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

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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 or Department) programs and services. Joining me today is Dr. Tom Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration (VHA); Brad Flohr, Senior Advisor for Compensation Services, Veterans Benefits Administration; and Carin Otero, Assistant Deputy Assistant Secretary for Human Resources Policy and Planning, Human Resources and Administration.

This written statement includes VA's views on eleven significant bills on important topics. Because of the timing of receipt of two of the bills, we are not able to provide formal views in this statement on S. 1279, the Veterans Health Administration Reform Act of 2017 or the draft bill, "The Department of Veterans Affairs Quality Employment Act of 2017". We also will follow up with the Committee on one section (section 10) of the Veterans Choice Act of 2017. We look forward to providing views at a later time and discussing these bills with you today.

S. 115 Veterans Transplant Coverage Act

S. 115 would add section 1788 to Title 38, authorizing the Secretary of Veterans Affairs (Secretary) to provide for an operation on a live donor to carry out a transplant procedure for an eligible Veteran, notwithstanding that the live donor may not be eligible for VA healthcare. VA would be required to provide to a live donor any care or services before and after conducting the transplant procedure that may be required in connection with the transplant.

VA supports S. 115, contingent on the provision of additional resources to support implementation, although we recommend some clarifications in the bill language. We believe it would be appropriate to limit the duty and responsibility to furnish follow-on care and treatment of a living donor to two years after the procedure is performed by a VA facility. This would be consistent with the recommendations of the United Network for Organ Sharing and the Organ Procurement and Transplant Network. We further recommend that the duty to provide follow-on care and treatment should be limited to that which is "directly related to" the living donor procedure (rather than what "may be required in connection with such procedure," as the bill would provide).

There are other potential issues related to organ transplantation that the bill does not address that we would be pleased to discuss with the Committee in its contemplation of this proposal.

We estimate the bill as written would cost $1.8 million in Fiscal Year (FY) 2018, $9.7 million over 5 years, and $21.5 million over 10 years.

S. 426 Grow Our Own Directive: Physician Assistant Employment and Education Act of 2017

S. 426 would provide new authorities for VA to provide educational assistance and other benefits to support physician assistants (PA).

Section 2 would require VA to carry out a pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as PAs.

Having a pilot program will help alleviate the healthcare workforce shortages in VA by requiring scholarship recipients to complete a service obligation at a VA healthcare facility after graduation and licensure/certification. Additionally, scholarships will enable students to gain academic credentials without additional debt burdens from student loans. Future benefits are gained in reduced recruitment costs as scholarship recipients will have obligated service agreements to fulfill. These service agreement obligations secure the graduates' services for up to three years, which reduces turnover and costs typically associated with the first two years of employment.

While VA supports section 2, contingent on the provision of additional resources to support implementation, we believe that the Congress should provide more flexibility in implementation. The bill is very specific, including in areas such as directing the management structure of the pilot program and the specific criteria for participant eligibility. VA should be afforded the flexibility to implement such a program in a manner that can minimize any unintended consequences and promote consistency across Title 38 programs.

We recommend removing language in paragraph (j) that would require the positions of Deputy Director for Education and Career Development for Physician Assistants and Deputy Director of Recruitment and Retention to be filled by a Veteran and a current employee. The limitation of filling the proposed Deputy Director positions with Veterans only (as opposed to employing Veteran preference) would significantly limit the pool of applicants with the necessary experience and skill sets necessary to successfully carry out the responsibilities of the positions, as well as potentially run afoul of Merit Systems Principles.

The total cost of administering the pilot program under section 2 would be $546,000 in FY 2018 and $2.9 million over 5 years.

Section 3 would add a new section 7618A that would ensure that not fewer than 25 new scholarships in the Health Professional Scholarship Program are awarded each year to individuals for education and training to become physician assistants. It would also add a new section 7676 that would similarly require that 25 new scholarships in the Employee Incentive Scholarship Program be awarded for education and training to become physician assistants.

While VA supports section 3 in principle, and contingent on the provision of additional resources to support implementation, VA already has the authority to dedicate scholarships toward these professions. Similar to section 2, providing these scholarships will help VA address workforce shortages through the required service obligation.

The total cost of section 3 of the Health Professional Scholarship Program (HPSP) with HPSP Stipend cost for 175 awards (35 per year) over five years would be $10.2 million.

Section 4 would require the Secretary of Veterans Affairs to establish standards for the Department for using educational assistance programs to educate and hire PAs. This provision would require that the standards ensure that VA's Educational Debt Reduction Program (EDRP) is available to participants in the PA pilot program. To the maximum extent practicable, VA would be required for each year over a five year period to increase the scholarships amounts under subchapters II and VI of chapter 76, Title 38, and any other relevant educational assistance programs offered by VA for courses of education or training to become physician assistants.

VA does not support this section because EDRP assistance is targeted for specific positions that are designated as difficult to recruit and retain. In order to meet local Veteran population needs, local medical centers have the flexibility to determine the positions that have the most critical need for EDRP awards and advertise accordingly. Loan repayment awards are an attractive tool; however, EDRP is a limited resource and offering EDRP to an entire occupational series would be contrary to the statutory mission of the program and would set a precedent for other occupations to seek similar authority.

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

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

the OIG's top 5 occupations represented 82 percent of all EDRP awards made in FY 2015.

EDRP awards are typically five year awards. If EDRP was offered to every new PA hire, nearly $4.6M would be needed each year for new awards, and additional funding would be required to sustain current participants.

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

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

Alternative approaches may be better suited for strengthening the PA occupation within VA, such as making compensation of PAs the primary driver in recruitment and retention.

VA supports section 5 of the bill, contingent on the provision of additional resources to support implementation, which seeks to eliminate the pay disparity between VA and the private sector.

The cost for 5,250 new EDRP awards over 5 years would be $68.2 million. Salary and development costs are estimated at an additional $792,451, bringing the total cost of this proposal (including cost of living adjustments) to $69 million.

S. 683 Keeping Our Commitment to Disabled Veterans Act of 2017

S. 683 would amend 38 U.S.C. § 1710A to extend until December 31, 2018, the period in which the Secretary shall provide nursing home care to certain Veterans.

VA supports this provision, which would ensure that Veterans in need of nursing home care for a service-connected disability and any Veteran who has a service-

connected disability rated at 70 percent or more are eligible to receive nursing home care.

If the authority in section 1710A continues to be extended, VA estimates the cost would be $4.73 million in FY 2018, $25.13 million over 5 years, and $53 million over 10 years.

S. 833 Servicemembers and Veterans Empowerment and Support Act of 2017

Section 2(a) of S. 833 would amend 38 U.S.C. § 1720D(a)(1) to authorize VA to provide a Veteran with counseling and care and services determined (by a VA mental health professional) to be needed to overcome psychological trauma resulting from cyber harassment of a sexual nature.

VA supports this subsection in principle, but we do not believe it is necessary because of VA's current authority. Under section 1720D, VA is authorized to provide counseling and treatment for trauma resulting from sexual harassment (defined as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character"), and this can include sexual harassment that is conducted through verbal or cyber contact, including the use of Internet social media services. We also note that the phrase "cyber harassment of a sexual nature" is ambiguous, and it is unclear exactly what the drafter intends to cover. It would also be helpful to clarify whether the bill is intended to extend eligibility to those who were the victim of cyber harassment in only one instance or if, as is the case with the definition of sexual harassment in 38 U.S.C. § 1720D(f), the harassment must be "repeated". As drafted, we presume the intent is to allow VA to define this term through rulemaking, but if there are specific parameters the drafter wishes to ensure are specified, including them in the bill text would be advisable.

Additionally, it is unclear if the language as drafted would cover all of the types of cyber harassment incidents that are intended. As amended, section 1720D would still require that the cyber harassment occur while the Veteran or Servicemember was on active duty, active duty for training, or inactive duty training. However, it may not be clear exactly when the harassment occurs. For example, the harassment could occur when the content is created (e.g., a photograph or video is made), when the content is posted online, when the individual discovers the content is online, or when content that was posted with permission is shared with others without permission (e.g., if a photo or video that was only intended for a limited number of parties is made available to others). Depending upon which standard controls, different Veterans and Servicemembers would be eligible. Due to the intricacies of the subject, it would be beneficial if the legislation addressed "cyber-harassment" in a separate subsection of section 1720D. We believe it would be prudent to phrase this authority in a way to ensure it does not become outdated by changes in technology. We would be happy to assist the Committee in exploring these issues further and in developing technical assistance to ensure the legislation reflects the drafter's intent.

Section 2(b) would amend section 1720D(a)(2) to permit VA to provide without a referral needed counseling, care, and services for sexual trauma that was suffered by Servicemembers, including members of the National Guard and Reserves, during periods of active duty, active duty for training, or inactive duty training. Current law authorizes VA to provide services under this authority only to Servicemembers, including members of the National Guard and Reserve, who are serving on active duty.

VA supports section 2(b), but notes this support is contingent upon additional resources to support implementation. While this provision is discretionary and could only be implemented in consultation with the Secretary of Defense, this subsection has potentially significant cost and workload implications that, without additional resources, could jeopardize VA's ability to provide timely services to Veterans.

It is difficult to estimate the new demand for care that would be produced by section 2, as VA has no data currently available on how many members of the National Guard and Reserve (as well as other members of the Armed Forces) experienced military sexual trauma while on active duty, active duty for training, or inactive duty training. Similarly, it is impossible to know how many of these persons would seek care from VA, and how many would continue to seek care on an ongoing basis. While VA currently furnishes care to Servicemembers through sharing agreements and other arrangements, the Department of Defense (DoD) reimburses VA for such care. It is unclear if DoD would do so when the Servicemember is no longer in active duty, active duty for training, or inactive duty training.

