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REPORT
114–395

HOMELESS VETERANS' REINTEGRATION PROGRAMS REAUTHORIZATION ACT OF 2015

DECEMBER 7, 2016.—Ordered to be printed

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

R E P O R T

together with

SUPPLEMENTAL VIEWS

[To accompany S. 425]

The Committee on Veterans' Affairs (hereinafter, "Committee"), to which was referred the bill (S. 425) to amend title 38, United States Code (hereinafter, "U.S.C."), to provide for a five-year extension to the homeless veterans reintegration programs and to provide clarification regarding eligibility for services under such programs, having considered the same, reports favorably thereon with an amendment in the nature of a substitute and an amendment to the title, and recommends that the bill, as amended, do pass.

INTRODUCTION

On February 10, 2015, Senator Boozman introduced S. 425, the proposed Homeless Veterans' Reintegration Programs Reauthorization Act of 2015. S. 425 would reauthorize homeless veterans' reintegration programs through fiscal year 2020 and expand eligibility for those reintegration programs to veterans participating in the Department of Housing and Urban Development-Veterans Affairs Supportive Housing (hereinafter, "HUD-VASH") program, Indian veterans receiving assistance under the Native American Housing Assistance and Self Determination Act of 1996 (hereinafter, "NAHASDA"), and veterans transitioning from being incarcerated. Senator Tester is an original cosponsor. Senators Inhofe

and Schumer were later added as cosponsors. The bill was referred to the Committee.

On February 26, 2015, Senator Wyden introduced S. 602, the proposed GI Bill Fairness Act of 2015. S. 602 would consider certain time spent by members of the reserves while receiving medical care from the Secretary of Defense as active duty for purposes of eligibility for Post-9/11 Educational Assistance and would make that change apply retroactively as if it were enacted immediately after the enactment of the Post-9/11 Veterans Educational Assistance Act of 2008. Senator Boozman is an original cosponsor. Senators Markey and McCain were later added as cosponsors of the bill. The bill was referred to the Committee.

On March 10, 2015, Senator Burr introduced S. 684, the proposed Homeless Veterans Prevention Act of 2015. S. 684 would increase per diem payments for transitional housing for homeless veterans placed in housing that will become permanent, authorize per diem payments for entities furnishing care for dependents of certain homeless veterans, authorize the Department of Veterans Affairs (hereinafter, "VA" or "Department") to partner with public or private entities to provide legal services to homeless veterans, expand VA authority to provide dental care to certain veterans, repeal the sunset on referral and counseling programs for veterans at risk of homelessness and transitioning from certain institutions, extend supportive services assistance for low-income veteran families in permanent housing, direct VA to assess comprehensive service programs for homeless veterans, require a Government Accountability Office (hereinafter, "GAO") study of VA homeless programs, and repeal a requirement for annual reports from VA on assistance to homeless veterans. Senator Manchin is an original cosponsor. Senator King was later added as a cosponsor. The bill was referred to the Committee.

On April 23, 2015, Senator Murray introduced S. 1085, the proposed Military and Veteran Caregiver Services Improvement Act of 2015. S. 1085 would expand eligibility for the program of comprehensive assistance for family caregivers to include veterans who were injured or fell ill in the line of duty prior to September 11, 2001; include child care, financial planning, and legal services in the program of comprehensive assistance for family caregivers; authorize the transfer of entitlement to Post-9/11 education assistance to family members by veterans who are in the program of comprehensive assistance for family caregivers, without regard to length-of-service requirements; expand eligibility for special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living; authorize VA to provide certain caregiver assistance to family caregivers of a member in receipt of monthly special compensation; authorize flexible work schedules or telework for Federal employees who are caregivers of veterans; designate a veteran participating in the program of comprehensive assistance for family caregivers as an adult with a special need for purposes of the lifespan respite care program; establish an interagency working group to review policies relating to the caregivers of veterans and members of the Armed Forces; and require studies on members of the Armed Forces who commenced service after September 11, 2001, and veterans who have incurred a serious injury or illness, including a mental health

injury, and their caregivers. Senators Brown, Collins, Coons, Durbin, and Tester are original cosponsors. Senators Baldwin, Bennet, Blumenthal, Boxer, Cantwell, Franken, Hirono, King, Markey, Menendez, Peters, Sanders, Schatz, Schumer, and Warner were later added as cosponsors. The bill was referred to the Committee.

On May 21, 2015, Senator Hirono introduced S. 1450, the proposed Department of Veterans Affairs Emergency Medical Staffing Recruitment and Retention Act. S. 1450 would authorize VA to modify the hours of employment for a physician or physician assistant appointed in VA on a full-time basis to more or less than 80 hours in a biweekly pay period provided the employee's total hours of employment in a calendar year do not exceed 2,080. The bill was referred to the Committee.

On May 21, 2015, Senator Hirono introduced S. 1451, the proposed Veterans' Survivors Claims Processing Automation Act of 2015. S. 1451 would authorize VA to provide certain benefits to a survivor of a veteran who has not filed a formal claim, if VA determines that the record contains sufficient evidence to establish the survivor's entitlement to such benefits. The bill was referred to the Committee.

On May 22, 2015, Senator Brown introduced S. 1460, the proposed Fry Scholarship Enhancement Act of 2015. S. 1460 would include under the Yellow Ribbon G.I. Education Enhancement Program (hereinafter, "Yellow Ribbon Program") the child of an individual who, on or after September 11, 2001, dies in the line of duty while serving on active duty. Senator Tillis is an original cosponsor. Senators Blumenthal and Coons were later added as cosponsors. The bill was referred to the Committee.

On June 22, 2015, Senator Baldwin introduced S. 1641, the proposed Jason Simcakoski Memorial Opioid Safety Act. S. 1641 would direct VA and the Department of Defense (hereinafter, "DOD") to jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; establish a working group on pain management and opioid therapy for individuals receiving VA or DOD health care within the Health Executive Committee (hereinafter, "HEC") of the VA/DOD Joint Executive Committee (hereinafter, "JEC"); require GAO to report to Congress on VA's Opioid Safety Initiative (hereinafter, "OSI") and VA's opioid prescribing practices and the Patient Advocacy Program; and require VA to request information on medical license violations during the past 20 years and on whether the health care provider has entered into any settlement agreement for a medical-related disciplinary charge. Senators Blumenthal, Brown, Capito, Hirono, Johnson, Kaine, Manchin, Markey, Moran, Murray, Sanders, and Tester are original cosponsors. Senators Durbin, Feinstein, Franken, Kirk, Klobuchar, McCaskill, Schumer, and Warner were later added as cosponsors. The bill was referred to the Committee.

On June 24, 2015, Senator Tester introduced S. 1676, the proposed Delivering Opportunities for Care and Services for Veterans Act of 2015. S. 1676 would prohibit the U.S. Department of Health and Human Services from including in determining the limitation on the total number of residents the residents for allopathic or osteopathic medicine who count towards meeting VA's obligation under the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146) to increase the number of graduate medical

education (hereinafter, "GME") residency positions at VA; extend the period for VA to increase graduate medical education residency positions to 10 years; require VA and the Department of Health and Human Services to conduct a pilot program on graduate behavioral medicine residency programs; include education and training of marriage and family therapists and mental health professionals in VA education and training programs; allow appointment of mental health counseling doctors to be eligible for appointment to VA counselor positions; offer competitive pay for physician assistants at VA; provide at least 30 percent of annual debt reduction payments to rural medical practices; address the pay for VA's Directors of Veterans Integrated Service Networks (hereinafter, "VISNs"); and conduct a pilot program to assess the feasibility of implementing a nurse advice line for rural areas. Senator McCaskill is an original cosponsor. Senators Bennet, Blumenthal, Brown, Durbin, Schatz, and Udall were later added as cosponsors. The bill was referred to the Committee.

On July 14, 2015, Senator Shaheen introduced S. 1754, which would make permanent the temporary increase in the maximum number of judges presiding over the U.S. Court of Appeals for Veterans Claims (hereinafter, "Veterans Court"). Senator Blumenthal was later added as a cosponsor. The bill was referred to the Committee.

On July 23, 2015, Senator Blumenthal introduced S. 1856, the proposed Department of Veterans Affairs Equitable Employee Accountability Act of 2015. S. 1856 would allow VA to suspend employees without pay based on performance or misconduct and remove such suspended individuals if it is determined necessary after investigation and review; allow suspended or removed individuals to appeal to the Merit Systems Protection Board and receive back pay if the suspension or removal is found to be unwarranted. Senators Brown, Hirono, Murray, Sanders, and Tester are original cosponsors. Senators Baldwin, Bennet, Booker, Boxer, Cantwell, Cardin, Casey, Durbin, Franken, Gillibrand, Heinrich, Kaine, Leahy, Markey, Menendez, Mikulski, Peters, Schumer, Shaheen, Stabenow, Udall, Warren, and Whitehouse were later added as cosponsors. The bill was referred to the Committee.

On July 29, 2015, Senator Blumenthal introduced S. 1885, the proposed Veteran Housing Stability Act of 2015. S. 1885 would expand VA's definition of homeless veteran to include those fleeing domestic violence; direct VA to provide intensive case management interventions for veterans enrolled in the homeless registry and the annual patient enrollment system; provide case management services to improve housing retention for transitioning or previously homeless veterans; expand the VA housing assistance program to include assistance for at risk and low-income veterans and their families transitioning to permanent housing; direct VA to conduct community outreach on the housing needs of veterans; codify the National Center on Homelessness Among Veterans; and require an annual review of each grant recipient and eligible entity that receives per diem payments for homeless services to evaluate its performance. Senators Brown, Hirono, and Sanders are original cosponsors. Senators Boxer and Schumer were later added as cosponsors. The bill was referred to the Committee.

On August 5, 2015, Senator Blumenthal introduced S. 1938, the proposed Career-Ready Student Veterans Act of 2015. S. 1938 would modify the criteria for approving educational institutions providing programs leading to licensure or certification to require that they meet certain state requirements or are approved by an appropriate state board or agency. Senators Brown, Carper, Cassidy, Coons, Durbin, Feinstein, Gillibrand, Merkley, Murphy, Reed, Schumer, Shaheen, and Tillis are original cosponsors. Senator Warren was later added as a cosponsor. The bill was referred to the Committee.

On August 5, 2015, Senator Hoeven introduced S. 2000, the proposed Veterans Access to Long Term Care and Health Services Act. S. 2000 would authorize VA to enter into a Veterans Care Agreement with an eligible provider to furnish certain care and services if VA is unable to do so, establish a process for certification of eligible providers, monitor the quality of care furnished to veterans, and allow the agreements to be made to provide veterans with nursing home care. Senator Manchin is an original cosponsor. Senator Rounds was later added as a cosponsor. The bill was referred to the Committee.

On September 10, 2015, Senator Graham introduced S. 2022, which would increase the special monthly pension for living Medal of Honor recipients. Senators Blumenthal and Markey were later added as cosponsors. The bill was referred to the Committee.

On October 5, 2015, Senator Tester introduced S. 2134, the proposed Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015. S. 2134 would direct VA to carry out a pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as a VA physician assistant, provide educational assistance to program participants for the cost of obtaining a master's degree in physician assistant studies or a similar master's degree, ensure mentors are available for program participants at each VA facility where a participant is employed, partner with specified government programs and appropriate educational institutions that offer degrees in physician assistant studies, establish standards to improve education and hiring of physician assistants, and implement a national plan for retention and recruitment that includes adoption of competitive pay standards. Senator Moran is an original cosponsor. Senators Baldwin and Brown were later added as cosponsors. The bill was referred to the Committee.

On November 5, 2015, Senator Blumenthal introduced S. 2253, the proposed Department of Veterans Affairs Veterans Education Relief and Restoration Act of 2015. S. 2253 would provide that, if a veteran is forced to discontinue a course as a result of an educational institution's permanent closure and did not receive credit or lost time training toward completion of the educational program, VA educational assistance payments will not be charged against the individual's entitlement to educational assistance or against the aggregate period for which such assistance may be provided (for school closures beginning with fiscal year 2015), and allow VA to continue paying a monthly housing stipend following a permanent school closure for a limited period of time. Senators Baldwin, Brown, Durbin, Gillibrand, Hirono, Murphy, Reed, Tillis, Warren, and Wyden are original cosponsors. Senators Boxer, Carper, Heller,

Klobuchar, McCaskill, Murray, Peters, Sanders, and Schumer were later added as cosponsors. The bill was referred to the Committee.

COMMITTEE HEARINGS

On May 13, 2015, the Committee held a hearing on legislation pending before the Committee. Testimony was received from David R. McLenachen, Acting Deputy Under Secretary for Disability Assistance, U.S. Department of Veterans Affairs; Anthony Kurta, Deputy Assistant Secretary of Defense, Military Personnel Policy, U.S. Department of Defense; Teresa W. Gerton, Deputy Assistant Secretary for Policy, Veterans' Employment and Training Service, U.S. Department of Labor; Alphonso Maldon, Jr., Chairman, Military Compensation and Retirement Modernization Commission; Jeffrey E. Phillips, Executive Director, Reserve Officers Association; and Aleks Morosky, Deputy Legislative Director, National Legislative Service, Veterans of Foreign Wars.

On June 3, 2015, the Committee held a hearing on legislation pending before the Committee. Testimony was received from Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration, U.S. Department of Veterans Affairs; Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans; Fred Benjamin, Vice President and Chief Operating Officer, Medicalodges, Inc.; Thomas J. Snee, National Executive Director, Fleet Reserve Association; and Sergeant First Class Victor Medina, U.S. Army, Retired.

On June 24, 2015, the Committee held a hearing on legislation pending before the Committee. Testimony was received from Dr. Rajiv Jain, Assistant Deputy Under Secretary for Health for Patient Care Services, Veterans Health Administration, U.S. Department of Veterans Affairs; Ian de Planque, Legislative Director, The American Legion; Pete Hegseth, CEO, Concerned Veterans of America; Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans; Carl Blake, Associate Executive Director, Paralyzed Veterans of America; Max Stier, President and CEO, Partnership for Public Service; and John Rowan, National President, Vietnam Veterans of America.

On September 16, 2015, the Committee held a hearing on legislation pending before the Committee. Testimony was received from Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration, U.S. Department of Veterans Affairs; Joseph W. Wescott II, Legislative Director, National Association of State Approving Agencies; Roscoe G. Butler, Deputy Director for Health Care, The American Legion; Aleks Morosky, Deputy Director, National Legislative Service, Veterans of Foreign Wars; and Donald F. Kettl, Professor, School of Public Policy, University of Maryland.

On October 6, 2015, the Committee held a hearing on legislation pending before the Committee. Testimony was received from Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration, U.S. Department of Veterans Affairs; Lauren Augustine, Legislative Associate, Iraq and Afghanistan Veterans of America; Lou Celli, Director, Veterans Affairs and Rehabilitation Division, The American Legion; Elisha Harig-Blaine, Principal Associate, Housing (Veterans and Special

Needs), National League of Cities; and David Norris, National Legislative Committee Vice-Chairman, Veterans of Foreign Wars.

On November 18, 2015, the Committee held a hearing on legislation pending before the Committee. Testimony was received from Curtis L. Coy, Deputy Under Secretary for Economic Opportunity, Veterans Benefits Administration, U.S. Department of Veterans Affairs; Elizabeth Hempowicz, Public Policy Associate, Project on Government Oversight; William Hubbard, Vice President of Government Affairs, Student Veterans of America; Aleks Morosky, Deputy Director, National Legislative Service, Veterans of Foreign Wars; Thomas Porter, Legislative Director, Iraq and Afghanistan Veterans of America; and Diane Zumatto, National Legislative Director, AMVETS.

COMMITTEE MEETING

After reviewing the testimony from the foregoing hearings, the Committee met in open session on December 9, 2015, to consider, among other legislation, an amended version of S. 425, including provisions derived from S. 425 as introduced and provisions derived from the other legislation noted above. The Committee voted by voice vote, without objection, to report favorably to the Senate S. 425 as amended and as subsequently amended at the Committee meeting.*

SUMMARY OF S. 425 AS REPORTED

S. 425, as reported (hereinafter, "the Committee bill"), consists of 57 sections, summarized below.

Section 1 provides a short title and a table of contents.

TITLE I—BENEFITS

Section 101 would amend section 5101 of title 38, U.S.C., to provide that VA may pay benefits under chapter 13 (dependency and indemnity compensation) and chapter 15 (pension) and sections 2302 (funeral expenses), 2307 (burial benefits), and 5121 (accrued benefits) of title 38, U.S.C., to a survivor of a veteran who has not filed a formal claim, if VA determines that the record contains sufficient evidence to establish the survivor's entitlement to those benefits.

Section 102 would amend section 1562 of title 38, U.S.C., to increase from $1,299 to $3,000 the monthly special pension VA provides to Medal of Honor recipients.

TITLE II—EDUCATION MATTERS

Section 201(a) would amend section 3312 of title 38, U.S.C., to provide that any payment of educational assistance to an individual for pursuit of a course or courses under the Post-9/11 GI Bill, if VA finds that the individual was forced to discontinue pur-

*The Committee notes that the information outlined in this report was current as of the December 2015 Committee meeting at which the Committee bill was ordered favorably reported. With regard to sections 416, 417, 418, 422, 423, 425, 431, 432, 433, 434, 441, and 442, the Committee also notes that, after that Committee meeting, Public Law 114–198 was enacted, which incorporated in title IX numerous provisions derived from the Committee bill and from S. 2921 as favorably reported by the Committee regarding opioid therapy and pain management at VA. For purposes of explaining the Committee's December 2015 actions, the Committee generally opted to retain the then-current background information in this report.

suit as a result of permanent closure of the institution and did not receive credit or lost training time toward completion of the program for that course or courses, will not be charged against the individual's entitlement to benefits under the Post-9/11 GI Bill or counted against the aggregate period for which section 3695 of title 38, U.S.C., limits the individual's receipt of educational assistance.

Section 201(b) would amend section 3680(a) of title 38, U.S.C., to provide that VA may continue to pay educational allowances to certain veterans and other education beneficiaries in order to pay the Post-9/11 GI Bill housing allowance during periods following a permanent closure of an educational institution, except that the payments may be continued only until the earlier of the date of the end of the term during which the closure occurred and the date 4 months after the school closure.

Section 202 would modify section 3319 of title 38, U.S.C., so that a servicemember must serve 10 years and agree to serve an additional 2 years in order to be eligible to transfer unused Post-9/11 GI Bill benefits.

Section 202 would amend section 3319 of title 38, U.S.C., to cap monthly housing allowance payments at 50 percent of the housing allowance that would otherwise be payable to a child using transferred Post-9/11 GI Bill benefits.

Section 203 would codify in a new section 3326 of title 38, U.S.C., the provisions now found in section 5003(c) of Public Law 110–252 and would add a provision to that new section providing that, in the case of an individual who on or after January 1, 2016, submits to VA an election of which program to use that VA determines is clearly against the interests of the individual or who fails to make an election, VA may make an alternative election on behalf of the individual that VA determines is in the best interests of the individual. This section would also provide that VA must promptly notify the veteran of such alternate election and allow the veteran 30 days to modify the election.

Section 204 would modify section 3684 of title 38, U.S.C., so that an "educational institution" for purposes of reporting to VA enrollments in education programs would include a group, district, or consortium of separately accredited educational institutions located in the same state that are organized in a manner that facilitates the centralized reporting of enrollments in the group, district, or consortium of institutions.

Section 205 would amend section 3672 of title 38, U.S.C., so that an education program would be deemed approved for purposes of VA education benefits only if a state approving agency determines that the program meets the deemed-approved criteria. It would also modify section 3675 of title 38, U.S.C., so that a program that is not subject to approval under section 3672 of title 38, U.S.C., may be approved by a state approving agency or VA acting in the role of a state approving agency when the criteria for approval of accredited programs at for-profit institutions are met.

Section 206 would modify section 3676 of title 38, U.S.C., so that additional criteria for approval of a non-accredited course may be required by a state approving agency only if the Secretary of Veterans Affairs, in consultation with the state approving agency and pursuant to regulations prescribed to carry out this requirement, determines that the additional criteria are necessary and treat

public, private, and proprietary for-profit educational institutions equitably. Section 206 would modify section 3675 of title 38, U.S.C., so that accredited courses must also meet those additional criteria to be approved.

Section 207 of the bill would amend section 3693 of title 38, U.S.C., to modify the conditions under which VA generally must conduct compliance surveys of educational institutions and training establishments offering approved courses.

Section 208 would amend sections 3675(b) and 3676(c) of title 38, U.S.C., to provide that, in order to be approved for purposes of VA education benefits, a program designed to prepare an individual for licensure or certification in a state, or for employment pursuant to standards developed by a board or agency of a state in an occupation that requires approval or licensure, the program also must meet any instructional curriculum licensure or certification requirements of the state, or meet such standards developed by a board or agency of a state. It would also require that any course of education designed to prepare a student for licensure to practice law be accredited by a recognized party and authorize the VA Secretary to waive any of those requirements in certain circumstances. It would add a subsection (d) to section 3679 of title 38, U.S.C., providing that VA must disapprove a course of education described above unless the educational institution providing the course publicly discloses any conditions or additional requirements to obtain the license, certification, or approval for which the course is designed to provide preparation. Finally, it would provide that, if, after enrollment in a course that is subject to disapproval by reason of these changes, an individual pursues courses at the same educational institution while remaining continuously enrolled, any course pursued by the individual at that institution will not be subject to disapproval.

Section 209 would amend section 3317 of title 38, U.S.C., to allow Marine Gunnery Sergeant John David Fry Scholarship (hereinafter, "Fry Scholarship") recipients to participate in the Yellow Ribbon Program.

Section 210 would amend section 3301 of title 38, U.S.C., to count as active duty for purposes of the Post-9/11 GI Bill reservists' service under section 12301(h) of title 10, U.S.C., under which the Secretary of a military department may order a reservist to active duty "to receive authorized medical care"; "to be medically evaluated for disability"; or "to complete a required Department of Defense health care study".

TITLE III—HOMELESS VETERANS MATTERS

Section 301 would amend section 2002(1) of title 38, U.S.C., so that the VA definition of homeless would include those individuals described in section 11302(b) of title 42, U.S.C., such as an individual fleeing domestic violence.

