

**STATEMENT OF
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VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE**

MAY 17, 2017

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 is Ms. Margaret Kabat, National Director, Caregiver Support Program, Veterans Health Administration (VHA); Phil Parker, Acting Associate Deputy Assistant Secretary, Office of Acquisition and Logistics, Office of Acquisition, Logistics, and Construction (OALC); Mr. James Ruhlman, Assistant Director for Policy & Procedures, Veterans Benefits Administration (VBA); Ms. Meghan Flanz, Interim General Counsel; Dave McLenachen, Director, Appeals Management Office, VBA; and Donnie Hachey, Chief Counsel for Operations, Board of Veterans Appeals (BVA).

There are a number of bills on the agenda today, and we are unable at this time to provide views and cost estimates on a few of these provisions. Specifically, we do not have cost estimates on S. 543 and S. 764.

S. 23 Biological Implant Tracking and Veteran Safety Act of 2017

S. 23 would direct VA to adopt and implement a standard identification protocol for use in the tracking and procurement of biological implants by VA.

Section 2(a) would add a new section 7330B to title 38 to require VA to adopt the unique device identification system developed by the Food and Drug Administration (FDA) for medical devices (or implement a comparable standard identification system) for use in identifying biological implants intended for use in VA medical procedures conducted in medical facilities of the Department. In procuring biological implants under this section, VA would be required to permit a vendor to use any of the accredited entities identified by the FDA as an issuing agency pursuant to 21 Code of Federal Regulations (C.F.R.) § 830.100. The Secretary would be required to implement a system for tracking biological implants from donor to implantation that is compatible with the tracking system to be adopted and implemented. VA would be required to implement inventory controls compatible with the tracking system to enable VA to notify, as appropriate (based on an evaluation by appropriate VA medical personnel), VA patients who are in receipt of biological implants that are subject to a recall. In addition, section 2 of the bill would provide that in cases of conflict between the proposed revision to title 38 and a provision of 21 United States Code (U.S.C.) § 301 *et seq.* or 42

U.S.C. §§ 262 and 264, (including any regulations issued pursuant to these statutes), the provisions of these other statutes or regulations would apply.

Section 2 of the bill would define the term “biological implant” as any human cell, tissue, or cellular or tissue-based product or animal product: (1) under the meaning given the term “human cells, tissues, or cellular or tissue-based products” in 21 C.F.R. § 1271.3 (or any successor regulation); or (2) that is regulated as a device under 21 U.S.C. § 321(h). Under section 2(c), the standard identification system for biological implants would have to be adopted or implemented not later than 180 days after the Act’s enactment. With respect to products that are regulated as a device, the Secretary would be required to adopt or implement such standard identification system in compliance with the compliance dates established by the FDA pursuant to 21 U.S.C. 360i(f).

If the tracking system for biological implants is not operational within 180 days of the bill’s enactment, section 2(d) would require the Secretary to submit a written explanation to the Committees on Veterans’ Affairs explaining why the system is not operational for each month until the system is operational.

Initially, we note that section 2(a) of the bill attempts to create a new section 7330B; however, there already is a section 7330B, requiring VA to issue an annual report on the Veterans Health Administration (VHA) and furnishing of hospital care, medical services, and nursing home care. This was enacted last December as part of the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 (Public Law 114-315, section 612(a)). We recommend as a technical matter the bill propose to create a new section 7330C, as that would be the next available statute in the U.S.C., and that references throughout the bill to 7330B be updated to 7330C.

While VA agrees with the bill's intentions, VA does not support section 2 of the bill as written. The bill recognizes the need for a higher standard for human biologics as indicated by the requirement in section 3 for the use of a distinct identifier at all stages in distribution. However, as written, the bill could force VA to treat human tissues the same as other biologics in terms of identification.

Additionally, the bill states that VA shall permit vendors to use any of the FDA accredited entities identified as an issuing agency for a standard identification system for biological implants. This effectively limits VA to the use of FDA’s minimum issuing agency accreditation standards. VA already tracks blood and cellular products successfully using ISBT 128 identifiers in its facilities, and as a result, VA should be able to extend this system to ISBT 128-labeled human tissue products providing both electronic health record documentation and inventory control. VA is working with the Department of Health and Human Services (HHS) and other Federal partners to identify the optimal tracking and tracing systems to ensure the highest safety standards for human tissues.

VA intends to institute new recommendations from HHS for tissue tracking. On April 7-8, 2015, the HHS Advisory Committee on Blood and Tissue Safety and Availability voted unanimously to recommend that the HHS Secretary adopt a step-wise, risk-based approach to standardizing the identification, tracking, and tracing of medical products of human origin. In particular, the Committee recommended establishing ISBT 128 labeling as “a universal standard for mandatory implementation of unique donation identifiers for all human tissue products.” It suggested that the HHS Secretary promote the integration of transplantation records into searchable, electronic patient records. It further recommended taking steps to ensure that patients are informed when they receive a tissue product and provided a means of tracing it. The Committee asked that the HHS Secretary promote education for health care providers regarding the risks of human tissue transplants, the need for meaningful informed consent, and the necessity of engaging in activities to ensure tracking and tracing of tissue products. Lastly, it noted the importance of promoting international collaboration and data sharing on outcomes of tissue transplantation.

VA notes that HHS does not consider FDA’s Unique Device Identifier (UDI) appropriate for use as a tracking system for all biological implants. Human and animal derived implants, which are not regulated as devices, have different requirements from the devices for which the UDI was created.

Section 3 would add a new section 8129 to title 38 to govern the procurement of biological implants. VA would be limited to procuring human biological implants from vendors that meet several conditions. First, the vendors supplying biological implants of human origin would have to use the standard identification system adopted or implemented by VA under new section 7330B (as added by section 2 of the bill) with safeguards to ensure that a distinct identifier has been in place at each step of distribution from its donor. Additionally, each vendor would have to be registered with the FDA, ensure that donor eligibility determinations and other records accompany each biological implant at all times, and agree to cooperate with all biological implant recalls initiated by the vendor, the manufacturer, or the FDA. Vendors would have to agree to notify VA of any adverse event or reaction report it provides to FDA as required by 21 C.F.R. §§ 1271.3 and 1271.350 or any warning letter from the FDA within 60 days of the vendor’s receipt of such report or warning letter. Vendors would also have to agree to retain all records associated with procuring a biological implant for at least 10 years and would have to provide assurances that the biological implants provided are acquired only from tissue processors that maintain accreditation with the American Association of Tissue Banks or a similar national accreditation.

VA would be required to procure biological implants under the Federal Supply Schedules (FSS) of the General Services Administration (GSA) unless such implants are not available under these schedules. VA would be required to accommodate reasonable vendor requests to undertake outreach efforts to educate VA medical professionals about the use and efficacy of biological implants with respect to implants that are listed on the FSS. In the case of biological implants unavailable on FSS, VA would be required to procure such implants using competitive procedures in accordance

with applicable law and the Federal Acquisition Regulation (FAR). The bill would also clarify that 38 U.S.C. § 8123, which addresses procurement of prosthetic appliances, does not apply to the procurement of biological implants.

Additionally, section 3 would establish penalties, in addition to any penalty under another provision of law, for procurement employees who are found responsible for a biological implant procurement transaction with intent to avoid or with reckless disregard of the requirements of this section. Such an official would be ineligible to hold a certificate of appointment as a contracting officer or to serve as the representative of an ordering officer, contracting officer, or purchase card holder.

The new section 8129 would take effect 180 days after the date on which the tracking system required by the new section 7330B is implemented. The bill also contains a special rule for cryopreserved products, allowing VA 3 years to procure biological implants produced and labeled before the effective date of section 8129 without relabeling the products under the standard identification system adopted or implemented under the new section 7330B.

VA does not support section 3 of the bill as drafted. Vendors would be required to retain records for up to 10 years under the bill. VA notes that some institutions permanently retain these records. In particular, some types of biologics may be stored for extended periods prior to use and it may take several years for an adverse outcome to manifest. Disposal of records, in particular, the actual production identifier and donor documentation, will prevent the ability to track human derived biologics to their donor and lead to the use of biologics in VHA that cannot reliably be tracked back to the original donor. Requiring providers to retain records for only 10 years could produce problems in the future, and we believe that permanent record retention would be preferable.

VA also has concerns with the requirement that biological implants be procured from FSS sources (unless the products are not available from these sources). This would unduly restrict VA clinicians' best judgment as to the right implants for a given patient. Clinicians are not involved in the decision to place biological implants on the FSS. Additionally, VHA has determined that biological implants should be procured through national contracts that would take precedence over FSS. VA is developing an appropriate initial contract vehicle to acquire such products.

VA is specifically concerned that enactment of the bill would end the applicability of 38 U.S.C. § 8123 to the procurement of biological implants. This change would have an immediate, measureable, and adverse effect on wait times and patient care. This could result in considerable morbidity in the Veteran population, who would be forced to wait until GSA contracting can arrange for specific implants required to restore function. It is important to stress that, for many patients, there is an optimal window of opportunity for the use of an implant to prevent permanent loss of function. Many of these items are custom made and purchased in low volume or single units and will not be on a GSA contract or be cost effective for the U.S. Government to place on a full contract. Full

contracting may take much longer than is clinically appropriate for Veterans. Further, it is not uncommon to purchase inventory in emergency situations from other local hospitals to meet acute needs. This occurs under the authority of 38 U.S.C. § 8123. Limiting this authority as provided in the bill will prevent this activity and could jeopardize timely patient care. VA may then be forced to refer these patients to providers in the community, which could increase costs to the Department and reduce patient care if these community providers are not subject to the same requirements in terms of procurement and tracking of biological implants.

VA is also concerned that the penalties imposed under proposed section 8129(b) could produce unfair results if a procurement employee needs to purchase a product off-contract to meet the immediate needs of a patient and provider. This could be exacerbated by vendors choosing not to contract with VA given the new requirements imposed upon them, thereby eliminating or limiting the availability of products for our patients. Shortages of biologic products could also affect VA's ability to obtain products under contract or through competitive processes. As a result, Veterans' medical care could be delayed. VA recommends this provision either be stricken or revised to apply penalties only for the procurement employees whose off-contract procurement is for irresponsible reasons. This would provide the Secretary the authority to distinguish between cases when a violation was willful and jeopardized patient care and when it was willful, but done with the purpose of supporting patient care.

We estimate that S. 23 would cost \$11.2 million in fiscal year (FY) 2018, \$33.6 million over 5 years, and \$66.3 million over 10 years.

S. 112 Creating a Reliable Environment for Veterans' Dependents Act

S. 112 would amend 38 U.S.C. § 2012(a) to permit a grantee receiving per diem payments under the Homeless Providers Grant and Per Diem (GPD) Program to use part of these payments for the care of a dependent of a homeless Veteran who is under the care of such homeless Veteran who is receiving services covered by the GPD grant. This authority would be limited to the time period during which the Veteran is receiving services under the grant.

