

**STATEMENT OF DR. PAUL R. LAWRENCE
UNDER SECRETARY FOR BENEFITS
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE**

August 1, 2018

Good morning, Chairman Isakson, Ranking Member Tester, and Members of the Committee. 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 are Ralph Erickson, M.D., M.P.H., Dr. PH, Chief Consultant, Post Deployment Health, VHA; Tammy Czarnecki, Assistant Deputy Under Secretary for Health/Administrative Operations, VHA; and Jessica Bonjorni, Acting Assistant Deputy Under Secretary for Health for Workforce Services, VHA.

H.R. 299 - Blue Water Navy Vietnam Veterans Act of 2018

Section 2: Clarification of Presumptions of Exposure for Veterans Who Served in
Vicinity of Republic of Vietnam

Section 2 of H.R. 299 would add a new section 1116A to title 38, United States Code (U.S.C.). The bill would expand the presumption of Agent Orange exposure to all Veterans who served "offshore" of the Republic of Vietnam, as defined in subsection (d) of the bill, and would presume the in-service incurrence or aggravation of all diseases covered in 38 U.S.C. § 1116 for these Veterans. It would also provide retroactive benefits for Veterans who had a previous claim for a covered disease denied and then file a new claim, comparable to the retroactive benefits available for Veterans who went ashore. This retroactivity would be accomplished via a special effective date rule contained in the bill. The bill would also expand the definition of "Vietnam-era herbicide-exposed veteran," codified at 38 U.S.C. § 1710(e)(4)(A), to include Veterans with "offshore" service for purposes of the provision of health care.

VA is opposed to section 2 of this bill. The legislative history of Veterans' disease presumptions dates back to 1921 when Congress established a presumption of service connection with an amendment (P.L. 67-47) to the War Risk Insurance Act (P.L. 63-193). In the following years, additions to the presumptive list were made by regulation, executive order, and legislation. In 1991, the Agent Orange Act (P.L. 102-4) established for Vietnam Veterans a presumption of a service connection for diseases associated with exposure to Agent Orange and certain other herbicides. For the first time, this Act required VA to contract with the Institute of Medicine (IOM) to biennially conduct a scientific review of the evidence linking certain medical conditions to herbicide exposure. VA was instructed to use the IOM's findings, and other evidence, to provide the rationale for establishing regulations and determining that a presumption for any disease would be warranted when there is scientific evidence of an association with herbicide exposure.

VA's view is that the evidence-based approach to creating or expanding presumptions should be maintained. Although presumptions exist to assist in proving claims that may otherwise be difficult for individual veterans to establish on a direct basis, the presumptions of exposure and/or medical causation should always be supported by historical, scientific, and/or medical evidence about the specific population of Veterans affected. VA recognizes Congress's prerogative in creating or expanding presumptions. However, VA is concerned that new Congressionally-created presumptions that are not adequately supported by evidence will erode confidence in the soundness and fairness of the Veterans' benefits system. Such statutory presumptions will lead to increased pressure on VA to create or expand additional presumptions administratively, under a similarly liberal approach. Because VA generally cannot establish regulatory presumptions that are not reasonably grounded in evidence, Veterans petitioning VA for new presumptions that are not supported by the required level of evidence will likely be unsatisfied with VA's response. These Veterans may feel that the system is inequitable in providing expansive presumptions favoring certain groups of Veterans but not others.

As a means of further assessing the potential for Agent Orange exposure, VA commissioned the IOM to produce the report, *Blue Water Navy Vietnam Veterans and Agent Orange Exposure* (2011). The report concluded that exposure among Blue Water Navy Veterans "cannot reasonably be determined", and it did not find supported and compelling evidence of Agent Orange exposure due to aerial spray drift, river water runoff, or potable sea water distillation. The report indicated that Agent Orange was destroyed by sunlight within hours of application and any that survived would rarely make it out to the South China Sea because of the major dilution factor. Additionally, United States Navy ships were required to draw up seawater for conversion to shipboard potable water at least twelve miles offshore from any river, a distance at sea where the presence of Agent Orange was unlikely.

Although there is insufficient scientific evidence to grant a blanket presumption of Agent Orange exposure for all Navy Vietnam Veterans, VA has a liberal policy of presuming exposure for all Veterans who served aboard Brown Water vessels operating on Vietnam's inland waterways, and for those Veterans serving aboard Blue Water ships that temporarily entered the inland waterways. Additionally, if evidence shows that a Blue Water ship off the coast sent crew members ashore for duty or visitation, any Veteran on the ship at that time will receive the presumption of exposure if they state that they personally went ashore.

As such, VA opposes section 2 because there is insufficient scientific evidence at this time showing Blue Water Navy Veterans were exposed to Agent Orange. At VA's request, the IOM (now National Academy of Medicine (NAM)) reviewed all available scientific evidence, concluding that it was "unable to state with certainty that Blue Water Navy personnel were or were not exposed to Agent Orange and its associated TCDD" (ref: *Blue Water Navy Vietnam Veterans and Agent Orange Exposure*, 2011). VA continues to review and monitor the peer-reviewed scientific and medical literature and is collaborating with Veterans Service Organizations (including the Veterans of Foreign Wars and the Blue Water Navy Vietnam Veterans Association) to gather more information. A new VA health study of Vietnam Veterans that includes the collection of

data on Blue Water Navy Veterans is currently ongoing. VA researchers are currently analyzing data from this effort. The timeline for initial results is expected to be in 2019, with publication of results potentially within 1 - 2 years. VA is committed to examining all available evidence on this issue and gathering input from stakeholders in order to make well-informed, scientific, evidence-based decisions for our Nation's Veterans.

VA is also concerned with the special effective date provisions of the bill. Our understanding is that these provisions are intended to provide Blue Water Navy Veterans with effective date treatment that is similar to that available under the *Nehmer* court decision and orders for those who served in the Republic of Vietnam. However, in enacting provisions extending benefits to other groups of Veterans, Congress generally has not extended those benefits retroactively, much less for such a significant time period. VA is concerned about the apparent inequity of this disparate treatment of different groups of Veterans. Further, VA is concerned that the procedures necessary for applying these special effective date provisions, including determining proper effective dates and establishing awards covering large retroactive periods, would be complex and labor-intensive tasks that would divert resources from other important claim adjudications.

Further, VA has concerns associated with the demarcation line used in this bill. Implementation of this provision would be impracticable. Currently, VA maintains a ship list for ships that operated on inland waterways. This requires VA to research and review deck logs in individual cases to assess the geographic coordinates of the ship, as well as the time periods on which the ship operated on an inland waterway. This bill would essentially extend that ships list to encompass an area no more than 12 nautical miles seaward of a line commencing on the southwestern demarcation line of the waters of Vietnam and Cambodia and intersecting certain geographic points. VA would be required to assess many more deck logs and coordinates to place additional ships on that list for certain time periods. Because of the nature of deck logs, it may be impossible to determine an exact location and determine whether a ship did, or did not, cross this line on a particular date. Additionally, based on the available scientific and medical evidence, VA is unaware of any association between a line twelve miles offshore and exposure to Agent Orange. VA understands that the Department of State also has concerns regarding this provision of the bill.

This bill would also add significantly to the number of benefit claims pending over 125 days. Because of the retroactive provisions and the intricacies of reviewing deck logs, each claim would take longer - more than twice as long, on average - to review than claims VA generally receives. In addition, a large volume of claims would be expected as a result of this bill. Thus, unless additional employees are provided, VA would expect the backlog to grow significantly due to this expected claims burden.

