STATEMENT OF
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DEPUTY SECRETARY
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

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Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today are Laura Eskenazi, Executive in Charge and Vice Chairman of the Board of Veterans Appeals (the Board), David McLenachen, Deputy Under Secretary for Disability Assistance for the Veterans Benefits Administration (VBA), and Baligh Yehia M.D., Assistant Deputy Under Secretary for Health for Community Care.

Thank you for the opportunity to come before you today to discuss the Department's legislative priorities, along with additional pieces of introduced legislation. I know the Committee has introduced an "omnibus" measure which will address many of the immediate needs of the Department of Veterans Affairs (VA) in serving Veterans.

Our pressing needs are items that we have outlined in letters to the committee, in previous testimony, and in countless meetings with the committee and members staffs, which support the MyVA Breakthrough Priorities. Some of these critical needs are addressed in bills you are considering in today's hearing, but we'd like to work with you on the particular language to ensure that, as enacted, the language will have the

desired effect of helping the Department best serve Veterans. In particular, the legislation being considered today to address consolidation of community care presents challenges and concerns.

I believe it is critical for Veterans that we all work together and gain consensus on a way forward for these pieces of legislation that will provide VA with the tools necessary to deliver care and benefits at the level expected by Congress, the American public, and deserved by Veterans.

S. ____ A bill to reform the rights and processes relating to appeals of decisions regarding claims for benefits under the laws administered by the Secretary of Veterans Affairs

Addressing the appeals claims process is a top priority. The draft bill being considered today would provide much-needed comprehensive reform for the VA appeals process. It would replace the current, lengthy, complex, confusing VA appeals process with a new appeals framework that makes sense for Veterans, their advocates, VA, and stakeholders. VA fully supports this bill.

The current VA appeals process, which is set in law, is broken and is providing Veterans a frustrating experience. Appeals have no defined endpoint and require continuous evidence gathering and readjudication. The system is complex, inefficient, ineffective, confusing, and splits jurisdiction of appeals processing between the Board of

Veterans' Appeals (Board) and the Veterans Benefits Administration (VBA). Veterans wait much too long for final resolution of an appeal. We face an important decision about the future of appeals for Veterans, taxpayers, and other stakeholders.

Within the current legal framework, the average processing time for all appeals resolved in FY 2015 was 3 years. For those appeals that reach the Board, on average, Veterans are waiting at least 5 years for an appeals decision, with thousands of Veterans waiting much longer. As Secretary McDonald noted in his February 23, 2016 testimony, in 2015, the Board was still processing an appeal that originated 25 years ago, even though the appeal had previously been decided by VA over 27 times. VA continues to face an overwhelming increase in its appeals workload. Looking back over FY 2010 through 2015, VBA completed more than 1 million claims annually, with nearly 1.4 million claims completed in FY 2015 alone.This reflects a record level of production. As VA has increased claims decision output over the past 5 years, appeals volume has grown proportionately. Since 1996, the appeal rate has averaged 11 to 12 percent of all claims decisions. The dramatic increase in the volume of appeals is directly proportional to the dramatic increase in claims decisions being produced, as the rate of appeal has held steady over decades. Between 2012 and 2015, the number of pending appeals climbed by 35 percent to more than 450,000 today. VA projects that, by the end of 2027, under the current process, without significant legislative reform, Veterans will be waiting on average 10 years for a final decision on their appeal.

Comprehensive legislative reform is required to modernize the VA appeals process and provide Veterans a decision on their appeal that is timely, transparent, and fair. This bill would provide that necessary reform. The status quo is not acceptable for Veterans or for taxpayers. Without legislative change, providing Veterans with timely answers on their appeals could require billions of dollars in net new funding over the next decade. By contrast, with legislation and a short-term increase in funding to address the current pending workload, VA could resolve the pending inventory, provide most Veterans with an appeals decision within 1 year by 2021, and greatly improve the efficiency of the Appeals process for years to come. We believe this can be done for net additional costs over 10 years in the millions of dollars, not the billions required by the status quo, saving money in the long-term compared to where we are headed without reform. If we fail to act now, the magnitude of the problem will continue to compound.