VA supports the intent of S. 112, conditioned on the availability of additional resources to implement this provision. We feel that this authority is needed to fully reach the entire homeless population. However, full implementation of the legislation would require additional funding to avoid diminished services in VA's full complement of programs for homeless Veterans.

VA estimates this bill would cost \$29.8 million in FY 2018, \$159.3 million over 5 years, and \$347.6 million over 10 years.

S. 324 State Veterans Homes Adult Day Health Care Improvement Act of 2017

S. 324 would amend 38 U.S.C. § 1745 to require the Secretary to enter into a contract or agreement with each State Veterans Home (SVH) for payment by VA for adult day health care (ADHC) provided to an eligible Veteran. Eligible Veterans would be those in need of nursing home care for a service-connected disability or who have a service-connected disability rated at 70 percent or more and are in need of nursing home care. Payments for each Veteran who receives medical supervision model adult day health care would be made at a rate that is 65 percent of the payment VA would make if the Veteran received nursing home care, and payment by VA would constitute payment in full for such care. The term “medical supervision model adult day health care” would be defined to mean adult day health care that includes the coordination of physician services, dental services, the administration of drugs, and such other requirements as determined appropriate by the Secretary. Currently, under a grant mechanism, VA pays States not more than half the cost of providing ADHC. States may currently obtain reimbursement for this care from other sources in addition to VA’s per diem payments.

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

First, VA notes that the bill would base payment rates for ADHC on nursing home care rates, though these are two distinctly different levels of care and are furnished for different periods of time. VA pays per diem for three levels of care at SVHs: nursing home care, domiciliary care, and adult day health care. The prevailing nursing home rate is calculated based on the cost of providing nursing home care, and VA negotiated that rate in conjunction with SVHs. Nursing home residents live at the facility and receive 24-hour skilled nursing care, including services after normal business hours with registered nurses involved in care at all times. ADHC is a distinctly different level of care that provides health maintenance and rehabilitative services to eligible Veterans in a group setting during daytime hours only. ADHC participants live at home and only use ADHC services for a portion of time during the day, normally about 8 hours, or one third of the length of time that skilled nursing care is provided. A per diem payment is made only if the participant is under the care of the facility for at least 6 hours (which can be 6 hours in one calendar day, or any two periods of at least 3 hours each in any 2 calendar days of the month). The nursing home rates that would be used to compute the ADHC rates under this bill are based on a formula that was developed in partnership with VA’s state home partners and is specific to nursing home care. VA would like the opportunity to thoroughly review the cost of providing ADHC and, as was accomplished for nursing home care, establish a mutually agreeable ADHC rate with our SVH partners. VA believes revising the language to allow for VA to propose a formula for computing ADHC rates and for SVHs to provide comments on the formula would be consistent with the way the nursing home care rates were developed under 38 U.S.C.

§ 1745. While this bill would specifically apply these payment rates to ADHC programs providing medical supervision, rather than any ADHC program, we still believe basing any ADHC payment rate on the rate for skilled nursing care is inappropriate.

Second, we note that the bill would direct VA to “enter into a contract or agreement” with each SVH. Agreements reached under this provision would still generally be contracts. VA has requested specific authority that would allow VA to enter into individual agreements not subject to certain provisions of law governing Federal contracts. We request this authority be granted before requiring VA to transition state payments from a grant to a contract mechanism.

We do support the bill’s focus on ADHC programs providing medical supervision. A medical supervision model would include physician services, dental services, and administration of drugs, whereas these would not be required for a socialized model.

Additionally, VA expects the numbers of both socialized and medical supervision model ADHCs to increase after publication of the proposed regulation. VA is not able to predict how many SVHs will adopt the new socialized model, nor how the new model’s use will affect costs. Until VA has such information, VA recommends against codifying a payment rate, as such a limitation could result in VA overpaying or underpaying states in the future.

VA estimates S. 324 would cost an additional \$492,972 in FY 2018, \$3.8 million over 5 years, and \$11.6 million over 10 years.

**S. 543 Performance Accountability and Contractor Transparency (PACT)
Act of 2017**

S. 543 would amend section 513 of title 38, U.S.C., to require VA to include performance metrics to service contracts under such authority and safeguards that will allow VA to levy financial penalties on service providers who fail to meet established thresholds of quality. The bill proposes to place additional requirements for contracts over \$100 million to include requiring the service provider to document its work in a database and submit reports to VA and the Committees on Veterans’ Affairs of the House of Representatives and the Senate. VA would be required to submit a report to these Congressional Committees if a service provider fails to meet its contractual obligations or if there are any modifications made on the contract. VA would be required to publish online information on the contract, including any modifications to the contract.

We are still examining the effect this bill would have, and would appreciate the opportunity to discuss this further with the Committee. VA agrees that there are opportunities to improve our oversight of contractors and program management associated with the contracting process; however, we believe the bill could impose undue additional costs to VA and taxpayers, duplicate existing requirements, and/or require clarifying language. Of note, the recently signed Program Management

Improvement Accountability Act (Public Law 114-264) requires Agencies to implement program management policies and develop a strategy for enhancing the role of program managers within the Agency. This law aligns to a program execution and governance model VA is currently executing, the Acquisition Program Management Framework (APMF). The APMF has been recognized by the Office of Federal Procurement Policy (under the Office of Management and Budget), the Federal Acquisition Institute, and the Government Accountability Office as addressing the critical needs of stronger program management and governance.

Many of the requirements in section 2 of the bill are already mandated by various parts of the Federal Acquisition Regulation (FAR) and/or Veterans Affairs Acquisition Regulation (VAAR). These regulations govern the process by which VA acquires goods and services by contract with appropriated funds. VA Quality Assurance, for example, requires government-led contract quality assurance at all times and places as may be necessary to determine that the supplies or services conform to contract requirements. Quality Assurance Surveillance Plans (QASP) should be prepared in conjunction with the preparation of the Performance Work Statement. These plans should specify: 1) all work requiring surveillance; and 2) the method of surveillance. Each contract shall designate the place or places where VA reserves the right to perform quality assurance.

Moreover, all major programs should have a Program Management Plan (PMP). PMP should identify key milestones, detail activities necessary to reach milestones, identify risks and issues, and develop strategies to mitigate risks and correct issues. Program Managers should also be measuring the health of the program as it relates to cost, schedule, and execution of contract through metrics.

Importantly, VA regulations recognize that a one-size-fits-all approach does not work for contracting and that there are times when it is not in VA's best interest to be overly prescriptive. Therefore, VA encourages work to be described in terms of required results rather than either "how" the work is to be accomplished or the number of hours to be provided; to enable assessment of work performance against measurable performance standards; and to rely on the use of measurable performance standards and financial incentives in a competitive environment to encourage competitors to develop and institute innovative and cost-effective methods of performing the work.

When utilized, such contracts include: (1) a performance work statement (PWS); (2) measurable performance standards (i.e., in terms of quality, timeliness, quantity, etc.) and the method of assessing contractor performance against performance standards; and (3) performance incentives where appropriate. In short, VA incorporates metrics for incentive or award fees into contracts when it is in VA's best interest to do so.

Furthermore, VA Contracting Officers may utilize liquidated damages clauses when appropriate. Before using a liquidated damages clause, VA Contracting Officers must consider the potential impact on pricing, competition, and contract administration. Liquidated damages clauses are only used when: (1) the time of delivery or timely

performance is so important that the Government may reasonably expect to suffer damage if the delivery or performance is delinquent; and (2) the extent or amount of such damage would be difficult or impossible to estimate accurately or prove.

Although VA agrees with the overall intent of the proposed legislation, VA would like to express a few concerns with key sections of the legislation.

VA also requests clarity on the types of modifications for which reports would have to be submitted. The FAR identifies many types of contract modifications, some of which may not be of congressional interest.

While VA agrees with much of the language in the bill, there are sections of the legislation where VA recommends modest changes such as placing “contract” with “program” (e.g., “use the appropriate project management accountability system of the Department to ensure that the contract provides an adequate return on the investment of the Secretary” in proposed section 513(b)(2)(B)) to clarify the broader responsibility of the Program Manager in ensuring adequate return on investment of programs that may have one or more contracts.

VA would appreciate the opportunity to discuss the proposed legislation with the Acquisition Community, as well as to conduct a more formal technical review of the proposed legislation at a later juncture. We look forward to ongoing collaboration with the sponsors of this legislation.

VA does not have a cost estimate for this bill at this time.

S. 591 Military and Veteran Caregivers Service Improvement Act of 2017

S. 591 would expand eligibility for VA’s Program of Comprehensive Assistance for Family Caregivers, expand benefits available to participants under such program, enhance special compensation for certain members of the uniformed services who require assistance, and make other amendments to increase the provision of benefits.

The Caregivers and Veterans Omnibus Health Services Act of 2010, Public Law 111-163, signed into law on May 5, 2010, provided expanded support and benefits for caregivers of eligible and covered Veterans. While the law authorized certain support services for caregivers of covered Veterans of all eras, other benefits were authorized only for qualified family caregivers of eligible Veterans who incurred or aggravated a serious injury in the line of duty on or after September 11, 2001. These new benefits for approved family caregivers, provided under the Program of Comprehensive Assistance for Family Caregivers, include a monthly stipend paid directly to designated primary family caregivers and medical care under CHAMPVA for designated primary family caregivers who are not eligible for TRICARE and not entitled to care or services under a health-plan contract.

Section 2 of S. 591, the Military and Veteran Caregiver Services Improvement Act of 2017, would remove “on or after September 11, 2001” from the statutory eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers, and thereby expand eligibility under the program to Veterans of all eras who otherwise meet the applicable eligibility criteria. Family caregivers could not receive assistance under this expanded eligibility until FYs 2018, 2020, or 2022 depending on the monthly stipend tier for which their eligible Veteran qualifies. Section 2 would also add “or illness” to the statutory eligibility criteria, and thereby expand eligibility to include those Veterans who require a caregiver because of an illness incurred or aggravated in the line of duty. In addition, the bill would expand the bases upon which a Veteran could be deemed to be in need of personal care services, to include “a need for regular or extensive instruction or supervision without which the ability of the Veteran to function in daily life would be seriously impaired.”

This section would also expand the assistance available to primary family caregivers under the Program of Comprehensive Assistance for Family Caregivers to include child care services, financial planning and legal services “relating to the needs of injured and ill Veterans and their caregivers,” and respite care that includes peer-oriented group activities. The bill would ensure that in certain circumstances VA accounts for the family caregiver’s assessment and other specified factors in determining the primary family caregiver’s monthly stipend amount. In addition, the bill would require VA to periodically evaluate the needs of the eligible Veteran and the skills of the family caregiver to determine if additional instruction, preparation, training, or technical support is needed, and it would require certain evaluation be done in collaboration with the Veteran’s primary care team to the maximum extent practicable.