Section 302 would amend section 2012 of title 38, U.S.C., to provide that the per diem rate paid to certain entities that provide services to homeless veterans may exceed the rate paid to State homes in the case of services provided to a homeless veteran who is placed in housing that will become permanent housing upon termination of those services (transition-in-place). In those cases, the maximum per diem would be 150 percent of the State home rate.

Section 303 would amend section 2062 of title 38, U.S.C., to provide that dental services may be provided to a veteran who, for 60 consecutive days, has been housed using the Housing and Urban Development-VA Supportive Housing program.

Section 304 would amend section 2021 of title 38, U.S.C., to expand the scope of the homeless veterans' reintegration program to include veterans participating in VA's supported housing program for which rental assistance is provided under section 8(o)(19) of the United States Housing Act; Indians who are veterans and receiving assistance under the Native American Housing Assistance and Self Determination Act; and veterans who are transitioning from being incarcerated.

Section 305 would add a new section 2013 to title 38, U.S.C., to require VA to carry out a program under which VA provides case management services to improve the retention of housing by veterans who were previously homeless and are transitioning to permanent housing and veterans who are at risk of becoming homeless. VA would be required to provide a report to Congress on the results of the program.

Section 306, in a freestanding provision, would require VA to carry out a pilot program under which the VA Secretary will provide intensive case management interventions to a veteran who is enrolled in the VA homeless registry and the VA health care system. VA would be required to provide a report to Congress on the results of the pilot program.

Section 307 would add a new section 2067 to title 38, U.S.C., to require VA to establish and operate a center known as the National Center on Homelessness Among Veterans, thereby codifying the already existing Center.

Section 308 would add a new section 2022A to title 38, U.S.C., to authorize VA to enter into partnerships with public or private entities to fund a portion of the general legal services provided by those entities to homeless veterans and veterans at risk of homelessness.

Section 309 would amend section 2012 of title 38, U.S.C., to require VA, each year, to review each grant recipient and eligible entity that received a per diem payment under section 2012 of title 38, U.S.C., for a service furnished to a veteran during the 1-year period preceding the review to evaluate the performance of the grant recipient or eligible entity during that period. For any grant recipient or eligible entity whose performance was evaluated, VA may only provide per diem to that grant recipient or eligible entity in the following year if VA determines that such performance merits continued receipt of per diem. Also, VA would be required to establish uniform performance targets throughout the United States for all grant recipients and eligible entities that receive per diem payments for purposes of evaluating their performance.

Section 310 would repeal section 2065 of title 38, U.S.C., to remove a requirement that VA provide an annual report to Congress on the activities of VA's programs for homeless veterans.

Section 311 would require that, not later than 270 days after enactment, GAO must complete a study of VA programs that provide assistance to homeless veterans, including an assessment of whether those programs are meeting the needs of veterans and a review

of recent efforts by VA to improve the privacy, safety, and security of female veterans.

Section 312, in a freestanding provision, would require VA to assess and measure the capacity of programs that receive grants or per diem payments. VA would be required to develop and use tools to examine the capacity of those programs at both the national and local level.

Section 313, in a freestanding provision, would require VA to submit a report to Congress describing and assessing outreach conducted by VA to realtors, landlords, property management companies, and developers to educate them about the housing needs of veterans and the benefits of having veterans as tenants.

TITLE IV—HEALTH CARE MATTERS

Section 401 provides a short title for Title IV of the bill: Jason Simcakoski Memorial Act.

SUBTITLE A—EMPLOYMENT OF DIRECTORS AND HEALTH CARE PROVIDERS

Section 411 would amend Public Law 113–146 to require VA to increase the number of graduate medical education residency positions at VA medical facilities by up to 1,500 positions over the next 10 years, rather than the current 5-year requirement, and would extend an annual reporting requirement through 2024.

Section 412 would amend section 7423(a) of title 38, U.S.C., to provide an exception to the requirement that the hours of employment for a full-time VA physician or physician assistant must consist of not less than 80 hours in a biweekly pay period, so that VA may modify the hours of employment for a full-time physician or physician assistant to be more or less than 80 hours in a biweekly pay period if the total hours for the employee do not exceed 2,080 hours in a calendar year.

Section 413 would modify section 7451(a)(2) of title 38, U.S.C., to allow VA to offer rates of pay that are competitive with non-VA facilities within the same labor market areas when hiring for physician assistant positions.

Section 414 would amend section 7306 of title 38, U.S.C., to require the Office of the Under Secretary for Health to include such Directors of Veterans Integrated Service Networks as may be appointed to suit VA's needs and would strike the requirement that directors be either a qualified doctor of medicine or a qualified doctor of dental surgery or dental medicine.

Section 415 would add a new section 7481 to title 38, U.S.C., providing that pay for a Medical Director or Director of a Veterans Integrated Service Network will consist of basic pay set forth under section 7404(a) of title 38, U.S.C., (setting grades and pay scales for VA health professionals) and market pay determined under this new authority. The amount of market pay would be determined by the Secretary on a case-by-case basis and must consist of pay intended to reflect the needs of VA with respect to the recruitment and retention of the Director.

Section 416, in a freestanding provision, would require VA, as part of the hiring process for each health care provider after the date of enactment, to request from the medical board of each state in which the health care provider has a medical license information

on any violation of the requirements of the medical license of the health care provider and information on whether the health care provider has entered into any settlement agreement for a disciplinary charge relating to the practice of medicine.

Section 417, in a freestanding provision, would provide that, notwithstanding section 552a of title 5, U.S.C., (regarding disclosure of Federal records about an individual), VA must, with respect to any VA health care provider that has violated a requirement of his/her medical license, provide to the medical board of each state in which the health care provider is licensed or practices all relevant information contained in the State Licensing Board Reporting File or any successor file.

Section 418, in a freestanding provision, would provide that, not later than 2 years after enactment, VA would be required to submit to the Committee on Veterans' Affairs of the Senate and House of Representatives a report on VA's compliance with its policy to conduct a review of each VA health care provider who transfers to another VA medical facility or leaves VA to determine whether there are any concerns, complaints, or allegations of violations relating to the provider and, if there are, to take appropriate action.

SUBTITLE B—OPIOID THERAPY AND PAIN MANAGEMENT

Section 421, in a freestanding provision, would provide that, not later than 1 year after enactment, VA and the Department of Defense must jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

Section 422, in a freestanding provision, would provide that, not later than 180 days after enactment, VA would be required to expand VA's Opioid Safety Initiative to include all VA medical facilities; require all employees responsible for prescribing opioids to receive increased education and training; establish a pain management team at each medical facility; require participation in the state prescription drug monitoring programs (hereinafter, "PDMP"); report on the feasibility and advisability of advanced real-time tracking of opioid use data in the Opioid Therapy Risk Report tool; increase the availability of opioid receptor antagonists such as naloxone and provide a report on compliance; include in the Opioid Therapy Risk Report tool information on when health care providers access the tool and the most recent urine drug test for each veteran; and require notification of opioid abuse risk in the computerized patient record system.

Section 423, in a freestanding provision, would require that VA and DOD ensure that the Pain Management Working Group (hereinafter, "PMWG") of the VA-DOD Health Executive Committee includes a focus on the opioid prescribing practices of health care providers of each Department; the ability of each Department to manage acute and chronic pain, including training health care providers with respect to pain management; the use by each Department of complementary and integrative health (hereinafter, "CIH"); the concurrent use by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines; the practice by health care providers of each Department of prescribing opioids to treat mental health disorders; the coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving

health care from DOD to VA; and the ability of each Department to identify and treat substance use disorders.

Section 424 would add a new section 7309A to title 38, U.S.C., to require VA to establish within each Veterans Integrated Service Network a Pain Management Board.

Section 425, in a freestanding provision, would require VA, not later than 2 years after enactment, to enter into a contract with an independent entity to conduct an independent review of the Opioid Safety Initiative and the opioid prescribing practices of VA health care providers. The VA Secretary must review annually the prescription rates of each medical facility and conduct investigations, through the Office of the Medical Inspector, on prescription rates that conflict with or are otherwise inconsistent with the standards of appropriate and safe care.

SUBTITLE C—PATIENT ADVOCACY

Section 431 would add a new section 7309B to title 38, U.S.C., to establish in the Office of the Under Secretary for Health an Office of Patient Advocacy to carry out VA's Patient Advocacy Program. The Director would be appointed by the Under Secretary for Health and would report directly to the Under Secretary for Health.

Section 432, in a freestanding provision, would provide that, not later than 90 days after enactment, and not less frequently than once every 90 days thereafter, each VA medical center must host a community meeting open to the public on improving VA health care and that, not later than 1 year after enactment, and not less frequently than annually thereafter, each community based outpatient clinic must host a community meeting open to the public on improving VA health care.

Section 433, in a freestanding provision, would provide that, not later than 90 days after enactment, VA must, in as many prominent locations as appropriate to be seen by the largest percentage of patients and family members at each medical facility, display the purposes of the Patient Advocacy Program and the contact information for the patient advocate at such medical facility and display the rights and responsibilities of patients and family members of patients and with respect to community living centers and other VA residential facilities, residents and family members of residents at such medical facility.

Section 434, in a freestanding provision, would provide that, not later than 3 years after enactment, GAO must submit to the Committee on Veterans' Affairs of the Senate and House of Representatives a report on the Patient Advocacy Program.

SUBTITLE D—COMPLEMENTARY AND INTEGRATIVE HEALTH

Section 441, in a freestanding provision, would provide that, not later than 180 days after enactment, VA must develop a plan to expand materially and substantially the scope of the effectiveness of research and education on, and delivery and integration of, complementary and integrative health services into the health care services provided to veterans.

Section 442, in a freestanding provision, would provide that, not later than 180 days after completion of the plan to expand research and education on, and delivery and integration of, complementary

and integrative health services, VA would be required to carry out a pilot program to assess the feasibility and advisability of integrating the delivery of complementary and integrative health services with other health care services provided by VA for veterans with mental health conditions, chronic pain conditions, other chronic conditions, and such other conditions as the VA Secretary determines appropriate.

SUBTITLE E—FAMILY CAREGIVERS

Section 451 would amend section 1720G of title 38, U.S.C., to expand eligibility for VA's Program of Comprehensive Assistance for Family Caregivers to veterans with a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service on or before May 7, 1975, during the 2-year period following the date on which the VA Secretary submits to Congress a certification that the Department has fully implemented the information technology system required by section 452(a) of the bill. After the date that is 2 years after the date on which the certification is submitted, eligibility would be expanded to also include veterans with a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service after May 7, 1975, and before September 11, 2001.

Section 452, in a freestanding provision, would require VA to implement an information technology system that fully supports the Family Caregiver Program and allows for data assessment and comprehensive monitoring by not later than December 31, 2016.

Section 453 would amend requirements in Public Law 111–163 for VA's annual evaluation report on the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support to include a description of any barriers to accessing and receiving care and services. The report on the Program of Comprehensive Assistance for Family Caregivers would also include an evaluation of the sufficiency and consistency of the training provided to family caregivers.

Section 454, in a freestanding provision, would establish a VA advisory committee on caregiver policy.

Section 455, in a freestanding provision, would require VA to contract with an independent entity to conduct a comprehensive study on veterans who have incurred a serious injury or illness and individuals acting as caregivers for veterans.

SUBTITLE F—OTHER HEALTH CARE MATTERS

Section 461 would add a new section 1703A to title 38, U.S.C., to provide that VA may enter into agreements to provide nursing home care and those agreements may be entered into without regard to any law that would require VA to use competitive procedures in selecting the party with which to enter into the agreement. Generally, a nursing home in carrying out that agreement would not be subject to any law that Medicare providers are not subject to.

Section 462 would amend section 1745 of title 38, U.S.C., to provide that VA may enter into agreements to provide nursing home care and those agreements may be entered into without regard to any law that would require VA to use competitive procedures in selecting the party with which to enter into the agreement. Gen-

erally, a State home in carrying out that agreement would not be subject to any law that Medicare providers are not subject to.

TITLE V—OTHER MATTERS

Section 501 would amend section 7253 of title 38, U.S.C., to temporarily expand the U.S. Court of Appeals for Veterans Claims from 7 to 9 judges through 2020.

Section 502 would repeal section 604(b) of Public Law 113–291 in order to realign the housing allowance provided to VA beneficiaries using Post-9/11 GI Bill benefits so it is paid at the same rate as the Basic Allowance for Housing provided to active duty military personnel in pay grade E–5 at the "with dependents" rate.

Section 503 would add a new section 527A to title 38, U.S.C., to require VA to carry out a program of internal audits and self-analysis to improve the furnishing of benefits and health care to veterans and their families. VA would be required to carry out the program through an office established for that purpose within the Office of the Secretary that is interdisciplinary and independent of the other offices within the Office of the Secretary and the administrations, staff organizations, and staff offices identified for audits.

Section 504, in a freestanding provision, would require the VA Secretary to provide each VA employee who is in a managerial position with periodic training on the rights of whistleblowers and how to address a report by an employee of a hostile work environment, reprisal, or harassment; how to effectively motivate, manage, and reward the employees who report to the manager; and how to effectively manage employees who are performing at an unacceptable level and access assistance from the VA human resources office and the Office of General Counsel with respect to those employees.

BACKGROUND AND DISCUSSION

TITLE I—BENEFITS

Sec. 101. Expedited payment of survivor benefits.

Section 101 of the Committee bill, which is derived from S. 1451, would authorize VA to pay benefits to a survivor of a veteran who has not filed a formal claim, if the record contains sufficient evidence to establish the survivor's entitlement to such benefits.

Background. Section 5101 of title 38, U.S.C., requires a claimant to file a formal claim as a condition of receiving VA benefits. When a survivor of a veteran files a claim for VA benefits based upon the veteran's death, however, the information and evidence necessary to decide the claim is often already in the veteran's claims file. In its Fiscal Year 2016 Budget, VA included a legislative proposal that would authorize VA to initiate and pay a survivor's claim without receipt of a formal application whenever sufficient evidence is in the veteran's record to begin processing such claim. Elimination of the claim requirement would allow VA to automate the delivery of uninterrupted benefits to qualifying survivors.

Committee Bill. Subsection (a) of section 101 of the Committee bill would amend section 5101 of title 38, U.S.C., to authorize VA to pay benefits under chapter 13 (dependency and indemnity compensation) and chapter 15 (pension) and sections 2302 (funeral ex-

penses), 2307 (burial benefits), and 5121 (accrued benefits) of title 38, U.S.C., to a survivor of a veteran who has not filed a formal claim if VA determines that the record contains sufficient evidence to establish the survivor's entitlement to those benefits. For purposes of establishing an effective date under section 5110 of title 38, U.S.C., the date on which VA is notified of the death of the veteran will be treated as the date of the receipt of the survivor's application for benefits. These changes would apply with respect to claims for benefits based on a death occurring on or after the date of enactment.

Sec. 102. Increase in special pension for Medal of Honor recipients.

Section 102 of the Committee bill, which is derived from S. 2022, would amend section 1562 of title 38, U.S.C., to increase from $1,299.61 to $3,000 the monthly special pension VA provides to Medal of Honor recipients.

Background. Under section 1562(a) of title 38, U.S.C., VA provides a monthly special pension to individuals who have been entered on the Medal of Honor roll of a military service. The current monthly payment is $1,299.61. Under section 1562(e) of title 38, U.S.C., VA is required to increase the monthly stipend effective December 1 of each year by the same percent increase as any cost-of-living adjustment provided to recipients of Social Security benefits.

Committee Bill. Section 102 of the Committee bill would amend section 1562(a) of title 38, U.S.C., to increase to $3,000 the monthly special pension provided to Medal of Honor recipients. That change would take effect 1 year after the date of enactment, except that, if that date is not the first day of a month, the change would take effect on the first day of the first month beginning after that date. If the increase takes effect before December 1, 2016, VA would not make a cost-of-living adjustment to the special pension amount until December 1, 2017.

The Committee is of the view that an increase is warranted to help to defray the out-of-pocket costs incurred by Medal of Honor recipients in order to speak at or attend events around the country.

TITLE II—EDUCATION MATTERS

Sec. 201. Restoration of entitlement to Post-9/11 educational assistance for veterans affected by closures of educational institutions.

Section 201 of the Committee bill, which is derived from S. 2253, would require VA to provide a continued monthly housing stipend and restore educational benefits to veterans affected by the permanent closures of educational institutions if a veteran is forced to discontinue a course and did not receive credit, or lost training time, toward completion of the educational program.

Background. Section 3680 of title 38, U.S.C., describes the manner in which VA is to provide educational assistance payments and subsistence allowances during the period of veterans' or dependents' enrollment in an educational program. At the 100 percent level of entitlement of the Post-9/11 GI Bill, veterans are eligible for 36 months of tuition benefits and a monthly stipend equivalent to the amount of basic allowance for housing payable under section

403 of title 37, U.S.C., for a member with dependents in pay grade E–5. This stipend is intended to cover housing, food, utilities, and other expenses while attending school.

Currently, section 3680, subsection (a)(3)(B), of title 38, U.S.C., authorizes VA to continue to pay educational assistance and subsistence allowances during certain temporary school closures. These temporary closures are subject to regulations the VA Secretary shall prescribe and include periods when schools are temporarily closed due to an emergency, such as a strike, or under established policy, such as the issuance of a presidential Executive Order. However, this temporary continuance of benefit payments may not exceed 4 weeks in any 12-month period and the VA Secretary is not granted similar statutory authority to continue benefit payments in the event of a permanent school closure.

VA pays benefits for the term, quarter, or semester up to the time of the school's permanent closure, but the student beneficiary is charged education entitlement for the period prior to the closure for which benefits are received, even though he/she does not earn credit toward his/her program due to the unexpected closure. In some instances, this could result in a beneficiary exhausting entitlement prior to completing an educational program. There is no statutory authority that would allow VA to restore Post-9/11 GI Bill entitlement for a term, quarter, or semester for which a beneficiary fails to receive credit toward program completion due to such a closure.

In April 2015, Corinthian Colleges, Inc., filed for bankruptcy and abruptly closed 28 schools while students were actively attending classes. Approximately 422 Post-9/11 GI Bill beneficiaries were adversely impacted by these closures and stopped receiving their housing allowances. In some instances, this resulted in a beneficiary exhausting his or her Post-9/11 GI Bill entitlement prior to completing an educational program with no additional VA benefits to complete their degree. This may cause a significant financial burden for veterans and other beneficiaries, as the monthly housing payments are often a primary source of income, and may prevent veterans from achieving their educational goals.

Committee Bill. Section 201(a) of the Committee bill would add a new subsection (d) to section 3312 of title 38, U.S.C., to allow for the restoration of entitlement to educational assistance and provide other relief for veterans affected by a school closure. Specifically, if VA determines that a beneficiary was forced to discontinue a course or courses as a result of a permanent school closure and did not receive credit, or lost training time, toward completion of the educational program, no payment of educational assistance would be charged against an individual's entitlement to educational assistance under the Post-9/11 GI Bill, or counted against the aggregate period for which an individual may receive educational assistance under two or more programs. Pursuant to subsection 201(a)(2) of the Committee bill, this provision would apply to any beneficiary impacted by education discontinuance in fiscal year 2015, so as to include those impacted by the Corinthian closures, and would apply to any beneficiaries impacted by future school closures.

Section 201(b) of the Committee bill would amend section 3680(a) of title 38, U.S.C., and grant the VA Secretary the authority to continue payments of monthly housing stipends until the date of the

end of the term, quarter, or semester during which the school closure occurred, or the date that is 4 months after the date of the school closure, whichever date is soonest. The Committee intends for this time to allow veterans and their dependents the ability to make alternative arrangements for income or enroll in a different educational institution to complete a course or program.

Sec. 202. Modification and improvement of transfer of unused Post-9/11 Educational Assistance to family members.

Section 202 of the Committee bill, which is an original provision, would modify section 3319 of title 38, U.S.C., so that a servicemember must serve 10 years and agree to serve an additional 2 years in order to be eligible to transfer unused Post-9/11 GI Bill benefits. Section 202 would also amend section 3319 of title 38, U.S.C., to cap monthly housing allowance payments at 50 percent of the housing allowance that would otherwise be payable to a child using transferred Post-9/11 GI Bill benefits.

Background. The National Defense Authorization Act of Fiscal Year 2013 (Public Law 112–239) established the Military Compensation and Retirement Modernization Commission (hereinafter, "MCRMC") to conduct a review of the military compensation and retirement systems and to make recommendations to modernize such systems. The MCRMC issued its final report in January 2015 that included 15 recommendations around Pay and Benefits, Health Benefits, and Quality of Life for Servicemembers and Retirees. Recommendations 11 and 12 focused largely on education benefits and transition programs. In May 2015, the MCRMC issued an addendum to its report updating its recommendations.

The Post-9/11 GI Bill allows the Secretary of Defense to authorize transfer of unused education benefits to dependent family members as a retention tool when a servicemember meets basic eligibility criteria. In its final report, the MCRMC noted a misalignment of Post-9/11 GI Bill benefits and certain retention needs of the military services. Specifically, they noted that the years of service required to transfer unused education benefits to dependents was not aligned with the years of service in which the continuation rate, or retention, was lower. The MCRMC reported that continuation rates for servicemembers at 6 years of service averaged 35.3 percent from 1980 to 2010, but the continuation rate of servicemembers with 10 years of service averaged only 19.3 percent from 1980 to 2010.[1] The MCRMC recommended changing the current requirement that a servicemember complete 6 years of service and agree to 4 more years in order to transfer his/her unused education benefits to dependents, and require that servicemembers complete 10 years of service and agree to serve 2 more years to be eligible for transferring the benefits.

Another part of the MCRMC recommendation to improve education benefits noted the disparity in housing allowances paid to dependents using transferred education benefits when compared to the actual on-campus costs of room and board. Recommendation 11 of the Final Report cited two annual studies from October 2013 in which the highest on-campus room and board fees and the lowest

[1] Final Report of the Military Compensation and Retirement Modernization Commission, at 166. www.mcrmc.gov/public/docs/report/mcrmc-finalreport-29jan15-lo.pdf.

on-campus room and board fees were identified, and then compared those costs to the amount in housing allowances paid to Post-9/11 GI Bill beneficiaries. The amount of housing allowances paid for the least expensive and most expensive room and board costs were 171 percent and 222 percent of the actual costs, respectively.[2] Based on this finding, the MCRMC recommended eliminating the monthly housing allowance portion of Post-9/11 GI Bill benefits for spouses and children using transferred education benefits.