Finally, VA does not support paying for the provisions of this bill by increasing the costs that some Veterans must bear to access their benefits. Section 6(b) of the bill would adjust the loan fee that certain Veterans, Servicemembers, and surviving spouses must pay to obtain home loans in VA's home loan program. In many cases, the adjustment would require borrowers to pay higher loan fees to obtain home loans. In other words, it appears that the bill would partially offset the Government's cost of

increased benefits spending on some Veterans by raising loan fees for others. Granting new benefits for some Veterans at the expense of other Veterans is counter to VA's mission.

VA's cost estimate for the bill is broken down into four categories: benefits, general operating expenses, information technology (IT), and health care expenditures. VA estimates the total benefits cost of this bill would be \$1.8 billion during fiscal year (FY) 2019, \$3.4 billion over 5 years, and \$5.7 billion over 10 years. In addition to benefits cost, VA estimates the Veterans Benefits Administration (VBA) General Operating Expenses (GOE) costs for the first year would be \$90 million and include salary, benefits, rent, training, supplies, other services, and equipment. Five-year costs are estimated to be \$215.2 million and 10-year costs are estimated to be \$349.1 million. VA further estimates that the IT cost to support VBA would be \$2.9 million for the first year, \$5.3 million over 5 years, and \$7.6 million over 10 years. This cost would include the IT equipment for full-time equivalent employees, installation, maintenance, and IT support. Regarding health care expenditures, VA estimates the costs of section 2 of the bill would be \$27.8 million in FY 2019, \$275.1 million over 5 years, and \$625.0 million over 10 years. In total, VA estimates section 2 of the bill would carry costs of approximately \$6.7 billion over 10 years.

Section 3: Presumption of Herbicide Exposure for Certain Veterans Who Served in Korea

Section 3 would add a new section 1116B to title 38, U.S.C., extending the presumptions of service connection for diseases associated with exposure to herbicide agents to all Veterans who served in the Korean demilitarized zone (DMZ) between September 1, 1967, and August 31, 1971. It would not provide retroactive benefits comparable to those available for Veterans who served offshore of the Republic of Vietnam, as proposed in section 2 of this bill.

VA is not opposed to presumptions for Veterans of service in the Korean DMZ, but has concerns with the prescribed presumptive dates, which we believe would unduly expand the start of the time period of presumptive exposure.

Following consultation with the Department of Defense (DoD), VA promulgated 38 Code of Federal Regulations (C.F.R.) § 3.307(a)(6)(iv), which provides a presumption of exposure to an herbicide agent to Veterans who served between April 1, 1968, and August 31, 1971, "in a unit that, as determined by [DoD], operated in or near the Korean DMZ in an area in which herbicides are known to have been applied during that period." As VA explained in the proposed and final rule notices implementing 38 U.S.C. § 1821, DoD has identified April 1968, as the earliest known use of herbicides along the Korean DMZ. See 74 Fed. Reg. 36,640, 36,641 (Jul. 24, 2009) ("[s]pecifically, DoD has reported that herbicides were applied between April 1968 and July 1969"); 76 Fed. Reg. 4245, 4246 (Jan. 25, 2011).

Additionally, the lack of retroactive benefits for Veterans who served in the Korean DMZ highlights the disparity between the treatment of Veterans who served offshore of the Republic of Vietnam, as addressed in Section 2 of this bill, compared to other groups of Veterans.

Costs associated with Section 3 are estimated to be insignificant.

Section 4: Benefits for Children of Certain Thailand Service Veterans Born with Spina Bifida

Section 4 would add a new section 1822 to title 38, United States Code, authorizing VA to provide the same benefits to children of Veterans with Thailand service, as defined in the bill, suffering from spina bifida as the benefits required to be paid to children of Vietnam Veterans suffering from spina bifida.

VA supports assisting family members who may have been adversely affected by a Veteran's in-service exposure to Agent Orange. However, VA is concerned with Section 4 because there is continued scientific uncertainty surrounding the association of spina bifida and exposure to Agent Orange. As found in the last relevant NAM report, an association between spina bifida and exposure to Agent Orange is no longer shown. Spina bifida was moved from the category of limited or suggestive evidence of association in update 2012 to the category of inadequate or insufficient evidence of association in update 2014.

VA estimates the total benefits cost of this bill would be \$748,000 during FY 2019, \$3.9 million over 5 years, and \$8.1 million over 10 years. GOE and IT costs are not associated with this section. We are unable to provide health care cost estimates at this time.

Section 5: Updated Report on Certain Gulf War Illness Study

Section 5 of the bill would require VA, within 180 days of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate, an updated report on the findings, as of the date of the updated report, of the Follow-up Study of a National Cohort of Gulf War and Gulf Era Veterans under VA's epidemiology program. VA has no objection to this requirement, as we anticipate this update would be available within that time period.

Section 6: Loans Guaranteed Under Home Loan Program of Department of Veterans Affairs

Section 6(a) would amend 38 U.S.C. § 3703(a)(1) by revising the definition of maximum guaranty amount to tie the maximum guaranty amount to the loan, regardless of whether the loan exceeds the Freddie Mac conforming loan limit.

Subsection (b) would amend the loan fee table at 38 U.S.C. § 3729 to adjust the statutory loan fees charged to borrowers obtaining loans made, guaranteed, or insured under VA's home loan program. Certain Veterans, Servicemembers, and surviving

spouses would pay increased loan fees when obtaining purchase, construction, and fully underwritten loans.

Subsection (c) would waive the statutory loan fees for Servicemembers who have received the Purple Heart award. However, subsection (c) would impose new statutory loan fees on disabled Veterans that have a service connected disability rated as less than total and surviving spouses who are currently exempt from the loan fee.

VA does not support section 6(a). Under current law, the maximum guaranty amount can prevent Veterans who live in high-cost areas from being able to obtain a zero down payment loan. By tying the maximum guaranty amount to the loan rather than to the Freddie Mac conforming loan limit, subsection (a) would eliminate what has restricted Veterans' use of their home loan benefits in certain high-cost areas. However, this provision may increase risks to the portfolio by increasing the effective loan-to-value ratio for these non-conforming loans. Higher loan-to-value ratios may lead to higher claim payments and lower recoveries in events of default.

VA does not support subsections (b) and (c) of the bill. As previously explained, VA does not support paying for the provisions of this bill by increasing the costs that some Veterans must bear to access their benefits.

VA still is refining estimates for benefits savings associated with section 6, but the 10-year savings likely will fall below \$3 billion. Therefore, VA anticipates that the bill's costs would far exceed any savings associated with this section.

Section 7: Information Gathering for Department of Veterans Affairs Home Loan Appraisals

Section 7 would amend 38 U.S.C. § 3731 to permit appraisers to make appraisals based solely on information gathered by a person with whom the appraiser has entered into an agreement for such services. The provision would result in less wait-time for Veterans who want to close their loans, particularly those Veterans who live in remote areas. Section 7 would also better align VA-appraisal policy and procedures with industry standards. VA believes this provision would address recent stakeholder concerns regarding timely delivery of VA-required appraisals. VA estimates that there are no costs associated with this section.