Section 2 would also authorize VA, in providing assistance under the Program of Comprehensive Assistance for Family Caregivers, to “enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, states, and private, nonprofit, and other entities” in certain circumstances. It would expand the definition of family member to include a non-family member who does not provide care to the Veteran on a professional basis, and it would amend the definition of “personal care services.” The bill would also end the Program of General Caregiver Support Services on October 1, 2022, but would ensure that all of its activities are carried out under the Program of Comprehensive Assistance for Family Caregivers. Finally, the bill would amend the annual reporting requirements for the Program of Comprehensive Assistance for Family Caregivers.

In September 2013, VA sent a report to the Committees on Veterans’ Affairs of the Senate and House of Representatives (as required by Section 101(d) of Public Law 111-163) on the feasibility and advisability of expanding the Program of Comprehensive Assistance for Family Caregivers to family caregivers of Veterans who incurred or aggravated a serious injury in the line of duty before September 11, 2001. In that report, VA noted that expanding the Program of Comprehensive Assistance for Family Caregivers would allow equitable access to seriously injured Veterans from all eras

(who otherwise meet the program's eligibility criteria) and their approved family caregivers.

In the report, however, VA noted difficulties with making reliable projections of the cost effect of opening the Program of Comprehensive Assistance for Family Caregivers to eligible Veterans of all eras, but estimated a population range of 32,000 to 88,000 additional Veterans in the first year (estimated for FY 2014), at a cost of \$1.8 billion to \$3.8 billion in the first year (estimated for FY 2014). After VA provided this report to Congress, the RAND Corporation published a report titled, "Hidden Heroes: America's Military Caregivers," which estimates a significantly larger eligible population (1.5 million) that may be eligible if the program were expanded to caregivers of pre-9/11 Veterans and those qualifying due to illness. VA's estimates in its 2013 report did not account for expansion to eligible Veterans with an illness incurred or aggravated in the line of duty, other Veterans who would become eligible for the program based on the amendments in section 2, or the additional assistance that would become available to primary family caregivers under the bill. This estimate also did not factor in a phased implementation of stipend expansion, as contemplated by the bill.

VA cannot responsibly provide a position in support of expanding the Program of Comprehensive Assistance for Family Caregivers without a realistic consideration of the resources necessary to carry out such an expansion, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. This is especially true as VA presses to strengthen mental health services and ensure the fullest possible access to care across the system.

We wish to make it very clear that VA believes an expansion of those benefits that are currently limited by era of service would result in equitable access to the Program of Comprehensive Assistance for Family Caregivers for long-deserving caregivers of those who have sacrificed greatly for our Nation. However, VA cannot endorse this measure before further engaging with Congress on these fiscal constraints, within the context of all of VA health care programs.

Additionally, before expanding eligibility under the Program, we believe it prudent for VA to ensure that the current eligibility criteria are applied in a consistent manner across the program. For example, the National Caregiver Support Program is undergoing an internal review to evaluate consistency in revocations and reductions from the Program and standardize communication with Veterans and Caregivers. On April 17, 2017, VA suspended certain VA-initiated revocations in order to carry out this review.

VA welcomes further discussion of these issues with the Committee.

Section 3 of this bill proposes to add a new section 3319A to title 38 to authorize individuals who are eligible for and participating in a program of comprehensive assistance for family caregivers under 38 U.S.C. § 1720G(a) the opportunity to transfer their unused Post-9/11 GI Bill education benefits to their dependents. Veterans may

complete the transfer of entitlement any time during the 15-year period beginning on the date of their last discharge or release from active duty. There is no length of service requirement, and the monthly rate of educational assistance would be the same rate payable to the individual making the transfer. The Secretary would be authorized to prescribe regulations to carry out this section. We note that the Survivors' and Dependents' Educational Assistance (DEA) program, or chapter 35, currently offers education and training benefits to eligible dependents of members of the Armed Forces and Veterans who have a service-connected disability rated as permanently and totally disabling, including individuals who are eligible for a program of comprehensive assistance for family caregivers. Assistance includes up to 45 months of full-time benefits.

VA supports the intent of section 3 to take care of caregivers; however, VA cannot support this section as written. The transfer of entitlement provisions of the Post-9/11 GI Bill were established as a recruitment and retention tool for the uniformed services. As such, the Department of Defense (DoD) determines eligibility for transfer of entitlement. If enacted, the proposed legislation would require VA to develop procedures to receive requests to transfer entitlement for certain individuals, determine eligibility, and award benefits for the transfer of entitlement program. However, VA notes that Congress would need to identify appropriate offsets for the cost of this legislation

Additionally, under the proposed section 3319A, dependents would receive the same rate of payment as otherwise payable to the individual making the transfer. This is different than the rate payable for a dependent child using transferred entitlement under section 3319. Currently, a dependent child is awarded benefits as if the individual making the transfer were not on active duty. As such, a child is entitled to the monthly housing allowance stipend even though the individual transferring benefits is still on active duty. Under the proposed legislation, a child would not be eligible for the housing allowance while the individual described in 38 U.S.C. § 1720G(a)(2) is on active duty. This change would impact the Long-Term Solution for processing Post-9/11 GI Bill claims, as VA would have to make system modifications in order to apply a blended set of rules for claims involving transferred education benefits.

Section 4(a) would amend 37 U.S.C. 439, providing for special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living, by amending the definition of covered members to include those Servicemembers who have a serious injury or illness that was incurred or aggravated in the line of duty and are in need of personal care services as a result of such injury or illness. Section 4(b) would further amend section 439 by requiring VA to provide family caregivers of a Servicemember in receipt of monthly special compensation the assistance available to family caregivers of eligible Veterans under 38 U.S.C. § 1720G(a)(3)(A), other than the monthly caregiver stipend. VA would provide assistance under this subsection in accordance with a memorandum of understanding (MOU) between VA and DoD, and an MOU between VA and the Secretary of Homeland Security. VA would be required to ensure that a family

caregiver in receipt of assistance under this subsection is able to transition seamlessly to the receipt of assistance under 38 U.S.C. § 1720G. Section 4(c) would require DoD, in collaboration with VA, to ensure that members of the uniformed services in receipt of monthly special compensation are aware of the eligibility of such members for family caregiver assistance. Section 4(d) would define the term “serious injury or illness,” which would replace the term “catastrophic injury or illness,” to mean an injury, disorder, or illness that (1) renders the afflicted person unable to carry out one or more activities of daily living; (2) renders the afflicted person in need of supervision or protection due to the manifestation by such person of symptoms or residuals of neurological or other impairment or injury; (3) renders the afflicted person in need of regular or extensive instruction or supervision in completing two or more instrumental activities of daily living; or (4) otherwise impairs the afflicted person in such manner as the Secretary of Defense or Homeland Security prescribes.

Regarding section 4 of the bill, VA defers to DoD and the Department of Homeland Security regarding sections 4(a), 4(c), and 4(d). VA does not support section 4(b) because DoD already provides many of the services and supports available under VA’s Program of Comprehensive Assistance for Family Caregivers including health care coverage, mental health services, and respite care. Requiring VA to provide services under its program would result in a duplication of efforts.

Section 5 would authorize the Office of Personnel Management (OPM) to promulgate regulations under which a covered employee, which would include a caregiver defined in 38 U.S.C. § 1720G or a caregiver of an individual receiving compensation under 37 U.S.C. § 439, to use a flexible schedule or compressed schedule or to telework. VA defers to OPM on this section.

Section 6 would amend the Public Health Service Act (42 U.S.C. § 300ii), which governs lifespan respite care, to amend the definition of “adult with a special need” to include a Veteran participating in the family caregiver program under 38 U.S.C. § 1720G(a). It would also amend the definition of “family caregiver” to include family caregivers under 38 U.S.C. § 1720G. Furthermore, in awarding grants or cooperative agreements to eligible state agencies to furnish lifespan respite care, HHS would be required to work in cooperation with the interagency working group on policies relating to caregivers of Veterans established under section 7 of this bill. Section 6 would also authorize appropriations of \$15 million for FYs 2017 through 2022 for these grants. VA defers to HHS on this section.

Section 7 would establish an interagency working group on policies relating to caregivers of Veterans and Servicemembers. The working group would be composed of a chairperson selected by the President, and representatives from VA, DoD, HHS (including the Centers for Medicare & Medicaid Service), and the Department of Labor. The working group would be authorized to consult with other advisors as well. The working group’s duties would include regularly reviewing policies relating to caregivers of Veterans and Servicemembers, coordinating and overseeing the implementation of policies relating to these caregivers, evaluating the effectiveness of such policies,

developing standards of care for caregiver and respite services, and others. Not later than December 31, 2017, and annually thereafter, the working group would be required to submit to Congress a report on policies and services relating to caregivers of Veterans and Servicemembers.

VA generally supports a working group that would provide a forum for analyzing and evaluating different issues that family caregivers of Veterans and Servicemembers face. Such a working group would be ideally suited to considering in depth the types of issues other provisions of this bill are intended to address and would also be able to evaluate emerging issues.

The Department of Justice advises, however, the bill's method for selecting members of the working group raises Appointment Clause concerns, which DOJ will convey in greater detail under separate cover.

We also note several technical concerns with the legislation in terms of the creation of the working group, its role, the potential applicability of the Federal Advisory Committee Act to such a group, and which agency (if any) would be responsible for initiating, managing, and funding the working group. We would be happy to discuss these issues with you upon your request.

Section 8(a) would require VA to conduct a longitudinal study on Servicemembers who began their service after September 11, 2001. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. Within 1 year of the date of the enactment of the Act, VA would be required to submit to the Committees on Veterans' Affairs a plan for the conduct of the study. Not later than October 1, 2021, and not less frequently than once every 4 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of the study. Section 8(b) would require VA to provide for the conduct of a comprehensive study on Veterans who have incurred a serious injury or illness and individuals who are acting as caregivers for Veterans. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. The study would be required to include the health of the Veteran and the impact of the caregiver on the health of the Veteran, the employment status of the Veteran and the impact of the caregiver on that status, the financial status and needs of the Veteran, the use by the Veteran of VA benefits, and any other information VA considers appropriate. No later than 2 years after the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of this study.