A wide spectrum of stakeholder groups recently met with VA to reconfigure the VA appeals process into something that provides a timely, transparent, and fair resolution of appeals for Veterans and makes sense for Veterans, their advocates, stakeholders, VA, and taxpayers. We believe that the engagement of those organizations that participated ultimately led to a stronger proposal, as we were able to incorporate their input and experience having helped Veterans through this complex process. The result of that summit was a new appeals framework, virtually identical to the draft bill, that would provide Veterans with timely, fair, and quality decisions. VA is

grateful to the Veterans Service Organizations and other stakeholders for their contributions of time, energy, and expertise in this effort.

The essential feature of this newly shaped design would be to step away from an appeals process that tries to do many unrelated things inside a single process and replace that with differentiated lanes, which give Veterans clear options after receiving an initial decision on a claim. For a claim decision originating in VBA, for example, one lane would be for review of the same evidence by a higher-level claims adjudicator in VBA; one lane would be for submitting new and relevant evidence with a supplemental claim to VBA; and one lane would be the appeals lane for seeking review by a Veterans Law Judge at the Board. In this last lane, intermediate and duplicative steps currently required by statute to receive Board review, such as the Statement of the Case and the Substantive Appeal, would be eliminated. Furthermore, hearing and non-hearing options at the Board would be handled on separate dockets so these distinctly different types of work can be better managed. As a result of this new design, the agency of original jurisdiction (AOJ), such as VBA, would be the claims adjudication agency within VA, and the Board would be the appeals agency.

This new design would contain a mechanism to correct any duty to assist errors by the AOJ. If the higher-level claims adjudicator or Board discovers an error in the duty to assist that occurred before the AOJ decision being reviewed, the claim would be returned to the AOJ for correction unless the claim could be granted in full. However, the Secretary's duty to assist would not apply to the lane in which a Veteran requests

higher-level review by the AOJ or review on appeal to the Board. The duty to assist would, however, continue to apply whenever the Veteran initiated a new claim or supplemental claim.

This disentanglement of process would be enabled by one crucial innovation. In order to make sure that no lane becomes a trap for any Veteran who misunderstands the process or experiences changed circumstances, a Veteran who is not fully satisfied with the result of any lane would have 1 year to seek further review while preserving an effective date for benefits based upon the original filing date of the claim. For example, a Veteran could go straight from an initial AOJ decision on a claim to an appeal to the Board. If the Board decision was not favorable, but it helped the Veteran understand what evidence was needed to support the claim, then the Veteran would have 1 year to submit new and relevant evidence to the AOJ in a supplemental claim without fearing an effective date penalty for choosing to go to the Board first.

To fully enable this process and provide the appeals experience that Veterans deserve, VBA, which receives the vast majority of appeals, would modify its claims decisions notices to ensure they are clearer and more detailed. This information would allow Veterans and their representatives to make informed choices about whether to file a supplemental claim with the AOJ, seek a higher-level review of the initial decision within the AOJ, or appeal to the Board.

The result of the draft bill would not only improve the experience of Veterans and deliver more timely results, but it would also improve quality. By having a higher-level review lane within the VBA claims process and a non-hearing option lane at the Board, both reviewing only the record considered by the initial claims adjudicator, the output of those reviews would provide a feedback mechanism for targeted training and improved quality in VBA.

Though some may view this reform effort as too accelerated, we would like to reiterate that the topic of "fixing the appeals problem" has been debated and studied by experts in the field for many, many years. The draft bill would solve the problem. The time to act is now. We are excited to be part of this work and to have the potential to lay down a path for future Veterans' appeals that is simple, timely, transparent, and fair. We owe it to our country to put in place a modernized framework for Veterans' appeals which we believe will serve Veterans, taxpayers, and the nation well for years to come.