S. ____ - Veterans Dental Care Eligibility Expansion and Enhancement Act of 2018

Section 2 of the draft bill would amend 38 U.S.C. § 1710(c) to authorize the Secretary to furnish dental services and treatment, and dental appliances, needed to restore functioning in a Veteran that is lost as a result of any services or treatment furnished under this subsection.

VA does not support this section because it is unnecessary. VA already has the authority to provide these services. While VA currently has limited authority to furnish dental care and services, VA can furnish care and services under a different provision of

law to Veterans who have been disabled by treatment. If the intent of this section is otherwise, VA would appreciate the opportunity to discuss this further with the Committee.

Section 3 of the draft bill would require VA to begin a 3-year pilot program not later than 540 days after the date of the enactment of this Act. Through this pilot program, VA would assess the feasibility and advisability of furnishing dental services and treatments to Veterans enrolled in VA health care who are not eligible for such care under other authorities. VA would have to carry out the pilot program at not fewer than 16 locations meeting certain criteria and based on certain considerations. No more than 100,000 Veterans could participate in the pilot program, and the Secretary would have to distribute this limitation among locations selected for the pilot program in a manner that takes appropriate account of the size and need of dental services at each location. The services that would be provided would have to be consistent with the services the Secretary furnishes to Veterans with service-connected disabilities rated 100 percent disabling under VA's laws. Veterans would be able to participate in the pilot at their election. VA would have the authority to collect copayments for dental services in accordance with authorities on the collection of copayments under VA's existing authorities, but could not be more than the copayments for medical care under chapter 17. VA would have to inform all Veterans eligible to participate in the pilot program of the services and treatment available, and VA could enter into contracts with appropriate entities for the provision of dental care, although each contract would have to specify performance standards and metrics and processes for ensuring compliance with such standards. Within 540 days and again within 3 years of the commencement of the pilot program, VA would have to submit a report to Congress on the pilot program, and 180 days after the completion of the pilot program, VA would have to submit another report to Congress. These changes would take effect on the date that is one year after the date of the enactment of this Act.

While VA supports the expansion of dental services and oral health, VA cannot support this section without additional resources, specifically funding, infrastructure, and staffing, to support such an effort. VA does not have the infrastructure or staff to furnish care to an additional 100,000 Veterans in 16 or more locations without reliance upon community providers. Therefore, implementation of this pilot program would significantly increase VA's financial obligations for community care at a time when VA is in the process of implementing the new Veterans Community Care Program required by the Caring for Our Veterans Act of 2018. We further note that, as this is structured to be a pilot program, we have significant concerns on how we would implement this and believe that Congress should make additional policy decisions concerning how this program would operate. While VA may be able to make these decisions through rulemaking, we expect these would potentially be controversial and could delay implementation of the program if VA is forced to decide these matters instead of Congress. For example, the bill provides no guidance on how VA should administer this benefit fairly – whether VA should rely upon first in time, a clinical assessment, priority group, or some other criterion for determining which 100,000 Veterans receive care under this program. Similarly, the legislation offers no guidance on how VA should make determinations concerning where such care would be furnished. Finally, as a term-limited program, VA is concerned about how VA would manage care authorized

near the end of the pilot program, as some Veterans may actually be worse off, if they received only a portion of a fuller episode of care. We would appreciate the opportunity to discuss these concerns in greater detail with the Committee.

VA anticipates that the total cost for clinical care (not including administrative or other costs) during the three year pilot program would exceed \$600 million.

Section 4 would require VA to construct or lease a VA dental clinic in any State that does not have a VA facility that offers onsite dental services. Within 180 days of the date of the enactment of this Act, VA would have to submit a plan to Congress for construction or lease of a dental clinic in each applicable State and begin construction of any such clinic not later than 1 year after such date of enactment. There would be authorized to be appropriated, and would be appropriated, \$10 million to carry out this section.

VA supports ensuring Veterans have access to dental services, but we believe decisions about establishing a new VA health care presence, whether leased or government-owned, should be made based upon an analysis of local conditions, namely the density of the population of eligible Veterans and the availability of other options to deliver cost-effective care.

Section 5 would require VA to carry out a program of education to promote dental health for Veterans who are enrolled in VA health care, although nothing in this authority would alter or revise the eligibility of any Veteran for dental care under VA's authorities. This education program would have to provide information concerning the association between dental health and overall health and well-being; proper techniques for dental care; signs and symptoms of commonly occurring dental conditions; and treatment options for commonly occurring dental issues. The education program would also provide information pertaining to options for obtaining access to dental care, including information on eligibility for care through VA, State and local governments or non-profit organizations; purchasing private dental insurance; available and accessible options for obtaining low or no-cost dental care, including through dental schools and Federally-qualified health centers; and such other matters relating to dental health as the Secretary considers appropriate. The education material would have to be provided through a variety of mechanisms, including print, online, and through presentations.

VA does not support section 5 because it is unnecessary. VA already develops, provides, and promotes educational information, including training and the availability and accessibility of options for obtaining low or no-cost dental care, including through dental schools and Federally-qualified health centers.

Section 6 would require VA, no later than 540 days after the date of the enactment of this Act, to expand the dental insurance pilot program established by 38 C.F.R. § 17.169 (as in effect on the date of the enactment of this Act) to establish a mechanism by which private sector dental care providers shall forward to VA information on dental care furnished to individuals under the pilot program for inclusion in the electronic medical records of VA with respect to such individuals. VA could continue the dental insurance pilot program for 2 years in addition to what is otherwise

provided for in 38 C.F.R. § 17.169 if the Secretary determines that the continuation is needed to assess the mechanism required by this section. Individuals could elect whether to participate in the mechanism. VA would have to include information on the mechanism in each report to Congress on the dental insurance pilot program. This section would take effect on the date that is one year after the date of the enactment of this Act.

VA does not support this section. We are concerned about the language in this section could create a requirement concerning medical records interoperability that is separate from VA's efforts to modernize its electronic health records generally. Many dentists are not accustomed to providing health record information electronically to other providers; the claims they submit to patients and insurers for payment are generally all that they provide. As a result, this could create additional requirements on individual providers, which could either become difficult for them to implement or could result in their refusal to participate in the Dental Insurance Program. We believe it is necessary to balance the interests of a complete medical record with the obligations and expectations of community providers. We further note that the dental insurance program is no longer a pilot program, but is now a permanent program that is codified at 38 U.S.C. § 1712C; moreover, the pilot program authority (Public Law 111-163, section 510) was repealed through the Act that codified this authority (Public Law 114-218). VA fully supports the existing VA Dental Insurance Program.

Section 7 would authorize VA to carry out a demonstration program to establish programs to train and employ alternative dental health care providers to increase access to dental care for Veterans who are entitled to such services from VA and reside in rural and other underserved communities. VA would give priority for participation in the demonstration program to VA medical centers or health systems in States with a technical college within the State college system that has established a degree or certificate level program for the training of alternative dental health care providers. Services through the demonstration program could be administered through telehealth-enabled collaboration and supervision when appropriate and feasible. Alternative dental health care providers would have the meaning given that term in 42 U.S.C. § 256g-1(a)(2).

VA is opposed to unproven alternative delivery of dental care models. While we support programs that expand dental health care to Veterans in a safe and effective manner, the scientific evidence does not currently support the proposed model for Veteran patients who require management of multiple physical and mental comorbidities and multiple prescription medications. The average VA dental patient is approximately 60 years old and is taking over 10 medications. Allowing Veteran patients to seek restorative oral health care from a non-dentist practitioner poses too great of a potential overall health risk. VA strongly believes that the professional education and clinical expertise of a licensed dentist is essential for the thorough evaluation and comprehensive treatment of patients in VA.