VA does not support section 8, as it would duplicate research in several ongoing or in-development studies. DoD and VA have a collaboration on the Millennium Cohort Study, a longitudinal cohort study that has and will continue to produce findings on health issues of multiple eras of military service. The Million Veterans Program creates a repository of clinical and genetic information on Veterans, including post-9/11 Veterans, which will provide data for targeted studies on health for years to come. VA's

Cooperative Studies Program is developing a study on the respiratory health of Gulf War and post-9/11 Veterans. Finally, a study of the life transitions of military Servicemembers who served in Iraq or Afghanistan is funded and in development.

VA estimates section 8 would cost \$4.3 million in FY 2018, \$17.5 million over 5 years, and \$34 million over 10 years, with additional close out expenses of \$3.3 million in FY 2028 for a total cost of \$37.3 million.

S. 609 Chiropractic Care Available to All Veterans Act of 2017

S. 609 would require VA to carry out a program to provide chiropractic care and services to Veterans through VA medical facilities at not fewer than 75 VA medical centers (VAMC) by not later than December 31, 2018, and at all VAMCs by not later than December 31, 2020. It would also modify 38 U.S.C. § 1701 to amend the definition of “medical services” to include chiropractic services, the definition of “rehabilitative services” to include chiropractic services and treatment programs, and the definition of “preventive health services” to include periodic and preventive chiropractic examinations and services.

VA does not support this bill. While adding chiropractic clinics would be consistent with ongoing VA initiatives to improve Veteran access to non-pharmacological pain treatment options, this can be accomplished through VA’s existing policies and processes for hiring, credentialing, and privileging chiropractors. Chiropractic treatment has been shown to be clinically effective, cost effective, and in high demand by Veterans. Patients who have access to chiropractic care are less likely to receive opiate medications and spinal surgeries. VA has already been expanding access to chiropractic services for Veterans. Currently, about half of the Level 1a VAMCs have chiropractic clinics, and other facilities offer chiropractic services as well. However, mandating that all VAMCs provide chiropractic services by the end of 2020 is unnecessary. The need for more chiropractic clinics across the VA health care system can most effectively be determined by continually assessing demand for chiropractic services and usage, and adding chiropractic care at those sites as warranted to meet demand. We do not believe it would be prudent as a matter of fiscal or clinical responsibility to increase the number of clinics in areas where demand is insufficient to support investment in such a clinic.

We recommend the legislation not amend the definition of preventive health services in section 1701(9). Chiropractic services are provided as part of the medical benefits package and are administered based on clinical need, similar to all other medical care. It would be inconsistent with the professional standards for other medical disciplines and inappropriate to provide periodic and preventative chiropractic examination and services when there are no clinical indications that such care is needed.

VA estimates S. 609 would cost \$1.68 million in FY 2018, \$60.23 million over 5 years, and \$155.9 million over 10 years.

S. 681 Deborah Sampson Act

S. 681 would amend title 38 of the U.S. Code to seek to improve the benefits and services provided by VA to women Veterans in a variety of ways.

Section 101 would require VA to carry out a 3-year pilot program to assess the feasibility and advisability of facilitating peer-to-peer assistance for women Veterans, including those who are separating or are newly separated from service in the Armed Forces, with an emphasis on women who suffered sexual trauma during their service, have posttraumatic stress disorder or suffer from another mental health condition, or are otherwise at risk of becoming homeless. Peer-to-peer assistance would consist of: (1) providing information about VA services and benefits, and (2) employment mentoring. VA would be required to commence the pilot program no later than January 1, 2018, and conduct outreach to inform women Veterans about the pilot program and assistance available under the pilot program. The pilot program may include training and the development of training materials for peer counselors. Under the pilot program, VA would be required to coordinate with specified government and community organizations to facilitate the transition of women Veterans into their communities. VA would also be required, to the degree practicable, to coordinate the pilot program with the Transition Assistance Program carried out under 10 U.S.C. § 1144.

VA supports section 101. Women Veterans who experienced military sexual trauma, who have mental health conditions, and/or who are at risk of becoming homeless face numerous barriers in seeking and accessing assistance, including through VA. Such women Veterans are considered to be among VA's most clinically complex patients. The program that would be required by section 101 has the potential to offer meaningful and powerful support to assist these women Veterans in connecting with needed services and assistance. Although section 101 would focus the provision of information about VA services and benefits and provision of employment mentoring, VA's experience with its existing peer program suggests that perhaps the biggest benefit the program would offer would be role modeling and the instillation of hope, as peer specialists have already overcome many of the obstacles the participants are experiencing.

Section 101 would expand VA's existing, well-established peer support program, which has demonstrated effectiveness in assisting Veterans in outpatient, inpatient, and residential mental health settings who are struggling with issues such as posttraumatic stress disorder, substance use disorders, serious mental illness, and homelessness. These programs include women Veterans, and there are many women Veterans currently working as mental health peer specialists in VA. VA believes that, if enacted, development of this program would have to proceed carefully given the complexity of the clinical needs of the target population. In this context, the bill's proposed creation of a pilot program seems most appropriate.

VA estimates section 101 would cost approximately \$723,000 in FY 2018 and approximately \$3.7 million over the 3 years of the program.

Section 102 would require VA to expand the capabilities of the Women Veterans Call Center of the Department to include a text messaging capability.

VA supports section 102. To meet the needs of women Veterans, VA needs to provide information and answer questions via methods that are convenient to them. The Women Veterans Call Center routinely answers questions by phone and by chat, and the logical next step would be to provide convenient and accessible information for women Veterans via text messages. VA understands that women Veterans have expressed interest in such a text messaging capability. VA currently includes a text messaging response capability for its Veterans Crisis Line.

VA estimates section 102 would cost approximately \$174,000 in FY 2018, \$924,000 over 5 years, and \$2.0 million over 10 years.

Section 103 would amend section 1712A of title 38, U.S.C., to authorize VA to furnish counseling in group retreat settings to persons eligible for Readjustment Counseling Services from VA. The reintegration and readjustment services furnished would include information on reintegration of the individual into family, employment, and community; financial counseling; occupational counseling; information and counseling on stress reduction; information and counseling on conflict resolution; and such other information and counseling as the Secretary considers appropriate. VA would be required to offer women the opportunity to receive such services in group retreat settings in which the only participants are women. These readjustment and counseling services would be available upon the request of the individual.

VA supports section 103. We agree that providing these retreats is beneficial to women Veterans, and believe other Veteran and Servicemember cohorts could also benefit from this treatment modality. Examples include those who have experienced military sexual trauma, Veterans and their families, and families that experience the death of a loved one while on active duty.

VA estimates that section 103 would cost approximately \$467,000 to conduct six retreats in FY 2018, \$2.5 million over 5 years, and \$5.6 million over 10 years.

Section 201 would require VA to establish a partnership with at least one non-governmental organization to provide legal services to women Veterans, focused on the 10 highest unmet needs of women Veterans as set forth in the most recently completed Community Homelessness Assessment, Local Education and Networking Groups for Veterans (CHALENG for Veterans) survey.

VA supports section 201. The consistency of legal issues arising in VA's annual CHALENG survey strongly suggests a relationship between Veterans' unmet legal needs and the risk of becoming homeless. Legal issues can be a significant barrier to

resolving homelessness, as these issues may be discovered in background checks conducted by landlords and employers, subsequently resulting in rejections for leases and employment offers. Additionally, legal issues may result in seizure of income or bank accounts, making it impossible to pay rent, or could result in the suspension of a driver's license, creating significant challenges for Veterans seeking employment or needing health care. A number of organizations stand ready to serve homeless or at-risk Veterans with legal services, but face financial limitations on their capacity to do so. The declining accessibility of civil legal aid, combined with persistent indicators of unmet need for it among Veterans, indicates that this passive approach is no longer viable. Providing additional funding for legal assistance would have a direct bearing on the housing stability of Veteran households. However, male Veterans who are homeless are also in need of legal services, as demonstrated by the CHALENG survey referenced in the proposed legislation. In the most recent CHALENG survey, five of the top ten unmet needs amongst both male and female homeless Veterans are legal needs, such as evictions/foreclosures, outstanding warrants/fines, child support, restoration of drivers' licenses, and discharge upgrades. Consequently, we recommend the bill be modified to make legal assistance available for both male and female Veterans needing such aid.

We note, though, that it is unclear what exactly is contemplated by entering into a "partnership" with a non-governmental organization. Typically, VA provides grants (when authorized by statute) or enters into contracts or cooperative agreements with non-governmental organizations to provide services, particularly to homeless Veterans. However, with only the term "partnership" in the bill, it is unclear that it would provide clear authority for VA to expend Federal funds to support legal services for women Veterans; VA would require more explicit authority in that regard. It is also unclear why the provision only mentions "at least one nongovernmental organization," to potentially exclude other public entities from participation. VA would be happy to discuss this section further with the Committee to understand better what is intended, and we would be pleased to provide technical assistance upon request.

Section 202 would amend section 2044(e) of title 38, U.S.C., to authorize additional amounts for the Supportive Services for Veteran Families (SSVF) grant program to support organizations that have a focus on providing assistance to women Veterans and their families. Specifically, section 202 would amend paragraph (1)(E) to strike 2017 and insert 2016, and add a new subparagraph (F) providing that \$340 million shall be available to carry out the SSVF grant program for each of FYs 2017 and 2018. In addition, section 202 would add a new paragraph (4) providing that not less than \$20 million shall be available under paragraph (e)(1)(F) for the provision of financial assistance to organizations that have a focus on providing assistance to women Veterans and their families.

VA supports section 202. SSVF is designed to rapidly re-house homeless Veteran families and prevent homelessness for those at imminent risk due to a housing crisis. Funds are granted to private non-profit organizations and consumer cooperatives that will assist very low-income Veteran families by providing a range of supportive

services designed to promote housing stability. In FY 2016, 13.3 percent of Veterans served by SSVF were women, the largest such percentage of any homeless services program. As women represent only 8 percent of the homeless Veteran population, it is evident that SSVF's unique blend of services and capacity to serve all household members, including dependent children, has been successful at addressing the needs of homeless women Veterans. Further evidence of this success can be found in the composition of SSVF enrolled households headed by women Veterans: 42 percent have dependent children compared to just 18 percent for men. The unique needs of these households led by women Veterans have imposed increased demands upon SSVF grantees, justifying a commensurate increase in resources to organizations providing support to these families.

The SSVF program supports rapid re-housing interventions. Such interventions generally are defined as permanent housing opportunities and, therefore, are likely subject to fair housing laws. It may be helpful for the bill to be amended to indicate that recipient organizations that have a focus on providing assistance to women and their families would still be subject to complying with all Federal fair housing laws.

VA estimates section 202 would result in additional costs of \$20 million for FY 2017 and FY 2018.

Section 301 would amend section 1786 of title 38, U.S.C., to extend from 7 to 14 days coverage of newborns of a woman Veteran receiving delivery care.