Consolidation of Community Care

We need your help, as discussed on many occasions, to overhaul our Care in the Community programs. Our Plan to Consolidate Programs of Department of Veterans Affairs to Improve Access to Care (the Plan) as required by Title IV of Public Law 114-41, the VA Budget and Choice Improvement Act, was delivered on October 30, 2015.

Determining the details of a program that could replace the current and temporary Veterans Choice program enacted in August 2014 will require close study

and collaboration with Veterans, Veterans Service Organizations (VSO), the Congress and other stakeholders and experts.

That is why VA staff and subject matter experts have communicated regularly with Committee and Member staff to further discuss concepts and specific concerns. While we know further discussions are required to get us to a fully streamlined program, we have identified components of the plan that could be enacted now and would improve Veterans experiences' with, and VA's performance under, the existing Veterans Choice Program.

We believe that together we can accomplish the necessary legislative changes to streamline the overwhelming number of varying Care in the Community programs before the end of this session of Congress. Many of the concepts are addressed in some way by the bill under consideration today.

VA's intense focus, and our mission, is to provide high quality health care that is tailored to the special needs of Veterans and that is accessible to Veterans. Part of that effort is to secure care through community providers when VA is not in a position to provide that care itself that meets our goals for reasonable access. The current Veterans Choice Act represents an effort to set rules to define the right balance in legislation.

S. 2896 – Care Veterans Deserve Act

The Department has serious concerns with the potential consequences of section 2 of S. 2896, which eliminates the existing sunset date for the Veterans Choice Program and removes the current eligibility criteria without providing any additional resources. About 80% of Veterans have some other form of health insurance and have a choice today about where to seek their health care. If Veterans who currently do not use the VA health care system begin to seek community care through the Choice Program, VA will have to divert resources away from the provision of internal VA care, dramatically undercutting our ability to provide care that is tailored to the unique health care needs of Veterans. The erosion of funding for internal VA care would in turn strike at the foundation of VA's other missions, notably training U.S. medical professionals, supporting the Department of Defense in readiness, and conducting ground-breaking research.

While it may be an appealing notion to make Veterans Choice universal, we believe such legislation would create a dynamic that could lead to serious erosion in VA's ability to address the critical special needs of Veterans, in a system that was created to serve their needs. Sections of this bill would render VA functionally as a health care insurer, rather than a health care provider. As noted, about 80% of Veterans have some other form of health insurance. When service connected care is provided under the Choice Program, VA is the only payer for the care. For non-service connected care, VA is secondary to other health insurance except for Medicare, Medicaid and TRICARE, from which VA cannot seek reimbursement. A Veteran may

choose to use the Choice Program for care, due to low or no cost-sharing requirements in the VA system, even if they otherwise would never come to the VA. This essentially utilizes VA resources for a portion of the Veteran population that wants to use VA as a health care insurer, rather than an integrated health care system. VA may never have a relationship with this Veteran other than paying their health care bills. This would weaken the VA health care system, which has a unique understanding of the consequences of military exposure, posttraumatic stress (PTS), polytrauma care, prosthetics, spinal cord injuries, and other types of care that are unrivaled by any other health care system in the world. Any recommendation for reform must be sure not to impede the contract VA has with Veterans to translate that understanding into state-of-the-art care that helps Veterans manage illness and achieve their highest level of health and well-being. We want to ensure that our services are available for those Veterans who need and want that type of care.