Section 8 would authorize to be appropriated \$500 million for fiscal year 2020 to carry out this Act, other than section 4. The amount authorized to be appropriated would be available for obligation for the 5-year period beginning on the date that is one year after the date of the enactment of this Act.

VA has no views on section 8.

S. 3184 - to amend title 38, United States Code, to modify the requirements for application for construction of State home facilities to increase the maximum percentage of nonveterans allowed to be treated at such facilities, and for other purposes.

S. 3184 would amend one of the requirements for applications for State home construction grants in 38 U.S.C. § 8135(a)(4). Specifically, it would require States that submit an application to provide reasonable assurance that, for purposes of providing care to spouses of Veterans, during a period in which a facility is operating with a bed occupancy rate of 90 percent or less, not more than 40 percent of the bed occupancy at any one time will consist of patients who are not receiving such level of care as Veterans.

While VA appreciates the intent of this legislation, we cannot support it as drafted. First, it is inconsistent with the intent of VA's grant program for State Veterans Homes, as this would allow a significant portion of the population in a State Veterans Home to be non-Veterans. This authority would only apply if the home has less than 90 percent occupancy, which suggests that there may be insufficient demand for the Veterans Home in the first place.

VA also has concerns with this legislation because the technical effects of the bill would result in adverse effects on Veterans and non-Veteran residents. Initially, we note that the additional language that would be added in § 8135(a)(4)(B) only refers to providing care to "spouses of veterans", but State homes may also provide services to other non-Veterans besides spouses, such as persons whose child or children died while serving in the Armed Forces. We note that this creates some ambiguity as to how VA is to calculate the percentages further discussed in that subparagraph.

VA's greater concern, though, is that we believe that the language concerning occupancy rates could lead to unfortunate outcomes. Our reading of this language is that it would prohibit a State home from having a relative percentage of non-Veterans above 40 percent; for example, if a 100 bed facility only had 90 beds filled, there could be no more than 36 non-Veterans (40 percent of 90). We would interpret this language to mean that the occupancy rates would refer to the relative percentage of residents; VA has interpreted similar language concerning bed occupancy rates in VA's regulations at 38 C.F.R. § 51.210(d) to refer to the total number of residents, rather than the total number of beds in the home. Applying this interpretation to this legislation, though, could result in significant disruptions in care. For example, if the 40 percent occupancy rate is a percentage of the relative number of beds and 90 beds were filled, 36 could be filled with non-Veterans and 54 with Veterans. However, if the next applicant for a bed were a Veteran, the facility would exceed the 90 percent total occupancy rate, as it

would have 91 residents if it admitted the Veteran. Because of this, it would no longer be authorized to have 40 percent of its available beds for non-Veterans; instead, it could only have 25 percent of its beds available for non-Veterans.

We think this requirement could force the facility to take actions that could lead to unfortunate outcomes. First, the facility could simply discharge a non-Veteran patient immediately and admit the Veteran, which would be very disruptive to the discharged non-Veteran patient. This also would be a perverse incentive because it would discourage States to fully use the beds already in place. Second, the facility could tell the Veteran to wait until a non-Veteran left the facility on his or her own, but this would delay the Veteran's care and would be a waste of resources, as the facility would have open beds available. We think one of these results would be required by the legislation because the bill would prohibit exceeding the 40 percent occupancy rate "at any one time", which we interpret to mean that if at any point, even only momentarily, a facility is not in compliance with this requirement, it cannot have the additional flexibility the bill intends. The phrase "at any one time" has been very difficult for State homes to administer in other contexts, as it requires them to take action in anticipation of even momentary changes in their resident population. If the legislation, instead, referred to an average over a period of time (monthly or quarterly would likely be appropriate), that would seem to provide more flexibility and prevent unnecessary discharges as described in the scenarios above.

VA does not anticipate that this bill would result in any additional costs.

S. ___ - Discussion Draft Regarding Transition Assistance reform

The draft bill would amend title 10, U.S.C., to improve the Transition Assistance Program (TAP) for members of the Armed Forces, and for other purposes. VA generally defers to DoD, to the extent that it is responsible for administering title 10. However, we provide input on sections of the bill affecting VA.

Section 2 of the draft bill would direct the interagency partners for TAP to improve the counseling, information, and services currently furnished to transitioning Servicemembers, and to provide these services to transitioning Servicemembers' spouses as appropriate. It would require that transitioning Servicemembers begin TAP no later than one year before their date of separation. It further would require sequencing of instruction and training provided by other agencies while allowing Servicemembers to complete VA training at a pace and order satisfactory to them.

VA appreciates Congress's interest in TAP and shares its desire to make sure that the program serves as many transitioning Servicemembers as possible, in the most effective way possible. To that end, VA and our TAP interagency partners currently have several interagency evaluations under way. These studies will provide us with the information needed to continue to make evidence-based policy decisions as to what improvements to TAP should be made, and how best to make them. While these evaluations are under way, we believe that legislation to mandate additional evaluations is premature at this time; nevertheless, we look forward to working with the Congress to improve TAP once we have completed these evaluations and have the evidence available to make evidence-based policy decisions.

With regards to requiring Servicemembers to begin TAP no later than one year before separation, VA continues to take action to fulfill its commitment to integrate TAP into the Military Life Cycle in order to inform, equip, and provide support to Servicemembers earlier and at critical touchpoints throughout their career.

With regards to the specific elements of counseling to be provided, VA supports the intent of proposed section 1142(f)(3)(A), regarding information on programs and benefits related to Veteran status, but is already providing benefits information to active duty Servicemembers who are separating from military service. This has facilitated earlier and easier enrollment and access to VA health care. Further, VA does not support subparagraph (E), which would require the pre-separation counseling include a description, developed in consultation with VA, of the assistance and support services for family caregivers of eligible Veterans furnished by VA under 38 U.S.C. § 1720G, including the Veterans covered by the program, the caregivers eligible for assistance and support through the program, and the assistance and support available through the program. VA does not support this subparagraph because VA has been working closely with DoD to implement a similar provision enacted in section 541 of the National Defense Authorization Act for Fiscal Year 2018 (Public Law 115-91). VA fully supports ensuring Veterans understand the benefits that may be available to them, including those provided by VA and DoD (such as Special Compensation for Assistance with Activities of Daily Living), and we do not believe further legislation is required. VA supports the intent of subparagraph (F), which would require the pre-separation counseling to include information on survivor benefits available under the laws administered by VA or DoD. VA supports efforts to increase awareness of survivor benefits, such as the Civilian Health and Medical Program of the Department of Veterans Affairs, which is an important health care benefits program available for the family members of certain severely disabled or deceased Veterans. However, VA already provides much of this information.

Subsection 1142(g)(4), would also extend VA's current 6-hour briefings into a one-day course of instruction. VA interprets a full day of instruction as 8 hours. VA is in support of extending the VA benefits briefings to a full-day of instruction, which will ensure that VA can better prepare Servicemembers for their transition and help foster what will be a lifetime relationship between their families and the Department. A full-day will further ensure that transitioning Servicemembers are presented information in a manner that is conducive to promoting increased awareness and understanding of VA benefits, services, and support tools. Increasing the VA benefits briefings to a full-day of instruction would require additional funding. VA suggests that the term "registration" in this section be replaced with the term "application."