Section 3(a) would amend 38 U.S.C. § 1154 by adding a new subsection (c). The current subsection (b) of section 1154 provides a liberal approach to evaluating claimed disabilities based on a Veteran's engagement in combat with the enemy. This provision acknowledges the disruptive "circumstances, conditions, or hardships" of combat, and the resulting incomplete record keeping, as the basis for a liberal approach to evaluating claims. The newly proposed subsection (c)(1) would establish a liberal standard of proof to "any Veteran who claims that a covered mental health condition was incurred in or aggravated by military sexual trauma during active military, naval, or air service."

VA appreciates the purpose of section 3 but does not support it as written. Under subsection (c)(1) of 38 U.S.C. § 1154, as proposed to be added, the military sexual trauma stressor/event would be required to be "consistent with the circumstances, conditions, or hardships of . . . service" in order to be associated with a current covered mental health condition. Although this language, as used in current section 1154(b) in relation to conditions allegedly incurred or aggravated in combat makes sense for the specific disruptive circumstances of combat as a potential posttraumatic stress disorder (PTSD) stressor, there are no specific circumstances, conditions, or hardships of service that are associated with military sexual trauma, which can occur at any time and any location during the period of service.

Section 3(b) would add a new section 1164 to title 38 that would codify VA's current liberal approach for evaluating PTSD/military sexual trauma claims under its regulation at 38 CFR 3.304(f)(5). While VA supports this provision in principle, it would be preferable to allow VA the flexibility to revise its regulations based on experience without the need to seek statutory amendments, as would be required if the current regulation is codified in statute.

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

Section 4 would require the Secretary of Defense to inform members of the Armed Forces of the eligibility of such members for services at VA's Vet Centers. The Secretary of Defense would be required to ensure that DoD's Sexual Assault Response Coordinators advise members of the Armed Forces who report instances of sexual trauma about their eligibility for services from VA's Vet Centers.

While VA defers to the Secretary of Defense on the specific obligations this bill would impose, we support this section in principle. VA currently provides counseling for military sexual trauma to active duty Servicemembers and is pleased to do so. Informing Servicemembers of the benefits for which they are eligible is important to ensuring they receive the care and services they need. We note there may be technical issues with some of the bill language, but we would be happy to discuss this with the Committee with DoD's input as well. In addition, additional resources to support implementation may be required.

S. 946 Veterans Treatment Court Improvement Act of 2017

S. 946 would require VA to hire additional Veterans Justice Outreach (VJO) Specialists to provide treatment court services to justice-involved Veterans. Specifically, S. 946 would require that VA hire not less than 50 VJO Specialists and place each such VJO Specialist at an eligible VA medical center (VAMC). The bill would require that the total number of VJO Specialists employed by the Department not be less than the sum of (a) the VJO Specialists employed on the day before the enactment of this provision; and (b) the number of VJO Specialists hired under this bill. The bill would require that the Secretary prioritize placement of the VJO Specialists at facilities that will create an affiliation with a Veterans treatment court that is established on or after the date of enactment of the bill, or one that was established prior to enactment but is not fully staffed with VJO Specialists. The bill would require the Secretary to submit a report to Congress on the progress and effects of implementing these provisions within one year, with new reports submitted annually after that. The bill would also require the Comptroller General to submit to Congress a report on the implementation of this authority and the effectiveness of the VJO Program. The bill would authorize to be appropriated $5.5 million for each of fiscal years 2017 through 2027, and would require the Secretary to submit to Congress a report that identifies such legislative or administrative actions that would result in reduction in expenditures by the Department that are equal to or greater than the amounts authorized to be appropriated.

VA supports the intent of this bill and is already working to hire more than the 50 additional VJO Specialists in FY 2017. However, the bill could ultimately result in a reduction of $5.5 million in funding to other programs (including possibly programs for homeless Veterans). Because of this potential reduction in funding, VA does not support the legislation as drafted. Demand for VJO Specialists has grown considerably over the past several years, partly as a result of the adoption of the Veterans Treatment Court model in new jurisdictions. Limited VJO staff resources have affected VA's ability to partner effectively with Veterans Treatment Courts, especially those newly established.

As a technical matter, we note that provisions of section 2(e) of the bill concerning the authorization of appropriations may not accomplish the intended objective. We understand this provision is intended to ensure that the Secretary identifies offsets to fund the program required by this bill. However, the bill only requires the Secretary to report to Congress on legislative or administrative actions that would result in a reduction of expenditures equal to or greater than $5.5 million. To the extent that the Secretary identifies legislative actions that would result in a reduction of expenditures, there is no guarantee that Congress would take such actions. We further note that the offsets would likely affect adversely VA's ability to implement and run other programs, which could result in delays in the provision of benefits, healthcare, and other critical services to Veterans and other beneficiaries. Ultimately, we do not believe this is an appropriate mechanism for funding the program required by this section.

We also note that the definition of "local criminal justice system" in section 2(f)(3) of the bill would exclude Federal law enforcement issues. We understand there are some Federal district courts that have Veterans treatment courts, and these would not be supported under this bill.

While we estimate the hiring of 50 additional VJO Specialists would cost $5.5 million in FY 2018, because the bill would require VA to identify offsets, we believe the ultimate cost would be $0 in FY 2018 and over both 5 and 10 years. We again caution that the costs for implementation would involve reductions to other VA programs.

S. 1153 Veterans Acquiring Community Care Expect Safe Services (ACCESS) Act of 2017

S. 1153 would require the Secretary of Veterans Affairs to deny or revoke eligibility of certain healthcare providers to provide non-VA healthcare services to Veterans. The bill would, in general, require that the Secretary deny or revoke the eligibility of a healthcare provider to provide non-Department healthcare services if the Secretary determines that: (1) the provider was removed from employment at VA due to conduct that violated a policy relating to the safe and appropriate delivery of healthcare; (2) the provider violated the requirements of a medical license; (3) the provider had a Department credential revoked that would impact that provider's ability to provide safe and appropriate healthcare; or, (4) the provider violated a law for which a

term of imprisonment of more than one year may be imposed. The bill would permit, but not require, the denial, revocation, or suspension of the eligibility of a healthcare provider to furnish non-Department healthcare when the Secretary has a reasonable belief that such action is necessary to immediately protect the health, safety, or welfare of Veterans and: (1) the provider is under investigation by the medical licensing board of a State in which the provider is licensed or practices; (2) the provider has entered into a settlement agreement for a disciplinary charge related to the practice of medicine; or, (3) the Secretary otherwise determines that such action is appropriate under the circumstances. The bill would require that the Secretary suspend the eligibility of a healthcare provider to provide non-Department care if that provider is suspended from serving as a healthcare provider of the Department. The bill also would require that the Secretary review, within one year of enactment, each non-Department healthcare provider to identify whether he or she was an employee of the Department to determine if the provider meets any of the criteria for denial, revocation, or suspension of eligibility. Finally, the bill would require the Comptroller General to submit a report to Congress within 2 years of enactment on the implementation of these authorities and its effects.

VA supports the proposed legislation in principle and would appreciate the opportunity to work with Congress to develop a proposal that builds upon similar requirements already in place without creating the unnecessary administrative burdens we believe the bill would produce, as these burdens could negatively impact Veterans' access to quality care. Currently, VA procures most community care using Third Party Administrators (TPA), under Patient Centered Community Care (PC3)/Choice contracts, which include the development and maintenance of an adequate provider network of high quality, credentialed/certified healthcare providers. VA monitors adherence by performing quality checks through the use of a Quality Assurance Plan (QASP). As part of the QASP, VA utilizes a "three lines of defense" model to oversee the credentialing and certification process of network healthcare providers. These lines of defense involve both VA and the TPA performing ongoing reviews to ensure the quality of the providers in the network. Additionally, VA requires the contractor to report to VA, not more than 15 days after being notified, of the loss of or other adverse impact to a network provider's certification, credentialing, privileging, or licensing. Future acquisitions will carry similar criteria as they pertain to review of provider licensure and credentialing, as VA remains committed to developing contracts for high performing networks.

Because of the measures already in place to ensure that VA only utilizes the highest quality providers in the community, VA is concerned that the administrative requirements of this legislation as written would have the potential to adversely impact Veteran access to community care as well as limit current and future contractors' ability to timely recruit and retain qualified providers within their networks.

VA also has concerns relating to due process protections under the bill. To the extent VA relies on any fact that had not been established through a complete and fair process satisfying the requirements of due process (e.g., a criminal conviction, or a full investigation and determination by a State licensing board), the Agency's decision

should be appealable. VA does not have an existing process that could accommodate such appeals. Affected providers must be given notice and an opportunity to be heard to contest such determinations or beliefs in order to satisfy due process requirements, but it is unclear how VA would provide for this.

VA is unable to provide a cost estimate for this proposal as currently written because it is unclear what additional administrative requirements would be needed to ensure appropriate review and protections are in place.

S. 1261 Veterans Emergency Room Relief Act of 2017

Section 2(a) of S. 1261 would add a new section 1725A to Title 38. This new section would require the Secretary to enter into contracts with urgent care providers under which the Secretary would pay the reasonable cost of urgent care provided to eligible Veterans. Eligible Veterans would be defined as Veterans who are enrolled in VA healthcare and who have received healthcare under chapter 17 during the preceding two year period. The bill would also require the Secretary to establish a cost-sharing amount that eligible Veterans would pay to the Secretary when receiving urgent care under this section. This cost-sharing measure would not apply to Veterans who are admitted to a hospital after the provision of urgent care or to Veterans receiving urgent care for a service-connected disability. VA would be the primary payer for care provided under this section. Section 2(b) would require the Secretary to establish a cost-sharing amount that Veterans would pay for the receipt of care at a VA emergency room, unless the Veteran is receiving care for a service-connected disability, is admitted to a hospital for treatment or observation after receiving emergency care, or meets a hardship exception established by the Secretary for purposes of this section. Under section 2(c), the Secretary could not require a Veteran to pay multiple cost-sharing amounts if the Veteran sought urgent care under section 1725A and at a VA emergency room for the same condition within a period of time determined by the Secretary. Finally, section 2(d) of the bill would require VA to submit a report to Congress within two years of enactment, and not less frequently than once every two years thereafter, on the use of urgent and emergency room care by Veterans.