VA believes that there needs to be the right balance of community care access especially when VA cannot provide the care or is not geographically accessible to Veterans. VA is open to reform and is indeed making key advances in access, quality, and patient satisfaction as part of the larger transformation called MyVA. VA is also continuing to develop a truly integrated community-based network of providers that can evolve and improve. By allowing all Veterans to opt to use community providers, some areas may be overwhelmed with demand, generating delays in care for both Veterans and non-Veterans if there are not enough community providers to support all types of patients. This could adversely affect continuity of care for Veterans if we no longer have

insight or relationships with community providers. The added value provided to the Veterans through the larger VA community, including such unique features as the network of peer specialists and other social services, would no longer be available if enough Veterans no longer relied on the VA system to support these services. We put forward an Administration proposal that better meets our needs and continue to believe that is the right approach.

Specifically concerning section 3, of S. 2896, which requires VA to contract with a nationwide chain of walk-in clinics to provide care to enrolled Veterans, VA understands and appreciates the value in expanding VA's use of urgent care centers for Veterans who need such services, but this provision is too broad and does not include any feature, such as the inclusion of copayments, to ensure that it is used in a measured way that would not overrun the funds appropriated by Congress. The use of measured cost-sharing is well-recognized in the private sector as a way to help ensure management of costs while providing patients the care they need. VA of course uses copayments under current law for certain veterans and certain types of care. More critically, section 3 would also create an inequity where Veterans using these services do not owe a copayment, while comparable Veterans who use VA could be subject to a copayment, when both Veterans receive essentially the same treatment. Having no cost-share may increase a Veteran's utilization of the cost-free services. This may move more Veterans to care outside of the VA, disrupting continuity of care if a Veteran chose to receive limited care through walk-in clinics instead of more comprehensive visits at VA that would address his or her conditions systematically.

VA supports enactment of a Federal law authorizing the provision of health care via telehealth or mobile technologies as appropriate regardless of where the Veteran or the provider is located. Section 4 of S. 2896 would eliminate one of the last roadblocks to VA's expansion of the provision of telehealth services. This would save Veterans the trouble of having to drive to a clinic hours away (even to use telehealth services) and instead could allow them to be seen in the comfort and security of their own home. Additionally, allowing VA providers to be able to deliver care from alternate work sites, even outside the State where the Veteran is located, could expand our capacity to deliver health care.

We do not expect enactment of section 4 would result in any costs.

VA would appreciate the opportunity to have further discussions on this legislation especially related to VA's Plan to Consolidate Community Care Programs. VA believes sections 2 and 3 would result in extremely large costs, and would be glad to discuss that aspect of the legislation with the Committee as well.

VA does not support section 5 to expand the operating hours for VA pharmacies. There is no evidence that pharmacies at VA medical facilities are not meeting the prescription needs of Veterans within the current hours of operation. Pharmacies at VA facilities have processes in place to provide urgent and emergent pharmacy services during times outside normal hours of operation. These services include on-call pharmacy staff, use of contracted pharmacies for urgent and emergent prescription

needs, and dispensing of urgent and emergent medications by a VA provider in the emergency department; many VA facilities have inpatient pharmacies that are always open or have extended hours of operations compared to the outpatient pharmacy and can provide urgent or emergent prescription needs for Veterans.

Additionally, there is independent evidence that VA's Pharmacy Benefits Management program continues to provide industry leading customer service year after year for the entire pharmacy industry in the United States. The VA Pharmacy Consolidated Mail Outpatient Pharmacy (CMOP) provides approximately 80 percent of the total number of prescriptions dispensed by VA to our Nation's Veterans. The VA CMOP has achieved the J.D. Power highest score for customer satisfaction for the mail-order pharmacy market segment in the United States for the last 6 consecutive years. This repeated achievement is a direct reflection of VA pharmacy staff's commitment and dedication to VA's mission to serve our Nation's Veterans.

The pharmacists at VA facilities provide counseling and education to Veterans on their new prescriptions, and then the facility pharmacy transmits the prescriptions to the VA CMOP or to the local VA pharmacy for dispensing to Veterans. Pharmacy staffs at VA facilities are responsible for answering Veterans' questions related to prescription refills and other medication related questions. These services provided by VA facility pharmacy staffs allow VA CMOP staff to focus on prescription fulfillment activities.