Committee Bill. Section 202(a) of the Committee bill would amend subsection 3319(b)(1) of title 38, U.S.C., to replace the required completed 6 years of service with a requirement to complete 10 years of service. It would also amend that subsection to replace the required agreement to serve at least 4 more years as a member of the uniformed services with an agreement to serve at least 2 more years. Section 202(b) of the Committee bill would amend subsection 3319(g)(1)(A) of title 38, U.S.C., to require that a servicemember transferring benefits to a spouse complete at least 10 years of service instead of only 6 years of service, before the spouse to whom benefits were transferred may commence using the benefits.

Section 202(c) of the Committee bill adds to subsection 3319(h)(3)(B) of title 38, U.S.C., an exception to the monthly rate of educational assistance payable to a child using transferred entitlement. The exception specifies that monthly housing stipends under section 3313 of title 38, U.S.C., paid to children using transferred benefits when they pursue degree programs or non-college degree programs, shall be paid at 50 percent of the rate they would otherwise be paid if the veteran was using the benefit.

Section 202 of the Committee bill also includes a technical correction to change "armed forces" to "Armed Forces" each place it appears in section 3319 of title 38, U.S.C., and specifies that the changes made by subsections (a) through (c) of the Committee bill will apply to the transfer of unused education benefits initiated beginning 180 days after enactment. Unused education benefits transferred to dependents prior to 180 days after enactment would not be subject to the new service requirements or to the exception for rate of monthly stipend payments to children using transferred benefits as implemented by the Committee bill.

Sec. 203. Codification and improvement of election process for Post-9/11 Educational Assistance.

Section 203 of the Committee bill, which is an original provision, would codify in a new section 3326 of title 38, U.S.C., the provisions now found in section 5003(c) of Public Law 110–252 and would add a provision to that new section providing that, in the case of an individual who on or after January 1, 2016, submits to VA an election of which program to use that VA determines is clearly against the interests of the individual or who fails to make an election, VA may make an alternative election on behalf of the individual that VA determines is in the best interests of the individual. This section would also provide that VA must promptly no-

[2] Final Report of the Military Compensation and Retirement Modernization Commission, at 167-168. www.mcrmc.gov/public/docs/report/mcrmc-finalreport-29jan15-lo.pdf.

tify the veteran of such alternate election and allow the veteran 30 days to modify the election.

Background. Section 5003 of the Post-9/11 Veterans Educational Assistance Act of 2008 (Public Law 110–252) created the Post-9/11 GI Bill by adding chapter 33 to title 38, U.S.C. Section 5003(c) of that law was added as a note to the newly created section 3301 of title 38, U.S.C., specifying procedures and rules for individuals with eligibility for the Montgomery GI Bill to use the Post-9/11 GI Bill instead. Part of those procedures for using the Post-9/11 GI Bill instead of another education benefit included requiring the veteran to make an irrevocable election to give up entitlement to a previous benefit in order to use the Post-9/11 GI Bill instead.

VA staff have reported to Congressional staff that the requirement for making an irrevocable election frequently delays processing new claims for Post-9/11 GI Bill benefits. This is due to veterans often electing to give up entitlement to a benefit to which they are not entitled, or they may make an election that goes against their best interests. When this occurs, VA staff must send clarification to the veteran in writing and request return of written confirmation of the election or an election to give up a different benefit entitlement to which the veteran is entitled.

Committee Bill. Section 203 of the Committee bill would create a new section 3326 in title 38, U.S.C. This new section would put into code the procedures and rules for an individual to use the Post-9/11 GI Bill benefit instead of another education benefit to which they are entitled. In addition to the existing procedures and rules governing this process, the Committee bill would authorize the VA Secretary to change the individual's irrevocable election to give up entitlement to a certain benefit when the original election is clearly against the individual's interest or when no such election was made. This section of the Committee bill would also repeal section 5003(c) of the Post-9/11 Veterans Educational Assistance Act of 2008 (Public Law 110–252; 38 U.S.C. 3301 note).

Sec. 204. Centralized reporting of veteran enrollment by certain groups, districts, and consortiums of educational institutions.

Section 204 of the Committee bill, which is an original provision, would modify section 3684 of title 38, U.S.C., so that an "educational institution" for purposes of reporting to VA enrollments in education programs would include a group, district, or consortium of separately accredited educational institutions located in the same state that are organized in a manner that facilitates the centralized reporting of enrollments in the group, district, or consortium of institutions.

Background. Some educational institutions operate as part of a district or consortium even though each school is individually accredited. Consolidation of certain functions can streamline administration and reporting. Under section 3684 of title 38, U.S.C., each separate educational institution must certify enrollment of students using VA educational benefits in order for those benefits to be paid. This applies to each institution even in cases where they otherwise operate as part of a consortium for purposes of reporting enrollment and student information.

Committee Bill. Section 204 of the Committee bill would amend section 3684 of title 38, U.S.C., to add chapters 32 and 33 of title

38, U.S.C., to the list of benefits requiring educational institutions to report enrollments of students to VA. Section 204 of the Committee bill also defines the term "educational institution" for purposes of section 3684(a) of title 38, U.S.C. This added definition specifies that an educational institution includes a group, consortium, or district composed of separately accredited schools in the same state, so long as they are organized to facilitate central reporting of enrollments from across the group of institutions.

Sec. 205. Improved role of state approving agencies in administration of veterans educational benefits.

Section 205 of the Committee bill, which is an original provision, would amend section 3672 of title 38, U.S.C., so that an education program would be deemed approved for purposes of VA education benefits only if a state approving agency determines that the program meets the deemed-approved criteria. It would also modify section 3675 of title 38, U.S.C., so that a program that is not subject to approval under section 3672 of title 38, U.S.C., may be approved by a state approving agency or VA acting in the role of a state approving agency when the criteria for approval of accredited programs at for-profit institutions are met.

Background. The Post-9/11 Veterans Educational Assistance Improvements Act of 2010 (Public Law 111–377) added section 3672(b)(2) to title 38, U.S.C., in order to streamline approval of education programs at certain educational institutions. This new provision made it easier for new programs at existing institutions to be approved for educational assistance but it also took the state approving agencies out of the approval process and limited their ability to deny approval to programs.

Committee Bill. In order to strengthen the ability of state approving agencies to oversee the approval of new courses of education, section 205 of the Committee bill amends section 3672 of title 38, U.S.C., to require that a state approving agency determine whether or not an educational institution is within one of the five listed categories before it can be deemed approved. The Committee bill also amends section 3675 of title 38, U.S.C., to clarify that only state approving agencies, or the VA Secretary when acting as the state approving agency, has the authority to approve accredited programs that are not covered under section 3672 of title 38, U.S.C.

Sec. 206. Modification of criteria used to approve courses for purposes of veterans educational benefits.

Section 206 of the Committee bill, which is an original provision, would modify section 3676 of title 38, U.S.C., so that additional criteria for approval of a non-accredited course may be required by a state approving agency only if the VA Secretary, in consultation with the state approving agency and pursuant to regulations prescribed to carry out this requirement, determines that the additional criteria are necessary and treat public, private, and proprietary for-profit educational institutions equitably. Section 206 would modify section 3675 of title 38, U.S.C., so that accredited courses must also meet those additional criteria to be approved.

Background. Section 3676 of title 38, U.S.C., specifies criteria for state approving agencies to use in approving nonaccredited courses for the use of VA education benefits. One such criteria in para-

graph (14) of subsection (c) of that section authorizes the individual state approving agency to establish additional criteria in addition to those listed in section 3676(c) of title 38, U.S.C. Although intended to allow for use of relatively minor additional criteria, in 2014 a state passed a law requiring additional criteria that were not applied equally to all institutions and created a significant new criteria for certain schools to meet.

Committee Bill. Section 206 of the Committee bill would amend section 3676(c)(14) of title 38, U.S.C., to require the VA Secretary to approve any additional criteria deemed necessary by a state approving agency. In making that determination, the VA Secretary must ensure such additional criteria treat all educational institutions equitably. This change would apply to additional criteria developed after January 1, 2013, or to investigations conducted on or after October 1, 2015, pursuant to section 3674 of title 38, U.S.C.

Sec. 207. Surveys for compliance of educational institutions and training establishments with requirements relating to administration of veterans educational benefits.

Section 207 of the Committee bill, which is an original provision, would amend section 3693 of title 38, U.S.C., to modify the conditions under which VA generally must conduct compliance surveys of educational institutions and training establishments offering approved courses.

Background. Section 3693 of title 38, U.S.C., directs the VA Secretary to conduct annual compliance surveys of institutions that enroll veterans or eligible individuals using educational assistance. These surveys are intended to ensure educational institutions and their courses comply with the relevant requirements under chapters 30 through 36 of title 38, U.S.C. In testimony before the Committee on September 16, 2015, Dr. Joseph W. Wescott II, of the National Association of State Approving Agencies, noted that the current requirements for VA, and state approving agencies that assist VA, to conduct compliance surveys are onerous and do not allow VA the needed flexibility to focus compliance surveys on the schools most in need of oversight. The National Association of State Approving Agencies submitted a legislative proposal to ensure more institutions receive compliance surveys at least once every 2 years. Their proposal also directed VA to identify which institutions would receive surveys in advance each year and preserved the ability for the VA Secretary to waive the compliance survey requirement for institutions with a record of demonstrated compliance.

Committee Bill. Section 207 of the Committee bill would amend section 3693 of title 38, U.S.C., to require VA to perform a compliance survey at least once every 2 years for each educational institution or training establishment which enrolls 20 or more individuals eligible for VA educational assistance. This section of the Committee bill also directs the VA Secretary to design the compliance surveys to ensure all applicable provisions of chapters 30 through 36 of title 38, U.S.C., are followed by the institution, that each compliance survey specialist not perform more than 40 surveys per year, and that VA provide to the state approving agencies in advance of each fiscal year a list of the institutions to be surveyed for that year.

Sec. 208. Modification of requirements for approval for purposes of educational assistance provided by Department of Veterans Affairs of programs designed to prepare individuals for licensure or certification.

Section 208 of the Committee bill, which is derived from S. 1938, would improve the approval of certain programs of education for purposes of VA educational assistance provided by requiring that educational programs meet state instructional curriculum licensure or certification requirements.

Background. State approving agencies were established by each state after the passage of the original "GI Bill," the Veterans' Readjustment Act of 1944, to approve, disapprove, and monitor education and training programs, specifically regarding oversight and approval of quality educational programming in which a veteran or dependent can enroll while using GI Bill benefits. In addition to program approval, state approving agencies conduct compliance, training, liaison, and outreach efforts.

However, due to different requirements for certification or licensure across states and differences in state approving agency approval practices, some veterans may use GI Bill benefits for educational programs that cannot count towards a credentialing requirement. Although a school has institutional accreditation, it may lack appropriate programmatic accreditation or fail to meet state-specific criteria required for certification or licensure. Examples of this have been found in programs teaching law, education, criminal justice, and health care, including nursing, psychology, medical assisting, dental assisting, and surgical technology. Veterans who graduate from programs that do not meet licensing or credentialing requirements are unable to sit for a qualifying examination to be hired in the field in which they studied. According to testimony from the National Association of State Approving Agencies in September 2015, "while it is true that all persons that attend career schools, such as law or nursing, do not always seek or find satisfying employment in that particular career field, it is certainly not an unfair expectation for a veteran who graduates from such programs to be qualified to sit for the license or certification exam."

The issue of unlicensed or unapproved programs that do not meet appropriate career qualifications is particularly evident when veterans attend law schools in California that are not approved by the American Bar Association. California allows graduates of an unaccredited law school to take the bar examination. Veterans who have used GI Bill benefits to attend unaccredited California law schools would be prohibited from taking the bar examination in other states or, in some cases, would have to first practice law in California for a period of time before being allowed to sit for the bar examination.

Educational assistance provided by the Department of Defense is subject to requirements meant to ensure that programs of education lead to employment. Section 541 of Public Law 113–66, the Fiscal Year 2014 National Defense Authorization Act, prohibits the use of Department of Defense educational assistance programs and authorities for education programs that do not meet the licensure or certification requirements of a state, or are not approved or li-

censed by the appropriate state board or agency. This policy change has not yet been applied to all VA educational assistance.

Committee Bill. Subsection (a) of section 208 of the Committee bill would amend subsection (c) of section 3676 of title 38, U.S.C., by requiring the appropriate state approving agency to approve the VA educational assistance application of an unaccredited educational course, which is designed to prepare a student for licensure or certification, only if the course meets the instructional curriculum requirements of such state. Section 208(a) of the Committee bill would further amend subsection (c) of section 3676 of title 38, U.S.C., by requiring that all courses designed to prepare an individual to practice law be accredited by an accrediting agency or association recognized by the Secretary of Education specified in section 1099(b) of title 20, U.S.C., namely the American Bar Association. This provision would require that Post-9/11 GI Bill beneficiaries only attend accredited law schools and ensure that beneficiaries attending law school in California would be eligible to take the bar examination in any state.

Subsection (b) of section 208 of the Committee bill would amend subsection (c) of section 3676 of title 38, U.S.C., by adding a new subsection stipulating conditions under which the VA Secretary could administer a waiver to override the aforementioned approval requirements for unaccredited educational courses. VA could waive approval requirements if the course does not meet requirements at any time during the 2-year period preceding the date of the waiver, but the waiver would further the purposes of VA educational assistance programs or further an individual's education interests, and the educational institution does not provide any commission, bonus, or incentive payment based on success in securing enrollments or financial aid during student recruiting or admission activities. The Committee intends this provision to allow the VA Secretary flexibility in allowing the use of GI Bill benefits at an educational institution that will further serve the education or employment interests of a veteran or dependent.

Subsection (c) of section 208 of the Committee bill would amend section 3675(b)(3) of title 38, U.S.C., and would apply the standards of approval for VA educational assistance established in subsections (b) and (c) of the Committee bill to already accredited courses, including non-degree accredited programs offered by for-profit educational institutions. Subsection (d) of section 208 of the Committee bill would amend section 3672(b)(2) of title 38, U.S.C., to further apply these standards of approval to accredited standard college degree programs offered at public or not-for-profit educational institutions. Both subsections (c) and (d) of the Committee bill are intended to ensure that the new standards of approval for VA educational assistance are applied equitably across all sectors of education.

Subsection (e) of section 208 of the Committee bill would amend section 3679 of title 38, U.S.C., by requiring the VA Secretary or state approving agency to disapprove any course of education unless the educational institution publicly discloses any conditions or additional requirements, including training, experience, or examinations, required to obtain the state license or certification and discloses each condition or requirement publicly. The Committee included this provision in order to ensure that GI Bill beneficiaries

are aware of state requirements in order to gain employment in their field of study before pursuing a course of education.

Subsection (f) of section 208 of the Committee bill would ensure that, if a student is enrolled in a course of education that is subject to disapproval for VA educational assistance, but continuously enrolled at the institution for another course of education that is not disapproved, this course would not be subject to disapproval and the student could continue in the approved course. This provision would ensure that VA education benefits are only prohibited from unaccredited programs, rather than entire institutions, if beneficiaries were to pursue more than one course of education at the same educational institution.

Sec. 209. Expansion of Yellow Ribbon G.I. Education Enhancement Program.

Section 209 of the Committee bill, which was derived from S. 1460, would extend the Yellow Ribbon Program to cover recipients of the Marine Gunnery Sergeant John David Fry Scholarship, a benefit available to surviving spouses and dependents of a servicemember who died in the line of duty, while serving on active duty, on or after September 11, 2001.

Background. The Fry Scholarship provides Post-9/11 GI Bill benefits specifically to the surviving spouses and children of servicemembers who died in the line of duty while on active duty after September 10, 2001. Fry Scholarship beneficiaries receive up to 36 months of benefits, including tuition and fees paid directly to the school, a monthly housing allowance, and a books and supplies stipend.

Tuition and fees at private schools may exceed the statutory limit on Post-9/11 GI Bill benefits. Subsection (e)(II) of section 3313 of title 38, U.S.C., stipulates that the Post-9/11 GI Bill benefit is capped at $17,500 per academic year at non-public or foreign institutions of higher education beginning on August 1, 2011. This rate is adjusted each subsequent academic year based on the yearly increase in the average cost of undergraduate tuition due to inflation (section 3015(h), title 38, U.S.C.). From August 2015 to July 31, 2016, Post-9/11 GI Bill payment rates to a private or foreign school will be capped at up to $21,084.89 per academic year.

In order to assist with tuition and fees in excess of the academic year cap, many institutions participate in the Yellow Ribbon Program. This program is a voluntary agreement between VA and the participating educational institution in which an institution agrees to make additional funds available for an eligible beneficiary and VA matches that amount and issues payments directly to the institution. This program provides additional funding for eligible Post-9/11 GI Bill beneficiaries when tuition and fee costs exceed the annual cap provided for under section 3313 of title 38, U.S.C.

The Yellow Ribbon Program is available to veterans and most transferred entitlement recipients receiving Post-9/11 GI Bill benefits at the 100 percent benefit level attending private institutions. However, Fry Scholarship beneficiaries are prohibited by law from receiving Yellow Ribbon Program funding. This creates inequity in eligibility for supplemental funding, as the children and spouses of a servicemember who died in service may face educational costs

that children and spouses of a veteran who did not make the ultimate sacrifice do not.

Committee Bill. Section 209(a) of the Committee bill would amend section 3317(a) of title 38, U.S.C., to include children and spouses of a servicemember who died in service as "covered individuals" under section 3311(b) for educational assistance, thus making them eligible for the Yellow Ribbon Program. This provision would ensure that all Post-9/11 GI Bill education benefit recipients, including veterans, transferees, and Fry scholars, are eligible to apply for supplemental Yellow Ribbon Program funding if they meet the basic eligibility requirements and their institution is a participating partner with VA. The Committee intends to remedy the inequity between Post-9/11 GI Bill recipients and ensure that surviving spouses and dependents are eligible for supplemental funding when applicable. Section 209(b) of the Committee bill would implement this expanded eligibility for academic years beginning after the date that is 1 year after enactment.

Sec. 210. Consideration of certain time spent receiving medical care from Secretary of Defense as active duty for purposes of eligibility for Post-9/11 Educational Assistance.

Section 210 of the Committee bill, which is derived from S. 602, would count as active duty for purposes of the Post-9/11 GI Bill reservists' service under section 12301(h) of title 10, U.S.C., under which the Secretary of a military department may order a reservist to active duty to receive authorized medical care, be medically evaluated for disability, or complete a required Department of Defense health care study.

Background. Section 3301 of title 38, U.S.C., defines active duty for purposes of determining eligibility for the Post-9/11 GI Bill. Members of the reserve components are considered to have served on active duty for purposes of determining eligibility based on specific authorities in sections from titles 10, 14, and 32, U.S.C. Not included on this list of authorities is section 12301(h) of title 10, U.S.C. Reserve component members are ordered to serve under section 12301(h) when they are receiving medical care, being evaluated for disability, or completing a health care study. The Department of Defense, in its testimony before the Committee on May 13, 2015, noted that reserve component members wounded in combat or injured in the line of duty are moved from service under an authority that qualifies for Post-9/11 GI Bill eligibility to serve under section 12301(h) instead. The effect of this administrative move results in less accrual of eligibility for Post-9/11 GI Bill benefits than their counterparts in the active components who are wounded or injured.

Committee Bill. Section 210 of the Committee bill would amend section 3301 of title 38, U.S.C., to add service under section 12301(h) of title 10, U.S.C., to the list of orders under which reserve component members can serve to earn active duty service time that counts towards their eligibility for the Post-9/11 GI Bill. This amendment would take effect 1 year after the date of enactment in order to allow VA sufficient time to implement changes to how it calculates eligibility for affected individuals. Any payment of benefits under chapter 33 of title 38, U.S.C., after 1 year from

enactment would reflect eligibility based on the relevant service under section 12301(h) of title 38, U.S.C.

TITLE III—HOMELESS VETERANS MATTERS

Sec. 301. Expansion of definition of homeless veterans for purposes of benefits under the laws administered by the Secretary of Veterans Affairs.

Section 301 of the Committee bill, which is derived from S. 1885, would expand the definition of homeless veteran for purposes of eligibility for VA benefits, to include a veteran or veteran's family member fleeing domestic or dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in their current housing situation.

Background. Congress has authorized several initiatives to provide VA with the tools necessary to end veteran homelessness. Those who meet the definition of homeless veteran are eligible to participate in these initiatives. Section 2002(1) of title 38, U.S.C., defines "homeless veteran," for purposes of eligibility for VA homeless programs, as the term is defined in section 11302(a) of title 42, U.S.C., which stipulates that a homeless individual must meet the following criteria: lacks a fixed, regular, and adequate place to sleep at night; has a primary nighttime residence that is a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation, including a car or park; lives in a transitional housing setting; resides in a location not meant for human habitation; will imminently lose his/her housing; or has experienced persistent housing instability.

The definition that the Department of Housing and Urban Development (hereinafter, "HUD") uses to describe a homeless individual includes the aforementioned definition, but also includes an additional class of individuals, as defined by section 11302(b) of title 42, U.S.C. This class of individuals is comprised of "any individual or family who is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions in the individual's or family's current housing situation, including where the health and safety of children are jeopardized, and who have no other residence and lack the resources or support networks to obtain other permanent housing."

In July 2011, a team led by Dr. Melissa E. Dichter, Research Health Scientist at VA's Center for Health Equity Research and Promotion, published a study entitled "Intimate Partner Violence Victimization Among Women Veterans and Associated Heart Health Risks." The study found almost one-third of the veteran participants had experienced intimate partner, domestic or dating violence, as compared with less than one-quarter of civilian participants. Within that sample, veterans experienced intimate partner violence at a higher rate than civilians.

Committee Bill. Section 301 of the Committee bill would expand the definition of homeless veteran by amending section 2002(1) of title 38, U.S.C., to include veterans and their families who may be homeless based on the circumstances defined in section 11302(b) of title 42, U.S.C. It is the intent of the Committee to align VA's definition of "homeless veteran" with HUD's, and expand the current VA definition to ensure that veterans fleeing domestic or dating vi-

olence and other life-threatening situations are eligible to participate in VA's programs for homeless veterans.

Sec. 302. Increased per diem payments for transitional housing assistance that becomes permanent housing for homeless veterans.

Section 302 of the Committee bill, which is derived from S. 684, would increase the maximum per diem rate VA is authorized to pay to providers that offer homeless veterans transitional housing units and allow the veterans to transition into permanent housing in the same unit.