VA supports the intent of this bill, contingent on the provision of additional resources to support implementation. We would like the opportunity to work with the Committee on this proposal to ensure Veterans have access to timely and urgent care.

We estimate the bill as written, with certain limiting assumptions, would cost $287.3 million in FY 2018, $1.525 billion over 5 years, and $3.298 billion over 10 years.

S. 1266 Enhancing Veteran Care Act

S. 1266 would authorize the Secretary to contract with a nonprofit organization that accredits healthcare organizations and programs to investigate a VAMC to assess and report deficiencies of the facility. The Secretary would be required to delegate this contracting authority to the Director of the Veterans Integrated Service Network (VISN)

in which the medical center is located or to the VAMC Director. Before entering into a contract, the VISN Director or VAMC Director would be required to notify the Secretary, the VA OIG, and the Comptroller General of the United States to ensure that the investigation conducted by the contracted entity is coordinated with any investigation conducted by one of these entities. Nothing in this bill would be construed to prevent the OIG from conducting any review, audit, evaluation, or inspection, or to modify the requirement that employees assist with any review, audit, evaluation, or inspection of the OIG.

VA does not support S. 1266. VA believes that this legislation is unnecessary and runs counter to long-standing procedures governing quality of care investigations. Within the VHA, the Office of the Medical Inspector (OMI) and other offices, including the Office of Compliance and Business Integrity, the National Center for Ethics in Healthcare, and the Office of Internal Audit and Risk Assessment, are integral elements of VHA's oversight and compliance program, with responsibility for assessing the quality of VA healthcare through site-specific investigations and system-wide assessments. Through coordination of all of these resources, VA is able to carry out a wide range of investigations of whistleblower allegations, patient complaints, compliance violations, and ethics questions, among other issues. VA is also equipped to produce comprehensive reports with actionable recommendations and to follow-up with line managers to ensure fulfillment of corrective actions. VA has successfully managed the volume of cases. Furthermore, the OIG has the statutory responsibility for conducting assessments, reporting deficiencies, and ensuring corrective actions at VA facilities. Given these existing functions within VHA and OIG, the bill would mandate an unnecessary additional function.

VA has demonstrated an ability to manage a large caseload and provide comprehensive reports. VA has the infrastructure in place to conduct timely quality-of-care investigations in VA health facilities and a professional staff with decades of experience in conducting such reviews. Many of our investigators have worked in VA medical centers and are intimately familiar with their operations, policies, procedures, and unique culture. We are concerned that requiring the organizations that perform accreditations to investigate the same medical facilities they accredit could result in a potential conflict of interest. Accrediting organizations do not routinely conduct investigations of the type envisioned by the bill. VA believes that by relying on its internal systems and specific experience in these types of investigations, the intended objective of the bill can be achieved in the most efficient and Veteran friendly way possible.

We are unable to provide a cost estimate for this bill, as it is unclear how often and when such investigations would occur, or how much they would cost.

S. 1325 Better Workforce for Veterans Act of 2017

The draft bill, “Better Workforce for Veterans Act of 2017”, contains a number of provisions intended to improve the authorities of the Secretary to hire, recruit, and train employees of the Department.

Section 101(a) would create a new section 718 that would authorize the Secretary to recruit and appoint qualified recent graduates and post-secondary students to competitive service positions within the Department, notwithstanding certain provisions of Title 5. The Secretary would only be authorized to appoint no more than a number equal to 15 percent of the number of hires made into professional and administrative occupations at the GS-11 level or below (or equivalent) during the previous fiscal year. The Secretary would be required to develop regulations governing this authority. To the extent practicable, the Secretary would be required to publicly advertise positions available under this section within certain constraints.

VA supports the concept of this provision, but also would like to note that the Administration authored a similar proposal that would be applicable to all agencies, and transmitted it for consideration in the FY 2018 National Defense Authorization Act (FY 2018 NDAA). This would provide greater flexibility to hire students and recent college graduates, providing an immediate opportunity for new employees to begin their careers with VA. The Administration would prefer a Government-wide solution that would provide a significant recruitment benefit if all agencies were able to utilize it.

Section 101(b) would create a new section 719 that would require the Secretary to prescribe regulations to allow for excepted service appointments of certain students and recent graduates leading to conversion to career or career conditional employment.

VA defers to OPM on implementation of this provision as an important element to implementing the program authorized by section 101(a) for certain students and interns. OPM would be best suited to provide any necessary technical drafting assistance to align these authorities with OPM's current Government-wide Pathways Program.

Section 102 would amend section 3304(a)(3)(B) of Title 5 to permit the Secretary to appoint directly for positions for which there is a severe shortage of highly qualified candidates. OPM would have the authority to determine what positions would qualify, as well as having the ability to delegate the authority to make those determinations.

VA supports this provision as this would provide greater flexibility to directly reach applicants when we have a severe shortage of highly qualified candidates. This would help the Department address some of its most critical vacancies.

Section 103 would create a new section 712 to authorize the Secretary to appoint a former Federal employee to a high-demand position within the Department for which the former Federal employee is highly qualified without regard to provisions concerning competitive appointments. The former Federal employee could be appointed to a

position at a higher grade or with more promotion potential than the position the employee previously held. Within 18 months of enactment, the Inspector General of the Department would be required to conduct an audit of the use of this authority by the Secretary and report to Congress on the results of that audit.

VA defers to OPM on this provision. Currently, we could hire someone non-competitively to a position at the same level they previously held, while this provision would allow VA to hire someone to a higher level than they previously held. Therefore, implementation would need to be measured, with appropriate controls in place to prevent misuse.

Section 104 would create a new section 720 to require the Secretary to develop and implement a resume-based application method for applications for appointment to senior executive positions within VA. The application would have to be, to the extent practicable, comparable to the resume-based application method for the Senior Executive Service (SES) developed by the Office of Personnel Management (OPM), and would have to be used for initial applications for a position as a senior executive to the extent such use will be more efficient and effective and less burdensome for all participants. The Secretary would be authorized to make an initial career appointment of an individual to a position as a senior executive if a review board convened by VA certifies the executive and managerial qualifications of the individual.

At this time, VA does not support this provision because we do not believe it is necessary. Resume-based application is allowed under current rules, and VA would like to maintain flexibility in hiring and assessment. VA currently uses a resume-based system for executive recruitment for its medical center Director positions, and with the recently enacted Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (Public Law 115-41), signed June 23, 2017, VA now has direct hiring authority for these and VISN Director positions. We continuously evaluate our hiring methods, timeframes, and outcomes to identify opportunities for improvement, and we would be happy to share our findings with the Committee.

Section 105 would establish a new section 721 that would require the Secretary to establish and periodically review a single database that lists each vacant position in VA that the Secretary determines is critical to VA's mission, difficult to fill, or both. If the Secretary determines that an applicant for a position listed in the database is qualified for such position, but the Secretary does not select such applicant, the Secretary, at the election of the applicant, would be required to consider the applicant for other, similar vacant positions listed in the database. If the Secretary did not fill a vacant position listed in the database after an appropriate time (as determined by the Secretary), the Secretary would be required to ensure that applicants who were not selected for other positions but who meet the qualification requirements are considered. The Secretary would also be required to use the database to assist in filling such positions. Within one year of enactment, the Secretary would be required to submit a report to Congress on the use and efficacy of the database established under this section.

We support the concept of identifying and maintaining a database of vacancies, but do not support this particular provision. VA completed the implementation of a commercial software product as the core foundation to our new enterprise automated human resources system. We will implement an enhancement in FY 2018 to manage positions, which will provide real-time vacancy information. With the systems we currently have in place and in development, we believe we can meet the intent of this provision without legislation, and in a way that is less administratively burdensome.

Section 106 would create a new section 722 that would require the Secretary to measure and collect information on indicators of hiring effectiveness concerning certain identified factors related to recruiting and hiring candidates, as well as the satisfaction of employees, newly hired employees, and applicants. To the extent practicable, and in a manner protecting personally identifiable information, the Secretary would be required to collect and report data disaggregated by facility and VISN to ensure the data is collected from human resources offices throughout VA. The Secretary would be required to submit an annual report to Congress on the information collected, and to make such information publicly available.

As written, we do not support this provision. We are concerned the vagueness of the language could result in application to virtually every aspect of the recruitment process. The terminology in this provision includes subjective terms, and we believe some provisions may be inconsistent internally. In addition, these provisions could be inconsistent with other agencies' recruitment and hiring information. We have a number of technical comments and recommendations and would be glad to share those with the Committee. We also would request that the Committee solicit OPM for technical drafting assistance on this provision.

Section 107 would create a new section 723 requiring the Secretary to develop and carry out a standardized, anonymous, voluntary exit survey for career and non-career employees who voluntarily separate from VA. The survey would have to ask questions regarding the reasons for leaving, any efforts made to retain the individual, the extent of job satisfaction and engagement, the intent of the employee to remain in or leave Federal employment, and other matters considered appropriate by the Secretary. The Secretary would be required to share the results of the survey with the directors and managers VA facilities and VISNs, and the Secretary would be required to report annually on the aggregate results of the exit survey.

We do not support this provision because we believe it is unnecessary, given that we already use exit surveys that capture almost all of the content this legislation would require.

Section 108 would amend section 2108(1) of Title 5 concerning Veteran preference so that any Veteran who served a total of more than 180 days would qualify, rather than only those who served more than 180 consecutive days.

We note that this provision would amend title 5 and apply to the entire Federal government. As a result, we defer to OPM on this provision.

Section 109 would amend section 705(a) of the Veterans Access, Choice, and Accountability Act of 2014 to clarify that recruitment, relocation, or retention incentives are not subject to the limitations on awards and bonuses available in the Department.

VA supports this provision. Currently, the limitations on awards and bonuses include recruitment, retention, and relocation incentives, which have severely limited the Department's ability to offer incentives to hire and retain critical positions. Under these limitations, the Department has attempted to reserve the bulk of the funds that are available to provide incentives to positions, particularly medical professionals with specialized skills and expertise that would be difficult or impossible to replace. This has resulted in an inequitable treatment among employees, as there are fewer resources available for those otherwise deserving and equally dedicated employees.