With regards to mandating the sequencing of TAP, VA encourages that transitioning Servicemembers undertake the VA Benefits I/II training in an order satisfactory to their own personal transition goals, emphasizing that early and consistent training on VA benefits is crucial to the Servicemember's successful transition outcomes.

In addition to the changes to TAP, the draft bill would require changes to interagency data-sharing requirements. Section 4 would require DoD to establish and maintain an electronic tracking system and database that contains data on Servicemember participation, survey answers, available resources, and counselor notes for the Department of Labor (DOL), VA, commanders, and other TAP partners. Section 5 would require the gathering of information and survey responses regarding TAP participation at various stages by various agencies and would require the information be made available electronically to VA, among other TAP partners.

Section 11 of the draft bill also calls for the identification of opportunities where VA can provide training to members which will lead to employment in critically understaffed positions in VA, using the DoD SkillBridge programs. With regards to identifying opportunities for job training and employment with VA in SkillBridge programs, VA and DoD have a shared goal to enhance services and employment opportunities at VA for transitioning Service members through SkillBridge programs. Since 2014, VA has offered opportunities for transitioning Servicemembers to complete a national-level training program that leads to an opportunity for an interview and potential job as a benefits claims examiner. More recently, VA launched the Military Transition and Training Advancement Course (MTTAC) which trains Servicemembers to become medical support assistants. Furthermore, VA and DoD are working to develop an overarching agreement that will expand these types of opportunities to additional VA job fields.

In sections 5, 12, and 13, the bill would require several different Servicemember studies and other evaluations of the effectiveness of transition-related training. It would require Servicemember surveys in order to assess the Servicemembers' and their spouses' experiences of the assistance provided through TAP. It also would require the evaluation of transition training and counseling relating to post-secondary education and use of educational assistance. Lastly, it would require VA, in consultation with interagency partners, to conduct a 5-year longitudinal study on three separate cohorts of Servicemembers who have separated from the Armed Forces.

VA has already begun development of a post-transitional longitudinal program, which will survey Veterans over time to gain detailed information about their outcomes and their evaluations of how TAP helped them prepare for their transitions to civilian life. The assessment instrument was submitted to the Office of Management and Budget (OMB) for review in February 2018, and the Federal Register notice has been published. To conduct full execution of this study, VA will require additional funding.

With regards to Servicemember surveys, VA receives feedback from participating Servicemembers and dependents through the Transition GPS Participant Assessment, which is a web-based instrument designed to measure and improve customer satisfaction with the curriculum and TAP overall. Using this transitioning Servicemember feedback, VA conducts a deep dive every other year to look for ways to improve the instructional delivery and design of its curriculum. In addition, we conduct a technical review every year to ensure all content is up to date.

Section 14 would require the establishment of a board within the Veterans Benefits Administration (VBA) to exchange information and develop partnerships to support the prevention of suicides, substance abuse, and homelessness among Veterans. This board would include representatives from VBA, VHA, DOL, the Department of Homeland Security (DHS), and DoD. The existing VA/DoD Joint Executive Committee established during the 108th Congress and the TAP interagency Executive Council have significantly enhanced interagency exchange of information and partnership development to support the prevention of suicides, substance abuse, and homelessness. Furthermore, the Federal Government is improving collaboration on suicide prevention as a result of Executive Order (EO) 13822. These existing governance bodies provide a valuable forum for information sharing and collaboration on addressing mental health and at-risk populations. VA agrees that there is a clear need to improve coordination between the administrations and offices within VA, as well as among other agencies, regarding suicide, drug overdose, and alcohol-related mortality prevention efforts. As we recently released in the National Strategy for Preventing Veteran Suicide, data and surveillance form the foundation of a public health approach to ending Veteran suicide. Coordination within VA has already begun under our annual Veteran suicide data reports but there is more to be done. While VA supports the intent of this section, VA is concerned that the language prescribes that this board reside in an office which no longer exists in the VBA organizational structure, rather than affording VA the ability to determine which VA office should lead this board, should it be established. In addition, VA notes that the proposed board would have no experts on substance use disorders.

Finally, section 15 would require VA, within 90 days of the enactment of this Act, to submit to Congress a report on current and future studies supported by VA's Office of Research and Development (ORD) and others relating to economic risk factors affecting suicide prevention and a report on how the Department's REACHVET program is incorporating or will incorporate economic risk factors in its algorithm for suicide prevention.

VA does not support this section, as we can already provide this information, or will provide this information upon its completion, at the Committee's request without legislation. Assessment of the effect of economic-related variables on risk for suicide is already part of the strategic plan within ORD that focuses on the transition period from active military status to Veteran status. Epidemiological data analyses indicate that the transition period is a high risk period for suicide and related behaviors. The ORD strategic plan for suicide prevention aligns with EO 13822, which requires VA, DoD, and DHS to provide seamless access to mental health care and suicide prevention resources for transitioning Servicemembers. The EO specifically emphasizes access to services during the critical first year period following discharge, separation, or retirement from military service.

In order to more closely examine the economic factors affecting suicide, ORD will leverage the existing data coordinating center at the Canandaigua VA Suicide Prevention Center of Excellence to identify, extract, and analyze data critical for a comprehensive suicide prevention program. ORD has identified funds (beginning in FY 2019) to support the Canandaigua data coordinating center in this added effort. It is expected the work will be conducted in collaboration with various units across VA as well as with external agencies such as DoD and the National Institutes of Health.

S. ____ - VA Hiring Enhancement Act

Section 2 of this legislation proposes to exempt VA physician hiring from the applicability of private sector covenants not to compete by adding new language to Subchapter 1 of Chapter 74 of Title 38 U.S.C. The applicability of covenants not to compete or non-compete clauses to federal hiring has been a recurrent problem around the country, especially for physician hiring. In short, the proposed 38 U.S.C. § 7413 states that any covenant not to compete with a non-departmental entity, facility or individual shall have no force or effect as it relates to an appointment to a physician position within VHA. It requires the appointee to provide clinical services at a VA medical facility for the duration of the covenant not to compete or for one year, whichever is longer. This service requirement may be waived by the Secretary. If the physician's appointment is terminated for any reason before the termination date of the covenant not to compete, then the proposed 38 U.S.C. § 7413 would no longer be applicable to the covenant not to compete.

VA supports section 2 of this proposed legislation as written, as it solves a problem known to medical facility Chiefs of Staff across the country and clarifies that VHA hiring is not subject to private sector covenants not to compete. This legislation should make it easier to hire physicians with these contractual obligations. It should be noted that exempting VA physician hiring from covenants not to compete entered into with non-Departmental facilities, entities and individuals should not result in additional costs to the federal government or VA.

While VA supports the intent of section 3, we do not support this provision as written. VA supports raising the qualification standard for physician hiring to completion of a full specialty residency program. This is the community standard and elevates VA standards to typical norms. VA changed the physician qualification standard over a year ago, and this section brings the statutory language in line with the current qualification standard. However, the inclusion of language regarding contingent appointments is unnecessary and confusing. VA already has the authority to extend job offers well before graduation from residency. Applicants must always meet the qualification standard prior to appointment. In addition, depending on state law, some residents may not gain the ability to be licensed immediately upon graduation from the residency program, as appears to be contemplated by section (3)(C)(ii).

VA anticipates that this bill would result in no additional costs.