VA supports section 301. A newborn needing care for a medical condition may require treatment extending beyond the current 7 days that are authorized by law. Additionally, the standard of care is to have further evaluations during the first two weeks of life to check infant weight, feeding, and newborn screening results. Pending these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may apply, including monitoring stability of the home environment or providing clinical and other support if the newborn requires monitoring for a medical condition. Extending care to 14 days would provide time for further evaluations appropriate for the standard of care, as well as sufficient time to identify other health care coverage for the newborn.

VA estimates section 301 would cost \$8.8 million in FY 2018, \$46.6 million over 5 years, and \$100.6 million over 10 years.

Section 302 would amend section 1786 of title 38, U.S.C., to clarify that amounts paid by VA for medically necessary travel in connection with health care services furnished under this section would be derived from the Medical Services appropriations account.

VA supports the intent of section 302. While most travel of a newborn is not a concern as the mother and newborn travel together to appointments, for those newborns that require transport from a community hospital to a neo-natal intensive care

unit by ambulance or helicopter, VA lacks clear authority currently to pay for this travel if the care is exclusively for the newborn. However, we are concerned the language in this section, which refers only to a source of funding for such travel, does not specifically authorize VA to furnish or pay for such transportation expenses under 38 U.S.C. § 1786.

Depending on how the bill is interpreted, we estimate section 302 could cost approximately \$587,000 in FY 2018, \$3.95 million over 5 years, and \$11.86 million over 10 years.

Section 401 would require VA to retrofit existing VA medical facilities with fixtures, materials, and other outfitting measures to support the provision of care to women Veterans at such facilities. Within 180 days of enactment, VA would be required to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a plan to address deficiencies in environment of care for women Veterans at VA medical facilities. There would be authorized to be appropriated \$20 million in addition to amounts otherwise available to VA to carry out this section.

While we appreciate the intent of this provision, we do not support section 401. VA currently has the authority, and has made it a priority, to renovate or improve its facilities to protect the privacy, safety, and dignity of women Veterans. We are concerned that subsection (a), for example, would legislate specific requirements that are better addressed through current construction standards. These standards are subject to review and revision on a regular basis, which provides flexibility for VA to identify and prioritize emerging needs. A statutory requirement would provide no such flexibility.

We believe the current process for identifying needs and obligating available resources to remedying them is more appropriate and better for Veterans. While we currently have authority to, and in fact do, conduct routine evaluations of our facilities to identify deficiencies, we would have no objection to a requirement for a recurring, system-wide assessment to identify deficiencies, similar to the requirement contemplated in subsection (b). We recommend that such a review occur only periodically, as some projects can take several years to complete, and that VA be given flexibility to take the time it needs to complete these reviews thoroughly and accurately instead of attempting to complete them within a statutory deadline. Such a revised requirement to review medical facilities would provide a comprehensive list of the specific needs of each facility. We would be happy to discuss our thoughts on this further with the Committee and to provide technical assistance as needed.

Without having completed a current, comprehensive review, we are unable to estimate the cost of section 401. However, we have reason to believe the costs for retrofitting every VA medical facility would be more than the \$20 million that would be authorized for appropriation under subsection (c).

Section 402 would require VA to ensure that each VA medical facility has at least one full-time or part-time women's health primary care provider whose duties include, to the extent possible, providing training to other VA health care providers on the needs of women Veterans.

VA fully supports the intent of section 402, but notes that the provision is unnecessary because VA already has authority to employ women's health primary care providers, resources permitting. Currently, approximately 475,000 women Veterans receive care at a VA facility, and there are approximately 2,500 designated women's health providers in our health care system. There are 102 VA sites of care without a designated women's health provider. For many sites, there is no justification to hire a full-time designated women's health provider due to the small number of women Veterans assigned to the clinic, so instead, VA trains an existing provider who will treat both men and women on their panel. There is approximately a 20 percent turnover each year for women's health providers, so training new providers is a constant need.

Section 403 would require VA to ensure that the VA Women Veteran Program Manager program is supported at each VAMC with a Women Veteran Program Manager and a Women Veteran Program Ombudsman, and that such individuals receive the proper training to carry out their duties.

VA supports the intent of section 403 in part. Currently, VHA Directive 1330.01, Health Care Services for Women Veterans, requires each VA health care system to have a full-time Women Veterans Program Manager. To that extent, the legislation is generally consistent with current practice. At the end of FY 2016, VA had 130 permanent Women Veteran Program Managers, 9 acting managers, and 1 vacancy. VA conducts training for these managers both virtually and face-to-face. VA does not support the requirement to appoint a Women Veteran Program Ombudsman, as we think this would be duplicative of services already available to women Veterans through the Patient Advocate Program.

Section 404 would authorize to be appropriated \$1 million for each fiscal year for the Women Veterans Health Care Mini-Residency Program to provide opportunities for participation by primary care and emergency care clinicians. The \$1 million would be authorized to be appropriated in addition to amounts otherwise made available to VA for purposes of this program.

VA supports section 404. Today, women are the fastest growing subgroup of U.S. Veterans. There are more than 2.2 million women Veterans in the United States, and women make up 15.1 percent of today's active duty military and 18.8 percent of National Guard and Reserve forces; the number of women Veterans is expected to grow in the future. VHA's efforts to train clinicians to meet the needs of an ever increasing number of women Veterans seeking care has included large scale initiatives to deploy core curricula covering the highest priority topics in women's health care (i.e., "Women's Health Mini-Residencies"). VA has developed four mini-residency programs

in recent years and offers mini-residency programs as large, national training conferences each year. Since 2008, VA has provided mini-residency training to over 3,000 primary care providers and more recently to approximately 500 primary care nurses and 250 emergency care providers and nurses. However, there is an ongoing need to train additional primary care and emergency care providers in the care of women Veterans to ensure that equitable, high-quality care is provided at all VA sites.

VA estimates section 404 would cost approximately \$920,000 in FY 2018, \$4.84 million over 5 years, and \$9.84 million over 10 years.

Section 501 would require VA to collect and analyze data on each VA program that provides a service or benefit to a Veteran, to disaggregate such data by sex and minority status when the data lend itself to such disaggregation, and to publish the data collected and analyzed, except for such cases in which the Secretary determines that some portions of the data would undermine the anonymity of a Veteran.

VA opposes section 501 because we are concerned about the breadth and potential implications of this legislation. While VA tracks various demographic information about Veterans, it does so only to the extent that these factors are related to eligibility for benefits or services or would assist in the delivery of benefits or services. Many programs and services offered by VBA and the National Cemetery Administration (NCA) do not differ in any way based upon gender, race, ethnicity, or other factors. Many of VHA's programs, though, do collect this information, as it is critical to providing quality health care. Moreover, many of our existing forms do not collect this information, or at least do not require a respondent to report such information (for example, for race or ethnicity). If the legislation is intended to require VA to collect this information, such an effort would increase costs for Veterans and VA. VA could be forced to remove other, more mission-critical collections of information to account for these costs in order to reduce the burden on the public. New requirements could also duplicate other reporting requirements if, for example, this section also applied to grants programs.

We would appreciate the opportunity to discuss this section to better understand specifically what information this provision is intended to produce. VA would be happy to provide such information upon the Committee's request, but we do not believe a statutory requirement to provide such information would be appropriate.

VA is unable to develop a cost estimate for this section at this time because we are unsure of the intended scope and effect of this provision.

Section 502 would require VA, not later than 1 year after the date of enactment, to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the availability from VA of prosthetics made for women Veterans, including an assessment of the availability of such prosthetics at each VA medical facility.

VA does not support section 502. VA provides comprehensive prosthetic and sensory aids and services that support and optimize the health and independence of all Veterans, regardless of gender. While VA does not oppose providing a national report at the end of each FY detailing the types of prosthetic items, quantity of items, and amount expended on women Veterans, VA opposes providing an assessment of the availability from VA of prosthetics made for women Veterans, including an assessment of the availability of such prosthetics at each medical facility of the Department. We oppose this provision because the process for procuring prosthetic items for Veterans is initiated by the clinician. Hence, the types of prosthetic items cannot be predicted due to prescription dependency on medical necessity. VA could produce a retroactive report regarding the type of prosthetic items provided to women Veterans, but providing a report on the availability of such items at a specific point in time would not provide meaningful information.

We estimate that section 502 would not have significant costs.

Section 503 would require VA to survey its Internet websites and information resources and publish a website that serves as a centralized source of information about VA benefits and services available to women Veterans. The website would provide women Veterans with information about all services available in the district where the Veteran is seeking such services, including the name and contact information of each women's health coordinator, a list of appropriate staff for other benefits from VBA and NCA, and any other information the Secretary considers appropriate. VA would be required to update the information on the website at least once every 90 days. Outreach conducted under 38 U.S.C. § 1720F(i) would include information about the website. VA would be directed to derive funds for this section from the amounts made available to publish VA internet websites.

VA supports the intent of section 503, but the provision is unnecessary because VA can accomplish the objectives of the provision under existing authority. VA already has in place for each medical center a website specific to women Veterans that highlights the services available and a point of contact at the facility. In addition, VA offers two national websites that offer facility locators on the site. The website required by section 503 would complement this information and could be more accessible to Veterans.

Section 504 would express the sense of Congress that the Secretary should change the motto of VA to be more inclusive. VA defers to Congress in terms of expressing its sense on policy matters.

S. 764 Veterans Education Priority Enrollment Act of 2017

S. 764 would add a new section, 3680B, to subchapter II of chapter 36 of title 38 U.S.C. that would prohibit the Secretary or a State Approving Agency (SAA) from approving a program of education offered by an institution that allows certain students priority enrollment, unless the institution allows "covered individual[s]" to enroll at the

earliest possible time pursuant to such a priority enrollment system. “Covered individual[s]” would be those individuals using educational assistance under chapters 30, 31, 32, 33, or 35 of title 38, U.S.C.; or under chapter 1606 or 1607 of title 10, U.S.C.

VA supports the intent of S. 764 but has some concerns. As currently written, the proposed legislation would not impact programs that are “deemed approved” as per the provisions of 38 U.S.C. § 3672(b)(2)(A), which includes accredited standard college degree programs at public and private, not-for-profit institutions of higher learning. If the intent is to have the requirement apply to programs at all types of institutions, then VA recommends inserting a conforming amendment to add reference to the new proposed section 3680B to the list of requirements affecting “deemed approval” section 3672(b)(2)(A) of title 38, U.S.C.

In addition, while the proposed amendment prohibits the Secretary or a SAA from approving programs that do not meet the specified criteria, it does not clearly require the disapproval of non-compliant programs that were approved prior to enactment or that cease to be compliant after approval. If the disapproval of non-compliant programs is intended to be a requirement as well, then we would recommend that this be specified in the bill as well. In the event that program disapproval is desired, VA would also suggest a future effective date of 12 months from the date of enactment in order to allow time for schools to change their policies and, thus, minimize the disruption of the educational pursuits of beneficiaries that are currently enrolled in such programs.