If this authority were enacted, VA would reallocate funds already appropriated for recruitment and retention of highly qualified employees.

Section 110 would amend section 7309 of Title 38 to remove the requirements that the Chief Officer of VA's Readjustment Counseling Service (RCS) must have at least 3 years of experience providing direct counseling services or outreach services through RCS, as well as 3 years of experience administrating direct counseling services or outreach services through RCS.

VA supports this provision. This would provide greater flexibility to appoint the Chief Officer of RCS, which oversees VA's Vet Centers, a critical component to providing Veterans and Servicemembers readjustment counseling and other services.

There would be no costs associated with this provision.

Section 111 would require, within 120 days of the date of the enactment of this Act, the Secretary to submit a report to Congress on vacancies within the Veterans Health Administration. This report would have to include vacancies of personnel appointed under section 7401 of title 38, vacancies of human resource specialists in VHA, a description of any impediments to filling certain vacancies, and an update on the implementation of several plans and reports.

We do not believe section 111 is necessary, but we do not oppose this requirement. Until the system enhancement previously mentioned is implemented in FY 2018, collecting this information is a manual and intensive effort. As a result, we are concerned that the 120 day deadline would be difficult to meet. We believe that we would be in a better position to gather this information within the next year.

Section 201 would create a new section 724 providing that for any reduction in force by VA, competing employees would be released with due effect to the following in

order of priority: tenure of employment, military preference, efficiency or performance ratings, and length of service.

We do not oppose section 201 because this would only change the order of consideration for how reductions in force would occur. However, we would defer to OPM, to ensure that reduction in force procedures remain consistent across the Government. We note that for hybrid title 38 positions, we think it would be appropriate to also consider the level and type of licensure, as well as the scope of practice, in making such determinations.

Section 202 would create a new section 725 authorizing the Secretary to arrange, with the agreement of a private-sector organization, for the temporary assignment of VA employees to such organization to occupy a position in that organization and for the private sector employee who held that position to temporarily occupy the position of the VA employee. In essence, these employees would be trading positions for a temporary period. The VA employee would return to work for the Department, and if either employee failed to carry out the agreement, the employee would be liable to the United States for payment of all expenses of the assignment, with certain exceptions; such liability would be a debt that could be waived if the Secretary determined collecting it would be against equity and good conscience and not in the best interests of the United States. The VA employee would be prohibited from using pre-decisional, draft deliberative, or other information for the benefit or advantage of the private sector organization. Assignments would be for periods between 3 months and 4 years. VA employees assigned to the private sector organization would be considered, during the period of assignment to be on detail to a regular work assignment in the Department for all purposes. The private sector employee assigned to VA employment would generally not be considered a Federal employee with certain exceptions and would have other constraints imposed upon the scope of that employee's work with the Department. The private sector organization would be prohibited from charging VA, as direct or indirect costs under a Federal contract, for the pay or benefits paid by the organization to the employee assigned to VA. The Secretary would be required to take into account certain considerations in operating this program.

In theory, VA supports the concept of rotational assignments for professional development, and notes that the Administration submitted, in the context of the FY 2018 NDAA, a similar proposal to provide government-wide authority for industry exchange programs. We note, however, that the potential for conflicts of interest in this provision are significant, notwithstanding the language in the bill attempting to limit this. There are several areas where this provision is ambiguous, and we would appreciate the opportunity to discuss this further with the Committee prior to taking a position on this section. We would recommend that the Committee work with the Office of Government Ethics on the appropriate language to address issues related to conflicts of interest.

Section 203 would amend section 7306 to allow for the appointment of VISN Directors in addition to medical center Directors to suit the needs of the Department. It would also remove the requirement for these Directors to be qualified doctors of

medicine, or doctors or dental surgery or dental medicine. It would further amend that section to allow the Secretary to establish qualifications for these Directors and appoint them under this authority. The Secretary and the Director would be required to enter into an agreement that permits employees appointed under this authority to transfer to SES positions in other Federal agencies and to be deemed career appointees who are not subject to competition or certification by a qualifications review board.

Section 207 of the Department of Veterans Affairs Accountability and Whistleblower Protection Act of 2017 (Public Law 115-41), signed June 23, 2017, significantly amended VA's authority to hire directly VISN and medical center Directors. In this context, we would like the opportunity to discuss this proposal further with OPM and the Committee to consider the effects of these proposed changes before taking a position on this section.

Section 204 would create a new subchapter VII in chapter 74 concerning pay for medical center Directors and VISN Directors. The new section 7481 would provide that pay for these Directors would consist of basic pay and market pay, which would be determined by the Secretary on a case-by-case basis and consist of pay intended to reflect the needs of the Department with respect to recruitment and retention of such Directors. The bill would impose other requirements in terms of determining market pay under this section. The Secretary would be required, not less frequently than once every 2 years, to set forth within defined parameters Department-wide minimum and maximum amounts for total pay for Directors, and to publish such limits in the Federal Register. Pay under this section would be considered pay for all purposes, including retirement benefits. A decrease in the pay of a Director resulting from an adjustment in market pay could not be considered an adverse action, while a decrease resulting from an involuntary reassignment in connection with a disciplinary action would not be subject to appeal or judicial review. The OPM Director would be required to undertake periodic reviews of the Secretary's determinations and certify to Congress each year whether or not the market pay is in accordance with the requirements of this section. If the Director determined the amounts were not in accordance with the requirements of this section, the Director would report to Congress on such determination as soon as practicable after making such determination.

We appreciate the Committee's interest in this regard. Similar to section 203, we note that given the recent change (Public Law 115-41) in our appointment authority for VISN and medical center Directors, we would like to discuss this proposal further with OPM and the Committee prior to taking a position on the specific provisions in this section. We anticipate there would be additional costs to implement this section.

Section 205 would create a new section 7413 that would require the Secretary to provide to VHA human resources professionals training on how best to recruit and retain VHA employees. The Secretary would provide such training in a manner considered appropriate considering budget, travel, and other constraints. The Secretary would be required to ensure that each VHA human resources professional received such training as soon as practicable after being hired and annually thereafter. The

Secretary would be required to ensure that a medical center Director, VISN Director, or senior officer at Central Office certified that the professional completed such training. The Secretary would be required to report annually on the training provided under this authority, including the cost of such training, and the number of professionals who receive such training.

We do not support section 205 because VA already has the authority to conduct such training. VA provides training to human resources professionals currently, and we are concerned that the specific requirements in this provision could constrain our ability to adapt training to emerging needs. We also have some technical concerns with this provision that we will share with the Committee.

Section 206 would require the Secretary to include education and training of marriage and family therapists and licensed professional mental health counselors in carrying out the education and training programs conducted under section 7302(a)(1). The Secretary would be required, to the degree practicable, to ensure that the licensing and credentialing standards for therapists and counselors participating in this program are the same as the licensing and credentialing standards for eligibility of other participants in the program. Finally, the Secretary would be required to apportion funding for education and training equally among the professions included in the program.

In general, we currently have the authority to carry out this section. VA has already established training programs for licensed professional mental health counselors and marriage and family therapists. We are concerned with the potential effect this could have on the quality of the education and training standards, and we would appreciate the opportunity to discuss this further with the Committee. We are also concerned that the language, particularly in subsection (c) of this provision, is too prescriptive and could limit VA's flexibility to adjust training needs and resources to meet operational needs.

Section 207 would require, within 180 days of the date of enactment of this Act, the Secretary and the Surgeon General to enter into a memorandum of understanding (MOU) for the assignment of not fewer than 500 commissioned officers of the Regular Corps of the Public Health Service to VA. The Secretary would reimburse the Surgeon General for expenses incurred in assigning commissioned officers to VA. Within 1 year of enactment, the Secretary and Surgeon General would each be required to submit to Congress a report on the MOU and the commissioned officers assigned under this authority.

We do not support this provision because it is unnecessary. VA and the Department of Health and Human Services (HHS) signed an MOU earlier this year to allow for commissioned officers of the Public Health Service to serve in VA. We would like the opportunity to discuss this further with the Committee and HHS to determine what, if any, legislative authority we need in this area.

Section 208(a) and (b) would require, within 1 year of the date of enactment of this Act, the Under Secretary for Health to develop a comprehensive competency assessment tool for VHA human resources employees to assess the knowledge of such employees on how employees appointed under section 7401(1) are treated differently than employees appointed under other authorities. Within 2 years of the date of enactment of this Act, and once every 2 years thereafter, the Secretary would have to submit a certification to Congress as to whether an assessment of all VHA human resources employees was conducted and whether such employees used the results of such assessment to identify and address competency gaps. Within 18 months of the date of enactment of this Act, the Under Secretary for Health would be required to evaluate the extent to which these training strategies are effective at improving the skills and competencies of VHA human resources employees.

Section 208(c) would require, within 1 year of enactment, the Under Secretary for Health to establish clear lines of authority that provide the Assistant Deputy Under Secretary for Health for Workforce Services the ability to oversee and hold the heads of the human resources offices of VA medical centers accountable for implementing initiatives to improve human resources processes and for ensuring employees undertake the assessment required under subsection (a). Within 1 year of enactment of this Act, the Secretary would be required to clarify the lines of authority and processes for the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration with respect to overseeing holding the VISN and VA medical center Directors accountable for the consistent application of Federal classification policies.

Section 208(d) would require the Secretary to ensure the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration are responsible for monitoring the status of corrective actions taken at human resources offices of VA medical centers and that such actions are implemented.

Section 208(e) would require the Secretary to ensure that meaningful distinctions are made in performance ratings for VHA employees.

Section 208(f) would require, within 1 year of enactment of this Act, the Under Secretary for Health and the Assistant Secretary for Human Resources and Administration to develop a plan to implement a modern information technology (IT) system to support employee performance management processes.