Background. The Homeless Providers Grant and Per Diem (hereinafter, "GPD") program was first established as a pilot program, known as the Comprehensive Service Programs, in 1992, through the Homeless Veterans Comprehensive Service Programs Act of 1992 (Public Law 102–590). Congress established it as the Homeless Providers GPD program in the Homeless Veterans Comprehensive Assistance Act of 2001 (Public Law 107–95).

Under current law, section 2012 of title 38, U.S.C., VA awards grants and provides per diem payments to public and non-profit private entities operating transitional housing facilities and supportive services programs for veterans. The per diem payment, which is set at a maximum of $43.32 per day, per veteran housed, is calculated based on the daily cost of care, but may not exceed the rate paid to State homes for domiciliary care. The GPD program is VA's largest transitional housing program.

In 2012, VA established the Transition in Place (hereinafter, "TIP") program for GPD providers, and it subsequently awarded grants to 31 GPD providers to carry out TIP. Following this model, providers offer transitional housing assistance in apartment-style housing and allow veterans to assume responsibility for the lease upon the end of participation in transitional housing. Implementation of this model, however, may cause an increase in operational costs for the providers.

Committee Bill. Section 302 of the Committee bill would amend section 2012(a)(2) of title 38, U.S.C., to increase the maximum per diem rate for homeless veteran service providers participating in the TIP program to compensate for an increase in operational costs. It would authorize the per diem rate VA provides to certain entities that provide services to homeless veterans to exceed the rate paid to State homes in the case of services provided to a homeless veteran who is placed in housing that will become permanent housing upon termination of those services (transition-in-place). In those cases, the maximum per diem would be 150 percent of the State home rate.

It is the Committee's intent to provide an incentive for GPD providers to join the TIP program and increase permanent housing opportunities for homeless veterans.

Sec. 303. Expansion of Department of Veterans Affairs authority to provide dental care to homeless veterans.

Section 303 of the Committee bill, which is derived from S. 684, would expand eligibility for the Homeless Veteran Dental Program (hereinafter, "HVDP").

Background. The Homeless Veterans Comprehensive Assistance Act of 2001 (Public Law 107–95) expanded VA's authority to pro-

vide one-time outpatient dental services and treatment for certain veterans who, for a minimum of 60 consecutive days, are receiving care in a domiciliary, a therapeutic residence, community residential care, or a setting for which VA provides funds for a GPD provider. VA provides these dental services to eligible homeless veterans through HVDP. Dental services provided include those necessary for the veteran to gain or regain employment, to alleviate pain, or to treat moderate, severe, or complicated and severe gingival and periodontal pathology.

Section 303 of the Committee bill would expand eligibility to include veterans receiving assistance under section 8(o) of the United States Housing Act, which includes veterans receiving housing through the HUD-VASH program. Expanding services to this group of veterans is aligned with VA's implementation of the Housing First model. Historically, VA has provided permanent housing to homeless veterans only after compliance with treatment or other requirements while veterans resided in other non-permanent housing. In January 2013, all VA facilities implemented the Housing First model, which provides access to permanent housing accompanied by access to supportive services. With this transition in strategy, veterans may be placed in permanent housing through HUD-VASH who could benefit from certain services currently only available to those considered homeless.

Committee Bill. Section 303 of the Committee bill would amend subsection (b) of section 2062 of title 38, U.S.C., to expand eligibility for HVDP to include veterans who, for 60 consecutive days, have been housed under section 8(o) of the United States Housing Act, which would include those veterans participating in the HUD-VASH program.

Sec. 304. Clarification of eligibility for services under homeless veterans reintegration programs.

Section 304 of the Committee bill, which is derived from S. 425, would expand eligibility for the Department of Labor's Homeless Veterans' Reintegration Program (hereinafter, "HVRP").

Background. The Stewart B. McKinney Homeless Assistance Act (Public Law 100–77) established HVRP. Through this program, competitive grants are annually awarded to public and private entities that provide employment and training services that veterans need to re-enter the labor force.

Under current law, section 2021 of title 38, U.S.C., HVRP is only open to homeless veterans. Section 304 would expand eligibility to veterans participating in HUD-VASH, Indians who are veterans and receiving assistance under NAHASDA, and veterans who are transitioning from being incarcerated.

Under VA's Housing First model, veterans placed in the HUD-VASH program are not required to meet any standards of employment prior to entry in the program. As a result, there are veterans, including those coming out of chronic homelessness, in HUD-VASH who are in need of employment assistance and could benefit from a program like HVRP, but are not eligible. In addition, veterans transitioning from being incarcerated and Indians who are veterans and receiving assistance under NAHASDA, since the HUD-VASH program is not widely available on reservations, could also

benefit from the availability of additional job training and assistance resources.

Committee Bill. Section 304 of the Committee bill would amend section 2021(a) of title 38, U.S.C., to include among those eligible for HVRP veterans participating in VA's supported housing program for which rental assistance is provided under section 8(o)(19) of the United States Housing Act of 1937; Indians who are veterans and receiving assistance under NAHASDA; and veterans who are transitioning from being incarcerated. The Committee recognizes that certain Federal programs that require homelessness for eligibility were established prior to the implementation of VA's Housing First strategy, therefore, restricting access to those who may be transitioning from homelessness to the HUD-VASH program.

Sec. 305. Program to improve retention of housing by formerly homeless veterans and veterans at risk of becoming homeless.

Section 305 of the Committee bill, which is derived from S. 1885, would require VA to award grants for the provision of case management services for veterans who are transitioning to permanent housing and those who are at risk for homelessness, addressing a current gap in case management service delivery.

Background. The Administration set a goal in 2009 to end nationwide veteran homelessness by 2015. The 2015 Annual Homeless Assessment Report indicated that homelessness among veterans has declined by 35 percent, or 25,642 veterans, since 2009. Despite this significant progress, 47,725 veterans remained homeless on a single night in January 2015 according to HUD's Point in Time count from January 2015.

As communities nationwide reach critical junctures in their efforts to end veteran homelessness, occupancy in transitional housing programs continues to decrease. In testimony before the Committee in October 2015, Dr. Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations at the Veterans Health Administration (hereinafter, "VHA"), stated: "As the number of homeless veterans decreases, the need for some of this transitional housing will diminish, but there will be a continued need for permanent housing interventions like rapid re-housing and permanent supportive housing." Many homeless veterans participating in transitional housing programs and seeking to transition to permanent housing are eligible to participate in HUD-VASH. Despite access to HUD-VASH vouchers, many veterans are finding that insufficient availability of affordable and safe permanent housing options is limiting the ability to secure long-term permanent housing.

In communities that have made significant progress in ending homelessness among veterans, the declining necessity of transitional housing but continued need for permanent housing interventions is especially challenging. Because there are fewer veterans in need of transitional housing facilities, facilities are receiving less funding based on the per diem payment structure. Veterans at risk of homelessness in these communities have less transitional housing opportunities and these facilities risk insolvency. VA and community partners must ensure there is sufficient availability of affordable permanent housing for veterans seeking long-term housing solutions. VA's GPD program should be restructured to include an option for GPD grantees to focus efforts on shorter lengths of stay

in transitional housing, achieve quicker permanent housing planning, and repurpose existing transitional housing facilities into permanent housing units to ensure long-term solutions for homeless veterans.

Committee Bill. Subsection (a) of section 305 of the Committee bill would amend title 38, U.S.C., to redesignate current section 2013 as 2014 and insert a new section 2013 to require VA to carry out a program to increase housing stability and retention by providing grants to community organizations that provide case management to formerly homeless veterans. This new section would require VA to implement a program to provide case management services to improve housing retention by formerly homeless veterans who are transitioning to permanent housing, and veterans who are at risk of becoming homeless. Subsection (b) of new section 2013 of title 38, U.S.C., would provide for the VA Secretary's provision of grants, in which the Secretary would be required to give priority to organizations that demonstrate a capability to provide such case management services previously described, particularly organizations that have, or are currently, providing transitional housing services and decide to convert their transitional housing programs into permanent housing for homeless veterans. These grants include the per diem payments established in section 2012 of title 38, U.S.C., and the grant program for homeless veterans stipulated in section 2061 of title 38, U.S.C. This provision would allow communities that are reaching critical junctures in the fight to end homelessness to repurpose existing transitional housing capacity for more pressing needs, such as permanent housing opportunities for veterans.

Subsection (b) of new section 2013 of title 38, U.S.C., would additionally require the VA Secretary to give grant provision priority to an organization that voluntarily stops receiving GPD payments and converts an existing transitional housing facility into a permanent housing facility that meets housing quality standards established in section 1437f(o)(8)(B) of title 42, U.S.C. This section would enable GPD grantees with the expertise and capacity to provide for homeless veterans to repurpose existing transitional housing facilities into permanent housing units without losing current GPD funding.

Subsection (c) of section 305 of the Committee bill would additionally require VA to submit a report to Congress within 1 year of enactment to assess the new program, which will include the following reporting requirements: percentage of veterans who received case management services who were able to retain permanent housing; percentage of veterans who were not in permanent housing at the end of the program; program use by veterans who received case management services provided through VA housing assistance; and an assessment of the employment status of veterans who received case management services under the program.

Sec. 306. Pilot program on provision of intensive case management interventions to homeless veterans who receive the most health care from the Department of Veterans Affairs.

Section 306 of the Committee bill, which is derived from S. 1885, would require VA to implement a 3-year pilot program in at least six locations to assess the feasibility and advisability of providing

intensive case management interventions to homeless veterans who receive the most health care from VA.

Background. Those who may be considered health care super-utilizers often struggle with chronic conditions or behavioral health needs, which lead them to make frequent trips to the emergency room and have many hospital admissions. Treating these most frequent health care users is challenging and costly, particularly when they face difficult environmental situations, such as unsanitary housing or homelessness.

Dr. Jeffrey Brenner, the executive director of the Camden Coalition of Healthcare Providers in New Jersey determined that treatment, particularly hospital admission and repeated use of expensive diagnostic tests, provided to a small group of individuals who were utilizing the most health care was accounting for the bulk of health care costs in the local area. Using this data, he established a program model that reduced health care costs by targeting the population that was utilizing the most health care and enrolling them in care coordination services and providing case management through a team of nurses, social workers, community health workers, and health coaches. These interventions build relationships necessary to facilitate the provision of health care services to the most vulnerable individuals and empower patients with skills and support to avoid hospital readmission, thus lowering health care costs.

This model may have similar success when applied to homeless veterans who use the most VA health care. On May 4, 2012, the VA Office of Inspector General (hereinafter, "OIG") published a report, "Homeless Incidence and Risk Factors for Becoming Homeless in Veterans," which analyzed a study conducted to estimate incidences and risk factors of veterans. In the report, the OIG concluded that the presence of mental health or substance abuse disorders or mental illness is the strongest predictor of homelessness among veterans. Almost half or more of the surveyed homeless veterans were diagnosed with mental disorders, including 48 percent of male Operation Enduring Freedom/Operation Iraqi Freedom veterans and 67 percent of women who were not Operation Enduring Freedom/Operation Iraqi Freedom veterans. Additionally, homeless veterans were more likely to receive VA disability benefits for service-connected disabilities than their domiciliary counterparts, and more than half of the homeless veterans studied were receiving VA compensation for these disabilities.

When left untreated, these behavioral conditions pose significant challenges to attaining and maintaining permanent housing and gainful employment, and substandard living conditions and homelessness often exacerbate existing health conditions. Applying the management intervention model that proved successful in New Jersey to veterans who use the most VA health care could address the health care needs of the most vulnerable veterans while simultaneously decreasing VA health care costs.

Committee Bill. Section 306 of the Committee bill would, in a freestanding provision, require VA to commence a pilot program on the provision of case management interventions to homeless veterans who receive the most health care from VA. Subsection (a) of section 306 of the Committee bill would require VA to commence a pilot program by September 1, 2016, that would assess the feasi-

bility and advisability of providing intensive case management interventions to "covered veterans." Subsection 306(b) of the Committee bill would define "covered veterans" as a veteran enrolled in the VA homeless registry and the annual patient enrollment system, section 1705(a) of title 38, U.S.C.

The pilot program would be carried out at not fewer than six locations as selected by the VA Secretary, as established in subsection (c) of section 306. The Committee intends that, by requiring VA to implement the program in at least six locations, VA will be able to determine the extent to which the program is successful before considering expansion or continuation of the program. The bill would direct the VA Secretary to select at least three locations in cities with the largest populations of homeless veterans in the United States and at least three locations in suburban or rural settings. Subsection 306(c) of the Committee bill additionally would establish that the VA Secretary shall only select locations for the pilot program in areas with an existing high degree of interaction and coordination between VA and community organizations that provide housing and social services for homeless veterans, veterans at risk of homelessness, and low-income veterans. The Committee intends this section to ensure that the pilot program is carried out in areas where a successful track record of coordination between VA and local organizations will increase the likelihood of success for the pilot and its ability to serve as a model to establish case management interventions nationwide.

Subsection (d) of section 306 of the Committee bill would require the VA Secretary to provide intensive case management services to at least 20 covered veterans who receive the most VA health care and related services at each location. These individuals would receive intensive case management assistance related to gaining and maintaining access to housing and services in order to improve the stability of their housing and the appropriateness of the health care that they receive.

Subsection (e) of section 306 of the Committee bill would require that no later than December 1, 2018, the VA Secretary submit to the Committee on Veterans' Affairs of the Senate and House of Representatives a report on the pilot program. The report must include assessments of: the types and frequencies of intensive case management interventions provided under the pilot program; the housing and employment status of each veteran who received an intensive case management intervention, including a comparison of employment status of each veteran before and after the intervention; the VA health care and related services used by veterans who received intensive case management interventions, including the cost incurred by VA to provide such care and services before and after receiving such interventions; the number of veterans who received intensive case management interventions based on urban versus suburban or rural locations; a comparison of the cost incurred by VA based on the pilot program carried out in urban versus rural or suburban locations; and a comparison of the costs VA would have incurred for the provision of health care and services without the intensive case management interventions in urban versus suburban or rural locations of the pilot program.

The Committee intends that VA deploy this pilot program in different communities nationwide to determine the success of the care

model in the veteran population, as well as any reduction in health care costs by improving the efficacy of outreach teams providing intensive case management interventions to homeless veterans.

Sec. 307. Establishment of National Center on Homelessness Among Veterans.

Section 307 of the Committee bill, which is derived from S. 1885, would codify the current role of the VA National Center on Homelessness Among Veterans (hereinafter, "NCHAV") as a center of research, evaluation, and dissemination of best practices regarding services for homeless veterans.

Background. The NCHAV was established in 2009 to support VA's Five Year Plan to End Homelessness Among Veterans, as outlined in the Administration's "Opening Doors: Federal Strategic Plan to Prevent and End Homelessness." The University of Pennsylvania serves as the NCHAV's primary academic partner and, as such, the center is located in Philadelphia, Pennsylvania. The center also has satellite facilities in Tampa, Florida, in partnership with the University of South Florida, and Bedford, Massachusetts, in partnership with the University of Massachusetts Medical School. The NCHAV has been an important contributor to the Administration's goal of ending veteran homelessness and, according to its Web site, "works in collaboration with [the Veterans Health Administration's] Homeless Programs Office, network directors, network homeless coordinators, national professional associations, and community partners as well as with their academic partners." This independent center has worked to ensure that VA is effectively collaborating with community partners and applying the necessary tools to reshape the housing and service delivery model in urban and rural communities that experience veteran homelessness. By analyzing VA homelessness programs and disseminating research and homeless program models to the field, the NCHAV has played an important role in ensuring continued progress in decreasing the number of homeless veterans nationwide. The success of the Housing First model is an example of how NCHAV research can be translated into more informed policy for homeless veterans.

Committee Bill. Subsection (a) of section 307 of the Committee bill would add a new section 2067 to title 38, U.S.C., to codify the existing NCHAV. This would require the VA Secretary to oversee a center that operates independently of other VA homelessness programs. Subsection (a) of new section 2067 of title 38, U.S.C., would require that the NCHAV implement the following functions: carry out and promote research into the causes and contributing factors to veteran homelessness; assess the effectiveness of VA programs to meet the needs of homeless veterans; identify and disseminate best practices with regard to housing stabilization, income support, employment assistance, community partnerships, and other matters as the VA Secretary deems appropriate; integrate evidence-based best practices, policies, and programs into VA programs for homeless veterans and ensure VA staff and community partners are effectively able to implement them; and serve as a resource center for all research and training activities carried out by VA, Federal entities, and community partners to promote the exchange of information with respect to veteran homelessness.

As more communities have ended, or are close to ending, veteran homelessness, VA will need to examine how to best allocate funding between various programs aimed at ending veteran homelessness. The Committee intends to codify the NCHAV to make permanent the important research regarding the most cost-effective approaches to ending veteran homelessness and the continuation of support to VA homelessness programs in order to fully eliminate veteran homelessness.

Sec. 308. Partnerships with public and private entities to provide legal services to homeless veterans and veterans at risk of homelessness.

Section 308 of the Committee bill, which is derived from S. 684, would authorize VA to enter into partnerships with public or private entities to fund a portion of the general legal services provided by those entities to homeless veterans and veterans at risk of homelessness.

Background. VA conducts an annual Community Homelessness Assessment, Local Education and Networking Groups (hereinafter, "CHALENG") survey to identify the needs of homeless veterans. The 2014 CHALENG survey results indicated that legal assistance was among the top ten highest unmet needs among both male and female veterans. Collectively, they indicated needing legal assistance to prevent eviction and foreclosure, for child support issues, to help restore a driver's license, and for outstanding warrants and fines. Such issues can be a result of homelessness, or can contribute to homelessness.

VA does not currently have statutory authority to fund any portion of legal services, but a number of VA facilities host non-VA legal service providers, such as law school clinics, private pro bono lawyers, and Legal Aid clinics to assist veterans who are homeless or at risk of homelessness.

In addition, the Supportive Services for Veteran Families Program (hereinafter, "SSVF") provides grants to organizations who will coordinate or provide supportive services to very low-income veteran families who are homeless or at risk of becoming homeless. Through this program, grantees are authorized to partner with legal services providers to address unmet legal needs that may be a barrier to stable housing. Providing legal services is not a requirement, however, and as a result, not all veterans who receive assistance through SSVF have access to legal services.

Committee Bill. Section 308 of the Committee bill would amend chapter 20 of title 38, U.S.C., by inserting a new section, 2022A, after section 2022, to authorize VA to enter into partnerships with public and private entities to fund a portion of legal services provided to homeless veterans and veterans at risk of homelessness. VA would also be required to ensure that, to the extent practicable, the partnerships are made with entities equitably distributed across the geographic regions of the United States, including rural communities, tribal lands of the United States, Native Americans, and tribal organizations. It is the intent of the Committee to expand legal services for homeless veterans and veterans at risk of homelessness by authorizing VA to partner with public or private entities to fund a portion of the cost of providing legal services.

Sec. 309. Administrative improvements to grant and per diem programs of Department of Veterans Affairs.

Section 309 of the Committee bill, which is derived from S. 1885, would implement administrative improvements to the GPD program of the Department.

Background. VA provides Federal funding to many transitional housing grantees to support their efforts to decrease veteran homelessness nationwide. These GPD program grantees help veterans secure residential stability, increase their skills and income, and achieve greater self-determination to support their transition from transitional to permanent housing.

There is currently no national standard among GPD grantees that serve homeless veterans, and GPD grantees are not required to demonstrate success in assisting veterans into permanent housing or increasing their income level. In testimony before the Committee on July 29, 2015, Lisa Tepper Bates, the Executive Director of the Connecticut Coalition to End Homelessness, recommended a policy change that would require the GPD program to move "away from the per diem payment structure to a competitive grant program or performance-based contract" to ensure that programs are outcome-oriented. By setting national performance targets for the housing placement rates and the average income improvements of veterans served by transitional housing grantees, VA will be equipped to assess whether the performance of a GPD grantee merits its continued funding, ensure financial integrity among GPD grantees, and increase the use of performance outcomes as an oversight tool to reduce waste or abuse.

Committee Bill. Section 309 of the Committee bill would amend section 2012 of title 38, U.S.C., by requiring the VA Secretary to review, on a yearly basis, each eligible GPD grantee to evaluate the performance of the grant recipient or per diem entity. This evaluation would assess the success of the grant recipient or eligible entity in assisting veterans to obtain, transition into, and retain permanent housing and increasing the income of veterans, whether by helping veterans obtain employment or receive income-related benefits for which the veteran may be eligible.

Section 309 of the Committee bill would require the VA Secretary to utilize these performance evaluations to determine whether the GPD grantee's performance merits continued receipt of GPD payments, and require the VA Secretary to only authorize continued funding if the aforementioned evaluation affirms the efficacy of the GPD grantee in assisting veterans' transition into permanent housing. This provision would additionally require the VA Secretary to establish uniform, nationwide performance targets for all grantees and eligible entities that receive per diem payments for the purpose of conducting fair and equitable performance evaluations. The Committee intends this section to ensure that GPD grantees are best utilizing these payments in a manner that will support homeless veterans. If the performance evaluations of grant recipients or eligible entities do not merit continued VA payments, this section grants the VA Secretary the authority to discontinue such payments to such grantees.

Sec. 310. Repeal of requirement for annual reports on assistance to homeless veterans.

Section 310 of the Committee bill, which is derived from S. 684, would repeal the requirement that VA annually submit to Congress a report on assistance to homeless veterans.

Background. The Homeless Veterans Comprehensive Assistance Act of 2001 (Public Law 107–95) established a requirement that VA submit an annual report to the Committee on Veterans' Affairs of the Senate and House of Representatives on its homelessness programs. The reports detail VA services for homeless veterans, including data from the previous year and an overview of Veterans Health Administration and Veterans Benefits Administration programs that serve homeless veterans.

Committee Bill. Section 310 of the Committee bill would repeal section 2065 of title 38, U.S.C., which requires VA to provide an annual report to Congress on the activities of VA's programs for homeless veterans. The Committee does not believe that this report continues to be necessary and believes VA could more effectively utilize the time and resources spent on the report to further support efforts to serve homeless veterans. The Committee expects VA to be responsive and transparent when requested to respond to questions about its programs for homeless veterans and recognizes that VA collects data and conducts analysis, regardless of a Congressional reporting requirement.

Sec. 311. Comptroller General of the United States study on homeless veterans programs of the Department of Veterans Affairs.

