. 203 includes many but not all of the provisions of H.R. 5059 in substantially similar form—specifically sections 1, 2, 4, 6, and 9 of H.R. 5059 as introduced. Enclosed please find for reference relevant testimony excerpts from that hearing. VA's detailed views on these provisions as provided then are unchanged.

Thank you for your continued support of our Nation's Veterans.

Sincerely,

ROBERT A. MCDONALD

Enclosure.

ENCLOSURE

Excerpts from Testimony Regarding H.R. 5059 (113th Congress) as introduced, delivered before the House Veterans' Affairs Health Subcommittee on November 19, 2014:

* * * * * * *

H.R. 5059, CLAY HUNT SUICIDE PREVENTION FOR AMERICAN VETERANS ACT

Mental health care and suicide prevention are among VA's highest priorities, and we appreciate that the Congress continues to raise awareness of these important issues. VA agrees with many of the goals of the bill, and as expressed below, existing efforts of the Department are aligned with those goals. VA would welcome discussion with the Committee to examine how some provisions could be adjusted to complement VA's ongoing multi-faceted efforts.

Turning to the specifics of the bill, Section 2 of H.R. 5059 would require VA and DOD to each have an independent third party conduct annual evaluations of the mental health care and suicide prevention programs that are carried out by the respective Departments.

VA supports the intent of this provision to further suicide prevention but has recommendations to improve its effectiveness to combat Veteran suicide, including addressing issues where there is duplication of robust activity that is ongoing at VA.

VA does not believe that requiring an additional ongoing evaluation effort is necessary for its mental health and suicide prevention programs, as they are regularly reviewed by external accrediting bodies including the Joint Commission and Commission on Accreditation of Rehabilitation Facilities (CARF) as well as many internal review processes. In addition, VA already has robust evaluation efforts focused on mental health care and suicide prevention. For example, in prior years the Congress mandated programs such as the North East Program Evaluation Center (NEPEC), Serious Mental Illness Treatment, Resource and Evaluation Center (SMITREC), and the Program Evaluation Resource Center (PERC). These internal resources allow for timely reports from subject matter experts in evaluation who are familiar with the complexities of using and analyzing VA's administrative data. Additionally, VA complies with current the Congressionally-mandated reporting requirements, which include posting of information online, pursuant to Public Law 112–239 (FY 2013 NDAA), section 726. Section 726 requirements overlap with some of the areas mentioned in section 2 of the proposed bill to report on the annual evaluation of VA mental health programs to the Congress and the public. Section 726 calls for the establishment of a contract with the National Academy of Sciences (NAS) to conduct an assessment and provide an analysis and recommendations on the state of VA mental health services. VA has actually already embarked on such a project with NAS that

is closely aligned with this requirement. For suicide prevention, VA has been increasing our understanding of suicide among Veterans by developing data sharing agreements with all 50 U.S. states and several U.S. territories. The initial VA Suicide Data Report issued in February 2013 was the first effort to analyze these more complete and timely data points and provide a more comprehensive understanding of Veteran suicide to inform VA's suicide prevention efforts. The February 2013 report contained data and analysis from 21 states.

In an effort to understand the picture of Veteran suicide more completely, VA has advanced development of a VA/DOD Suicide Data Repository (SDR). The January 2014 update to the VA Suicide Data Report is the first analysis using the SDR information. This update also incorporates more recent data from the National Death Index and provides information about suicide rates, which the initial VA Suicide Data Report issued in February 2013, did not.

VA does support, with some modification, the bill's requirement for review of the Department's suicide prevention programs, and looks forward to discussion of this important element of the bill. A Joint VA/DOD Clinical Practice Guideline (CPG) for the Assessment and Management of Patients at Risk for Suicide was released in 2013. VA recommends that a one-time evaluation of the suicide prevention program be conducted to support implementation of these guidelines. VA believes it can benefit from a one-time, targeted evaluation of this effort.

[Testimony regarding Section 3 omitted]

VA supports the intent of section 4. This section would require VA to: (1) provide Veterans information regarding all of the mental health care services available in the VISN where the Veteran is seeking such services, including the name and contact of each social work office, mental health clinic, and a list of appropriate staff; (2) update the information every 90 days; and (3) include information about the Web site in outreach efforts.

This requirement generally aligns with the goals and efforts currently underway for ensuring that Veterans can easily locate information about VA mental health services on the Internet. Each VISN and facility maintains their own Web site. National policy could be reviewed and updated to meet the requirements of this section, ensuring that appropriate information on mental health services is available and updated on those Web sites. VA recommends conducting an assessment of available tools for locating information about mental health services, including seeking input from Veterans in order to determine the most useful framework through which VA can provide such information. This requirement should also be considered in the context of the Secretary's goal of creating one phone number and one Web site for all VA services. VA would welcome discussion with the Committee on how the goals of this section can be furthered.

[Testimony regarding Section 5 omitted]

Section 6 would establish a pilot program for the repayment of educational loans for mental health professionals. VA supports the aims of section 6, but we believe the recent enactment of significant changes to VA's education-debt repayment programs (in section 302

of Public Law 113–146 and section 408 of Public Law 113–175) make some parts of section 6 obsolete. We would welcome discussion of this provision with the Committee in light of these developments.

[Testimony regarding Section 7–8 omitted]

Section 9 of H.R. 5059 would require VA to establish a pilot program focused on assisting Veterans transitioning from active duty. The pilot program would be established in at least 5 VISNs and would establish a community-oriented peer support network and a community outreach team for each medical center in those VISNs.