Section 208(g) would require, within 1 year of enactment of this Act, the Under Secretary for Health to establish clear lines of authority and accountability for developing, implementing, and monitoring strategies for improving employee engagement across VHA. The Under Secretary for Health would be required to report to Congress on whether VHA should establish an employee engagement office at the headquarters level with appropriate oversight of VISN and VA medical center employee engagement initiatives.

We do not believe this section is necessary. We are currently implementing the requirements of these provisions based on the recommendation of a Government Accountability Office (GAO) report (GAO 17-30). We also have some technical concerns we believe need to be addressed, and we will be glad to provide those to the Committee.

Section 208(h) would require, within 1 year of enactment, the Comptroller General to examine the overlapping functions of human resource structures within VHA and the Office of the Assistant Secretary of Human Resources, whether there are opportunities to centralize offices and tasks that are duplicative, and whether the use of multiple hiring structures has had an effect on the speed with which VA hires new employees. The Comptroller General would report to Congress on the Comptroller General's findings.

VA defers to the Comptroller General on this provision.

Section 209 would require, within 120 days of enactment of this Act, the Secretary to report to Congress on the effect the freeze on the hiring of Federal civilian employees ordered by the President on January 23, 2017, has had on the ability of VA to provide care and services to Veterans.

We do not believe this is necessary, and do not support it, as the hiring freeze was only in effect, at most, for a limited number of positions not related to patient care or access. We also do not believe it would be possible to identify to any meaningful degree any effects that may have occurred as a result of the hiring freeze.

Section 210 would require, within 180 days of enactment of this Act, the Secretary to report to Congress on how the Secretary plans to implement the portions of the plan of the OPM Director to reduce the size of the Federal workforce through attrition as it pertains to VA.

We believe this provision is unnecessary. VA is working to implement an agency reform plan, consistent with the OMB Director's requirements. We are looking at how we will be filling administrative positions that become vacant, along with other potential actions, and will be updating these plans and assessments in the future. We would be happy to share with the Committee the plan the Department submits to OMB when it is available.

Section 211 would require, within 180 days of enactment of this Act, the Secretary to publish online information on staffing levels for nurses at each VA medical facility. The head of each medical facility would be required to update the information as changes to the staffing level of nurses at the facility occur. The Secretary would be required to consult with Centers for Medicare & Medicaid Services in developing the information required by this section. The Secretary would be required to submit a report to Congress discussing and assessing the use by medical center Directors of authorities to provide nurses pay that reflects market conditions, the adequacy of training

resources for nurse recruiters, the key recruitment and retention incentives of VHA for nurses, and other factors.

We do not support this provision for two major reasons. First, the staffing levels referenced in the bill are not defined. Second, the actual number of nurses varies on an almost daily basis given the volatility in terms of staffing. It would be incredibly cumbersome to maintain this information and update it in real time. We already report to Congress each year on efforts to provide nurses greater pay, and this report would be duplicative of that effort.

Section 212 would require, within 1 year of enactment of this Act, the Secretary, in consultation with the OPM Director, to ensure that the job description, position classification, and grade for each position as a police officer or firefighter in VA are in accordance with standards for the classification of such positions prepared by OPM. The Secretary would be required to develop a staffing model for the positions of police officers and firefighters within the Department. The VA Inspector General would be required to conduct an audit of VA's efforts to recruit and retain police officers and firefighters and report to the Secretary and Congress on the audit's findings. Finally, the Secretary would be required to report to Congress on the use by medical center Directors of special pay incentives to recruit and retain trained and qualified police officers and the steps the Secretary plans to take to address the critical shortage of police officers throughout the Department.

We have some concerns with this provision. We believe the reviews required by this section could require a considerable amount of resources. We would like the opportunity to discuss this proposal further with the Committee and OPM to determine what we may be able to do currently to address the Committee's concerns and interests in this matter.

Section 213 would require, within 1 year of enactment of this Act, the VA Inspector General to complete a study on how VHA communicates its directives, policies, and handbooks to the field, including the compliance with such documents, and the effectiveness of each VISN in disseminating information to employees within the Network and Veterans served by the Network.

The Department defers to the Inspector General on this provision.

As noted above, VA will be providing follow-up views for the record on S. 1279, the Veterans Health Administration Reform Act, the draft Department of Veterans Affairs Quality Employment Act of 2017, and section 10 of the Veterans Choice Act of 2017.

S. XXXX Veterans Choice Act of 2017

The draft Veterans Choice Act of 2017 contains a number of provisions intended to improve VA's community care program. Community care has helped significantly

expand access to care for Veterans nationally and plays an important role in VA's effort to build a modern, integrated healthcare network.

Section 3(a) of the bill would amend section 1703 of title 38 to authorize the Veterans Choice Program. Under this Program, all enrolled Veterans would be eligible to elect to receive hospital care, medical services, mental health services, and certain diagnostic services, outpatient dental services, and diagnostic services from specified eligible providers. These services could be provided through telemedicine, at the election of the Veteran. The Secretary would be required to enter into consolidated, competitively bid regional contacts with healthcare organizations or third party administrators to establish networks of eligible providers for the purpose of providing sufficient access to care and services. The bill would define various responsibilities for these organizations or administrators, including enrolling covered Veterans, conducting referrals and authorizations, customer service, and maintaining an interoperable electronic health record. These parties would be required to leverage advanced technology to allow Veterans to make their own appointments, including online and through smart phone applications. Veterans who need assistance making their appointments could receive assistance from the organization or administrator or the Secretary. The organizations or administrators would be required to meet capability, capacity, and access standards established by the Secretary, including those established pursuant to sections 9 and 10 of this bill. Providers who currently furnish care or services under another authority would be offered the opportunity to furnish care and services through this Program.

Under the Veterans Choice Program, the rates paid for care or services could not exceed the Medicare rate, except in highly rural areas, in the State of Alaska, in a State with an All-Payer Model Agreement that became effective on January 1, 2014, or at other rates established by the Secretary if no Medicare rate exists. The Secretary would be authorized to recover from a third party for any care furnished for a non-service-connected disability, and the Secretary would be responsible for paying the copayment, deductible, or coinsurance charged to the Veteran for care or services. Veterans could not be required to pay a greater amount for receiving care or services than they would if they had received comparable care or services at a VA medical facility or from a VA medical provider.

The proposed amendments to section 1703 would impose other requirements. For example, VA would have to ensure the Veterans Health Identification Card issued to every enrolled Veteran includes the words “Choice eligible” and additional information needed to serve as an identification card for the Program. Additionally, the Secretary would be required to monitor a number of quality and access standards related to the care furnished under this Program. These changes would become effective upon the termination of the current Veterans Choice Program operated pursuant to section 101 of the Veterans Access, Choice, and Accountability Act of 2014.

We support many of the principles in the proposed section 1703. We appreciate that the section’s eligibility criteria would be simple to administer by making every

enrolled Veteran eligible to participate. We also appreciate the flexibility in terms of eligible providers, and the regional network model generally matches our current plans with the Community Care Network solicitation. We also appreciate the section's recognition of the importance of ensuring quality care is furnished to Veterans through this Program.

However, we have some significant concerns with certain provisions of proposed section 1703. In many areas, there are provisions that are overly prescriptive and that would narrow the Secretary's authority to adjust to evolving situations. For example, the Secretary would be prohibited from directing Veterans to certain health care providers. While we support Veterans' choosing their own providers, we understand that many Veterans do not express a specific preference for an individual provider, and this language could restrict our ability to direct Veterans to high-performing providers who are available. Also, the responsibilities of the regional networks are too specific—we would prefer the language be silent on these matters so that we can adjust responsibilities between VA and our regional networks to ensure the best services are available for Veterans. Furthermore, the language concerning payment rates is too limiting. There will be situations where VA will need to pay more than the Medicare rate other than in highly rural areas, the State of Alaska, and States with All-Payer Model Agreements. We have serious concerns with the language in proposed 1703(h), which would require the Secretary to pay the amount of a Veteran's copayment, deductible, or coinsurance. This would be inconsistent with private sector and VA's current practice. Section 1729 currently provides that Veterans are not required to pay a copayment, deductible, or coinsurance required under the terms of their health insurance for care and services furnished by the Department. Moreover, requiring the Department to pay a Veteran's copayment, deductible, or coinsurance could significantly increase the Department's expenses, including its administrative costs, in ways that we cannot currently project given the variability in insurance plans and payment responsibilities for the millions of Veterans with such insurance. While we support the principle of ensuring quality care, we are concerned that some of the language in proposed 1703(l) would be too prescriptive, and we would prefer more general language.

Requiring that the words "Choice eligible" appear on a Veterans Health Identification Card (VHIC), as provided for in proposed section 1703(k), would create redundancy and be extremely costly. The bill would make any enrolled Veteran eligible for Choice, and all enrolled Veterans are issued VHICs, so any person with a VHIC would already establish his or her eligibility by virtue of having the VHIC. Requiring Veterans to have a VHIC with the words "Choice eligible" would also produce greater demands on Veterans who would have to come to a VA facility to receive an updated version of their VHIC.

Finally, we are concerned that there is no transition period contemplated by section 3(a)(3). The new 1703 would take effect immediately upon the expiration of the current Veterans Choice Program, based on the exhaustion of the Veterans Choice Fund. We believe that either a clear timeline (such as one year from enactment) or an event within the Department's control (such as the publication of regulations) would be

preferable for the transition between the current Choice Program and the future Choice Program. We also may encounter problems where individual authorizations made under the current 1703 would no longer have any legal authority for payment upon this transition, as this provision would completely rewrite section 1703. While the Department would try to reduce the potential for this issue, we would not be able to eliminate this problem.

Section 3(b) would prohibit VA from entering into or renewing any contract or agreement under a non-Department provider program, which would include the current Veterans Choice Program; the Patient-Centered Community Care (PC3) program; the Project Access Received Closer to Home (ARCH) program; VA's retail pharmacy network; agreements entered into with DoD, IHS, or other Federal agencies; agreements entered into with academic affiliates of VA; agreements to furnish care, including on a fee basis; or agreements with non-governmental entities. If the Secretary continued to administer any of these programs after the date on which the new Veterans Choice Program begins, they could only be administered under that Program. The Secretary would be required to ensure continuity of care by making services available through regional contracts or other agreements entered into under the new Veterans Choice Program.