Section 311 of the Committee bill, which is derived from S. 684, would require the Comptroller General to complete an assessment of VA programs that provide assistance to homeless veterans and a review of VA efforts to improve the safety and security of female veterans participating in the programs.

Background. VA has six strategic pillars that include at least 25 programs intended to assist homeless veterans. These pillars include outreach and communication, treatment, prevention, housing/supportive services, income/employment/benefits, and community partnerships.

Nine percent of the 47,725 homeless veterans identified in HUD's Point in Time count from January 2015 were women. A September 2011 report by VA's OIG, entitled "Safety, Security, and Privacy for Female Veterans at a Chicago, IL Homeless Grant Provider Facility," a December 2011 GAO report entitled "Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing," and a March 2012 OIG report entitled "Audit of the Homeless Providers Grant and Per Diem Program" highlighted safety and security risks affecting women veterans within the GPD program. GAO recommended that VA establish gender-specific safety and security standards for GPD programs, especially those serving both men and women. In its 2012 report, the OIG made a similar recommendation, in addition to recommending that the GPD program application process include provider commitment to veteran safety, security, and privacy.

According to GAO, in response to one of its recommendations, in July 2013, VA revised and published its GPD Handbook, which included a new section on services for female veterans. GAO also in-

dicated that VA changed its GPD application process to require new applicants to include information about the gender of the homeless population the applicant plans to serve.

Committee Bill. Section 311 of the Committee bill would require that, not later than 270 days after enactment, the Comptroller General complete a study of VA programs that provide assistance to homeless veterans, including an assessment of whether those programs are meeting the needs of veterans, any gaps or duplication in the provision of services, and a review of recent efforts by VA to improve the privacy, safety, and security of female veterans.

As the number of homeless veterans continues to decline, it is important to ensure homeless programs are targeted to the demographics in the geographic areas that need them. A full assessment of VA's homelessness programs would also assist with identifying gaps or duplication in services in order to more effectively utilize resources and serve homeless veterans.

The OIG and GAO findings in regard to the safety and security risks faced by female veterans within VA GPD programs are alarming. It is important to ensure policies and procedures are in place to protect female veterans in VA homeless programs.

Sec. 312. Requirement for Department of Veterans Affairs to assess comprehensive service programs for homeless veterans.

Section 312 of the Committee bill, which is derived from S. 684, would require VA to assess and measure the capacity of programs that receive grants or per diem payments in addition to developing and using tools to examine the capacity of those programs at both the national and local level.

Background. A March 2012 VA OIG report entitled "Audit of the Homeless Providers Grant and Per Diem Program" found that VA's GPD program did not assess bed capacity to inform funding priorities and needs in underserved geographic areas and did not accurately report program outcomes. The OIG determined that the improvement of program evaluation would ensure program funding is aligned with program goals. This report followed the December 2011 GAO report entitled "Homeless Women Veterans: Actions Needed to Ensure Safe and Appropriate Housing," which found that VA lacked data on the needs and characteristics of homeless women veterans at the national, state, and local levels. GAO indicated that, without this information, VA is unable to effectively plan services, allocate grants, and monitor progress in ending veteran homelessness.

Committee Bill. Section 312(a) of the Committee bill, in a free-standing provision, would require VA to assess and measure the capacity of GPD programs, including how well they achieve their stated goals at the national level, placements in permanent housing and employment, and increases in the regular income of participants in the programs. Section 312(b) of the Committee bill would require that, in conducting the required assessment, VA develop and use tools to examine the capacity of the programs at the national and local levels in order to assess whether sufficient capacity exists to meet the needs of homeless veterans in each geographic area; whether existing capacity meets the needs of the subpopulations of homeless veterans located in each geographic area; and the amount of capacity that GPD providers have to provide

TIP services. In its assessment, VA would also be required to consider the availability of resources to GPD programs. Section 312(d) of the Committee bill would require VA to utilize information collected under this section to set specific goals to ensure the GPD programs are effectively serving homeless veterans, to assess whether the programs are meeting the specific goals, to inform funding allocations for the programs, and to improve the referral of homeless veterans to GPD programs. Section 312(e) of the Committee bill would require that not later than 180 days after the assessment is completed, VA submit a report to the Committee on Veterans' Affairs of the Senate and House of Representatives on the assessment and include recommendations for legislative and administrative actions for improving the programs.

As the number of homeless veterans continues to decrease, it is important that VA assess the demographics and geographic region of those who could benefit from transitional housing to ensure appropriate allocation of resources. In addition, proper assessment of the program will also help inform VA efforts to establish specific goals to ensure the program is effectively meeting the needs of homeless veterans.

Sec. 313. Report on outreach relating to increasing the amount of housing available to veterans.

Section 313 of the Committee bill, which is derived from S. 1885, would require a VA report on outreach related to the amount of housing available to veterans.

Background. In order to combat veteran homelessness, VA is conducting outreach to ensure that veterans are appropriately connected with VA and community services. VA is currently working to proactively seek out veterans in need of assistance and connect veterans with housing solutions, health care, and employment services. This outreach to identify and engage veterans who have experienced chronic homelessness is necessary to facilitate connections between homeless veterans and community-based providers.

VA is additionally collaborating with Federal, state, and local agencies to expand employment and affordable housing options for veterans seeking transitional and permanent housing. The Committee is aware of current VA efforts to conduct outreach to realtors, landlords, property management companies, and developers, particularly in communities with competitive housing markets. Given the shortage of safe and affordable permanent housing, these outreach efforts may help to ensure that more housing opportunities are made available to veterans who are currently homeless or at risk for homelessness. Greater information is necessary to determine whether VA's current outreach efforts are effectively increasing availability of safe and affordable housing options nationwide, particularly in communities with a high level of veteran homelessness. With additional information about current outreach, VA could explore additional measures that could be implemented to encourage entities to rent to homeless or formerly homeless veterans.

Committee Bill. Section 313 of the Committee bill, in a free-standing provision, would require the VA Secretary to submit to the Committee on Veterans' Affairs of the Senate and House of Representatives a report describing and assessing VA outreach to realtors, landlords, property management companies, and devel-

opers to educate them about the housing needs of veterans as well as the benefits of having veterans as tenants. The Committee intends this report to serve as a resource to assess the current outreach and determine its success in decreasing homelessness among veterans.

TITLE IV—HEALTH CARE MATTERS

Sec. 401. Short title.

Section 401 of the Committee bill, which is derived from S. 1641, would establish the short title of Title IV as the Jason Simcakoski Memorial Act.

Background. On August 30, 2014, U.S. Marine veteran Jason Simcakoski died at the Tomah Veterans Affairs Medical Center (hereinafter, "VAMC") in Tomah, Wisconsin, as a result of mixed drug toxicity. Jason was 35 when he died.

Since 2003, Jason was a patient at the Tomah VAMC, primarily being treated for anxiety, post traumatic stress disorder (hereinafter, "PTSD") and substance use disorder. At the time of his death, he was prescribed numerous medications including opioids, specifically buprenorphine along with benzodiazepines. While he occasionally presented with intermittent pain, not chronic pain, VA providers at the VAMC prescribed a number of opioid pain medications in combination with benzodiazepines. In addition to other prescribed analgesics, commonly known as painkillers, at the time of his death, Jason was given buprenorphine—an opioid intended to treat addiction—at a higher than the U.S. Food and Drug Administration recommended dose, although he was not diagnosed with an opioid addiction. He was also prescribed several benzodiazepines including diazepam, which, together with the buprenorphine, produced a known dangerous interaction that ultimately led to his death.[3]

The growing use and abuse of prescription painkillers such as opioids is a growing public health crisis in the United Sates. More Americans now die every year from drug overdoses, mostly from prescription painkillers, than they do in motor vehicle crashes. In 2012, health care providers wrote 259 million prescriptions for opioid pain medications— enough for every American adult to have a bottle of pills.[4] Inappropriate use of opioids is a particular problem in the veteran community and at VA. Jason's tragic story illustrates a larger, ongoing problem of dangerous use and over prescription of opioids at the Tomah facility as well as throughout the VA.

Committee Bill. Section 401 of the Committee bill would name Title IV of the Committee bill in honor of Jason's memory. The Committee believes the Jason Simcakoski Memorial Act would aid VA in providing safer and more effective pain management care to our nation's veterans.

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[3] Office of Inspector General, Department of Veterans Affairs; "Unexpected Death of a Patient During Treatment with Multiple Medications Tomah VA Medical Center Tomah, Wisconsin." Report No: 15–02131–471; August 6, 2015.

[4] Centers for Disease Control and Prevention (CDC); CDC Vital Signs, "Opioid Painkiller Prescribing." July 2014; http://www.cdc.gov/vitalsigns/opioid-prescribing/.

SUBTITLE A—EMPLOYMENT OF DIRECTORS AND HEALTH CARE PROVIDERS

Sec. 411. Extension of period for increase in graduate medical education residency positions at medical facilities of the Department of Veterans Affairs.

Section 411 of the Committee bill, which is derived from S. 1676, allows VA an additional 5 years to increase the number of graduate medical education residency positions at medical facilities of VA by 1,500 positions.

Background. The Veterans Access, Choice, and Accountability Act of 2014 (P.L. 113–146; 38 U.S.C. 7302 note), requires the VA Secretary to increase the number of GME residency positions by 1,500 residency slots during the 5-year period that began 1 year after enactment of Public Law 113–146. In filling the increased residency slots, the VA Secretary is required to focus on residencies in the areas of primary care, mental health, and any other specialty the Secretary determines appropriate. Furthermore, P.L. 113–146 requires the Secretary to give a priority to GME residency slots at medical facilities that do not have existing medical residency programs and that are located in communities that have a high concentration of veterans. As of January 2016, only 372 new residency positions have been filled. The Committee has learned that expanding these residency slots requires VA employees to conduct many hours of outreach to facilities and academic medical centers that would potentially serve as partners for the residency slots, particularly because of the requirement that VA focus on facilities that do not have existing medical residency programs. As a result, the full increase in residency slots is not expected to be complete within the originally mandated timeline.

Committee Bill. Section 411 of the Committee bill would amend paragraph (2) of section 301(b) of P.L. 113–146 by extending the timeline for completing the expansion of the residency slots from 5 years to 10 years.

Sec. 412. Modification of hours of employment for physicians and physician assistants employed by the Department of Veterans Affairs.

Section 412 of the Committee bill, which is derived from S. 1450, would modify the requirements for full-time employee status for physicians and physician assistants employed by VA.

Background. Section 7423(a) of title 38, U.S.C., establishes the hours that are used to determine whether an employee physician or physician assistant is a full-time employee. A full-time employee is one who works eighty hours over a 2-week period. The Committee has learned that these strict hour requirements for physicians and physician assistants, while similar to those of other VA employees, can create complications, particularly when scheduling physicians and physician assistants for emergency call schedules. The Committee has heard from stakeholders that allowing more flexible scheduling when determining whether a physician or physician assistant employee is a full-time employee would simplify staffing for VA medical facilities and make it easier to ensure facilities are appropriately staffed.

Federal agencies, including VA, are able to implement alternative work schedules including flexible work schedules and compressed work schedules in order to help the employee balance work and family or personal responsibilities.

Committee Bill. Section 412 of the Committee bill would create an exception for determining full-time employee status for physicians and physician assistants by amending section 7423(a) of title 38, U.S.C., as long as the total hours of employment for a calendar year do not exceed 2,080 hours.

The Committee intends that this provision allow VA flexibility in scheduling physicians and physician assistants to better reflect the schedules that those providers typically keep in health care systems outside of VA. The Committee does not intend that this provision affect the current requirements related to overtime pay or flexible work schedules.

Sec. 413. Requirement that physician assistants employed by the Department of Veterans Affairs receive competitive pay.

Section 413 of the Committee bill, which is derived from S. 1676, would include physician assistants in the types of providers who are eligible for locality pay.

Background. Section 7451(a)(2) of title 38, U.S.C., allows VA to ensure that rates of pay for health care personnel positions within VA facilities are competitive with the rates of pay in non-VA facilities in the same labor market area. This allows VA to operate on fair footing with other potential health care employers that would be competing to hire for the same or similar positions. VA is explicitly authorized to use locality pay for registered nurses and the positions listed in section 7401(1) and (3) of title 38, U.S.C. Although the VA Secretary is able to appoint other specialties to the list, this authority has yet to be utilized. VA is affiliated with more than 30 accredited physician assistant education programs and offers continuing medical education programs, tuition support programs, education debt reduction programs, and employee incentive scholarship programs as incentives to help grow the number of physician assistants within VA. However, physician assistant positions can still be difficult for facilities to fill. According to a September 2015 VA OIG review entitled, "Office of Inspector General Determination of Veterans Health Administration's Occupational Staffing Shortages," physician assistants were the occupation with the fourth largest staffing shortages for 2014.

Committee Bill. Section 413 of the Committee bill would amend section 7451(a)(2) of title 38, U.S.C., to allow VA to offer rates of pay that are competitive with non-VA facilities within the same labor market areas when hiring for physician assistant positions.

Sec. 414. Establishment of positions of Directors of Veterans Integrated Service Networks in Office of Under Secretary for Health of Department of Veterans Affairs and modification of qualifications for Medical Directors.

Section 414 of the Committee bill, which is derived from S. 1676, would amend section 7306 of title 38, U.S.C., to create positions of Directors of Veterans Integrated Service Networks and change the qualifications for a Medical Director.

Background. Under section 7306(a)(4) of title 38, U.S.C., the Office of the Under Secretary for Health consists in part of "[s]uch Medical Directors as may be appointed to suit the needs of the Department, who shall be either a qualified doctor of medicine or a qualified doctor of dental surgery or dental medicine." Under current law, a VISN Director or Medical Director is not eligible to be hired under VA's hiring authority provided by title 38, U.S.C., because VA is not able to appoint non-physicians using its title 38 hiring authority. Both Medical Directors and VISN Directors are hired under title 5, U.S.C., as part of the Senior Executive Service (hereinafter, "SES") of the government. Even though individuals hired to these positions are hired as an SES and paid at a higher rate than the general schedule pay for title 5 employees, they are paid substantially less than their private sector counterparts as well as the VA medical providers reporting to them. This pay disparity makes it difficult for VA to recruit non-VA employees and current VA providers to fill positions of VISN Directors and Medical Directors.

Committee Bill. Section 414 of the Committee bill would amend section 7306(a)(4) of title 38, U.S.C., by inserting "and Directors of Veterans Integrated Service Networks" after "such Medical Directors" and further amend the section by deleting the requirement that Medical Directors appointed under this section shall be a qualified physician or dentist.

Sec. 415. Pay for Medical Directors and Directors of Veterans Integrated Service Networks.

Section 415 of the Committee bill, which is derived from S. 1676, would add a new section 7481 to title 38, U.S.C., providing that pay for a Medical Director or Director of a Veterans Integrated Service Network will consist of basic pay set forth under section 7404(a) of title 38, U.S.C., (setting grades and pay scales for VA health professionals) and market pay determined under this new authority.

Background. Under current law, a VISN Director or Medical Director is not eligible to be hired under VA's hiring authority provided by title 38, U.S.C., because VA is not able to appoint non-physicians using its title 38 hiring authority. Both Medical Directors and VISN Directors are hired under title 5, U.S.C., as part of the SES. Even though people appointed to these positions are hired as an SES and paid at a higher rate than the general schedule pay for title 5 employees, they are paid substantially less than their private sector counterparts as well as the VA medical providers reporting to them. This pay disparity makes it difficult for VA to recruit non-VA employees and current VA providers to fill positions of VISN Directors and Medical Directors.

Committee Bill. Section 415 of the Committee bill would change how the pay for VISN Directors and Medical Directors is calculated.

Section 415(a) of the Committee bill would create a new subchapter VII in chapter 74 of title 38, U.S.C., to create a new section 7481 entitled "Pay for Medical Directors and Directors of Veterans Integrated Service Networks." Section 7481(a), as added, would direct that the basic pay for a Medical Director or VISN Director will be set under section 7404(a) of title 38, U.S.C. Section 7481(b)

would allow for market pay through an adjustment of such pay dependent on the experience of the Directors, the complexity of the facility, the labor market in the geographic area, and other considerations as deemed appropriate by the VA Secretary. Under section 7481(c), the VA Secretary would be directed to determine every 2 years a maximum and minimum level of pay for Medical Directors and VISN Directors and publish those amounts in the Federal Register. Section 7481(d) would clarify that pay received under this section would be considered pay for the purposes of receiving retirement benefits under chapters 83 and 84 of title 5, U.S.C. Subsection 7481(e) would clarify that a decrease in pay due to an adjustment by the Secretary to the market pay for Medical Directors and VISN Directors will not be treated as an adverse action.

Section 415(b) of the Committee bill would make a clerical change to add the new subchapter VII to the table of contents in title 38, U.S.C.

Section 415(c) of the Committee bill would provide for an effective date that is 1 year after the date of enactment.

Sec. 416. Additional requirements for hiring of health care providers by the Department of Veterans Affairs.

Section 416 of the Committee bill, which is derived from S. 1641, would require the VA Secretary to consider information from the medical boards of each state in which a health care provider holds or has held a medical license during the hiring process at VA.

Background. When hiring health care providers, VA's policy is to conduct license verification of all active and currently held licenses as part of credentialing, which must be completed before any provider delivers health care at a VA facility. This is typically accomplished by querying the respective state licensure board's (hereinafter, "SLB" or "board") public facing Web site in the state where the provider holds a license. If the licensure board has taken an action on the license, that information will be available. This practice is outlined in VHA Handbook 1100.19 and VHA Directive 2012–030. However, recent media reports regarding practicing VA providers whose credentials have not been verified, who have been misrepresented, and who have previously entered into settlements or completed disciplinary actions in other states where they may hold a medical license have highlighted the need to ensure protocols are being followed.[5] VA must do more to guarantee its providers are of the highest quality and are, at the very least, in good standing with each SLB in which they hold a license to protect our nation's veterans.

Committee Bill. Section 416 of the Committee bill would, in a freestanding provision, require the Department to issue regulations that require, as part of the hiring process, VA to obtain information on medical license violations from each SLB where a provider holds or has held a license during the provider's career as well as information on whether the provider has entered into any settlement agreements with the board for disciplinary charges relating to medical practice.

[5] http://www.desmoinesregister.com/story/opinion/editorials/2016/01/04/editorial-va-doctors-should-licensed-where-they-practice/78127258/ and http://www.kare11.com/story/news/investigations/2015/11/20/va-doctor-certification-scandal-grows/76130672/

Sec. 417. Provision of information on health care providers for Department of Veterans Affairs to state medical boards.

Section 417 of the Committee bill, which is derived from S. 1641, would require VA to send to each state licensing board, where a provider holds a license, and the board in the state where the provider practices, information concerning a report of a violation during the provider's practice at VA without the board making a request for such information.

Background. Under the current policy outlined in VHA Handbook 1100.18, medical facilities must report each licensed health care professional whose behavior or clinical practice so substantially fails to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. In each instance, the medical facility Director must prepare a Reporting File to submit to each SLB where the professional holds a license.[6] However, the report statement sent to the SLB is typically limited to a generic description of the clinical shortcomings involved, unless the SLB responds to the Director with a formal request for more information. SLBs and the Federation of State Medical Boards have indicated that it is quite difficult for boards to receive up-front, timely, and comprehensive information on violations or assistance with investigations from VA. SLBs also highlighted that they find it extremely difficult to gain any information even if the SLBs follow VA's exact procedure to gain such information. Material received is so heavily redacted it is of little use. It is critical VA improve communication with SLBs and improve transparency surrounding medical practice violations to remain accountable for high-quality and safe care.

Committee Bill. Section 417 of the Committee bill would, in a freestanding provision, require the Department to send each SLB where a provider holds a license, and the SLB in the state where the provider practices, the full information concerning a report of a violation during the provider's practice at VA without the board making a request for such information. While VA providers are not required to hold a license in the same state where the medical facility resides, the Committee believes that such state's board should, nonetheless, have access to information about a clinical violation committed at a facility in their state to ensure the board can fulfill its obligation to uphold safe medical practice.

Sec. 418. Report on compliance by Department of Veterans Affairs with reviews of health care providers leaving the Department or transferring to other facilities.

Section 418 of the Committee bill, which is derived from S. 1641, would require VA to submit a report to Congress on compliance with the VA policy to conduct a review of every VA clinician leaving or transferring to another facility to uncover any concerns, complaints, or allegations of violations of medical practice and to take appropriate action.

Background. There are approximately 1400 points of care across VA's health care system. Transfers of health care providers to different VA facilities can occur as a positive job opportunity for pro-

[6] VA Views for S. 1641, Testimony submitted before the Senate Veterans' Affairs Committee, "Legislative Hearing" on June 24, 2015.

viders,[7] as a result of need for providers in specific facilities, or as a major adverse employment action.[8] Because a provider transferring to a new facility can occur for a variety of reasons, it can be difficult to determine whether a provider has left a facility with outstanding allegations of violations related to their medical practice without an active review of their employment records being conducted. This is also true when a provider moves to a non-VA medical facility.

VHA has the authority under section 501 of title 38, U.S.C., to report medical professionals employed at VA whose behavior or clinical practice failed to meet the generally accepted standards of clinical practice as to raise reasonable concerns for patient safety. VHA Handbook 1100.18 requires VA to cooperate with SLBs by initiating reports regarding concerns about patient safety and in terms of cooperating with inquiries from an SLB. VA's quality assurance program authorized under Public Law 99–660, the Public Health Service Act, requires the Department to report to the relevant SLBs any licensed health care professional who was fired or who resigned following the completion of a disciplinary action relating to such professional's clinical competence, resigned after having had his or her clinical privileges restricted or revoked, or resigned after serious concerns about such professional's clinical competence had been raised but not resolved. The Committee has heard from stakeholders that compliance with the reporting requirements in VHA Handbook 1100.18 to SLBs varies from facility to facility.

Committee Bill. Section 418 of the Committee bill would, in a freestanding provision, require VA to report to the Committee on Veterans' Affairs of the Senate and House of Representatives its compliance with the VA policy of review and credentialing to ensure it is carried out consistently across facilities to maintain accountability for safe, high-quality care within 2 years of enactment of the Committee bill. This report would include a review of whether VA took appropriate action on concerns, complaints, or allegations of violations that relate to the medical practice of health care providers. The report would be due not later than 2 years from the enactment of the Committee bill.