VA supports the intent of S. 764, and is willing to provide technical assistance as needed to ensure that the bill has the intended outcome.

VA does not have a cost estimate for this bill at this time.

S. 784 Veterans’ Compensation Cost-of-Living Adjustment (COLA) Act of 2017

S. 784 would require the Secretary to increase the rates of disability compensation and Dependency Indemnity Compensation by the same percentage as any increase to Social Security benefits effective on December 1, 2017. The bill would also require VA to publish these increased rates in the Federal Register.

VA strongly supports this bill because it would express, in a tangible way, this Nation’s gratitude for the sacrifices made by our service-disabled Veterans and their surviving spouses and children. The bill would also ensure that the value of these benefits keeps pace with increases in consumer prices.

VA estimates the cost of this bill to be \$1.3 billion in FY 2018, \$8.1 billion over 5 years, and \$17.5 billion over 10 years. However, the cost of these increases is included in VA’s baseline budget because VA assumes that Congress will enact a cost-of-living adjustment each year. Therefore, enactment of the bill would not result in additional costs, beyond what is included in VA’s baseline budget.

S. 804 Women Veterans Access to Quality Care Act

S. 804 would seek to improve the provision of health care for women Veterans by VA through several different provisions.

Section 2 would require VA to establish standards to ensure that all VA medical facilities have the structural characteristics necessary to adequately meet the "gender specific" health care needs, including privacy, safety, and dignity, of Veterans at these facilities. VA would be required to promulgate regulations within 180 days of the date of enactment to carry out this section. Within 270 days of the date of enactment, VA would be required to integrate these standards into the prioritization methodology used by VA with respect to requests for funding of major medical facility projects and major medical facility leases. Not later than 15 months after the date of enactment, VA would be required to report to the Committees on Veterans' Affairs of the House and Senate on the standards established under this section, including a list of VA medical facilities that fail to meet the standards; the minimum total cost to ensure that all VA medical facilities meet such standards; the number of projects or leases that qualify as a major medical facility project or major medical facility lease; and where each such project or lease is located in VA's current project prioritization.

VA appreciates the intent of section 2, but we do not believe it is necessary given other actions we are already taking. For example, in 2012, VA developed and published a Space Planning Criteria Chapter for Women Veterans Clinical Service, which identifies space standards for the delivery of primary care services to Women Veterans Clinical services within VA. These space standards support care for women Veterans from basic primary care to ultrasound and mammography services. A standard examination room plan for Women Veterans Clinics was developed including access to bathroom facilities directly connected to the examination room and including such details as privacy curtains, locking hardware, and exam table placement. VA's Medical/Surgical Inpatient Units and Intensive Care Nursing Units Design Guide, developed in 2011 and 2012, addresses the needs of women Veterans. These standards are available online at: www.cfm.va.gov/TIL. Since 2012, the health care needs of women Veterans have been an instrumental consideration in the development and update of the standards that are utilized in the planning and design of all VA facilities to support the delivery of Veterans' health care. Moreover, it is unclear why VA would need to promulgate regulations for this section. Absent the requirement in the bill, VA would not need to promulgate regulations. VA's construction standards have been established through policy for years, and revising our standards through this process is less resource intensive and faster than formal regulations.

Section 3 would require VA, not later than 60 days after the date of enactment, to establish policies for environment of care inspections at VAMCs. These inspections would include an alignment of the requirements for such inspections with the women's health VHA Handbook, a requirement for the frequency of such inspections, and a delineation of the roles and responsibilities of staff at the VAMC who are responsible for compliance. It would also require the Secretary to certify to the Committees on

Veterans' Affairs of the House and Senate that the policies required under this section have been finalized and disseminated to VAMCs.

VA also appreciates the intent of section 3 but does not believe this provision is necessary because VA established a Comprehensive Environment of Care (CEOC) Program policy in February 2016. VHA Directive 1608, Comprehensive Environment of Care (CEOC) Program, outlines the requirements of a CEOC Program and assigns responsibilities and accountability from VA Central Office, through the Veterans Integrated Service Network (VISN), to the medical centers, detailing the requirements for leadership involvement, routine environment of care rounds, discipline-based standardized checklists, and a requirement to identify and track deficiencies through resolution. VHA Directive 1608 is aligned with VHA Directive 1330.01, Health Care Services for Women Veterans, and VA believes this meets the intent of the proposed language in the bill. We note that the bill specifically refers to a "women's health handbook", but the current form of this policy is in a Directive. We recommend the language be revised to simply refer to a "policy", rather than either a "handbook" or a "directive" to avoid possible confusion.

Section 4 would require the Secretary to use health outcomes for women Veterans furnished hospital care, medical services, and other health care by VA in evaluating the performance of VAMC directors. It would also require VA to publish on an Internet Web site information on the performance of directors of VAMCs with respect to health outcomes for women Veterans, including data on health outcomes pursuant to key health outcome metrics, a comparison of how such data compares to data on health outcomes for male Veterans, and explanations of this data to help the public understand this information.

VA already is focused on tracking access and outcomes for women Veterans, and on addressing disparities in care, and thus we do not believe section 4 is necessary. VA has a robust method for evaluating ambulatory care using the Healthcare Effectiveness Data and Information Set (HEDIS) measures and inpatient care quality using The Joint Commission ORYX® measure set. VA also evaluates Veteran assessments of their health care experiences by administering the Consumer Assessment of Healthcare Providers and Systems survey that focuses on inpatient and outpatient services. Both the clinical quality measures and Veteran experience measures are collected for men and women, so that comparative analyses and reporting are possible. These results are used to assess individual medical center Directors and to compare facility results to internal and external benchmarks. Results also are posted on a publicly available internet Web site.

Section 5 would seek to increase the number of obstetricians and gynecologists employed by VA. Paragraph (a) of this section would require, not later than 18 months after enactment, that VA ensures that every VAMC have a full-time obstetrician or gynecologist.

VA supports the intent of section 5(a) and already is taking steps to expand access to gynecological care throughout VA. Currently, approximately 76 percent of VAMCs have a gynecologist on staff, and we plan to add this service at roughly another 20 facilities. This will ensure that all facilities with a surgical complexity of intermediate or complex will have a gynecologist on staff. At facilities with a surgical complexity designation of standard or less, we do not believe that there is sufficient patient demand to support a full-time gynecologist or obstetrician. For Veterans needing these services at these facilities, VA uses its community care authorities to ensure these Veterans are able to access care. Moreover, in some areas of the country, particularly in smaller or more rural areas, VA faces recruitment challenges in hiring new staff, and we anticipate we would face similar challenges if this legislation were enacted.

Paragraph (b) of section 5 would require VA, within 2 years of enactment, to carry out a pilot program in not fewer than three VISNs to increase the number of residency program positions and graduate medical education positions for obstetricians and gynecologists (OB-GYN) at VA medical facilities.

VA supports the intent of paragraph (b) of section 5, and would respectfully submit that VA already has this authority and is using it. VA currently funds 31 OB-GYN residency positions across 40 sites. Family Medicine also provides many aspects of gynecological care that meet the needs of women Veterans for which VA funds 154 residency positions at 81 VAMCs. We would welcome Committee feedback as to how we could improve these efforts. While gynecologic services are widely available across VA, the limited number of women Veterans seeking care and the scope of services at some sites makes it difficult to provide the educational resources to fulfill the accreditation needs for training in obstetrics and gynecology. This limits an approach to national increases in these residency positions. A three VISN pilot program would be limited in its ability to start within 2 years given the need to develop relationships with residency programs in this area, as well as understand the needs of women Veterans in those VISNs.

Section 6 would require VA to develop procedures to share electronically certain information with State Veterans agencies to facilitate the furnishing of assistance and benefits to Veterans. The information would include military service and separation data, a personal email address, a personal telephone number, and a mailing address. Veterans would be able to prevent their information from being shared with State Veterans agencies by using an opt-out process to be developed by VA. VA would be required to ensure that the information shared with State Veterans agencies is only shared by such agencies with county government Veterans service offices for such purposes as VA would determine for the administration and delivery of assistance and benefits.

VA believes strong relationships with State Veterans agencies, as well as outreach to Veterans, are critical. However, we do have concerns with this section. The information required, we believe, would have Privacy Act implications. Also, managing opt-out requests would require additional resources, although the amount

cannot be projected with specificity. We would be glad to discuss with the Committee VA's collaborative efforts with State Veterans agencies on outreach and how the goals of section 6 could be fulfilled while avoiding the concerns expressed above.

Finally, section 7 would direct VA to carry out an examination of whether VAMCs are able to meet the health care needs of women Veterans and to submit this report within 270 days of enactment. Again, we would respectfully submit that VA has this authority, and is using it in this way. VA fully agrees with the importance of assessing access for women Veterans and implementing comprehensive primary care at all sites. We are already tracking wait times, access, the number of designated women's health providers at each site, recruitment efforts, and staff training. VA believes that the additional examination required by this section is unnecessary as it would include examining sites that we know are performing well. VA has begun efforts to use evaluation data to work with those sites that have challenges to assist them in improving services for women Veterans. Since 2010, VA has assessed the implementation of comprehensive women's health through national site visits. Women's Health Services contracted with a private company to develop the methodology, metrics, and tools needed to evaluate Women's Health Programs (WHP) across VA. By end of FY 2016, 100 percent (140) of the VA health care system WHPs comprehensive evaluations were completed. Additionally, VA monitors access, including wait time data, for women Veteran appointments. VA also has evaluated disparities in health outcomes since 2008, and we lead the Nation in reducing health disparities for women Veterans.

VA estimates a contract to conduct the examination and prepare the report required would cost approximately \$10.3 million.

S. 899 VA Transition Improvement Act

VA supports S. 899, which would require VA to establish a leave transfer program for the benefit of health care professionals appointed under 38 U.S.C. § 7401(1) and authorize the establishment of a leave bank program for the benefit of such health care providers. Inclusion of this provision would ensure that disabled Veteran employees performing health care services in Title 38 occupations have the same opportunity to schedule medical appointments and receive medical care related to their disability without being charged leave as employees in Title 5 and Hybrid Title 38 occupations. The bill would also provide disabled Veteran employees an opportunity to undergo medical treatments for their disabilities without having to consider their leave balances or work-life issues to obtain such services outside of scheduled work hours.

It is projected that VA will continue to hire Veterans with service-connected disabilities of 30 percent or greater into Title 38 occupations at a rate that mirrors the current percentage (3.5 percent) of employees occupying such positions within VHA. VA estimates that this legislation would be cost neutral as it does not increase full-time employee equivalent levels or salaries of the employees hired into the positions.