We are very concerned with this provision and do not support it. It would require VA to renegotiate, reissue, or terminate every agreement and contract, regardless of the terms or conditions of such an agreement permitting extensions or other flexible authorities. We believe this could affect such agreements as those with DoD, IHS, and tribal health programs, as well as with our academic affiliates and contractors. This would include thousands of agreements, would be very difficult and costly to do, and would not produce any clear, tangible benefit. If these agreements would also now be subject to the limitations in proposed section 1703, this provision could put conditions on these agreements that would be unacceptable to certain providers or in certain areas. This could also potentially impact our relationships with certain providers, such as IHS and tribal health programs, which require consultation prior to changes. We also note, given the breadth of section 3(b)(4)(E), that extended care services procured from the community would be included, but note that the language for the Veterans Choice Program in section 1703 does not address such services; as a result, it is unclear what terms and conditions would apply to these services.

Section 4 would establish a new section 1703A authorizing VA to enter into Veterans Care Agreements (VCA). VCAs could be entered into when the Secretary is not feasibly able to furnish hospital care, medical services, or extended care services at VA facilities or when such care or services are not available under the Veterans Choice Program. Providers could opt to enter into a VCA, at the discretion of the eligible provider. The eligibility of Veterans for care would be the same as if they received care in a VA facility. The Secretary would be prohibited from directing Veterans seeking care or services to healthcare providers who have entered into contracts or sharing agreements under different authorities, except for Veterans Choice Agreements authorized under section 101 of the Veterans Access, Choice, and Accountability Act of

2014 or under the regional contracts or other arrangements made under section 1703, as revised by section 3 of this bill.

The Secretary would be required to establish a process for the certification of eligible providers. VCAs would have to include certain terms, including accepting payment at Medicare rates (except in highly rural or underserved areas), accepting payment as payment in full, and other terms and conditions. Each VCA would permit the provider to submit to the Secretary clinical justification for any services furnished without authorization when seeking payment, and the Secretary would review these submissions on a case-by-case basis in determining whether or to pay the provider for such services. The Secretary would be required to review periodically VCAs of a material size to determine whether it is feasible and advisable to furnish the care and services at a VA facility or through contracts or sharing agreements. VCAs would not be subject to laws requiring competitive procedures in selecting the party with which to enter the agreement. Parties entering into a VCA would not be treated as a Federal contractor by the Office of Federal Contract Compliance Programs (OFCCP) of the Department of Labor, and they would not be subject to any laws that such a provider would not be subject to under the original Medicare fee-for-service program under Parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), except for laws applying to integrity, ethics, fraud, or that subject a person to civil or criminal penalties. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000c et seq.) would apply to parties entering into a VCA. The Secretary would be required to establish a system or systems, consistent with those used by the Centers for Medicare and Medicaid Services, to monitor the quality of care provided and would be required to establish administrative procedures for dispute resolution. The Secretary would be required to prescribe an interim final rule within 1 year of enactment to carry out this section.

We generally support this provision, but have some concerns we would like to address. In particular, proposed section 1703A(a)(2)(A)(ii) would prohibit the Secretary from entering into a VCA if care or services are available under the new Veterans Choice Program. Although we appreciate the intent of this provision, we believe there may be situations where the clinical need of the Veteran will require the use of a VCA notwithstanding the availability of such services under the Choice Program. For example, a Veteran may require a certain type of orthopedic procedure, and while orthopedics in general are “available” under a contract, the specific procedure or a specialist may not be included within the contract, or would only be available at a lesser quality. In other situations, a Veteran may elect to receive care from a certain provider that would be ideally suited to furnishing the care required, but who is not a member of the network. We want to ensure we have flexibility in situations like these to deliver the care the Veteran requires in a timely and appropriate way. We also note these provisions apply for when the Secretary may “enter into” agreements, rather than “use” agreements. We have found, through our experience with the current Veterans Choice Program that it is more efficient to enter into these agreements before they are needed to ensure that there is no delay in the receipt of care by eligible Veterans. We believe the language could be modified slightly to impose restrictions on the utilization of VCAs

to ensure the integrity and use of the network of providers under the new Veterans Choice Program.

Proposed section 1703A(e)(2) is unclear, and depending upon what the intent is, we may or may not support it. If the provision is intended to simply allow providers to submit claims for care that was unconnected or unrelated to the services VA originally authorized, we are concerned this could create situations where VA pays for services that were neither authorized nor clinically needed. This would create a significant administrative burden on both the providers and VA. If, on the other hand, this is intended to apply only in limited circumstances for care that VA would have authorized, then we have no objection to it.

Regarding proposed section 1703A(g), VA agrees with the idea of monitoring how VCAs are utilized by VA. However, we are concerned that the threshold for when an agreement for the purchase of extended care services is considered to be of "material size", i.e., exceeding "$1,000,000 annually", is too low. Costs for long term extended care and nursing home care costs can easily exceed this level. The threshold also does not account for providers who may have a national presence.

Section 5(a) would establish a new section 1703B concerning payment of non-Department healthcare providers. Specifically, VA would be required to comply with the provisions in this section and in chapter 39 of title 31 (the Prompt Payment Act). Non-Department providers would be required to submit a claim for reimbursement within 180 days, and the Secretary would have to pay claims according to specified time standards or else interest would accrue on the amount owed. If a provider submits a clean claim, VA would have to pay the claim within 30 days if it was submitted electronically or 45 days if it was submitted other than electronically. If a claim were not clean, the Secretary would have to inform the provider within 10 days on the steps that would be needed to make it clean. By January 1, 2020, the Secretary would only be authorized to accept claims electronically except in certain circumstances.

We generally support section 5(a), but have some concerns with a few of the provisions. For example, we think there should be more flexibility to accept paper claims from smaller providers, such as Homemaker/Home Health Aides. We are also concerned that, as written, this language could require that late payments of providers who have entered into contracts with the Regional Networks could subject VA to interest payments, even though VA has no privity of contract with these providers and is paying the Network on time. Finally, we do not believe the Committee had transactions between VA and other Federal entities in mind when it included a prompt payment standard in the draft bill. An exception could be added in this section to address this issue.

Section 5(b) would require the Secretary, not later than 2 years after the date of the enactment of this Act, to enter into an agreement with a third-party entity to process claims for reimbursement through an electronic interface.

We are concerned about the intended scope of this provision. If the electronic interface processing the claims is only preparing them for adjudication and approval by VA, we do not support this provision because VA is currently working on a process internally that would perform this function. If the term "process" is intended to cover adjudication and payment as well, we would like to discuss with the Committee our reservations about such an arrangement and propose potential alternatives instead.

Section 6 would amend section 1745 to authorize the Secretary to enter into agreements with State Veterans Homes that would not be subject to laws requiring competitive procedures in selecting the party with which to enter the agreement. State Homes entering into these agreements would not be subject to any laws that such a provider would not be subject to under the original Medicare fee-for-service program under Parts A and B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), except for laws applying to integrity, ethics, fraud, or that subject a person to civil or criminal penalties. Title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000c et seq.) would apply to State homes entering into these agreements. These changes would become effective upon the Secretary's publishing regulations to implement these new authorities.

We generally support section 6, although, we have similar concerns to those we expressed regarding section 4 with respect to the applicability of certain laws.

Section 7 would amend section 1705 to require the Secretary, upon the enrollment of a Veteran in the VA healthcare system, to assign the Veteran to a dedicated primary care provider of the Department, unless the Veteran elects to choose a primary care provider from among the healthcare providers furnishing care in the network established under the new Veterans Choice Program.

We do not support section 7 because this would require all enrolled Veterans to be enrolled in provider panels, even if we do not furnish care to those Veterans. We typically only assign Veterans to a panel once they have expressed interest in receiving care from the Department. We are concerned that assigning other Veterans to panels will complicate our projection models for demand and our estimates for resources for our facilities. We are also concerned that the ability of a Veteran to elect to choose a primary care provider from among VA's network of community providers could allow for the control and coordination of care, including the authorization of care (and the obligation of Federal funds), to move to a non-Federal agent, which presents issues concerning the proper use of appropriated funds.

Section 8 would require the Secretary to enter into national contracts with private healthcare providers to make dialysis treatments available in the community. Veterans would be able to choose the provider from which they would receive dialysis services. Under subsection (c), the Secretary could not pay more than the Medicare rate for the same dialysis services or treatment.

While we support the intent of this proposal, we are concerned that this could potentially limit the Department's ability to furnish dialysis care. This provision would limit VA to paying the Medicare rate; we currently pay more than the Medicare rate in certain circumstances, and it is unclear if we could enter into contracts for the same care at a reduced rate. If we were unable to enter into these contracts, VA would not be able to provide this essential clinical service.

Section 9 would require VA to establish a demand profile with respect to each health service furnished under the laws administered by the Secretary. The demand profile would have to include various factors, such as the number of requests for services, the number of appointments (both in VA and the community), the capacity of the Department to provide such services, and an assessment of the need for community care for the service. The Secretary would use these profiles to inform the capability and capacity of the provider networks established in the new Veterans Choice Program. Within 120 days of the date of enactment of this Act, the Secretary would be required to submit to Congress a strategic plan with a 5 year forecast on the demand for care and the Department's capacity and capability to satisfy that demand within its facilities. The Secretary would have to update the strategic plan annually.

VA agrees in concept with the provisions in section 9; however, we believe this provision is not necessary as VA has currently embarked upon a national market-by-market assessment effort that will produce the same level of information called for in the bill. VA's market-by-market assessment is in response to a requirement in section 240 of Division A of Public Law 114-223, the "Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017." That law requires VA to develop a national realignment strategy. As a result, the assessment of VA's 98 marketplaces across the United States is currently underway.