SUBTITLE B—OPIOID THERAPY AND PAIN MANAGEMENT

Sec. 421. Guidelines on management of opioid therapy by Department of Veterans Affairs and Department of Defense and implementation of such guidelines by Department of Veterans Affairs.

Section 421 of the Committee bill, which is derived from S. 1641, would require the Secretaries of Veterans Affairs and Defense to update the joint VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

Background. In 2010, VA and DOD updated the joint VA/DOD CPG for Management of Opioid Therapy for Chronic Pain. However, despite the growing number of opioid prescriptions and changes in best practices and treatments, the CPG, which guides clinicians in making treatment decisions regarding prescription of opioids for patients suffering from chronic pain, has not been up-

[7] http://www.vacareers.va.gov/students-trainees/physicians.asp.
[8] VA Handbook 5021/10 Transmittal Sheet, Employee/Management Relations, updated November 8, 2012.

dated for more than 5 years. Additionally, a 2014 OIG report found that not all of VA's practices concerning opioid prescribing align with recommendations in the CPG.[9]

Committee Bill. Section 421 of the Committee bill would, in a freestanding provision, outline requirements for updating the joint VA/DOD CPG for Management of Opioid Therapy for Chronic Pain. Subsection (a) of section 421 of the Committee bill would require VA and DOD to update and enhance the joint VA/DOD CPG for Management of Opioid Therapy for Chronic Pain. It would further require the updated CPG to incorporate the Centers for Disease Control and Prevention's (hereinafter, "CDC") safe opioid prescribing guidelines for the treatment of chronic, non-cancer pain in outpatient settings where practical. The Committee believes it is critical for opioid prescribing guidance to be up-to-date and consistent across Federal agencies to ensure that all providers have access to the same tools to make the best treatment decisions for their patients. The Committee expects VA and DOD to incorporate CDC guidelines where applicable and acknowledges that some CDC recommendations may not be appropriate for the veteran community. The Committee also expects that CDC guidelines alone, which only address chronic pain in outpatient settings, would not be sufficient to serve as an update to the CPG and directs VA and DOD to consider all relevant evidence to ensure that the final CPG is robust and relevant to the patient population of both departments.

This subsection would also require the updated CPG to enhance guidance concerning absolute contraindications for opioid therapy, including prescribing opioids and benzodiazepines concurrently, and prescribing opioids to treat mental health conditions and patients without any pain. Stronger guidance is needed because the OIG found that VA's practice of prescribing and dispensing benzodiazepines concurrently with opioids was not fully in alignment with acceptable standards.[10] This is despite the fact that the current CPG advises clinicians against this practice and notes it as an absolute contraindication.[11] Updated recommendations against prescribing opioid therapy for patients with severe mental health conditions, including PTSD and substance use disorder, as well as to treat mental health conditions are also needed due to the inappropriate practices at the Tomah VAMC where a psychiatrist was among the top opioid prescribers—providing large amounts of narcotics to patients with mental health issues.[12]

Moreover, section 421 would require the CPG to include stronger recommendations regarding consistent urine drug screenings—including that such screenings should be done at least once a year—for patients on long term opioid therapy and guidance that clinicians must appropriately interpret and act on the results. At the Tomah VAMC and throughout VHA, reports show that clinicians have not been consistently conducting or taking appropriate action

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[9] Office of Inspector General, Department of Veterans Affairs; "Healthcare Inspection—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy." Report No. 14–00895–163; May 14, 2014.

[10] OIG report; VA Patterns of Dispensing Opioids, May 2014.

[11] VA/DOD Clinical Practice Guideline for the Management of Opioid Therapy for Chronic Pain; May, 2010, at 25.

[12] OIG; Administrative Closure, Tomah VA Medical Center.

based on urine drug screenings to determine if a patient on opioid therapy is misusing opioids.[13]

The Committee recognizes the CPG contains non-binding recommendations aimed to inform and help clinicians in decisionmaking, and that providers' practices will vary when they appropriately take into account the needs of their individual patients. However, the Committee is concerned that, despite the recommendations in the 2010 CPG, overprescribing and abuse of opioids within VA has risen dramatically. Further, evidence indicates VA's opioid prescribing practices are not always consistent with acceptable standards as recommended in the CPG. As such, the Committee expects the updated CPG to include stronger and more robust recommendations to help guarantee clinicians deliver the safest and most effective care.

Finally, subsection (a) of section 421 would direct the updated CPG to include a requirement that all VA providers utilize the VA Opioid Therapy Risk Report tool prior to starting a patient on opioid therapy. Comprehensive use of this electronic tool, which helps providers manage their entire panel of patients' prescribed pharmacotherapy for acute or chronic pain, for all VA patients on opioid therapy, is absolutely essential to ensuring providers deliver and are held accountable for high quality and safe care.

Subsection (b) of section 421 would require the VA Secretary and the Secretary of Defense to jointly consult with the Pain Management Working Group of the Health Executive Committee of the Department of Veterans Affairs-Department of Defense Joint Executive Committee before updating the CPG.

Subsection (c) of section 421 would define the term "controlled substance" as having the same meaning as in section 802 of title 21, U.S.C. The Committee intends to ensure consistency in defining "controlled substance" for the purpose of this bill.

Sec. 422. Improvement of opioid safety measures by Department of Veterans Affairs.

Section 422 of the Committee bill, which is derived from S. 1641, would require VA to expand the Opioid Safety Initiative across all medical facilities; enhance pain management education and training for VA providers; identify and designate pain management teams at each VA medical facility; augment tracking and monitoring of opioid use at the Department; increase the availability of opioid receptor antagonists; include certain information and capabilities on the Opioid Risk Report tool; and incorporate notification of risk in the computerized health record.

Background. Started in August 2012 as a pilot program in Minneapolis, Minnesota, to reduce dependency on opioid use, the OSI was implemented nationwide a year later. In written testimony to the Committee on March 26, 2015, the then Interim Under Secretary for Health at VHA, Dr. Carolyn Clancy, noted key clinical metrics measured by the OSI from quarter 4, fiscal year 2012 to quarter 1, fiscal year 2015 indicated a 13 percent reduction in the number of patients receiving opioids. It should be noted VA saw a 2 percent increase in the number of patients utilizing its outpatient

[13] OIG; Administrative Closure, Tomah VA Medical Center and OIG report; VA Patterns of Dispensing Opioids, May 2014.

pharmacy services during that same period. Given the relative success of OSI to date, it is critical VHA expand and fully implement the initiative in all of its facilities as soon as possible to improve safe pain management.

The OSI and VHA's National Pain Management Strategy offers providers education and training to enhance competencies and to promote the CPG for Management of Opioid Therapy for Chronic Pain, including through such efforts as the dissemination of the OSI toolkit.[14] To enhance this effort and ensure consistency across the whole system, VHA should leverage the existing Interdisciplinary Chronic Pain Management Training Team Program to provide education on the CPG, additional training on screening, and improve identification and referral of patients with substance use disorder.

Limiting the provision of opioids, as appropriate, to providers with expertise in analgesics or pain care is critical in holding providers accountable for safe care and to prevent patient abuse and diversion. For example, at the Tomah VAMC, one of the most prolific prescribers of opioids was a psychiatrist without expertise in pain management. The use of interdisciplinary pain medicine specialty teams at VA facilities should serve as a valuable resource in combating such abuse and be implemented system-wide. As of 2014, 40 facilities (28 percent) have fully implemented interdisciplinary pain medicine specialty teams while another 56 (40 percent) have partially implemented these teams.

A critical aspect of the OSI is the Opioid Therapy Risk Report tool, an electronic tool that helps providers manage their entire panel of patients prescribed pharmacotherapy for acute or chronic pain. Not all VA providers currently use this tool, as VA does not mandate its use. VA providers who prescribe opioids should use this tool consistently to ensure safe prescribing and to help prevent diversion, abuse, and double-prescribing.

The Opioid Therapy Risk Report tool should also be enhanced to provide real-time data updates on patient information, rather than once in a 24 hour period, and by better interacting with providers in the community. Many veterans who access care at VA also obtain care in the community who may also prescribe them medication. The lack of access to a state's prescription drug monitoring program presents VA providers a challenge in safely prescribing opioids to their patients. Therefore, the Opioid Therapy Risk Report tool could be further enhanced by allowing VA providers to access the state PDMPs in an effort to see a patient's opioid therapy history from outside providers. Moreover, VHA should seek to fully implement its clinicians' ability to transmit VA prescription information to state PDMPs to guarantee that private clinicians have comprehensive information about their patients' history of prescribed controlled substances. Currently, 83 of the 130 VAMCs are transmitting prescription drug information to their respective state PDMPs.

Finally, while all VA facilities have naloxone on emergency crash carts, only 77 percent of VA facilities are currently dispensing naloxone rescue kits for patient take home use. Not all facility

[14] VHA National Pain Management Strategy, Implementation of the Stepped Care Model; October 2012. Power Point Presentation. http://www.va.gov/PAINMANAGEMENT/docs/VHA_Natl_Pain_Mgmt_Strategy_Kerns_Oct2012.pptx

pharmacies have such kits immediately on hand for dispensing and must order it or have it mailed to a patient who is prescribed a rescue kit. In an effort to improve VA's Overdose Education and Naloxone Distribution Program, the Department should expand access to naloxone and other opioid receptor antagonists by requiring every medical facility pharmacy to have opioid receptor antagonists on hand for dispensing and to expand the naloxone take home program.

Committee Bill. Section 422 of the Committee bill would, in a freestanding provision, outline requirements for improving VA's opioid safety measures. Subsection (a) of section 422 of the Committee bill would require an expansion of the OSI to all medical facilities within 180 days of enactment of the Committee bill. The Committee believes it is critical the OSI be expanded and fully implemented in all VA facilities as soon as possible to improve safe pain management. Subsection (b) would require all prescribers of opioid medications to receive pain management and safe opioid prescribing education and training to safely and effectively manage patients with chronic pain, and to appropriately comply with the updated CPG. Subsection (c) would require each medical facility to identify and designate a pain management team of clinicians. Each VISN would establish protocols for the designation of such teams that specify that providers without expertise in prescribing analgesics or who have not completed the education and training may not prescribe opioids unless done in consultation with a provider with pain management expertise or who is on the pain management team, and refers such patient to the team for any subsequent prescriptions and related therapy.

Subsection (d) would require VA to improve the Opioid Therapy Risk Report tool by enabling access to information from state PDMPs to help clinicians identify opioid use by veterans outside VA and must also submit information to the state PDMP. It would also require VA to conduct a feasibility study on further enhancements to the real-time tracking of, and access to data on, opioid use by veterans, concurrent prescribing of opioids in different health care settings, and mail-order prescriptions of opioids to veterans.

To help reduce overdose deaths, subsection (e) would require the Department to increase the availability of opioid receptor antagonists, such as naloxone, for veterans. Every medical facility pharmacy would be required to have opioid receptor antagonists on hand for dispensing. All veterans at risk of opioid overdose would have greater access to an opioid receptor antagonist kit and receive training on the proper administration of such drugs. VA would be required to report to Congress regarding implementation of this requirement.

Subsection (f) would require the VA Secretary to include information on the most recent time a health care provider accessed the tool and information on the results of the most recent urine drug test for each veteran. The VA Secretary would also be required to ensure the Opioid Therapy Risk Report tool could determine whether a VA health care provider prescribed opioids without accessing the information in the tool.

Subsection (g) would require VA to update its Computerized Patient Record System with an alert that a patient is at high risk of being an opioid abuser, or has a history of opioid abuse to help all

clinicians prevent abuse and diversion, and to help improve identification and treatment of substance use disorders.

Subsection (h) would define the term "controlled substance" as having the same meaning as in section 802 of title 21, U.S.C. The Committee intends to ensure consistency in defining "controlled substance" for the purpose of this bill.

Sec. 423. Enhancement of joint working group on pain management of the Department of Veterans Affairs and the Department of Defense.

Section 423 of the Committee bill, which is derived from S. 1641, would enhance the existing Health Executive Committee working group on pain management, established through the VA/DOD Joint Executive Committee, by incorporating opioid therapy issues. It would also require the HEC working group to work with other relevant working groups to address opioid prescribing practices, the management of chronic pain and substance use disorders, the use of complementary and integrative health services, and continuum of care issues related to the military to civilian transition. The VA and DOD Secretaries would also be required to consult with the HEC working group prior to release of any updates to the CPG on opioid therapy.

Background. As part of the VHA National Pain Management Strategy, the HEC Pain Management Working Group, established through the JEC, is working to consider the current clinical practice guidelines for opioid therapy and the opioid risk strategy.[15] The HEC PMWG focuses on efforts to improve pain management for VA and DOD beneficiaries that are complementary to the Institute of Medicine (hereinafter, "IOM") report on pain and the forthcoming National Pain Action Plan being developed by the Interagency Pain Research Coordinating Committee through the National Institutes of Health (hereinafter, "NIH"). Recent HEC activities include developing a standardized pain screening and assessment protocol, clinical pain policy support for VA and DOD providers, the creation of a new VA/DOD pain management curriculum, and integration of nonpharmacologic treatment options or integrative medicine into practice. As part of this work, the HEC PMWG addresses some issues surrounding the use of opioid therapy, such as developing a coordinated program for long-term opioid therapy principles of practice to include prescribing practices and provider/patient agreement standards.[16]

Opioid therapy has become a primary component of pain management and treatment within VA/DOD, so it is critical that the HEC PMWG officially incorporate issues surrounding opioid therapy as a key, consistent focus of its work. Due to the comprehensive expertise of the HEC, the group should be required to consult and review any updates to the CPG on opioid therapy before release. Further, issues surrounding opioid therapy fundamentally overlay with the wide-range of pain related issues considered by the HEC and other relevant committees, such as the HEC on mental health.

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[15] http://www.va.gov/PAINMANAGEMENT/docs/VHA_Natl_Pain_Mgmt_Strategy_Kerns_Oct2012.pptx

[16] VA/DOD Joint Executive Committee Annual Report, Fiscal Year 2014, at 37.

Committee Bill. Section 423 of the Committee bill would, in a freestanding provision, outline requirements for the HEC PMWG. Subsection (a) of section 423 of the Committee bill would require the HEC PMWG to include issues related to opioid prescribing practices, the management of chronic pain, as well as substance use disorders, the use of CIH services and continuum of care issues surrounding servicemembers' transitioning from the Armed Services to the civilian sector in its areas of focus. Subsection (b) of section 423 of the Committee bill would further require the HEC PMWG to coordinate and consult with other relevant Federal agencies, including the CDC, to review and comment on the VA/DOD CPG for Management of Opioid Therapy for Chronic Pain, or any successor guideline, before any update is released. During this process, the Committee expects that the working group closely coordinate with related HEC working groups on related issues, including the concurrent use of opioids and prescription drugs such as benzodiazepines, and the use of opioids to treat mental health disorders. Subsection (c) of section 423 of the Committee bill would require the HEC working group to report, within a year of enactment of the Committee bill, on VA/DOD efforts to update their joint CPG for Management of Opioid Therapy for Chronic Pain as required in subsection (a) of section 421 of the Committee bill.

Sec. 424. Establishment of pain management boards of the Department of Veterans Affairs.

Section 424 of the Committee bill, which is derived from S. 1641, would create a pain management board in each VISN to serve as an expert resource for patients, families, providers, and other employees of VA on the treatment of veterans with pain.

Background. VA currently offers multidisciplinary chronic pain management services through pain medicine, neurology, anesthesia, physical medicine and rehabilitation, psychology, psychiatry, nursing, and integrated medical teams. These services can include comprehensive pain assessment, pain psychology, acupuncture, interventional procedures, physical therapy, medication management, yoga, psychoeducation, aquatic therapy, and biofeedback. VA also provides training and resources for providers through the Opioid Safety Initiative toolkit that was developed through a national task force convened by the National Pain Management Program.

The March 2014 OIG Administrative Closure on opioid prescribing at the Tomah VAMC recommended that the facility should consider some variant of the tumor board model as one avenue by which to foster interdisciplinary management when presented with very complex cases requesting early opioid refills.[17] Tumor board reviews are interdisciplinary treatment plans in which doctors from different specialties discuss the care plan for a specific patient.

On March 30, 2015, the Senate Homeland Security and Governmental Affairs Committee and House Committee on Veterans' Affairs held a joint oversight hearing on the Tomah VAMC. At that hearing, Dr. Carolyn Clancy testified on behalf of VA and supported the inclusion of pain management boards at VA. Dr. Clancy

[17] Office of Inspector General, "Administrative Closure, Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center." Tomah, Wisconsin. March 2014 at 11.

expressly supported the inclusion of veterans and family members on pain management boards.[18]

Committee Bill. Subsection (a) of section 424 of the Committee bill would add a new section 7309A to title 38, U.S.C., to establish pain management boards in each VISN. These pain management boards would supplement the Department's ability to provide recommendations for treatment of patients with complex pain; provide consultations with health care professionals, patients, and family members about pain management resources and best practices of the Department; oversee compliance with and provide recommendations to improve compliance with the best pain management practices of providers, including the prescribing guidelines; oversee the pain management practices of the pain management teams of each medical facility of the Department in the VISN covered by the pain management board; host education events on pain management and treatment; and hold public events on best practices on pain management and CIH.

The VA Secretary would be required to appoint individuals to each pain management board. Membership would include a board certified pain medicine specialist, a trained and qualified member of the primary care team of a VA medical facility with experience in pain care, a pain psychologist, a pain social worker, a clinical pharmacist, a pain point of contact for the VISN, a physician with addiction and psychopharmacology experience and expertise, an allied health care professional, a clinician with expertise in CIH, a clinical behavioral therapist, a patient advocate, a representative of the labor interests of employees of the Department who are responsible for prescribing drugs, two current or former clinical patients who are representative of the demographic of patients covered by the VISN, and a family member of a current or former clinical patient who is representative of the demographic of patients served by the VISN. The Committee intends that one individual be able to meet the criteria for multiple required categories.

The VA Secretary would be required to take into consideration the clinical duties of Department employees in determining their terms of service. Members of the pain management board would not be paid for their service on the pain management board except to receive travel expenses, including per diem, in lieu of subsistence for travel that relates to their duties as pain management board members. Members of the pain management board may be temporarily excused from their clinical duties as an officer or employee of the Department when they are needed to carry out their duties as members of the pain management board. However, should the Department determine that such employees are needed for clinical care duties at a given time in order to maintain patient access to quality health services, their clinical duties would supersede their duties for the pain management board. In order to protect patient privacy and confidentiality, certain pain management board members, including patient advocates, labor union representatives as described above, and current or former clinical patients or their family members would not have access to identifying infor-

[18] Response to Representative Kind from Dr. Carolyn Clancy, M.D., Interim Under Secretary for Health, Veterans Health Administration before the U.S. Senate Homeland Security and Governmental Affairs hearing on Tomah VAMC Oversight; March 30, 2014. http://www.cq.com/doc/congressionaltranscripts–4656019?4

mation of a patient or other confidential information to a patient unless that individual is the patient advocate and has been granted permission by the patient to be present in order to represent the interest of the patient. The Committee intends membership on the pain management board to be non-disruptive to VA employees' other duties. An employee of the Department may not have an adverse personnel action taken against them as a result of communicating with a member of a pain management board.

Each pain management board may provide treatment recommendations for patients with complex clinical pain cases. Each pain management board may only provide specific clinical recommendations concerning a patient's complex pain management case if the patient or other qualifying individual has already requested and received a recommendation from the pain management team at their respective facility and is not satisfied with the team's recommendation. Members of the board who are not clinical professionals would not be permitted to participate in treatment recommendations and would not be permitted to access patient information. However, at the request and consent of the patient, a patient advocate may be present to ensure that the patient's interests are represented and that the veteran has a stronger voice in his or her care decisions. An individual may request a clinical recommendation if that individual is a patient, the spouse of a patient, an individual who has been designated by the patient to make health care decisions for the patient or to receive health care information for the patient, a physician of the patient or an employee of a Department medical facility. It is not the Committee's intent that treatment recommendations dictate the treatment plan to be used by the health care provider, but rather would be used to assist the patient and health care provider in determining the best treatment plan. Based on the board activities and treatment recommendations, each pain management board may provide recommendations on best practices regarding pain management in cases of complex clinical pain to VISN-level health care professionals.

Not later than January 31 of each year, each pain management board must submit a report to the Committee on Veterans' Affairs of the Senate and House of Representatives on the pain management practices carried out in the VISN including a summary and explanation of the treatment recommendations made throughout the previous year and recommendations for best practices that were provided to health care professionals in the previous year.

Subsection (b) of section 424 of the Committee bill would modify the table of sections at the beginning of chapter 73 of title 38, U.S.C., to include pain management boards. Subsection (c) of section 424 of the Committee bill would make the amendments in this section effective 1 year from enactment of the Committee bill.

Sec. 425. Review, investigation, and report on use of opioids in treatment by Department of Veterans Affairs.

Section 425 of the Committee bill, which is derived from S. 1641, would direct VA, within 2 years of the enactment of this bill, to enter into a contract with an independent expert on clinical prescribing practices to conduct a review of the VA's OSI and VA providers' opioid prescribing practices. In addition, this section would require VA to conduct an internal annual review, investigate cer-

tain opioid prescribing patterns, and report on its use of opioid therapy.

Background. According to the March 2014 OIG Administrative Closure concerning opioid prescribing at the Tomah VAMC, providers at Tomah were among the highest opioid prescribers in the region and their prescribing practices varied considerably among their peers.[19] At the request of this Committee, the OIG recently conducted a general investigation on VA opioid prescribing patterns and submitted a report to Congress, which found that not all of VA's practices concerning opioid prescribing aligned with recommendations in the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.[20]

Currently, VA does not have a process in place for a systematic and regular review, investigation, and reporting of its opioid prescription practices and trends by medical facility and by provider. Such information would allow Congress to conduct more effective oversight of VA and would allow VA to more effectively manage this important aspect of patient care. Similarly, ensuring that the Committee and members of Congress from the areas where VA's opioid use requires investigation are informed of this scenario in a timely way allows for better oversight and any intervention that may be helpful in supporting patients in these facilities.