VA fully supports the intent of this section but views it as duplicative and redundant with work that is already being done in every VISN throughout the country. With regard to peer support, VHA has a very robust peer support program that includes outreach and community integration as a major focus. There are at least 3 peer specialists for every VA medical center and 2 for each "very large" Community Based Outpatient Clinic (CBOC) and a total of 973 peer specialists nationwide. As required by Public Law 110–387, VA has established training guidelines and has instituted a training program that results in certification of peer specialists. VA has a very active national network that includes a peer specialist and a mental health professional from each VISN. These individuals provide linkages to the peer support network throughout the country and mentorship to peer specialists in each VISN. VA's peer support teams interact a great deal with community Veterans' organizations and mental health organizations via the mental health summits that occur at each medical center as well as other activities.

In 2013, VA implemented a national requirement for each medical facility to host a mental health community summit annually. During the summits each facility invites community providers in their area to begin new partnerships or strengthen existing partnerships based on Veteran and family needs in their geographic location. In 2014, each facility selected a community mental health point of contact to provide ready access to information about VA eligibility and available clinical services, ensure warm handoffs at critical points of transition between systems of care, and provide an ongoing liaison between VA and community partners. VA created an online map containing the name and contact information for all facility POCs by state. http://www.mentalhealth.va.gov/communityPOC.asp

Costs associated with the provisions of H.R. 5059 cannot be provided at this time.

* * * * * * *

CHANGES IN EXISTING LAW

In compliance with paragraph 12 of rule XXVI of the Standing Rules of the Senate, changes in existing law made by H.R. 203 are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman).

Title 38. Veterans' Benefits

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Part II. General Benefits

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Chapter 17. Hospital, Nursing Home, Domiciliary, and Medical Care

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Sec.

SUBCHAPTER I. GENERAL

1701. Definitions.

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1709A. Teleconsultation.

1709B. Evaluations of mental health care and suicide prevention programs.

SUBCHAPTER II. HOSPITAL, NURSING HOME, OR DOMICILIARY CARE AND MEDICAL TREATMENT

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Subchapter I. General

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1709B. EVALUATIONS OF MENTAL HEALTH CARE AND SUICIDE PREVENTION PROGRAMS

(a) EVALUATIONS.—(1) Not less frequently than once during each period specified in paragraph (3), the Secretary shall provide for the conduct of an evaluation of the mental health care and suicide prevention programs carried out under the laws administered by the Secretary.

(2) Each evaluation conducted under paragraph (1) shall—

(A) use metrics that are common among and useful for practitioners in the field of mental health care and suicide prevention;

(B) identify the most effective mental health care and suicide prevention programs conducted by the Secretary, including such programs conducted at a Center of Excellence;

(C) identify the cost-effectiveness of each program identified under subparagraph (B);

(D) measure the satisfaction of patients with respect to the care provided under each such program; and

(E) propose best practices for caring for individuals who suffer from mental health disorders or are at risk of suicide, including such practices conducted or suggested by other departments or agencies of the Federal Government, including the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

(3) The periods specified in this paragraph are the following:

(A) The period beginning on the date on which the Secretary awards the contract under paragraph (4) and ending on September 30, 2018.

(B) Each fiscal year beginning on or after October 1, 2018.

(4) Not later than 180 days after the date of the enactment of this section, the Secretary shall seek to enter into a contract with an independent third party unaffiliated with the Department of Veterans Affairs to conduct evaluations under paragraph (1).

(5) The independent third party that is awarded the contract under paragraph (4) shall submit to the Secretary each evaluation conducted under paragraph (1).

(b) ANNUAL SUBMISSION.—Not later than December 1, 2018, and each year thereafter, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report that contains the following:

(1) The most recent evaluations submitted to the Secretary under subsection (a)(5) that the Secretary has not previously submitted to such Committees.

(2) Any recommendations the Secretary considers appropriate.

Subchapter II. Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

SEC. 1710. ELIGIBILITY FOR HOSPITAL, NURSING HOME, AND DOMICILIARY CARE

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(e)(1) * * *

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[(3) Hospital care, medical services, and nursing home care may not be provided under or by virtue of subsection (a)(2)(F) in the case of care for a veteran described in paragraph (1)(D) who—

[(A) is discharged or released from the active military, naval, or air service after the date that is five years before the date of the enactment of the National Defense Authorization Act for Fiscal Year 2008, after a period of five years beginning on the date of such discharge or release; or

[(B) is so discharged or released more than five years before the date of the enactment of that Act and who did not enroll in the patient enrollment system under section 1705 of this title before such date, after a period of three years beginning on the date of the enactment of that Act.**]**

(3) In the case of care for a veteran described in paragraph (1)(D), hospital care, medical services, and nursing home care may be provided under or by virtue of subsection (a)(2)(F) only during the following periods:

(A) Except as provided by subparagraph (B), with respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, or air service after January 27, 2003, the five-year period beginning on the date of such discharge or release.

(B) With respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, or air service after January 1, 2009, and before January 1, 2011, but did not enroll to receive such hospital care, medical services, or nursing home care pursuant to such paragraph during the five-year period described in subparagraph (A), the one-year period beginning on the date of the enactment of the Clay Hunt Suicide Prevention for American Veterans Act.

(C) With respect to a veteran described in paragraph (1)(D) who is discharged or released from the active military, naval, or air service on or before January 27, 2003, and did not enroll in the patient enrollment system under section 1705 of this title on or before such date, the three-year period beginning on January 27, 2008.

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