Section 10 would require the Secretary to establish uniform access standards for furnishing healthcare services, including through community providers, for urgent care, routine care, referral or specialty care, and wellness or preventive care. These access standards would have to include the average time a Veteran is expected to wait to receive an appointment, the average time a Veteran is expected to drive to arrive at an appointment, the average time a Veteran is expected to wait at a facility to receive healthcare services, and such other factors as the Secretary considers appropriate. The Secretary would be required to coordinate with DoD, the Department of Health and Human Services (HHS), private entities, and other non-governmental entities in establishing these standards. The Secretary would be required to submit a report to Congress within 120 days of the date of the enactment of this Act detailing the standards established under this section.

We do not have views on section 10 at this time.

Section 11 would require the Secretary, within 1 year of enactment, to procure a commercial, off-the-shelf electronic health record platform that conforms to the standards of interoperability required under section 713 of the National Defense

Authorization Act for Fiscal Year 2014. The bill would define a number of requirements for this system, including its interoperability with DoD's systems and private sector systems and compliance with national standards identified by the VA and the DoD Interagency Program Office in collaboration with HHS' Office of the National Coordinator for Health Information Technology.

VA does not believe section 11 is necessary because the Secretary has already announced his intention to procure a commercial system for VA's Electronic Health Record capability. Similar to our concern with other provisions, we note that the specificity in this provision could limit the Secretary's ability to ensure this new system is responsive to Veterans' needs.

Finally, section 12 would make various conforming amendments to reflect the changes made by section 3 of this bill by updating references in other statutes to VA's community care authorities.

We support section 12 as a measure to consolidate VA's community care programs.

We are unable to provide cost estimates on the bill at this time but will follow up after the hearing with any estimates we can develop and our thoughts on the potential budget implications. We will also provide technical comments for your consideration.

S. XXXX Improving Veterans Access to Community Care Act of 2017

The draft Improving Veterans Access to Community Care Act of 2017 also contains a number of provisions intended to improve VA's community care program.

Section 101(a)(1) would create a new section 1703A, establishing the Veterans Community Care Program. Many of the terms and conditions governing this Program would be similar to those applicable to the existing Veterans Choice Program. Under this new Program, hospital care and medical services would be furnished to eligible Veterans at the election of the Veteran through contracts or agreements with eligible providers. The Secretary would be responsible for coordinating care and services, including ensuring that an eligible Veteran receives an appointment for care and services within the wait-time goals of the Veterans Health Administration (VHA). To be eligible under the Program, Veterans would have to be enrolled in VA healthcare and meet one of the following criteria: reside in a location, other than Guam, American Samoa, or the Republic of the Philippines that requires the Veteran to travel by air, boat or ferry to reach a VA medical facility; be enrolled in Project ARCH; the Veteran and the Veteran's VA provider determine the Veteran should be eligible based upon the eligibility criteria in the current Veterans Choice Program, namely being unable to schedule an appointment within the clinically indicated timeframe, residing more than 40 miles driving distance from the nearest VA medical facility with a full-time primary care physician, residing within a State without a full-service VA medical center, or facing an unusual or excessive burden in accessing services from a VA medical facility. The

Veteran and provider could also determine whether the Veteran should be eligible under the Program based upon a compelling reason that the Veteran needs to receive care and services from a non-Department facility. The Secretary would be required to establish a process to review any disagreement between Veterans and their providers, and the Secretary would make the final determination as to the eligibility of the Veteran.

While we appreciate the intent of the eligibility criteria for Veterans, we are concerned with how this program is structured. We fully agree that the provider-patient relationship should be the basis for eligibility to receive community care. However, the draft bill would combine this approach with the current administrative eligibility criteria in the Choice Program. We believe this would result in an ultimately confusing "hybrid" standard that would be difficult for providers to apply. In addition, we believe continuing to use administrative criteria would be inappropriate, as they are arbitrary in nature and not informed by the patient-provider relationship. The proposed approach would also be unduly limiting in terms of the types of clinical factors that a provider could consider; for example, a Veteran who lived across the street from a full-service VA medical center with no wait times and who was fully ambulatory would not appear to qualify under any of these provisions, and yet the Veteran may require a certain type of service that would be best delivered by a community provider. We would like to work with the Committee to better understand the underlying issue that proposed subsection (b)(2), concerning the review of provider determinations, is intended to address.

Under section 1703A, providers would have to meet the same eligibility criteria in the current Veterans Choice Program to participate in the new Program, including maintaining the same or similar credentials and licenses as VA providers. The Secretary would be authorized to create a tiered provider network, but would not be able to prioritize providers in a tier over providers in any other tier in a manner that limits the choice of an eligible Veteran to select that provider. The Secretary would be required to enter into contracts with eligible providers for furnishing care and services, but before entering into such a contract, the Secretary would be required, to the maximum extent practicable and consistent with the requirements of this section, to furnish care and services with eligible providers pursuant to sharing agreements, existing contracts, or other processes available for procuring care. In this section, the term "contract" would have the definition given that term in subpart 2.101 of the Federal Acquisition Regulations. Providers would be paid under a negotiated rate that, to the extent practicable, would not exceed the Medicare rate, with limited exceptions for highly rural areas, Alaska, and States with an All-Payer Model Agreement. Eligible providers would be prohibited from collecting any amount greater than the negotiated rate. The Secretary would be authorized in negotiating rates to incorporate the use of value-based reimbursement models to promote the provision of high-quality care. The Secretary would be authorized to collect from third-parties the costs of furnishing care for non-service-connected disabilities under this section, and such collections would be deposited into the Medical Community Care account and remain available until expended.

We do not support the provision requiring providers to maintain the same or similar credentials and licenses as VA providers; while this is a requirement in the current Veterans Choice Program, we have found it to be administratively difficult (and at times impossible) to implement in certain situations. We believe strongly in the importance of ensuring our providers furnish quality care, but recommend a different approach than this obligation. We are also concerned that some of the language regarding the terms of the agreements with providers contemplates a direct relationship between VA and the providers, rather than a relationship between VA and a network administrator, and a separate relationship between the administrator and the provider. Similarly, we do not support the provision that would require the deposit of collected funds into the Medical Community Care account. Funds collected by VA under sections 1725 and 1729 of title 38, and section 2651 of title 42 are currently deposited in the Medical Care Collections Fund, where they may be used to support both VA and community care. We believe creating a separate collection account would be duplicative and would limit our funding flexibility. Finally, we note that referencing the definition of "third party" in section 1729 produces a narrower effect than if the definition in section 1725 were referenced.

The Secretary would be required to provide Veterans information about this Program upon their enrollment and when they become eligible based on a determination between the Veteran and his or her provider. The Secretary would be required to ensure that follow up care, including specialty and ancillary services deemed necessary, are furnished through the Program at the election of the Veteran. Veterans would be required to pay a copayment for care under this Program, but the copayment could be no more than what the Veteran would owe if such care or services were furnished directly by the Department. The Secretary would also be required to establish a claims processing system to ensure prompt and accurate payment of bills and claims for authorized care. Under subsection (j), a Veteran's election to receive care under this Program would serve as written consent for purposes of section 7332(b)(1), which governs the disclosure of certain protected health information. Providers would be required under subsection (k)(1) to submit copies of the Veteran's medical records upon the completion of the provision of such care and services, but these records could not be required prior to reimbursement. Under subsection (m), the Secretary would be required to track missed appointments to ensure the Department does not pay for care or services that were not rendered.

We note that subsection (j) is no longer needed given the amendments to section 7332 made by Public Law 115-26. In terms of subsection (k)(1), we believe it would be better for the records to be required as determined by the Secretary to ensure that the records are provided in a timely fashion and that care provided by VA and others is informed. We also recommend against including subsection (m), regarding the tracking of missed appointments, as our experience with the current Veterans Choice Program has proven this difficult to implement. We have taken other precautions to ensure the Department is not paying for care and services that were not provided, and we believe this approach is more suitable for the legislation's intent.

Section 101(a)(3) would terminate the current Veterans Choice Program authority and make other conforming amendments.

We do not support this provision, as the Department will need a transition period during which it can prepare for the future of community care while still ensuring Veterans receive care through the current Choice Program.

Section 101(a)(4) would require a report within 1 year of the date of enactment of this Act providing information about services rendered under the new Program.

We note that subparagraph (D) of this provision would require a report on the results of a survey of Veterans who have received care or services under this program. Given the time it may take us to develop a survey, VA may not be able to gather meaningful information in the time between OMB approval of the information collection and the reporting deadline. Regarding subparagraph (E), which would require an assessment of the effect of furnishing care and services under new section 1703A on wait times, we have not found reliable data that would support a firm assessment through the current Choice Program, and we believe we would encounter the same issues under this proposal.

Section 101(b) would provide that services under various programs and authorities be considered services under the Veterans Community Care Program established under the new section 1703A, including PC3, contracts through VA's retail pharmacy network, VCAs, and healthcare agreements with other Federal and non-Federal agencies.

We are not sure exactly what it means for services under another program to be "considered" services under the Veterans Community Care Program. If this would require that all of the agreements and programs identified in this subsection meet the terms and conditions of the Veterans Community Care Program, we would not support that requirement.

Section 101(c) would state that all amounts required to carry out the new Program would be derived from the Medical Community Care account, and that all amounts in the Veterans Choice Fund would be transferred to the Medical Community Care account. Section 802 of the Veterans Access, Choice, and Accountability Act of 2014 would be repealed, and conforming amendments would be made to section 4003 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015.

We agree with the importance of consolidating funding for community care, but we recommend that the transfer of funds from and the repeal of the Veterans Choice Fund only apply to unobligated funds and provide a delayed effective date to support the transition from the current program to the future program.

Section 101(d) would require, within 90 days of the enactment of this Act, the Secretary to establish consistent criteria and standards for furnishing non-Department care, including the eligibility requirements of providers and reimbursement rates (which, to the extent practicable, would be the Medicare rate). These standards would not apply to the Veterans Community Care Program established under section 101(a)(1).