H.R. 5418 - Veterans Affairs Medical-Surgical Purchasing Stabilization Act

H.R. 5418 would require multiple regional prime vendors to carry out the Medical Surgical Prime Vendor (MSPV) Program and successors. It would require each employee that conducts formulary analysis or makes decisions on formulary management have medical expertise relevant to the items being considered. The proposed legislation would also require a quarterly report to Congress of the names and medical expertise of employees who are participating in formulary management.

VA agrees that there is a need for a clinically driven sourcing capability. The proposed legislation limits consideration of the full spectrum of MSPV delivery solutions available to efficiently provide medical products to VA healthcare facilities. The requirement to provide quarterly reports on clinicians who participate in formulary management is excessively burdensome.

Further, MSPV costs are affected by many variables including: contract language; vendor geographic presence; mix of items purchased; etc. These variables change in relation to one another and in relation to how many vendors VHA uses. VA believes the MSPV legislation will likely increase medical commodity identification and procurement costs. Further, Congress has already provided tools for evaluating options for changing the number of vendors in subsequent acquisitions. Statutes on contract bundling and consolidation provide criteria for evaluating potential cost savings or other acquisition benefits to determine if such actions are necessary and justified. Thus, VA does not support this proposed legislation as written.

VA is unable to provide a cost estimate at this time. MSPV costs are affected by many variables including: contract language; vendor geographic presence; mix of items purchased; etc. These variables change in relation to one another and in relation to how many vendors VA uses. VA believes the bill would likely increase medical commodity identification and procurement costs.

S. 1596 - BRAVE Act of 2017

S. 1596 would increase the basic non-service connected monetary burial benefit allowance and tie monetary burial benefit allowances to the current rate of inflation according to the Consumer Price Index (CPI). Under current law, VA may only pay a sum not exceeding \$300 under section 2302 of title 38 U.S.C. for basic burial allowance. This bill would increase the basic burial allowance payment to \$749 and increase it by the CPI on an annual basis. The bill would also increase the service-connected burial benefit under section 2307, title 38 U.S.C. based on the CPI.

As a technical matter, VA notes that the burial allowance under section 2303 is currently \$762, after the CPI adjustment. The \$749 amount in this bill may be derived from FY17's CPI calculation. However, the legislation would apply to deaths that occur one year after the bill's enactment. Therefore, we suggest changing the starting amount from \$749 to \$762 in order to achieve parity between the burial benefits in sections 2302 and 2303.

VA supports S. 1596 provided Congress finds corresponding funding offsets. The last increase in the non-service-connected burial allowance under section 2302 occurred October 1, 1978, through the enactment of Public Law 95-479, increasing the allowance from \$250 to \$300. The last increase in the service-connected burial allowance under § 2307 occurred December 27, 2001 through the enactment of Public Law 107-103, increasing the allowance from \$1,500 to \$2,000.

In 2007, and 2008, VA's Office of Policy and Planning (OPP) conducted a study to determine whether the burial program was achieving expected outcomes and to determine the program's impact on Veterans and families. OPP found that funeral costs had increased at a greater pace than the cost of other services since 1990. OPP noted that in 1973, the service-connected burial allowance covered 72 percent of a Veteran's funeral and burial expenses, and the non-service-connected allowance covered only 22 percent of a Veteran's funeral and burial expenses. According to OPP, by 2007, the value of these benefits had decreased significantly; the service-connected burial allowance reimbursed only 23 percent of the cost of a Veteran's burial, and the non-service-connected burial allowance reimbursed only four percent of the cost of a Veteran's burial. The National Funeral Directors Association (NFDA) reports on its Web site, www.nfda.org, that the median cost of a funeral and burial was \$7,045 in 2012. The reported cost did not include the cost of a vault or cemetery plot or other miscellaneous cash advance charges, such as charges for flowers or obituaries. Further, NFDA reports that the median cost for an adult burial and funeral in the United States had increased from \$708 in 1960, to \$7,045 in 2012.

The proposal will allow VA to offer a more valuable reimbursement for the costs of a Veteran's funeral during a very difficult and vulnerable period of transition for the survivor. Additionally, the proposal will tie the burial allowances to the current rate of inflation consistent with burial benefits under section 2303.

Benefit costs are estimated to be: no budget impact in 2019, \$75.8 million over five years, and \$259.2 million over ten years. This estimate is based on the rate of \$749 for basic burial allowance in the bill. The cost would increase slightly if the rate is corrected to match the rate for burial benefits under section 2303.

S. 2881 - Mare Island Naval Cemetery Transfer Act

S. 2881 would require VA to seek an agreement with the City of Vallejo, California, under which the city would transfer all right, title, and interest in Mare Island Naval Cemetery to the control of VA, at no cost to VA. If the cemetery is transferred, VA would be required to maintain the cemetery as a national shrine.

VA does not support S. 2881, because the transfer of the Mare Island Naval Cemetery to VA could disrupt efforts currently underway to address the condition of the cemetery, and because acquisition of the cemetery by VA does not align with VA's current strategic objectives with respect to providing burial access to Veterans and their families. Finally, VA does not support S. 2881 because it sets an unwanted precedent regarding Veteran cemeteries in disrepair managed by localities, allowing them to eschew their responsibility to our Nation's heroes.

In 2017, concerned citizens began an effort to persuade VA to "take back" the Mare Island cemetery to address the deteriorating condition of the property. However, Mare Island cemetery has never been under the jurisdiction of VA. Mare Island was a Naval Base and a Navy shipyard that was closed in 1996; the on-base cemetery was closed to new interments sometime prior to that. When the base closed in 1996, the physical land and facilities, including the cemetery, were transferred to the City of Vallejo, at its request, which agreed to maintain the cemetery and has been solely responsible for its maintenance since that time. Despite the subsequent sale of some of the transferred land by the City of Vallejo, no funds were set aside to ensure the upkeep of the cemetery.

VA is very concerned with the conditions observed at the Mare Island Cemetery and has been aiding the City of Vallejo to find ways to address the repairs needed. VA's National Cemetery Administration (NCA) has provided expert advice to the city in developing its application for support from DoD's Innovative Readiness Training (IRT) program. IRT establishes partnerships between DoD and U.S. communities that provide training for Servicemembers while addressing public and civic needs. DoD assessed Mare Island Naval Cemetery as a potential IRT project in May 2018 and has reported that a decision is pending evaluation of legal and historical considerations, as well as federal and state environmental review requirements. DoD has indicated that the city's application for IRT assistance would not transfer to VA should ownership be transferred from the City of Vallejo to VA. Costs of repairs and upkeep for the cemetery would become a VA responsibility, one for which VA has received no appropriation.

In addition to disrupting the current efforts to address the condition of Mare Island Naval Cemetery, transfer of the cemetery to VA does not align with VA's strategic objective to provide reasonable access to a burial option to 95 percent of eligible

veterans and their families. Because this cemetery is closed to new interments, it does not offer new burial options for Veterans, and the transfer of the cemetery to VA would divert resources that should be used to provide additional burial options elsewhere. The service area within which Mare Island is located is already covered by other open VA national cemeteries. For instance, NCA currently operates the Sacramento Valley National Cemetery in Dixon, California, to serve Veterans and families members in the northern Bay Area. NCA also is seeking to improve burial access in this area with development of a columbaria-only urban cemetery (currently in design) at the new Alameda Point National Cemetery, which will provide enhanced access to burial benefits for approximately 420,478 Veterans, spouses and other eligible dependents.