Committee Bill. Section 425 of the Committee bill would, in a freestanding provision, outline the requirements for a review of VA's use of opioids in treatment. Subsection (a) of section 425 of the Committee bill would require VA to contract, within 2 years of the enactment of this bill, with an independent party experienced with assessing clinical prescribing practices to conduct a review of VA's OSI and VA health care providers' opioid prescribing practices. The Committee intends for VA to identify a credible expert or organization such as an appropriate component of the National Academies of Science, Engineering, and Medicine to carry out this review. This subsection would require the independent entity conducting the review to provide a report on its findings and recommendations within 30 days after completing the review. The report would be submitted to the VA Secretary and the Committee on Veterans' Affairs of the Senate and House of Representatives.

This subsection further details the specific elements that would be required in the report, including: recommendations for improvements to the OSI; information on veteran deaths as a result of sentinel events related to opioids prescribed by a VA provider; VA prescription rates and indications for opioid prescriptions at all VA medical facilities where opioids are used to treat non-cancer, non-palliative, and non-hospice care patients; prescription rates and indications by provider for benzodiazepines and opioids prescribed concurrently; an assessment of the extent to which VA prescription rates are aligned with standards for appropriate care; an assessment of the practice and effectiveness of VA providers treating patients without any pain, including patients with mental health conditions, with opioids; and an assessment of the extent to which VA

[19] Office of Inspector General, "Administrative Closure, Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center." Tomah, Wisconsin, March 2014.

[20] Office of Inspector General, Department of Veterans Affairs; "Healthcare Inspection—VA Patterns of Dispensing Take-Home Opioids and Monitoring Patients on Opioid Therapy." Report No. 14–00895–163; May 14, 2014.

is in compliance with the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. In addition, this subsection would provide additional topics that could be covered in the review, such as policy recommendations for VA employee performance management practices to address VA providers who are not practicing according to VA standards or are not following the VA/DOD clinical guidelines for contraindications for opioid use. The Committee intends to use this report as a means of holding the Department accountable for safe opioid prescribing practices.

Subsection (b) of section 425 of the Committee bill would require VA to conduct an internal annual review, investigation, and report on its use of opioid therapy. Within 1 year of enactment of this bill and at least annually thereafter, VA would be required to collect and review data on opioid prescriptions at each VA medical facility for non-cancer, non-palliative, and non-hospice care patients. The review would include rates, by health care provider, of (1) concurrent prescriptions for benzodiazepines and opioids, (2) prescribed or dispensed mail-order opioids to patients who were simultaneously being treated with opioids as in-patients, and (3) prescribed opioids for patients who were concurrently prescribed opioids by a non-VA provider. The Committee intends for this review to provide a baseline of information about the opioid prescribing practices and patterns of specific facilities and providers which may help in identifying trends and outliers in this area of clinical practice.

This section would also require VA to investigate opioid prescription rates when the Secretary determines that they are inconsistent with the standards of appropriate and safe use. Such investigations would include information on the specific facility and provider rates of opioid prescription and must be conducted through the VHA Office of the Medical Inspector. The bill would require that VA immediately notify the Committee on Veterans' Affairs of the Senate and House of Representatives and each member of the Senate and House who represent the area in which the investigation is being conducted. The Committee intends to ensure that information on relevant opioid use is shared in a timely manner with appropriate members of Congress, including Committee members and local delegations. In addition, within 1 year of the enactment of this bill and at least annually thereafter, VA would be required to submit a report to the Committee on Veterans' Affairs of the Senate and House of Representatives that includes the previous year's number of patients and percentage of VA patients who were prescribed opioids absent any pain or were prescribed benzodiazepines and opioids concurrently by VA providers. The report must also include the number and percentage of non-cancer, non-palliative, and non-hospice care patients treated with opioids, both as an in-patient and by mail-order prescription or who received opioid prescriptions from VA and non-VA providers concurrently. In addition, VA must report, by medical facility, the number of times a pharmacist overrode a critical drug interaction involving opioids, the full results of the review and investigation referenced above, and an assessment of VA's compliance with the VA/DOD CPG for Management of Opioid Therapy for Chronic Pain. In general, the Committee intends for these reviewing, reporting, and investigating measures to reveal the opioid prescribing practices of VA providers, including compliance with the updated guidelines,

deaths from opioids, prescribing rates, and concurrent use of opioids and benzodiazepines and to add a measure of accountability for VA's opioid use.

Subsection (c) of section 425 of the Committee bill would define the term "prescription rate" as the number of patients treated with opioids divided by the total number of pharmacy users of a particular facility or provider, the average number of morphine equivalents per day prescribed for patients being treated with opioids, and the average number of opioid prescriptions per patient of the patients being treated with opioids at a particular facility by a particular provider.

SUBTITLE C—PATIENT ADVOCACY

Sec. 431. Establishment of Office of Patient Advocacy of the Department of Veterans Affairs.

Section 431 of the Committee bill, which is derived from S. 1641, would create an Office of Patient Advocacy that reports to the Under Secretary for Health to manage the responsibilities of patient advocates, and to ensure that the mission of the program is focused on advocating on behalf of patients. The Office of Patient Advocacy would ensure that patient advocates receive appropriate training in patient advocacy that is consistent throughout VA. In addition, VA would be required to submit an annual report to Congress on the activities of the Office of Patient Advocacy.

Background. In 2010, when the Office of Patient Centered Care and Cultural Transformation (hereinafter, "OPCC&CT") was initially stood up, VA's Office of Patient Advocacy functions were moved to this office. As a result, VA does not currently have a stand-alone Office of Patient Advocacy. The Associate Director for Veteran Experience within VA coordinates a Patient Advocacy Program, which VA plans to update to ensure that the functions are clearly meeting the needs of veterans and prioritizing veteran experience with VA services.

A number of veterans and veterans service organizations have noted that VA's patient advocates are often ineffective or experience barriers to effectively advocating for veterans due to a conflict of interest inherent in the current structure of the program. Specifically, the written testimony that the Veterans of Foreign Wars provided for the legislative hearing on June 24, 2015, raised concerns that patient advocates cannot effectively meet their obligations to veterans when their chain of command includes VA medical facility staff who are responsible for the actions and policies they are required to address. These concerns about a conflict of interest based on the organization of the program have been echoed by other stakeholders.

Committee Bill. Subsection (a) of section 431 of the Committee bill would amend subchapter I of chapter 73 of title 38, U.S.C., to establish an Office of Patient Advocacy (hereinafter, "Office") within the Office of the Under Secretary for Health. The bill would require the VA Secretary to appoint a Director of the Office of Patient Advocacy to lead the Office and report to the Under Secretary for Health.

Creating a dedicated Office is central to achieving this goal. Establishing the Office within the Office of the Under Secretary for

Health and having the Director report to the Under Secretary would signal the Committee's commitment to elevating the responsibility for patient advocacy to top leadership within VA. In addition, a dedicated office reporting to the Under Secretary for Health would ensure that the program remains accountable to the needs of veterans and their families, would help prevent any undue pressure on advocates from the local medical facility leadership and would help to ensure that patient advocates perform their duties with an emphasis on addressing the patients' concerns rather than protecting the medical facility's leadership.

Further, this section would establish that the function of the Office is to carry out VA's Patient Advocacy Program. While VA is working to re-focus the Patient Advocacy Program on veteran experience, the Committee believes that this essential program needs to be strengthened and intends that the Patient Advocacy Program would guarantee that the veteran is at the center of patient advocacy efforts. This section would also delineate that patient advocacy responsibilities include: resolving complaints by veterans, presenting issues experienced by veterans to a variety of audiences, apprising veterans of their rights and responsibilities as patients in the VA system, tracking and compiling data on veteran complaints, establishing a process for sharing that data, identifying—at least quarterly—opportunities to improve health care services based on veteran complaints, elevating significant complaints to appropriate staff for further review, supporting any VA patient advocacy programs, ensuring that all appeals and final decisions regarding veteran health care issues handled through patient advocacy programs are tracked, understanding all relevant laws and directives related to veterans' rights in receiving health care, ensuring veterans receiving mental health care services are aware of their rights established under the Protection and Advocacy for Mentally Ill Individuals Act of 1986, fulfilling requirements for the inspection of controlled substances, and documenting and reporting any potentially threatening behavior to appropriate authorities. The Committee intends that establishing these responsibilities in statute would further advance the effort to keep the patient as the top priority in its advocacy efforts.

In addition, this section would require the Director of the Office to provide training to patient advocates and ensure that the training is consistent throughout VA. The Committee intends that the Director establish a uniform means of training patient advocates to ensure that a consistent message and instruction would be conveyed across all VA locations. Lastly, the section would define the term "controlled substance" as having the same meaning as in section 802 of title 21, U.S.C. The Committee intends to ensure consistency in defining "controlled substance" for the purpose of this bill.

Subsection (b) of section 431 of the Committee bill would add "7309B. Office of Patient Advocacy" to the table of sections at the beginning of chapter 73 as amended by section 424(b). Subsection (c) of section 431 of the Committee bill would direct VA to establish the Office referenced in section (a) and would ensure that it is fully operational by 1 year after enactment. The Committee intends to allow VA the necessary time to stand up the new Office, but also

to ensure VA does so in a timely way so that veterans receive the benefit of the work of the Office quickly.

Sec. 432. Community meetings on improving care from Department of Veterans Affairs.

Section 432 of the Committee bill, which is derived from S. 1641, would require each medical facility to host public, community meetings on improving VA's health care services.

Background. In October 2014, following a series of town hall meetings held at each VA medical facility and regional benefits office in August and September 2014, the VA Secretary directed all medical and benefits facilities to hold similar town hall meetings on a quarterly basis to improve communication with and to hear feedback directly from veterans across the country on their experiences with VA benefits and services. The Secretary noted that, at that time, VA was taking a hard look at all of its practices and functions in order to reorganize the Department around the needs of veterans. The Secretary emphasized that direct feedback from veterans, employees, and stakeholders was an important component of that reorganization, and key to improving VA's services and operations.

Committee Bill. Section 432 of the Committee bill would, in a freestanding provision, outline requirements for community meetings. Subsection (a) of section 432 of the Committee bill would require each VA medical center to host a community meeting—open to the public—on improving VA health care. The Committee believes that formalizing these meetings would help to ensure that veterans, families, staff, and other stakeholders have a stronger voice as VA plans and implements its strategy for transforming the Department to make it more veteran-centric.

The Committee bill would require that the first meeting take place not later than 90 days after enactment and that subsequent meetings take place at least every 90 days thereafter. In addition, this section would require Community Based Outpatient Clinics to hold, at least annually, publicly open community meetings on improving VA health care, the first of which to be convened no later than 1 year after the enactment of this bill.

Subsection (b) of section 432 of the Committee bill would require the VISN Director to attend at least one community meeting per year at each medical center in the VISN. The VISN Director may send a designee to attend at least one community meeting per year at each of the Community Based Outpatient Clinics in the VISN. Subsection (c) of section 432 of the Committee bill would require each VA medical center and Community Based Outpatient Clinic to announce its schedule of community meetings to the Committee on Veterans' Affairs of the Senate and House of Representatives and to each member of Congress who represents the region where the meetings are being held.

The Committee believes that this section of the bill is consistent with Secretary McDonald's earlier efforts to solicit feedback from veterans by hosting town hall meetings to hear the concerns of veterans, families, staff, and other stakeholders.[21]

[21] VA Views for S. 1641, Testimony submitted before the Senate Veterans' Affairs Committee, "Legislative Hearing" on June 24, 2015.

Sec. 433. Improvement of awareness of patient advocacy program and patient bill of rights of Department of Veterans Affairs.

Section 433 of the Committee bill, which is derived from S. 1641, would require VA to prominently display information on the Patient Advocacy Program in each medical facility, including contact information for that facility's patient advocate. VA would also be required to display the VA patients' bill of rights in a well-traveled area of each medical facility.

Background. VA currently posts information in medical facilities concerning the contact information for the patient advocate and the rights and responsibilities of patients and family members. This bill would require VA to also post the Patient Advocacy Program's purpose and to enhance the visibility of all of this information in medical facilities nationwide, thus giving it greater prominence and creating better visibility on this information for patients and family members who may need support from a patient advocate.

Committee Bill. Section 433 of the Committee bill would, in a freestanding provision, require the VA Secretary to display, at each VA medical facility, the purpose of the Patient Advocacy Program with the contact information for the facility's patient advocate. It would also require the VA Secretary to post the rights and responsibilities of patients, residents, and family members at VA medical facilities, community living centers, and other VA residential facilities. The section would also require that this information be displayed within 90 days of the enactment of the Committee bill and would require that the VA Secretary ensure that it is displayed in prominent locations where the greatest possible number of patients and family members can see it.

The Committee intends that VA place a high importance on disseminating this key information and that VA seek additional ways to improve awareness of the Patient Advocacy Program and the services it can provide to veterans and family members. The Committee further intends that the VA Secretary ensure that this critical information would be easily visible in as many locations in the facility as possible.

Sec. 434. Comptroller General report on Patient Advocacy Program of Department of Veterans Affairs.

Section 434 of the Committee bill, which is derived from S. 1641, would require GAO to conduct a study and issue recommendations to Congress on improving VA's Patient Advocacy Program as carried out and managed by the new Office of Patient Advocacy established by this bill.

Background. The Patient Advocacy Program is for all veterans who receive care at VHA facilities and clinics and their families to have someone to go to with concerns about patient care. The Patient Advocacy Program establishes a Patient Advocate at every VA medical center. The VHA Patient Advocacy Program Handbook provides the requirements for the Patient Advocacy Program including what is required from the service-level advocates up to what is required at the facility and VISN level. The Handbook establishes minimum expectations for the Patient Advocacy Program including that patients must have easy access to someone who will hear their complaint, patients must have their complaints addressed in a timely manner, advocates must utilize the Patient Advocate Track-

ing System, and the Patient Advocacy Program must be integrated with the Facility Veteran Customer Service and Service Recovery Activities. The Handbook was last updated in 2005.

Committee Bill. Subsection (a) of section 434 of the Committee bill would, in a freestanding provision, require GAO to deliver a report on VA's Patient Advocacy Program within 3 years of the enactment of this bill. Subsection (b) of section 434 of the Committee bill would establish that the elements to be included in the report are: recommendations for improving the program and any other information about the program as GAO deems appropriate. The bill would further provide options for additional elements that may be included in the report: a description of the Patient Advocacy Program, including its purpose and activities; the extent to which the program is achieving its purpose at the time of the review; an assessment of the staffing of the program; an assessment of the adequacy of training for program staff; and a review of veteran and family member awareness and use of the program.

The Committee intends for the report to provide a general sense of the working of the program at the time of the review and an assessment of its general effectiveness. The Committee included several potential topics that might be included, but intends for GAO to have the flexibility to determine the key elements included in the report based on what their research and investigation of the program uncovers. The Committee intends that, in addition to providing critical information about the current state of the program, the review and culminating report would serve as a baseline for future evaluations of the patient advocacy services provided by VA.

SUBTITLE D—COMPLEMENTARY AND INTEGRATIVE HEALTH

Sec. 441. Expansion of research and education on and delivery of complementary and integrative health to veterans.

Section 441 of the Committee bill, which is derived from S. 1641, would direct VA to develop a plan to expand research and education on and delivery of CIH to veterans.

Background. In recent years, VA has worked to transform the traditional practice of medicine to one that is patient-centered and optimizes overall health while minimizing risk of harm to the patient. The approach is focused on the overall well-being of individuals, rather than solely disease management. To better meet the goals of providing patient-centered care to veterans, VA created the OPCC&CT. The OPCC&CT plays a role in identifying best practices for VA care, such as the movement toward patient-centered care or the utilization of CIH services and therapies. However, further research and education on, and the delivery and integration of, CIH into the health care services provided to veterans is necessary. VA needs to understand the comparative effectiveness of various CIH therapies as well as the various approaches for integrating such therapies into traditional health services. Finally, identifying barriers to receiving or providing CIH to veterans will allow VA to overcome such barriers and improve delivery of these therapies to veterans. A variety of terms are used to describe therapies such as acupuncture, massage therapy, and guided imagery. Particular organizations and individuals have strong preferences and rationales for the utilization of one particular termi-

nology over another. For the purposes of this legislation, the utilization of the term "complementary and integrative health services" to describe these therapies should not be construed to interject a position of this Committee in this debate. Rather, this terminology is utilized to conform to the terminology currently utilized by NIH. NIH currently defines complementary and integrative health services as "practices and products of non-mainstream origin" and the practice of incorporating complementary approaches into mainstream health care.

Committee Bill. Section 441 of the Committee bill would, in a freestanding provision, outline requirements for VA to develop a plan to expand research and education on CIH. Subsection (a) of section 441 of the Committee bill would require VA, within 6 months of the effective date of that section, to develop a detailed plan to expand research and education on and the delivery and integration of CIH services for veterans. Subsection (b) of this section would specify that the plan shall outline research on the comparative effectiveness of various CIH services and strategies to integrate CIH services into other health care services provided by the Department. Additionally, the plan would outline education and training of health care professionals in the Department on CIH services, the appropriate uses of those services, and how such services would be integrated into existing health care services for veterans. Furthermore, the plan would require centers of innovation at Department medical centers to carry out research, education, and clinical activities on CIH. Finally, the plan would outline an approach for the identification or development of metrics and outcome measures to evaluate the delivery of CIH services as well as an approach to integrate and deliver CIH services with other health care services provided by the Department.

Subsection (c) of section 441 of the Committee bill would require VA, in creating the plan, to consult with the Director of the National Center on CIH of the NIH; the Commissioner of Food and Drugs; institutions of higher education, private research institutes, and individual researchers who have extensive experience in CIH; nationally recognized CIH providers; and other officials, entities, and individuals who have experience in CIH as VA deems appropriate. VA would consult with these parties in developing the plan; identify specific CIH services that are promising or supported by research for veterans; identify barriers to the effective implementation and integration of CIH services; and offer solutions to overcome such barriers. Subsection (d) of section 441 of the Committee bill would define the term "complementary and integrative health" to have the meaning given that term by the NIH. As the Committee seeks to align VA's terminology used to describe CIH services, VA should follow any recommendations and actions by NIH and the Department of Health and Human Services to revise said terminology.

Sec. 442. Pilot program on integration of complementary and integrative health within Department of Veterans Affairs medical centers.

Section 442 of the Committee bill, which is derived from S. 1641, would require VA to carry out a 3-year program to assess the feasibility and advisability of integrating the delivery of CIH services

with other health care services provided by the Department for veterans' mental health diagnoses, pain management, and chronic illness.

Background. Currently, CIH is used in VA facilities primarily for the purpose of pain management. Additionally, according to VA/DOD Clinical Practice Guidelines for Management of post traumatic stress, CIH therapies may be more acceptable to patients "reluctant to accept mental health labels or interventions" and have "the added benefit of increasing socialization" because many of these therapies are practiced in a group setting. CIH is also used to help individuals manage stress and to promote general wellness. According to the April 2011 edition of "VA Research Currents," a 2011 study conducted by VA's Health Care Analysis and Information Group showed the use of CIH has grown substantially within VA over the last 10 years. VA's survey noted that, out of 125 VA facilities nationwide that responded, only 12 percent have an integrated medicine clinic where CIH is provided. Integration of CIH services within VA's Patient Aligned Care Teams (hereinafter, "PACT") is necessary to ensuring its utilization in collaboration with other primary care services. The integration of mental health services as part of PACT is vital for the improved utilization of these services and the reduction of stigma associated with their use. CIH services may also benefit from such integration.

While CIH services are not currently available at every VA facility, there is interest in expanding access to such services for veterans. Of the remaining facilities that participated in the 2011 survey that did not provide CIH services at the time, half either indicated a desire to provide CIH or were in the process of establishing a program. CIH therapies provide an alternative to veterans who do not respond to more conventional therapies as well as for those interested in avoiding the use of prescription medications. Such therapies could also be used in conjunction with more conventional therapies to maximize veterans' health and well-being. Additionally, CIH therapies may be utilized in the treatment of seriously injured veterans—such as those receiving care at VA's polytrauma centers—as well as veterans receiving new, less acute diagnoses.

Committee Bill. Section 442 of the Committee bill would, in a freestanding provision, outline requirements for the pilot program. Subsection (a) of section 442 would require VA to carry out a program, through the OPCC&CT, to assess the feasibility and advisability of integrating CIH services with other health care services provided by the Department. Under the program, CIH services would be provided to veterans with mental health, chronic pain, or other chronic conditions. This subsection would specify that, during the development of the program, potential barriers to the integration of CIH services into VA medical centers must be identified and resolved.

Subsections (b) and (c) of section 442 of the Committee bill would require the program to be carried out during a 3-year period at no fewer than 15 separate VA medical centers. Subsection (c) of section 442 of the Committee bill also would require that at least two VA medical centers designated by VA as polytrauma centers be included as program sites. The medical centers chosen must include locations in rural areas, areas that are not in close proximity to an active duty military installation, and different geographic locations.

Furthermore, consideration of medical centers with prescription rates of opioids that are in conflict with or are inconsistent with the standards of appropriate and safe care would be given priority. Subsection (d) of section 442 of the Committee bill would require VA to, as part of the program, provide covered CIH services to covered veterans. Subsection (e) of section 442 of the Committee bill would specify that covered veterans shall include any veteran who has a mental health condition diagnosed by a VA clinician, experiences chronic pain, or has a chronic illness being treated in a VA facility. Additionally, veterans who do not meet any of the above criteria can request to participate or be referred by a VA clinician.

Subsection (f) of section 442 of the Committee bill would define covered services as those CIH services selected by the VA Secretary. Under the program, those covered CIH services would be administered by clinicians hired by VA who, to the extent possible, solely provide such services. Covered services must be included in the PACT initiative of the Office of Patient Care Services, Primary Care Program Office in coordination with the OPCC&CT. Covered services would be available to veterans for the treatment of mental health disorders, chronic pain, or other chronic conditions who have or have not received traditional treatments from VA for such conditions. Subsection (g) of section 442 of the Committee bill would specify that, in order to participate in the program, veterans must voluntarily elect to participate in consultation with a VA clinician. Subsection (h) of this section would require VA to report to Congress not later than 3 years after commencing the pilot. The reports must include the findings, conclusions, and recommendations with respect to the utilization and efficacy of CIH centers established under the program, an assessment of the benefits of the program, and the comparative effectiveness of various CIH therapies, barriers identified, and recommendations for continuation or expansion.

SUBTITLE E—FAMILY CAREGIVERS

Sec. 451(a)(1). Expansion of family caregiver program of Department of Veterans Affairs.

Section 451(a)(1) of the Committee bill, which is derived from S. 1085, would expand eligibility for VA's Program of Comprehensive Assistance for Family Caregivers.