S. 1024, Veterans Appeals Improvement and Modernization Act of 2017

Modernizing the appeals process is a top priority for VA. It is more critical than ever that we continue to work together to transform an appeals process that is failing Veterans. There are currently over 470,000 appeals pending in VA, some 40 percent more than were pending only 5 years ago. Those Veterans are waiting much too long for answers on their appeals. Although Veterans wait an average of only 116 days for a decision on VA disability compensation claims, they are waiting an average of 3 years for their appeal to be resolved. Appeals that go all the way to the Board of Veterans' Appeals (Board) take even longer - an average of 6 years to resolve. A system that can deliver an answer on an initial claim in 116 days, but takes many years to resolve an appeal is a system that is not working for Veterans. If appeals reform is not passed, these already unacceptable wait times will only get worse.

S. 1024 would provide much-needed comprehensive reform for the VA appeals process to ensure that Veterans receive a timely, VA decision on their appeal. It would replace the current, lengthy, complex, confusing VA appeals process with a new appeals process that makes sense for Veterans, their advocates, VA, and stakeholders. VA supports the intent of S. 1024; however, we have some concerns with certain provisions in S. 1024 as drafted, such as the provisions that would remove finality from the process upon judicial review and require the Secretary to certify that he has the resources necessary to timely process appeals in the future. We look forward to working with the Committee to address those concerns. The Department stands committed to getting appeals reform accomplished for Veterans this year.

The current VA appeal process, which is set in law, is broken and provides Veterans a frustrating experience. In the current process, appeals have no defined endpoint. Veterans and VA adjudicators are instead engaged in continuous evidence gathering and repeated re-adjudication of the same appeal. This cycle of evidence gathering and re-adjudication means that appeals often churn for years between the Board and the agency of original jurisdiction (AOJ) to meet complex legal requirements, with little to no benefit flowing to the Veteran. The multiple layers of adjudication built into the current appeals process exacerbate delays even more. Jurisdiction is also split between the Board and the AOJ, meaning that Veterans often don't fully understand where in VA their appeal is located any given time. All of this has resulted in a system that is complicated, inefficient, ineffective, and confusing. Due to this complex and inefficient process, Veterans wait much too long for final resolution of their appeal.

Without significant legislative reform, wait times and the cost to taxpayers will only increase. It was this stark reality that led to VA's unprecedented level of collaboration with stakeholders to design a modernized appeals process. The new appeals process contained in S. 1024 would provide Veterans an appeals decision that is timely, transparent, and fair. The new process is not just a VA idea. It is the product of over a year of collaboration between the Board, Veteran Benefits Administration, Veteran Service Organizations, the private bar, and other stakeholders. The new appeals process we designed is simpler and easier for Veterans to understand. It

provides a streamlined process focused on early resolution of appeals, and generating long-term saving for taxpayers. VA is grateful to all of the stakeholders for their contributions of time, energy, and expertise in this effort.

S. 1024 would empower Veterans by providing them with the ability to tailor the process to meet their individual needs – choice that is not available in the current appeals process. Veterans in the new process can pursue one of three different lanes. One lane would be for review of the same evidence by a higher-level claims adjudicator at the AOJ. One lane would be for submitting new and relevant evidence with a supplemental claim at the AOJ, and one lane would allow Veterans to take their appeal directly to a Veterans Law Judge at the Board. In this last lane, the intermediate and duplicative steps currently required by statute to receive Board review, such as the Statement of the Case and the Substantive Appeal, would be eliminated. Furthermore, hearing and non-hearing options at the Board would be handled on separate dockets so these distinctly different types of work can be managed more efficiently.

As a result of this new design, the AOJ would be the claims adjudication agency within VA and the Board would be the appeals agency. This design would remove the confusion caused by the current process, in which a Veteran initiates an appeal in the AOJ, but the appeal is really a years-long continuation of the claim development process. It would ensure that all claim development occurs in the context of a supplemental claim filed with the AOJ, which the AOJ can quickly adjudicate, rather than in an appeal.

Currently, VA has a statutory duty to assist the Veteran in the development of a claim for benefits. This duty includes obtaining relevant Federal records, obtaining other records identified by the claimant, and providing a medical examination in certain circumstances. The new design contains a mechanism to correct any duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim/appeal would be returned to the AOJ for correction unless the claim/appeal could be granted in full. However, the Secretary's duty to assist would not apply to the lane in which a Veteran requests higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim. Moreover, S. 1024 would require VA to modify its claims decision notices to ensure they are clearer and more detailed. This notice would help Veterans and their advocates make informed choices as to which a review option makes the most sense.

The disentanglement of processes achieved by S. 1024 would be enabled by one crucial innovation. In order to make sure that the Veteran fully understands the process and can adapt to changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have 1 year to seek further review while preserving an effective date for benefits based upon the original filing date of the claim. For example, a Veteran could go straight from an initial AOJ decision to an appeal to the Board. If the Board decision was not favorable, but helped the Veteran understand what evidence

was needed to support the claim, then the Veteran would have 1 year to submit new and relevant evidence to the AOJ in a supplemental claim without fearing an effective-date penalty for choosing to go to the Board first. The robust effective date protections built into the draft bill enhance Veterans' rights and ensure that Veterans and their advocates cannot make a wrong turn in navigating the new appeals process.

Beyond stopping the flow of appeals into the existing broken system, S. 1024 provides opt-ins to allow as many Veterans as possible to benefit from the streamlined features of the new process. A claimant who receives a decision after enactment and prior to the applicability date of the law could elect to participate in the new process, which would give VA discretion regarding whether to apply the new process to the claimant. However, while subsection (x)(3) envisions the possibility of processing individual claimants who opt-in under the new system prior to the applicability date, as a practical matter, VA cannot realistically offer the new system on a piecemeal basis before the entire new system is ready, which in turn depends on the certification date. Therefore, in practice, only Veterans who receive notice of decision within the 1 year period prior to the effective date of the law would be able to opt-in. Veterans who received an earlier notice of decision would not be able to submit a timely appeal into the new process within 1 year of their decision. Also, a claimant who receives a statement of the case or supplemental statement of the case in a legacy appeal could elect to participate in the new appeals system.

While VA strongly supports the fundamental features of the new process outlined in S. 1024, we have concerns with some aspects of the proposed legislation as presently drafted, as discussed below.

VA opposes a substantive change that would make the effective date protection afforded by the filing of a supplemental claim within 1 year of a decision applicable to supplemental claims filed within 1 year of a decision by the United States Court of Appeals for Veterans Claims (CAVC). This provision goes against an essential construct of the new process, which encourages Veterans to stay within VA to achieve the earliest resolution possible. It would be unfortunate to eliminate sources of unnecessary churn in VA, only to create new incentives for endless appeal at the CAVC. To the greatest extent possible, judicial review should be for substantive legal disagreements between a claimant and VA, not for record development questions that can easily be obviated simply by pursuing additional development and assistance in the supplemental claim lane.

With regard to applicability and the proposed certification of the readiness to carry out the new system by the Secretary, the requirement that the Secretary submit a statement to Congress that he has the resources necessary to timely operate the system is problematic, given the annual budget cycle. While VA will be prepared to implement the new system at the end of the 18-month period prescribed in S. 1024 and shut off the flow of appeals to the broken process, the Secretary cannot predict the outcome of future budget cycles. Therefore, the Secretary will only be able to make a

certification regarding resources available at the time of the certification and not into the future.

Moreover, if S. 1024 was enacted with this provision, it would create significant uncertainty in implementing the opt-in component of the law. We note that S. 1024 provides VA discretion to apply the new process to claimants who elect to participate in the modernized appeals system at any time after enactment and before the applicability date. The applicability date in S. 1024 is necessarily indeterminate because it depends upon when the Secretary will be able to certify under subsection (x)(1) that VA has the resources it needs to operate the modernized system; it is not possible to know when the one year period allowing claimants the functional ability to elect begins. As previously noted, although S. 1024 does not set the 1 year period for opt-ins, current law provides that claimants must submit a notice of disagreement within 1 year of a decision, and it will not be administratively feasible to provide claimants with the new system on a piecemeal basis before the administrative and regulatory work necessary to stand up the new system is complete. In order to provide Veterans with meaningful choice in how their appeal is handled, we must be able to inform them as to whether they will have the option of appealing into the new system. We would be happy to continue working with the Committee to discuss alternative approaches to the applicability date of the law.

S. 1024 also adds notice requirements to higher-level review and Board decisions, for the purpose of explaining whether the claimant submitted evidence that was not considered, and if so, what the claimant or appellant can do to have that evidence considered. VA views this addition as unnecessary, as a claimant who had elected either a higher-level review or an appeal to the Board would have already received notice addressing all lane options in the new process, including restrictions on the submission of new evidence. They would also be aware of the option to file a supplemental claim, where they would have the opportunity to submit new evidence for consideration by the AOJ. Additionally, the issue of how to handle improperly submitted evidence is an administrative matter that would best be determined by VA.

S. 1024 also includes reporting requirements that we believe could be adjusted to be less onerous but still provide valuable information to the Congress. We look forward to working with the Committee to better shape these provisions in a manner that achieves adequate protection for Veterans and robust information for Congressional oversight, while at the same time using administrative resources wisely.

VA stands ready to provide additional technical assistance on several other aspects of the proposed legislation. We appreciate any opportunity to work with Congress to further refine this legislation.

S. 1094 Department of Veterans Affairs Accountability and Whistleblower Protection Act

S. 1094, the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017, would amend and create a number of new authorities regarding the Department of Veterans Affairs (VA) employment practices.

VA strongly supports the aims of this bill, which would improve our oversight and investigation of whistleblower disclosures and retaliation complaints, and allow for more timely disciplinary action against employees whose misconduct or poor performance undermines Veterans' and the public's trust in VA care and services. We deeply appreciate the Committee's efforts to understand and meet VA's needs for greater flexibility in dealing with under-performing and misbehaving employees. We look forward to continuing to work with the Committee, through the technical assistance process, to resolve a few concerns we have with the bill, including constitutional ones. The Department of Justice (DOJ) has informed us that it also looks forward to working with the Committee in the technical assistance process, to address these constitutional concerns. DOJ believes that this can be done without impeding the aims of the bill.

By our reading, the bill addresses five different policy areas, sometimes in different sections. For ease of discussion, we will summarize our understanding of each of these sections individually, then relay VA's position on these policy areas in general.

Section 101 would establish a new Office of Accountability and Whistleblower Protection, under the leadership of a new Assistant Secretary reporting directly to the Secretary. Among other things, the new office would be responsible for receiving and investigating whistleblower disclosures, and for investigating allegations of misconduct, retaliation and poor performance involving Senior Executives, other specified management officials, and supervisors who are alleged to have retaliated against employees for making whistleblower disclosures. The new Assistant Secretary would also be responsible for recommending disciplinary action against individuals who are found to have committed misconduct, including whistleblower retaliation.