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

VA strongly agrees that identifying and spreading best practices is crucial for continuing VA's transformation to a high performing health care organization, but we do not support section 6 which would require an additional review of efficacy at each VA Medical Center. We concur that it will be important to engage leading private sector hospital and health care organizations to share best practices with VA and learn about best practices VA has developed. In fact, we are well underway in achieving the very goals and objectives of this bill. Last summer, the Under Secretary for Health made best practice consistency one of VHA's top priorities for transformation, launching the Diffusion of Excellence Initiative to identify and diffuse best practices systematically across VHA. The initiative is a systematic way that VHA continuously identifies best practices in care delivery from the field and diffuses them across the system. The diffusion process helps minimize variability and empowers employees to share innovations. We would be happy to update the Committee on our progress and accomplishments in this area.

While VA greatly appreciates the goals of the legislation, we believe that, as drafted, the bill would both duplicate current efforts and prove to be cost-prohibitive. We do not have a specific cost estimate at this time, as the actual costs to implement this provision could vary greatly depending upon the scope of the reviews and the timing of implementation.

Other Healthcare Bills

VA is serving a growing number of women, and ensuring that women receive appropriately tailored, safe, and effective mental health and substance use disorder services, including the screening for substance use disorders, is consistent with VA's core mission and values. **S. 2487, the Female Veteran Suicide Prevention Act**, would require the tracking and measuring of specific metrics applicable to women, and which are most effective for women Veterans and those having the highest satisfaction rates among women Veterans.

VA supports S. 2487, but would require additional appropriations to implement the legislation as written. Women Veterans have been found to be at higher risk for suicide than women non-Veterans, which further supports the need to ensure that strong and effective mental health and substance use disorder services are available in VA for women Veterans.

VA estimates this bill would cost $2.2 million in fiscal year (FY) 2017 and $6.6 million over 3 years.

S. 2520, the Newborn Care Improvement Act, would increase from 7 to 14 the number of days after the birth of a child for which VA may furnish covered health care services to the newborn child of an eligible woman Veteran receiving maternity care and delivery services through VA.

Although VA supports this bill, VA would require additional appropriations to implement this legislation as written. If a full term newborn has fever or respiratory distress after delivery, they may need additional inpatient treatment to manage these complications. This treatment may extend beyond the current 7 days that are allowed in the VA medical benefits package. Additionally it is standard of care for further evaluations during the first 2 weeks of life to check infant weight, feeding, and newborn screening results. Upon review of these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may apply, including monitoring stability of the home environment, or providing clinical and other support if the newborn requires monitoring for neonatal abstinence syndrome (e.g., withdrawal for maternal drug use during pregnancy) and screening and referral for substance use disorder services. VA must carefully consider the resources necessary to implement this bill, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services.

On July 14, 2015, before the House Committee on Veterans' Affairs, Subcommittee on Health, VA testified that the companion bill, H.R. 423, would cost $2.3 million in the first year, $12.7 million over 5 years, and $28.2 million over 10 years. VA would be happy to update these cost estimates at the Committee's request.

S. 2679, the Helping Veterans Exposed to Burn Pits Act, would require VA to establish a Center of Excellence in the prevention, diagnosis, mitigation, treatment, and rehabilitation of health conditions relating to exposure to burn pits and other environmental exposures. The requirements in this bill would be met through the further

expansion of the existing VA Airborne Hazards Center of Excellence (AHCE) at the War Related Illness and Injury Study Center (WRIISC), East Orange Campus, VA New Jersey Health Care System.

Although VA supports this bill, VA would require additional appropriations to implement the legislation as written. The VA AHCE was established in 2013 to provide an objective and comprehensive assessment of Veterans' cardiopulmonary function, military and non-military exposures, and health-related symptoms for those with airborne hazard concerns. In addition, consistent with the mission of the WRIISC, the AHCE conducts clinical and translational research and actively develops and delivers new educational content for health care providers, Veterans, and other stakeholders. As planned, the AHCE has expanded in phases to become the Veterans Health Administration's (VHA) only comprehensive clinical assessment program for airborne hazards concerns of deployed Veterans.