Finally, transfer of Mare Island Naval Cemetery to VA would establish an unwanted precedent with respect to Veterans cemeteries or sections of cemeteries not managed by VA, a state or tribal government that may fall into disrepair. VA could be asked to assume operational responsibility for gravesites in some of these locations and does not have the resources to address these requirements.

VA cannot accurately assess the costs associated with S. 2881, because we have not performed our own assessment of the extent of repairs necessary to remediate the deterioration of the cemetery. In particular, we do not know the extent of structural problems that may not be visible from the surface, nor the cost of addressing those problems.

Issues noted on visual observation include headstones that are misaligned and lacking proper maintenance, some of which may need to be replaced; restoration or replacement of perimeter fencing, foundation wall, and flagpole; turf restoration; and replacement of the irrigation system and water source. Based on a subject matter expert comparison of prior cemetery projects of similar size and potential scope, we estimate the cost of these discernable repairs to have a rough order of magnitude between \$1.5 million and \$3.2 million.

VA is aware of media reports that raised the possibility of sub-surface issues with the property, but we are unable to verify these reports without a complete survey and assessment of the cemetery. If those reports are validated, the estimated costs to restore the cemetery in compliance with S. 2811 could be \$15 million or more.

S. 1952 - VA Financial Accountability Act of 2017

Section 2 expresses the sense of Congress regarding VA's budgeting process. We defer to Congress in expressing its sense.

Section 3 would require, not later than 90 days from the date of the enactment of this Act, VA to enter into a contract with an independent third party to, within 180 days, review and audit VA's financial processes, including reporting structures, and actuarial and estimation models, and develop recommendations for improving such structures. Within 60 days of the completion of this review, VA would have to submit a plan to Congress to implement the recommendations developed by the third party. VA would

have to appoint one individual within the Office of the Secretary of Veterans Affairs to be responsible for monitoring the status and progress of implementation of recommendations submitted to the Secretary by third parties, including those submitted pursuant to the contract described above, and all such other recommendations as may be submitted to VA by the Comptroller General, the Special Counsel, and the VA Office of Inspector General. Subsection (c) would require VA to, not later than 45 days before the date on which a budgetary issue would start affecting a program or service, submit a justification for any supplemental appropriation request it submits to Congress, including a plan for how VA intends to use the requested appropriation, how long the requested appropriation is expected to meet the needs of VA, and certification that the request was made using an updated and sound actuarial analysis. Subsection (d) would require starting in FY 2019 and in each FY thereafter, the VA Chief Financial Officer (CFO) to submit to Congress a statement of assurance that the financial projections included in the President's annual budget request or the supporting materials submitted along with such budget are sufficient to provide benefits and services under laws administered by VA; a certification of the CFO's responsibility for internal financial controls of the Department; and an attestation that the CFO has collaborated sufficiently with the financial officers of the facilities and components of VA to be confident in such financial projections.

VA concurs with the intent to make our Departmental resource requests more analytically based and transparent to Congress and other stakeholders. However, we do not support this bill as we find it to be duplicative of existing laws and policies within the Department. For example, subsections (a) and (b) are duplicative of current processes. VA's budget and financial processes are already the subject of frequent external audits and reviews. In particular, the Enrollee Health Care Projection Model (EHCPM) has been reviewed extensively by stakeholders, including OMB, VA leadership, Congressional staff, the Congressional Budget Office, , and the Government Accountability Office (GAO). GAO published a review of the EHCPM in 2011, "VA Uses a Projection Model to Develop Most of Its Health Care Budget Estimate to Inform the President's Budget Request" (GAO-11-205) and is currently reviewing the EHCPM as part their review of the VA Community Care Budget (102732). The RAND Corporation has also conducted an external review of the EHCPM The Department always takes the findings and recommendations of external audit bodies, including GAO and the VA Inspector General, seriously. Our progress in addressing these recommendations is described annually in our Congressional Budget Justification books, and we regularly monitor progress throughout the year via internal reviews.

Similarly, subsection (c) is redundant, as it was enacted through section 141 of the VA MISSION Act of 2018. Moreover, as with all appropriations requests to Congress, VA already provides the most detailed justification possible to explain the need for resources and the consequences should they fail to be provided. While we try to anticipate funding needs well in advance of their becoming urgent, some funding needs are true emergencies, and we are concerned that the rigidity of the 45-day advance timeline required will constrain both Congress and VA in ensuring Veterans' needs are adequately met in the face of unexpected funding crises.

Finally, subsection (d) is duplicative of laws and administration policies governing the Budget request and annual audit process, including the Congressional Budget Act and the Chief Financial Officers Act of 1990.

S. 1990 - Dependency and Indemnity Compensation Improvement Act of 2017

S. 1990 would change the formula for calculating Dependency and Indemnity Compensation (DIC) payments, which would increase the payment amounts. The bill would also lessen the number of years a Veteran must be rated totally disabled prior to death for a surviving spouse to be entitled to DIC and it would entitle a surviving spouse to all benefits under Chapter 13 when the surviving spouse remarries after the age of 55.

VA supports the bill. Increasing the amount of DIC benefit payments will help survivors continue to live a sustainable life. Lowering the remarriage age to 55 creates parity with certain DoD survivor benefits.

VA is developing a cost estimate, but no estimate is available at this time. Although the bill would not require additional employee resources, there would be additional mandatory costs and associated required PAYGO savings, as well as information technology development costs.

S. 2485, Medal of Honor Surviving Spouses Recognition Act of 2018

S. 2485 would codify the current rate of \$1,329.58 for the Medal of Honor special pension paid to eligible Veterans. The bill would also establish entitlement for surviving spouses of Medal of Honor (MOH) recipients to this special pension at the same rate. To be eligible, the surviving spouse must have been married to the Veteran for one year or more prior to the Veteran's death or for any period of time if a child was born of the marriage, or was born to them before the marriage.

VA supports this bill provided Congress finds corresponding funding offsets. Paying special pension to surviving spouses would provide assistance to dependents of our most courageous Servicemembers and Veterans. Additionally, setting specific parameters concerning receipt of only one special pension, regardless if a surviving spouse has been married to more than one Veteran who was in receipt of a MOH, remarriage, and age is in-line with the other survivor benefits VA administers. Benefit costs are estimated to be \$1.7 million in 2019, \$9.0 million over five years, and \$19.1 million over ten years.

S. 2748 - BATTLE for Servicemembers Act

S. 2748 would make participation in the Transition Assistance Program (TAP) to prepare for higher education, technical training, or entrepreneurship mandatory for Servicemembers unless a waiver is granted.

VA defers to DoD and DHS, as those Departments would have responsibility to implement the bill. VA fully collaborates with our interagency partners to address the complex challenges faced by our transitioning Servicemembers and Veterans. VA notes that a complicating factor in rapid identification of risk – or lack thereof for groups – is that often the signs and symptoms that stem from the challenges experienced during transition do not appear or begin until well after transition from military service. This delayed onset presents further challenges, as there are times when the Departments do not have regular contact with the transitioning Servicemember/Veteran.

VA anticipates no additional costs to VA resulting from this bill.

S. ____ - to require the Secretary of Veterans Affairs to establish a program to award grants to persons to provide and coordinate the provision of suicide prevention services for veterans transitioning from service in the Armed Forces who are at risk of suicide and for their families, and for other purposes.