We support the intent of subsection (d). We have minor technical recommendations that we would be pleased to discuss with the Committee.

Section 101(e) would require the Secretary to establish a working group to assess the feasibility and advisability of considering under subsection (b) services under healthcare agreements with healthcare providers of the Indian Health Service (IHS) and tribal health programs to be provided under the Veterans Community Care Program. The working group would include representatives of IHS, tribal health programs, and Veterans who receive services from either IHS or tribal health programs. Within 180 days of enactment of this Act, the working group would be required to submit a report to the Secretary on the feasibility and advisability of considering such services to be services under the Veterans Community Care Program, and within 90 days of receiving this report, the Secretary would be required to submit a report to Congress on the feasibility and advisability of implementing the working group's recommendations.

We do not oppose greater coordination and discussion with IHS or tribal health programs, but we do not believe the timelines in the legislation are realistic. We also do not believe it is necessary to require this coordination in law, as we are already working with these groups to improve cultural understanding and resource sharing. We also note that the Federal Advisory Committee Act (FACA) would likely apply to the working group, given the inclusion of non-government personnel.

Section 102(a) would create a new section 1703B regarding prompt payment of providers. It would require substantially the same things required by section 5(a) of the draft Veterans Choice Act of 2017, with a few exceptions. For example, this bill would authorize the Secretary to accept claims and medical records submitted other than electronically if the Secretary determines the provider is unable to submit claims or medical records electronically. It would also authorize the Secretary to accept non-electronic claims if the Secretary determines doing so is necessary for the timely processing of claims due to a failure or serious malfunction of the electronic interface of the Department (required in section 102(b)) for submitting claims.

As discussed with respect to section 5(a) of the draft Veterans Choice Act of 2017, we generally support these provisions and appreciate the flexibility contained in this version.

Section 102(b) would require, not later than January 1, 2019, the Chief Information Officer of the Department to establish an electronic interface for healthcare providers to submit claims for reimbursement under section 1703B. The bill would define various requirements in terms of functions of the interface and protection of

information. By January 1, 2018, or before entering into a contract to procure or design and build such an interface, the Secretary would be required to conduct an analysis to determine whether it would be better to build or buy such an interface and submit a report on such analysis to Congress. The bill would define various requirements of this analysis and report, and the Secretary would not be authorized to spend any amounts to procure or design and build the electronic interface until 60 days after the required report is submitted to Congress.

We are concerned about the intended scope of this provision. If the electronic interface processing the claims is only preparing them for adjudication and approval by VA, we do not support this provision because VA is currently working on a process internally that would perform this function. If the provision is intended to cover adjudication and payment as well, we would like to discuss with the Committee our reservations about such an arrangement and propose potential alternatives instead. We also caution that the deadline in subsection (b)(2) of January 1, 2018, for making a decision to internally design and build or enter into a contract to procure an electronic interface is likely too soon, given the uncertainty regarding community care funding, continuing developments of the design of the new EHR, and the potential implications to other information technology projects.

Section 103 would amend 38 U.S.C. § 1151(a) by adding a paragraph that would require VA to pay compensation if a Veteran's disability or death was caused by hospital care or medical services furnished under proposed section 1703A of title 38, United States Code, and the proximate cause of the disability or death was carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault by the provider or an event not reasonably foreseeable.

VA fully supports ensuring that Veterans have access to high quality care, and that they are made whole in the event of a medical error. However, VA does not support this provision as written based on several concerns. First, section 103 would expand section 1151(a) to require VA benefit payments where the "proximate cause" of a Veteran's disability or death was the negligence of a non-Department healthcare provider or an unforeseeable event occurring during treatment by such a provider. The "term 'proximate cause' is used to label generically the judicial tools used to limit a person's responsibility for the consequences of that person's own acts. At bottom, the notion of proximate cause reflects 'ideas of what justice demands, or of what is administratively possible and convenient.'" *Holmes v. Sec. Investor Prot. Corp.*, 503 U.S. 258, 268 (1992) (quoting W. Keeton, D. Dobbs, R. Keeton, & D. Owen, PROSSER AND KEETON ON LAW OF TORTS § 41, p. 264 (5th ed. 1984)). Section 103 would make the Federal government liable for disability or death that is the proximate result of a non-Department medical provider's negligence or an unforeseeable event. This is contrary to the basic principle of American law, which holds an individual legally responsible for injuries caused by his or her negligent conduct.

Second, VA adjudicators would be required to develop evidence regarding care that is not provided by VA employees or in VA facilities, including DoD and other

Federal healthcare providers and academic affiliates, and to determine whether a Veteran's disability was proximately caused by negligence on the part of the community provider or an unforeseeable event occurring during non-Department medical care. *See* 38 U.S.C. § 5103A. This would entail gathering medical and other records from community providers as well as expert medical opinions about whether the event that occurred during the non-Department treatment was not foreseeable. This development burden of obtaining and evaluating evidence from non-Department providers and facilities can be expected to slow the adjudication of other Veterans' claims for benefits and potentially add to the disability compensation backlog.

Third, under 38 U.S.C. §1151(b), a recovery under the Federal Tort Claims Act as a result of a judgment or settlement for a disability or death for which compensation is awarded under 38 U.S.C. § 1151(a) results in a suspension of the section 1151 benefits until the amount of the judgment or settlement is recouped. In contrast, section 103 does not provide for a suspension of compensation for any recovery by a Veteran or Veteran's survivors from the non-Department provider as a result of a private lawsuit based upon the same disability or death. As a result, a Veteran or a Veteran's survivor could receive a recovery of both section 1151 benefits and tort damages based upon a judgment or settlement. This would create an inequity by allowing duplicative recovery for the same disability or death for persons whose entitlement is based on care furnished by community providers.

We have not yet had time to estimate the costs for section 103. However, we do know that, in FY 2016, 2.2 million Veterans received care from community providers under existing VA statutory authorities. During the first three quarters of FY 2017, 1.2 million Veterans have received such care. VA purchases care from more than 500,000 community providers, and the number continues to grow. VA's FY 2018 budget requests a 13 percent increase in funding for community care. As a result, VA could potentially be liable for section 1151 benefits for any of these 2 million Veterans who suffer additional disability or death due to negligence or an unforeseeable event caused by community care provided by community providers despite the absence of a causal connection between the additional disability or death and VA medical treatment.

Section 104 would add a sunset provision to section 1703 of title 38 terminating that program on December 31, 2018. It would make other conforming amendments similar to those proposed in section 12 of the draft Veterans Choice Act of 2017.

We support section 104.

Section 201 would add a new section 1703C to authorize the Secretary to enter into VCAs, similar to the authority that would be provided under section 4 of the draft Veterans Choice Act of 2017. However, there are a few differences in the proposed section 1703C that section 201 would create. First, the draft Veterans Choice Act of 2017 would require that care be unavailable under the Veterans Choice Program established in that draft bill prior to entering into a VCA, while the Improving Veterans Access to Community Care Act of 2017 has no such limitation. The draft Veterans

Choice Act of 2017 would authorize providers to opt out of a VCA, but the Improving Veterans Access to Community Care Act of 2017 does not include this provision. The draft Veterans Choice Act of 2017 would limit the ability of the Secretary to direct patients to providers that have entered into contracts or agreements under other authorities, while the Improving Veterans Access to Community Care Act of 2017 does not include such a restriction. The draft Improving Veterans Access to Community Care Act of 2017 would include greater flexibility in terms of the Medicare rate through inclusion of the phrase "to the extent practicable" in prescribing the rates the Secretary would pay under VCAs. While we believe the draft Veterans Choice Act of 2017 would allow the Secretary, on a case-by-case basis, to determine whether or not to pay for care not authorized, the Improving Veterans Access to Community Care Act of 2017 would allow the Secretary to pay a provider who provides services in the course of treatment pursuant to an agreement with the Secretary but is not a party to the agreement. Finally, the draft Veterans Choice Act of 2017 would state uniformly that the OFCCP would not have authority over parties to a VCA, while, through section 205, the Improving Veterans Access to Community Care Act of 2017 would apply the limits established for the TRICARE Program in Directive 2014-01 of OFCCP to any healthcare provider entering into an agreement or contract with VA under section 1703A, 1703C, or 1745.

We support section 201 and prefer those provisions that differ from the draft Veterans Choice Act of 2017.

Section 205 would apply the OFCCP moratorium to VA, and VA supports that provision. We recommend against including a specific deadline, as that would allow flexibility in the event that the OFCCP Directive is further revised. Many of the technical concerns we identified with the draft Veterans Choice Act of 2017 regarding VCAs apply here as well, and we look forward to working with the Committee and the Department of Labor to address concerns.

Section 202 would modify VA's authority under section 1745 and is identical to section 6 of the draft Veterans Choice Act of 2017.

VA's views on that provision apply here as well.

Section 203 would amend section 106 of the Veterans Access, Choice, and Accountability Act of 2014 to require that, at the beginning of each fiscal year, the Secretary to transfer to VHA an amount equal to the estimated amount required to furnish hospital care, medical services, and other healthcare through non-Department providers during the fiscal year. The Secretary would be authorized to make adjustments to the amount transferred to accommodate variances in demand for such care and services from non-Department providers.

We support section 203 because this would provide greater flexibility to adjust resource allocations based upon actual demand.

Section 204 would create a new section 1730B, which would allow the Secretary, notwithstanding sections 1341(a)(1) and 1501 of title 31, to record an obligation of the United States for non-Department care on the date on which a claim for payment is approved, rather than the date on which the care or services are authorized.

VA understands this provision is intended to bring the Department closer to industry practices in terms of allocating resources for care and developing better estimates concerning our community care liabilities. VA appreciates the Committee's willingness to engage on this issue given our prior discussions on this, and we look forward to working with you further on this proposal.

Section 205 of the bill is discussed above in the analysis of section 201, and the Department's views on this provision are provided in that discussion.

We are unable to provide cost estimates on the bill at this time but will follow up after the hearing with any estimates we can develop and our thoughts on the potential budget implications. We will also provide technical comments for your consideration.

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