VA estimates this bill would cost approximately $4 million in FY 2017, $20.3 million over 5 years, and $40.7 million over 10 years.

The draft bill on **health care for rural veterans** would expand the Veterans Choice program to include Veterans who have received care under the Access Received Closer to Home (ARCH) program. VA supports this bill however, we recommend some technical revisions to define the scope of this eligibility to ensure that only veterans who received care under ARCH and who still reside in an area where they

would be eligible to participate in ARCH would qualify; essentially, if a Veteran received care under ARCH previously and subsequently moved to another location that was not participating in Project ARCH, that Veteran would not be eligible to participate in the Choice Program on this basis.

VA supports efforts to share continuing medical education (CME) programs for non-VA medical providers who treat Veterans and their family members under laws administered by VA, and runs several programs of the type referenced in **S. 2049**. VA established VHA TrainingFinder Real-time Affiliate Integrated Network (TRAIN), an external learning management system to provide valuable, Veteran-focused, accredited, CME at no cost to community healthcare providers. Since the launch of VHA TRAIN on April 1, 2015, more than 14,000 people have created an account or subscribed to VHA content through a previously established account. VHA TRAIN reports more than 7600 completions from healthcare and public health providers.

S. 2883, the Appropriate Care for Disabled Veterans Act of 2016 would make permanent the requirement of the Secretary to submit a report on the capacity of VA to provide for the specialized treatment and rehabilitative needs of disabled Veterans. VA recommends against using “recidivism” as a metric. While “recidivism” meaning a return to substance use services after an intensive treatment episode, could be measured, it is conceptually at odds with medical understanding of substance use disorders as a chronic disease of the brain requiring on-going monitoring and treatment to avoid a return to substance use. VA attempts to engage stable, abstinent patients in on-going

services to prevent return to substance use, and has no way of distinguishing this follow-up care for secondary prevention from care for symptom recurrence.

In general, the majority of the new requirements of **S. 2888, the Janey Ensminger Act of 2016,** would fall to the Secretary of Health and Human Services, through the Administrator of the Agency for Toxic Substances and Disease Registry (ATSDR). VA appreciates the work and collaboration with ATSDR, and defers to that agency on views. We note that CDC receives funding through a separate appropriation to carry out activities under the Comprehensive Environmental Response, Compensation, and Liability Act of 1980, and would require funding accordingly.

However, VA does not support the provisions of this bill which would effectively defer Veteran eligibility decisions to ATSDR. It would also require VA to continue providing hospital care and medical services to Veterans who have received such care or services under section 1710(e)(1)(F) notwithstanding a determination that the evidence of connection of an illness or condition and exposure is not categorized as sufficient or modest.

This legislation would require VA to recognize new conditions that are not currently listed in 1710(e)(1)(F) if ATSDR places them in the “sufficient” or “modest” evidence of connection categories. We recommend that the ATSDR reports be submitted to VA in an advisory capacity only, as has been done with previous reports from the Institute of Medicine and National Research Council. If enacted, VA may

require additional resources to assist the Veterans and family members who would become eligible for hospital care and medical services.

As a technical matter, we note that the time period specified in section 1710(e)(1)(F) of title 38, United States Code, ends on December 31, 1987, whereas the time period in proposed section 399V-6(a)(1)(A) of the Public Health Service Act would end on December 21, 1987.