This section would also require the new office to track recommendations made by VA's Inspector General and by external oversight bodies such as the Office of Special Counsel and the Comptroller General, and to provide annual reports to this Committee and to the House Committee on Veterans' Affairs on matters within its responsibility.

Section 102 would strengthen protections for whistleblowers by holding supervisors accountable for promoting such protections and by requiring VA to provide training to all employees on whistleblower processes and protections.

Section 103 would require VA to report to this Committee and the House Committee on Veterans' Affairs on methods used to investigate employees, with an eye towards ensuring that investigations are not used to retaliate against whistleblowers.

Section 201 would provide a new framework for removal, demotion, suspension, reassignment, or reprimand of Senior Executives for misconduct or poor performance. This section would set timelines for pre-decisional due process and provide for post-discipline appeals through an internal grievance process and/or appeal to a U.S. District Court.

Section 202 would provide a new framework for removal, demotion, or suspension of employees who are not in the Senior Executive Service. Like section 201, section 202 would set timelines for pre-decisional process and authorizes post-discipline appeals. This section would provide for appeals to the Merit Systems Protection Board, or for bargaining unit employees through the negotiated grievance process, and would specify that such appeals would be subject to a more deferential burden of proof and penalty review than are applicable under current law.

Section 203 would provide for reduction of retirement benefits for an employee who has been removed from service (or retired with a proposed removal pending) and is convicted of a felony that influenced the employee's performance while employed at VA. This section seeks to provide for pre-decisional due process and for post-decisional appeal to the Office of Personnel Management (OPM).

Section 204 would authorize recoupment of a bonus or award paid to an employee who engaged in misconduct or poor performance prior to receiving the award, where the Secretary determines the award or bonus would not have been paid had the misconduct or poor performance been known prior to payment. Like section 203, this section seeks to provide for pre-decisional due process and for post-decisional appeal to OPM.

Section 205 would provide for recoupment of relocation expenses that were authorized following an act of fraud or malfeasance that influenced the authorization. Like the prior sections, this section seeks to provide for internal pre-decisional due process and an external post-decision appeal to OPM. We have a small technical edit to offer on this section and will provide that separately.

Section 206 would reduce the pre-decisional notice period from 14 days to 10 days for actions against supervisors who are found to have engaged in whistleblower retaliation.

Section 207 would add Medical Center Directors and Network Directors to our title 38 direct hire authority.

Section 208 would align pre-decisional timelines for title 38 adverse actions to match the timelines in sections 201 and 202. This section would also revamp the

appeal process for title 38 disciplinary actions that do not involve issues of professional conduct or competence.

Section 209 would require periodic training for supervisors on whistleblower rights, motivating/managing/rewarding employees, and managing poor performers.

Section 210 would require the Secretary to report to this Committee, and to the House Committee on Veterans' Affairs, on the impact of sections 201-208 on Senior Executive morale, engagement, hiring, promotion, retention, productivity, and discipline.

Section 211 would require the Secretary to measure, collect, and report information on the outcomes of disciplinary actions taken under these new authorities.

As noted, the bill addresses five different policy areas: whistleblower protections, accountability, recoupment authorities, hiring authorities, and reporting requirements. Each of these will be discussed below in turn. By way of technical assistance, we note that the current wording of section 308(a)(1) of title 38 limits VA to seven Assistant Secretaries. That would need to be amended to authorize eight Assistant Secretaries to include the new position established by this bill.

In general, VA is supportive of the sections regarding whistleblower protections and of the Committee's assistance in strengthening whistleblower protections and in enhancing VA's oversight of whistleblower disclosures.

Regarding the accountability provisions, VA is strongly supportive of these sections, which afford the Secretary much-needed flexibilities to hold employees accountable and to take necessary actions more quickly and to sustain well-founded actions on appeal. We believe these authorities would fix some of the legal problems we had exercising the authority contained in the Veterans Access, Choice, and Accountability Act of 2014, and would provide the Secretary with the authority needed to take timely, decisive action.

Several sections of the bill would also address recoupment of pay or benefits. We appreciate the care with which the Congress has drafted these to be narrowly tailored, and to apply only in cases of egregious misconduct.

We strongly support the provisions concerning direct hiring authority, which would provide the Secretary with sorely needed flexibility in hiring top talent into these critical leadership positions. We look forward to working with the Committee to fill in some of the blanks around this new authority, such as what pay authority would apply to these positions and whether and how Senior Executives hired under other authorities could move into or out of these roles.

Finally, several sections of the draft bill would require VA to provide detailed reports to this Committee, and to the House Committee on Veterans' Affairs, on matters relating to whistleblower protections, employee accountability, and Senior Executive

recruitment and management. While we have some concerns about the administrative burden imposed by these requirements, we understand the Committee's interest in such information.

Draft **Veteran Partners' Efforts to Enhance Reintegration (PEER) Act**

The draft bill would require the Secretary to phase in and conduct a program whereby peer specialists would be included in patient aligned care teams at VAMCs to promote the use and integration of mental health services in a primary care setting. Not later than 180 days after the date of enactment, this program would have to be established at not fewer than 10 VAMCs. By not later than 2 years from the date of enactment, it would have to be in place at not fewer than 25 VAMCs. Under the bill, the Secretary would be directed to consider specified factors when selecting sites for this program, but, not fewer than five would have to be established at VA designated Polytrauma Centers, and not fewer than ten would have to be established at other VAMCs. The draft bill would also require that all peer specialist programs established under this mandate: (1) ensure that the needs of female Veterans are considered and addressed; and (2) include female peer specialists. Finally, this measure would establish initial, periodic, and final Congressional reporting requirements, as detailed in the bill.

VA has no objection to the bill, but notes that it is not necessary because VA already has the authority to execute this program. However, we would require additional funding to implement it. We also note that a few technical changes are needed for clarity. This legislation, if enacted, would complement VA's ongoing pilot program (commenced in 2014) whereby peer support through peer specialists has been extended beyond traditional mental health sites of care to include Veterans receiving mental health care in primary care settings. Under the pilot program, trained peer specialists work with VA primary care teams to, in general terms, help improve the health and well-being of other Veterans being treated in VA primary care settings. All 25 sites now have assigned one peer specialist to work in Primary Care at least 10 hours per week. The first cohort of eight sites began seeing Veterans in primary care in January 2016, the second cohort of eight began in August 2016, and the final nine sites began April 1, 2017. To date, the peers in this program have provided services to more than 3,000 Veterans. The response from Veterans, peers, and primary care clinicians has been overwhelmingly positive. Sites made a 1- year commitment to participate in the project, and VA will have a formal program evaluation based on clinical and other outcomes in 2018. It is likely that some of the existing sites will not be able to continue the pilot program after FY 2017 without additional funding.

The bill specifies program participation of female peer specialists. I am pleased to report that women peer specialists are already well represented, with 16.2 percent of the national peer specialist workforce being women. While at first glance 16.2 percent may seem a low rate, please bear in mind that this figure is higher than the percentage of Veterans seeking services through VA who are women. We do recognize, however, that the current number of women Veteran peer specialists in the pilot is unevenly

distributed across the country, with some VAMCs having greater difficulty than others in attracting qualified applicants.

Also, it is unclear if the peers will address substance use disorders under the umbrella of their mental health duties. Given the comorbidity of these issues, the need for integration of substance use disorder identification and care, the need for overdose prevention and links as needed to Medication Assisted Treatment for opioid use disorders, and the need to increase the numbers of Veterans achieving long-term recovery, we recommend that this be clarified and, if possible, included.

We estimate this bill would cost \$4.94 million in FY 2018, \$25.99 million over 5 years, and \$55.48 million over 10 years.

Draft Serving our Rural Veterans Act of 2017

The draft bill would amend 38 U.S.C. § 7406(c) to authorize training and supervision of residents at facilities operated by an Indian tribe, a tribal organization, or the Indian Health Service, Federally-qualified health centers, and community health centers. It would also direct VA, in consultation with the Director of the Indian Health Service, to carry out a pilot program to establish graduate medical education residency training programs at such facilities and to affiliate with established programs. VA would be required to carry out the pilot program at not more than four covered facilities and would carry out the pilot program for a period of 8 years beginning on the date that is 180 days after the date of enactment. VA would be required to reimburse certain costs associated with the program and to enter into agreements with individuals participating in the pilot program under which they would agree to serve a period of 1 year at a covered facility (including a VA facility) service for each year in which the individual participates in the pilot program. The bill would provide terms related to breach of the agreement, loan repayment, and concurrent service. VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate not later than 3 years before the termination of the pilot program on the feasibility and advisability of expanding the pilot program to additional locations and making the pilot program or any part of it permanent. The draft bill would authorize to be appropriated to VA \$20 million per year to carry out the pilot program and would also authorize appropriations for the Secretary of HHS, acting through the Director of the Indian Health Service, and to VA such sums as may be necessary to cover loan repayments under each agency's respective loan repayment programs.

VA supports the draft bill in principle. VA strongly supports the imperative to build Graduate Medical Education capacity in rural and underserved areas with the strategic intent to address a geographically inequitable distribution of the Nation's physician and clinical workforce.

While we appreciate the purpose of this bill, it is likely that a relatively small proportion of the patients seen by residents in such programs would be Veterans, yet VA would incur much of the burden for program initiation and maintenance including

resident salaries, faculty time and development, curriculum development, and recruitment efforts.

Under the draft bill, a medical resident who participates in the pilot program would be eligible for participation in the Indian Health Service Loan Repayment Program under section 108 of the Indian Health Care Improvement Act (section 1616a of title 25, U. S. C.) and the VA Education Debt Reduction Program. The draft bill also would include a period of obligated service (1 year of service at VA for each year of participation in the program). VA supports such a loan repayment and obligated service scheme, but recommends requiring 2 years of service for each year of program participation. Moreover, because residents typically receive a salary and are not obligated, post-residency, to perform services as a result of participating in a residency program, VA requests the authority to concurrently provide educational loan repayment to residents in the program(s) as a tool to recruit highly qualified residents.

VA fundamentally believes that supporting the practice of rural health care in the United States is crucial to fulfilling its mission to provide the highest quality care for Veterans and that we must include within our broad health professions education portfolio a focus on rural health in order to meet our statutory mission to provide medical education for VA and for the Nation. VA endorses educating all physicians regarding the unique health needs of Veterans and providing clinical training opportunities in rural health care delivery systems.

VA estimates the cost of implementation at four sites would be \$20.3 million in FY 2018, \$90.6 million over 5 years, and \$201.8 million over 10 years.

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