The draft bill would require VA, not later than 1 year after the date of the enactment of this Act, to establish a program to award grants to persons to provide and coordinate the provision of suicide prevention services for eligible Veterans who are at risk of suicide and for their families. A Veteran would be eligible for services under this section if the Veteran is within the first 3 years of transitioning from a member of the Armed Forces to civilian status. Grant applicants would be required to submit an application that describes the suicide prevention services to be provided; the identified need for these services; a detailed plan describing how the suicide prevention services would be delivered, including the community partners with whom the applicant proposes to work, the arrangements currently in place with such partners; and how long such arrangements have been in place. Additional information required is a description of the types of Veterans at risk for suicide and the families of such Veterans to be provided such services; an estimate of the number of Veterans at risk for suicide and the families of such Veterans proposed to be provided such services and the basis for the estimate; evidence of the experience of the person and proposed partners in providing suicide prevention services to individuals at risk for suicide, and particularly to Veterans at risk for suicide and the families of such Veterans; and a description of the managerial capacity of the applicant in several different areas.

VA would be required to give priority in awarding grants to applicants who: have been providing or coordinating the provision of suicide prevention services for Veterans at risk of suicide and the families of such Veterans; have demonstrated the ability to provide or coordinate such services to such persons; have demonstrated the ability to provide opportunities for social connectedness for Veterans; and have demonstrated how they measure the effectiveness of their program. VA would also have to give priority to applicants providing services in rural or tribal areas, or in areas that have experienced high rates of or a high burden of veteran suicide and where no health care is furnished by the Department. Grants awarded under this program would be used to provide or coordinate the provision of suicide prevention services for Veterans who are at risk of suicide and their families. The suicide prevention services provided or

coordinated would have to include the following: outreach to identify Veterans at risk of suicide, with an emphasis on Veterans who are at highest risk of not receiving health care or services from VA; screening risk assessment and referral to care; education of suicide risk and prevention to families and communities; case management services; peer support services; assistance in obtaining benefits from VA and other Federal, State, and local government entities; temporary assistance in transportation in the form of a voucher, when appropriate and applicable, to be used in accessing services; personal financial planning; legal services to assist with issues that interfere with obtaining or retaining housing or supportive services; and other services necessary for improving the resiliency of veterans at risk for suicide and their families.

VA could require grantees to submit to the Secretary reports describing the use of the grant amounts. Grantees would have to notify each person who receives services that the services are being paid for in whole or in part by VA. VA would have to establish evaluation criteria for grantees under this section, require each grantee to submit a report with information necessary to evaluate the grantee at least annually, and evaluate each grantee at least annually. In planning and preparing to carry out this program, VA would have to consult with Veterans Service Organizations and various national and local organizations. VA would be required to report to Congress within 1 year of starting the program on the program and on the grant recipients under the program.

VA strongly supports the concept of this legislation subject to Congress finding appropriate offsets. In June 2018, VA published a report on its findings from the most comprehensive analysis of Veteran suicide in our nation's history, examining more than 55 million Veteran records from 1979 to 2015 from all 50 States and four territories. The report built on previous VA Suicide Data Reports. Key findings include that in 2015, on average, 20 Veterans died by suicide each day. Six of the 20 were users of VHA services, while 14 Veterans had not used any VHA care in the calendar year of or prior to their death. While VA has a number of programs devoted to reducing Veteran suicide, and we continue to develop and enhance these programs and efforts, they are designed to reduce risk of suicide in the population of Veterans who are under VA care. Therefore, we believe this legislation could provide a critical tool for coordinating with other entities in the community to reach this population of Veterans who do not rely on VA for care. VA's efforts to reduce the incidence of suicide ideation, behavior (and suicide completions) among all Veterans could be complemented by partnering with community-based providers who are able to replicate VA's suicide prevention programs in the community and to connect with Veterans that are currently beyond VA's reach. VA considers effective partnering with eligible grantees key to being able to reduce the number of Veterans dying by suicide.

We would appreciate the opportunity to work with the Committee to explore some technical alternatives or modifying language that may improve this proposal. For example, we have concerns about the narrow scope of eligibility for Veterans, as the bill would exclude Veterans who separated from the Armed Forces more than 3 years before; this would include the population of Vietnam Veterans who have some of the highest rates of suicide. We also recommend including members of the Armed Forces (including members of the Reserve Forces and the National Guard) up to a year prior to

their separation. This would better inform them of VA services and help facilitate needed wraparound services for this high-risk population as they transition. It would also facilitate a warm handoff to VA upon their separation should the new Veteran be interested. Further, we recommend that the legislation authorize eligible entities, rather than persons, to receive grants. We are also concerned about the timeline for implementation, as pursuant to 38 U.S.C. § 501, VA will need to publish regulations for this program prior to awarding grants. Finally, we note that additional resources would be needed to support a new grant program, including funding for grant awards and program administration.

S.____ - Modernization of Medical Records Access for Veterans Act

The proposed legislation would require VA to establish a pilot program that would provide patients with a physical device, the size of a credit card, which would be used by patients to support the review of their personal health information and the exchange of information with other healthcare providers they might see, both inside and outside of VA. VA would be required to conduct a full and open acquisition and award a contract within 120 days of the enactment of the Act. VA would need to conduct a pilot in at least one VISN for a one-year period.

VA agrees that patient-mediated health information exchange is a valuable strategy to support making health information available directly to patients and then under their direction, making that same health information available to the providers across the health system they entrust with their care. However, VA does not support this bill as written.

Currently, VA has technologies that support interoperable patient health information exchange nationwide. VA's My HealthVet Blue Button is piloting technology that allows Veteran patients to share their VA health records with their community care provider directly from their personal devices. VA's eHealth exchange technology is a rapidly growing network that connects VA with community health providers who can then securely share clinical information using a standardized approach.

As noted above, the proposed legislation would require VA to establish a pilot program that would evaluate a physical device, the size of a credit card, which would be used by patients to support the exchange of information. Providing physical devices to patients with their health information has not been a part of VA's strategy for supporting patient-mediated data exchange, and we do not believe that this approach would add significant value beyond current efforts. VA believes Veterans would prefer to minimize the number of physical devices or items they would need to manage. Given the near ubiquity of smart mobile devices owned and used by health care consumers, VA believes a strategy that focuses on improved health data availability and exchange on a mobile platform would be preferred.

VA believes that continued work on expanding query based exchange and on patient-mediated exchange via mobile and web applications supported by Federal

Health Interoperability Resource Application Program Interfaces should remain top priorities at this time. Additionally, VA is preparing for the Department of Health and Human Services Trusted Exchange Framework direction that supports the ability for patients to access their health information electronically without any special effort. This direction supports a significant step towards achieving interoperability for the patient.

Finally, no additional funding will be provided to support any efforts that would be required, should this bill become law. This would adversely affect other higher-priority health interoperability programs.

S. 514 - No Hero Left Untreated Act

S. 514 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 (MeRT)) to treat Veterans suffering from posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), military sexual trauma (MST), chronic pain, or opiate addiction. VA would provide access to MeRT to no more than 50 Veterans in carrying out this program. VA would have to submit a report to Congress on the program no later than 90 days after the completion of the program. 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 the Food and Drug Administration (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 FDA 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 will have a one-time \$1.83 million cost to implement.

This concludes my testimony. We appreciate the opportunity to present our views on these bills and look forward to answering any questions the Committee may have.