VA cannot provide a cost estimate for the bill because it is unknown what illnesses and conditions, if any, for which ASTDR would find that there is evidence that exposure to a toxic substance at Camp Lejeune during the specified time period may be a cause of such illness or condition at the “sufficient” or “modest” standard. The cost to VA of implementing this provision will depend upon which conditions ATSDR finds satisfy these requirements, how many Veterans and family members will qualify for hospital care and medical services for those conditions and illnesses, and the average cost for the necessary hospital care and medical services of those conditions or illnesses.

Benefits Legislation

VA supports the **draft bill related to the compensation and pension evidentiary threshold**. This legislation would promote consistency of

adjudications and reduce delays in processing claims due to the need to obtain an examination or report.

As a result of current law, medical examiners are required to provide an opinion regarding the etiology of a claimed disability or symptoms in cases in which there is little or no objective evidence concerning in-service incurrence of an injury, symptoms, or event that could cause the disability or symptoms. In such cases, an examiner's opinion is likely to be based on speculation rather than objective findings. Providing an examination in such cases also leads to unnecessary delay in finally resolving Veterans' claims for compensation.

The draft bill would amend section 5103A(d)(2) to add a requirement that VA would request a medical examination or opinion for purposes of a claim for disability compensation only if there is objective evidence in the record, except for certain circumstances.

Mandatory cost savings for the first year are expected to be $93.1 million. Five-year cost savings are estimated to be $504.3 million and 10-year cost savings are estimated to be $1.1 billion.

S. ____ - Automobile Adaptive Grants (draft bill). While VA appreciates the intent of this bill, which would ensure Veterans are able to make personal selections related to automobiles receiving modifications, VA does not support this legislation as it

is unnecessary. VA already has a policy for the Automobile Adaptive equipment program which establishes uniform and consistent system-wide procedures when furnishing automobile adaptive equipment. In addition, VA does not manufacture or install adaptive equipment on a beneficiary's vehicle. Rather, VA pays for automobile adaptive equipment that accommodates beneficiaries' driving and/or passenger needs as identified by a VHA certified Drivers Rehabilitation Specialist.

The draft bill entitled "**SOLVE Act of 2016**" would amend section 4102A of title 38 to provide greater flexibility to States in carrying out the Disabled Veterans' Outreach Program (DVOP) and employing Local Veterans' Employment Representatives (LVER), and it would direct the Secretary of Labor to encourage Governors to co-locate DVOP specialists and LVERs with one or more Department of Labor one-stop centers.

Respectfully, we defer to DOL's views on the bill.

The Construction Reform Act of 2016 draft bill would require the Secretary to use industry standards, standard designs, and best practices to carry out the construction of medical facilities, and then to contract to conduct external forensic audits of the expenditures relating to any major medical facility or super construction project where the total expenditures exceed the amount specified in the law for that project by more than 25 percent.

VA generally supports the intent of the draft bill but offers some technical assistance. VA agrees with the use of standard designs and best practices in carrying out the construction of medical facilities. We would like to clarify, however, that there are no official "industry standards" for health care facilities. Private facilities usually rely on the technical advice of their individual Architects/Engineers regarding best practices. VA already uses various specific industry recommendations, which we adapt as necessary for our project location, climate and site, to accommodate VHA's functional programs for each project. We use standard design templates for all outpatient clinics. We also use standard Design Guides and Space Planning criteria for health care departments and specialty functions. Of course, VA follows all Federal regulations regarding construction, including physical security, sustainability, energy use, renewable energy, accessibility, and environmental/cultural compliance

VA notes that in views on a House bill, H.R. 3106, that established the "super construction" threshold at $100 million, VA suggested substituting a threshold of $250 million. VA noted that the majority of active major projects are in fact over that threshold, but this allows for a better work distribution between VA and outside Federal entities. Congress established the threshold at $100 million in Public Law 114-58, and VA is of course implementing that law in concert with the United States Army Corps of Engineers. VA notes for the record that we believe a $250 million threshold would still present those advantages.

Mr. Chairman, this concludes my statement. Thank you for the opportunity to appear before you today. We would be pleased to respond to questions you or other members may have.