Background. The Caregivers and Veterans Omnibus Health Services Act of 2010 was signed into law on May 5, 2010. It established the Program of General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers. The Program of Comprehensive Assistance for Family Caregivers (hereinafter, "the Program") provides additional support services to caregivers beyond what is provided through the Program of General Caregiver Support Services, including a monthly financial stipend, health care coverage through the Civilian Health and Medical Program of the Department of Veterans Affairs (hereinafter, "CHAMPVA"), counseling and mental health services, respite care, and technical assistance. The Program is only available to veterans who have serious injuries (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated

in the line of duty in the active military, naval, or air service on or after September 11, 2001.

In September 2014, GAO released a report on the Program entitled "Actions Needed to Address Higher-Than-Expected Demand for the Family Caregiver Program." The report noted, "Caregivers enable those for whom they are caring to live better quality lives and can contribute to faster rehabilitation and recovery." Supporting caregiving activities not only ensures equity of services and benefits available to the caregivers of our most seriously injured veterans, it may further enable veterans to remain at home rather than admitting them to a potentially more expensive institutional setting, such as a nursing home.

Prior to the Program's implementation, VA initially estimated that 4,000 caregivers would be approved for the program; however, as of December 14, 2015, 22,616 caregivers had been approved. GAO's 2014 report on the Program made specific recommendations for improvement. Among its recommendations, GAO recommended that VA "expedite the process for identifying and implementing an [information technology (hereinafter, "IT")] system that fully supports the program and will enable [the Veterans Health Administration] program officials to comprehensively monitor the program's workload, including data on the status of applications, appeals, home visits, and the use of other support services, such as respite care." GAO also recommended that the VA Secretary direct the Under Secretary for Health "to use data from the IT system, once implemented, as well as other relevant data to formally reassess how key aspects of the program are structured and to identify and implement modifications as needed to ensure that the program is functioning as envisioned so that caregivers can receive the services they need in a timely manner."

Committee Bill. Section 451(a)(1) of the Committee bill would amend section 1720G of title 38, U.S.C., to require VA to expand eligibility for the Program to all eras of veterans in two phases. The first phase of expanded eligibility would begin during the 2-year period beginning on the date on which the VA Secretary submits to Congress a certification that VA has fully implemented an IT system to support the Program. Section 451(a)(1)(B) of the Committee bill would require VA to submit the certification date in the Federal Register within 30 days to ensure public notification. The first phase includes veterans with a serious injury incurred or aggravated in the line of duty in the active military, naval, or air service on or before May 7, 1975. The second phase of eligibility would begin 2 years after the first phase. This includes those injured in the line of duty after May 7, 1975, and before September 11, 2001.

The eligibility criteria created an inequity between post-9/11 veterans and pre-9/11 veterans. However, VA has encountered numerous challenges in implementing the program, and it is clear improvements are needed to ensure the program is meeting the needs of those currently enrolled and can sustain an increase in eligible veterans.

The Program's expansion in two phases, as required by this section, is intended to ensure the Program does not get overwhelmed and continues to operate as intended, providing services in a timely manner, while enrolling those who have become newly eligible. The

publication of the VA Secretary's certification date in the Federal Register is intended to ensure veterans are notified of the Program's impending expansion.

Sec. 451(a)(2). Expansion of needed services in eligibility criteria.

Section 451(a)(2) of the Committee bill, which is derived from S. 1085, would expand the Program's eligibility criteria for needed services.

Background. Current law, section 1720G of title 38, U.S.C., provides that veterans eligible for the Program must be in need of personal care services because of an inability to perform one or more activities of daily living, a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury, or such other matters as the VA Secretary considers appropriate.

Committee Bill. Section 451(a)(2) of the Committee bill would amend subsection (a)(2)(C) of section 1720G of title 38, U.S.C., to include a need for regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired among the criteria considered for needed personal care services. It is the intent of the Committee to ensure the Program is consistently inclusive of the caregiving needs required by mental health conditions, traumatic brain injuries or other conditions with which eligible veterans may be diagnosed.

Sec. 451(a)(3). Expansion of services provided.

Section 451(a)(3) of the Committee bill, which is derived from S. 1085, would expand the services provided to caregivers under the Program of Comprehensive Assistance for Family Caregivers to include legal and financial planning services.

Background. In 2014, the RAND Corporation released a report, "Hidden Heroes: America's Military Caregivers," which examined characteristics of military caregivers and services available to them. The report indicates that, of the military caregiver-specific programs identified by RAND, few provide long-term planning assistance, including legal and financial planning, for military caregivers.

Committee Bill. Section 451(a)(3) of the Committee bill would amend subsection (a)(3)(A)(ii) of section 1720G of title 38, U.S.C., to require VA to include financial planning services and legal services related to the needs of injured veterans and their caregivers as among the services provided to caregivers. The section makes clear that VA should provide these services through the use of contracts with or the provision of grants to public or private entities.

While section 451(a)(3) requires that financial planning and legal services be offered to caregivers in the Program, it is the Committee's intent that VA not provide these services themselves, but instead partner with public or private entities. It is also the Committee's intent that, to the maximum extent practicable, VA should utilize partnerships that will provide the services pro bono.

Sec. 451(a)(4). Modification of stipend calculation.

Section 451(a)(4) of the Committee bill, which is derived from S. 1085, would expand the number of factors VA should consider

when determining the amount and degree of personal care services provided for certain veterans.

Background. Currently, there are three levels of caregiver stipends based on the amount and degree of personal care services provided. This was established pursuant to section 1720G of title 38, U.S.C. According to current regulations, the stipend payment is based on the number of hours of caregiving required by the veteran. The maximum stipend is based on the requirement of 40 hours of caregiving each week, the median stipend is based on the requirement of 25 hours of caregiving each week, and the lowest stipend is based on the requirement of 10 hours of caregiving each week. In order to determine the degree of personal care services required by the veteran, VA evaluates the veteran and establishes a clinical rating based on specific criteria regarding the ability to perform activities of daily living and the need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury.

Committee Bill. Section 451(a)(4) of the Committee bill would amend subsection (a)(3)(C) of section 1720G of title 38, U.S.C., to ensure VA is considering the assessment by the family caregiver of the needs and limitations of the veteran; the extent to which the veteran can function safely and independently in the absence of such supervision, protection, or instruction; and the amount of time required for the family caregiver to provide such supervision, protection, or instruction to the veteran when determining the amount and degree of personal care services provided for a veteran whose need for personal care services is based on a need for supervision or protection or regular instruction or supervision under subsection (a)(2)(C) of section 1720G of title 38, U.S.C.

The Committee understands that these determinations are made at the VA Medical Center level and the intent is to ensure consistency by VA in determining the amount of hours of caregiving required by the veteran.

Sec. 451(a)(5). Periodic evaluation of need for certain services.

Section 451(a)(5) of the Committee bill, which is derived from S. 1085, would require VA to periodically evaluate the needs of the veteran and the skills of the family caregiver to determine if additional instruction, preparation, training, or technical support is needed.

Background. Under section 1720G of title 38, U.S.C., VA is required to provide instruction, preparation, and training for family caregivers to provide care to veterans, in addition to ongoing technical support to address routine, emergency, and specialized caregiving needs of the family caregiver.

Committee Bill. Section 451(a)(5) of the Committee bill would amend subsection (a)(3) of section 1720G of title 38, U.S.C., to require that, in providing instruction, preparation, and training under subparagraph (A)(i)(I) of that section and technical support under subparagraph (A)(i)(II) of that section to each approved family caregiver, the VA Secretary periodically evaluate the needs of the veteran and the skills of the family caregiver to determine if additional instruction, preparation, training, or technical support is necessary.

The requirement for periodic evaluation of this support will ensure that caregivers have ongoing access to resources and support for their unique needs as they care for veterans, especially given that a veteran's needs may change over time as well as caregiving techniques and best practices.

Sec. 451(a)(6). Use of primary care teams.

Section 451(a)(6) of the Committee bill, which is derived from S. 1085, would require the VA Secretary to collaborate with the veteran's primary care team when evaluating applications for the Program, to the extent practicable.

Background. Under subsection (a)(5) of section 1720G of title 38, U.S.C., when reviewing applications submitted jointly by the veteran and family caregiver, VA is required to evaluate the veteran to identify the personal care services required and to determine whether the requirements could be significantly or substantially satisfied through personal care services from a family member. The determination for a veteran's approval for the Program is a clinical decision; however, there is no statutory requirement that VA include the veteran's primary care team in the evaluation.

Committee Bill. Section 451(a)(6) of the Committee bill would amend subsection (a)(5) of section 1720G of title 38, U.S.C., to require that the VA Secretary evaluate each application submitted jointly by an eligible veteran and family member in collaboration with the veteran's primary care team to the maximum extent practicable.

Though the veteran's primary care team maintains the veteran's treatment once in the Program, it is the intent of the Committee to ensure multidisciplinary input in the initial evaluation process, when possible.

Sec. 451(a)(7). Assistance for family caregivers.

Section 451(a)(7) of the Committee bill, which is derived from S. 1085, would authorize VA, in providing caregiver services required under current law, to partner with Federal agencies, States, and private, non-profit, and other entities to provide the assistance.

Background. There are numerous public and private entities that provide caregiver services. According to VA's fiscal year 2013 annual report to Congress on assistance and support services for caregivers, among the services VA provides under the Program, it contracts with a non-profit organization to provide the family caregivers' core curriculum training and with respite care providers in communities.

Committee Bill. Section 451(a)(7) of the Committee bill would amend subsection (a) of section 1720G of title 38, U.S.C., to authorize VA to enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private, non-profit, and other entities to provide family caregiver services required by section 1720G of title 38, U.S.C. The VA Secretary may provide assistance under this authority only if it is reasonably accessible to the family caregiver and is substantially equivalent or better in quality to similar services provided by VA. In addition, the VA Secretary could provide fair compensation to entities that provide assistance under this authority.

The Committee recognizes that other entities provide services the Program is required to provide, including respite care, and that VA in some cases is already partnering with these other entities to provide services. It is the Committee's intent that, if appropriate in order to provide the services and they are equivalent or better in quality to similar services provided by VA, VA continues to utilize its authority to partner with entities. This could ensure availability of services and could reduce any duplication.

Sec. 451(b). Modification of definition of personal care services.

Section 451(b) of the Committee bill, which is derived from S. 1085, would modify the definition of personal care services.

Background. Subsection (d)(4) of section 1720G of title 38, U.S.C., defines "personal care services" as services that provide the veteran assistance with one or more independent activities of daily living (subsection (d)(4)(A) of section 1720G of title 38, U.S.C.) and any other non-institutional extended care (subsection (d)(4)(B) of section 1720G of title 38, U.S.C.).

Committee Bill. Section 451(b) of the Committee bill would strike "independent" in subsection (d)(4)(A) of section 1720G of title 38, U.S.C., and amend subsection (d)(4) to include supervision or protection based on symptoms or residuals of neurological or other impairment or injury and regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired.

This section is consistent with changes made by sections 451(a)(2) and 451(a)(4) of the Committee bill, which recognize the need for regular or extensive instruction or supervision within the definition of personal care services and ensure the consideration of these personal care needs when determining the caregiver stipend.

Sec. 452. Implementation of information technology system of Department of Veterans Affairs to assess and improve the family caregiver program.

Section 452 of the Committee bill, which is derived from S. 1085, would require VA to implement a new IT system and conduct ongoing monitoring and modifications after the system is implemented.

Background. The requirement that VA implement a new IT system that can easily retrieve data that will allow all aspects of the Program to be assessed and comprehensively monitored, that can manage data, and that has the ability to integrate with other relevant VHA IT systems, is consistent with recommendations made by GAO in its September 2014 report. The report indicated that the IT system currently utilized, the Caregiver Application Tracker, was developed quickly due to time constraints on implementing the Program. VA initially expected the Program to be much smaller, and the Caregiver Application Tracker was not designed to manage a high volume of information. As a result, VA is not able to effectively monitor and assess the Program.

Committee Bill. Section 452 of the Committee bill would, in a freestanding provision, outline requirements for implementing an IT system. Section 452(a) of the Committee bill would require VA to implement an IT system that fully supports the Program and allows for data assessment and comprehensive monitoring of the Program not later than December 31, 2016. The IT system would also

be required to include the ability to easily retrieve data that will allow for comprehensive monitoring of all aspects of the Program and workload trends, in addition to the ability to manage data with respect to a number of caregivers that is greater than the number of caregivers expected to apply for the Program, and the ability to integrate the system with other relevant Veterans Health Administration IT systems. These requirements are consistent with the GAO recommendations, and it is the Committee's understanding that the process for developing the new IT system to support the Program is already underway.

Section 452(b) of the Committee bill would require VA to use the IT system to assess key aspects of the Program within 180 days of implementation. Section 452(c) of the Committee bill would require VA to also use the IT system for ongoing monitoring and assessment, including data on the status of applications and the use by caregivers of support services such as respite care. In addition, VA would be required to identify and implement necessary modifications to ensure the Program is functioning as intended and providing veterans and caregivers with services in a timely manner. These requirements are also consistent with the recommendations made by GAO. In order for expansion of the Program to begin, the VA Secretary must certify to the Committee on Veterans' Affairs of the Senate and House of Representatives and the Comptroller General that the IT system has been implemented. Section 452(d)(3) of the Committee bill would require VA to submit the certification, along with a description of its implementation and utilization for program monitoring not later than December 31, 2017.

Section 452(d)(1) of the Committee bill would require VA, within 90 days of enactment, to submit a report to the Committee on Veterans' Affairs of the Senate and House of Representatives and the Comptroller General, providing an update on the status of the planning, development, and deployment of the IT system. The section would also require that the report include an assessment of the needs of family caregivers and veterans who would be eligible for the Program, as expanded, as well as resources needed for their inclusion.

The intent of this requirement is to ensure proper preparation for the expansion. The Committee expects to be kept up to date on the progress of the IT system implementation and deployment and be informed of any changes to the timeline. By including GAO as a recipient of the report, GAO will have the opportunity to review VA's progress in implementing its recommendations, as required by section 452(d)(2) of the Committee bill. While GAO's audit quality control processes require GAO to at least annually follow up on, track, and record the extent to which GAO's recommendations have been implemented, the Committee expects GAO to follow up on its recommendations for the Program more often than annually and periodically inform the Committees on VA's implementation status until VA has taken the appropriate corrective actions to address GAO's findings and recommendations. The Committee also directs the Comptroller General to notify the Committee on Veterans' Affairs of the Senate and the House of Representatives once it has verified that the recommended actions have been implemented and, to the extent possible, that the desired outcomes are being achieved, within 45 days of that determination.

Sec. 453. Modifications to annual evaluation report on caregiver program of Department of Veterans Affairs.

Section 453 of the Committee bill, which is derived from S. 1085, would amend requirements for VA's annual evaluation report on VA's caregiver programs.

Background. Pursuant to the Caregivers and Veterans Omnibus Health Services Act of 2010 (section 1720G note of title 38, U.S.C.), VA submits an annual report to the Committee on Veterans' Affairs of the Senate and House of Representatives. Currently, VA is required to report on both the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support and include information regarding the number of caregivers receiving assistance, the cost to VA to provide such assistance, a description of outcomes achieved by the program, an assessment of their effectiveness and efficiency, and recommendations for legislative or administrative action. For the Program of Comprehensive Assistance for Family Caregivers, VA is also required to report on outreach activities carried out, in addition to an assessment of the manner in which resources are expended.

Committee Bill. Section 453 of the Committee bill would amend subparagraph (A)(iv) of section 101(c)(2) of the Caregivers and Veterans Omnibus Health Services Act of 2010 to require that VA's annual evaluation report on the Program of Comprehensive Assistance for Family Caregivers and the Program of General Caregiver Support include a description of any barriers to accessing and receiving care and services. It would also amend subparagraph (B) of such section to require that the report on the Program of Comprehensive Assistance for Family Caregivers also include an evaluation of the sufficiency and consistency of the training provided to family caregivers. The additional information on barriers to care and services and the sufficiency and consistency of training will help further inform the Committee on the effectiveness of the Program and potential issues that may need to be addressed.

Sec. 454. Advisory committee on caregiver policy.

Section 454 of the Committee bill, which is derived from S. 1085, would establish a VA advisory committee on caregiver policy.

Background. VA has 25 advisory committees, including 15 that were established by statute. Advisory committees provide VA with the opportunity to gain insight from experts and those impacted by programs and policies. The recommendations and reports from advisory committees can be a beneficial resource as VA develops new programs and policies and strengthens its current programs and policies.

Committee Bill. Section 454 of the Committee bill, in a free-standing provision, would direct VA to establish an advisory committee on caregiver policy to regularly review and recommend veteran caregiver policies to VA, to examine and advise the implementation of the policies, to evaluate their effectiveness, to recommend standards of care for caregiver services and respite care services provided to veterans or caregivers by private entities, to develop recommendations for legislative or administrative action to enhance and eliminate gaps in the provision of services to caregivers and veterans, and to make recommendations on coordination with state and local agencies and relevant non-profit organizations on

maximizing the use and effectiveness of resources for veteran caregivers. The advisory committee would be required to submit to VA and Congress annual reports on its assessments, recommendations, and evaluations. The advisory committee would be authorized through December 31, 2021.

The intent of the advisory committee is to not only review and evaluate VA policies relating to caregivers of veterans, but also to identify gaps and duplication in services and opportunities for coordination with state and local agencies and relevant non-profit organizations. Federal and state agencies, in addition to other private entities, provide services to caregivers, and the Committee believes there is potential for increased coordination to reduce duplication and maximize opportunities. If legislation establishing a similar committee that may have duplicative responsibilities is enacted through separate legislation, the Committee recognizes that this specific committee may no longer be necessary.

Sec. 455. Comprehensive study on seriously injured veterans and their caregivers.

Section 455 of the Committee bill, which is derived from S. 1085, would require VA to provide for the conduct of a comprehensive study on veterans and caregivers by an independent entity.

Background. VA conducts numerous studies, through collaboration with public and private entities, on health care related issues impacting veterans. While VA is currently engaged in research on such issues as traumatic brain injury, post traumatic stress disorder, and certain aspects of caregiving, it is not engaged in a comprehensive study on veterans and caregivers.

Committee Bill. Section 455 of the Committee bill, in a free-standing provision, would require VA to partner with an independent entity through a grant or contract to conduct a comprehensive study on veterans who have incurred a serious injury or illness, including a mental health injury or illness, and individuals who are acting as caregivers for veterans. Section 455(d) of the Committee bill would require that the study would begin 4 years after the expansion of the Program, though specific requirements for veteran or caregiver participation in the Program in order to be included in the study are not specified and left up to the independent entity. Section 455(b) of the Committee bill would require the study to include the health of the veteran, and if applicable, the impact of the caregiver on the health of the veteran; the employment status of the veteran, and if applicable, the impact of the caregiver on the employment status of the veteran; the financial status and needs of the veteran; and the veteran's use of benefits available through VA. Section 455(e) of the Committee bill would require VA to submit a report on the results of the study to the Committee on Veterans' Affairs of the Senate and House of Representatives. Additional insight into the impact of caregivers on veterans' health and well-being and the needs of caregivers and the veterans for whom they care will help inform VA and Congress on any improvements or modifications that could be made.

SUBTITLE F—HEALTH CARE AGREEMENTS

Sec. 461. Authorization of agreements between the Department of Veterans Affairs and non-Department extended care providers.

Section 461 of the Committee bill, which is derived from S. 2000, would add a new section 1703A to title 38, U.S.C., to provide that VA may enter into agreements to provide nursing home care and those agreements may be entered into without regard to any law that would require VA to use competitive procedures in selecting the party with which to enter into the agreement. Generally, a nursing home in carrying out that agreement would not be subject to any law that Medicare providers are not subject to.

Background. Currently, if VA cannot provide extended care services to veterans at a VA nursing home or community living center, VA may contract to provide those services in the community. However, the contract VA would enter into with a community extended care provider would be required to be Federal Acquisition Regulation (hereinafter, "FAR") based agreements. FAR-based agreements require reporting of employee and applicant data and demographics that would be burdensome to extended care providers, and has served as a deterrent for extended care providers to care for veterans. As Fred Benjamin, Vice President and Chief Operating Officer of Medicalodges, Inc., testified before the Committee on June 3, 2015, "[f]or our company, and many extended care providers, FAR-based agreements are simply not workable, and a streamlined approach that still protects Veterans, taxpayers, and preserves oversight is desperately needed." Medicare and Medicaid providers are not considered to be Federal contractors by regulations developed by the Department of Labor; however, if those same extended care providers care for a veteran they will be required to enter into a FAR-based agreement.

Committee Bill. Section 461 of the Committee bill would authorize VA to enter into agreements that are exempt from certain provisions of law to provide extended care services to veterans.

Section 461(a) of the Committee bill would create a new section 1703A in title 38, U.S.C., which would provide VA the authority to enter into provider agreements to provide extended care services to veterans. Section 1703A(a) of title 38, U.S.C., would allow VA to provide extended care services to veterans through the use of agreements if that care cannot be provided at a VA facility. Section 1703A(b) defines which veterans would be eligible for care under a Veterans Extended Care Agreement and directs that VA may not direct veterans to a particular provider. Section 1703A(c) would define the eligible providers to be participants of the United States Medicare and Medicaid programs or other providers the VA Secretary deems appropriate. Section 1703A(d) would require VA to promulgate regulations to establish a certification process for providers. Section 1703A(e) would establish the terms of the Veterans Extended Care Agreements to specify the rates VA would reimburse, ensure the return of medical records to VA, ensure that the provider does not attempt to collect compensation from a third party or health care plan for extended care services provided under the agreements, ensure that only care authorized by VA would be provided under the agreement, and would establish a methodology for providers to submit bills to VA. Section 1703A(f) would estab-

lish the circumstances under which an agreement could be terminated.

Section 1703A(g) would direct VA to conduct periodic reviews of agreements over $1,000,000 annually to determine if the extended care services should be provided at VA, through a contract, or through a sharing agreement. Section 1703A(h) would exclude the Veterans Extended Care Agreements from any law that would require VA to use competitive contracting procedures; however, the providers would be required to follow certain laws relating to ethics, fraud, integrity, or those laws that subject a person to civil or criminal penalties as if they were incorporated in the agreements. The language in section 1703A(h) was overwhelmingly agreed upon on a bipartisan basis by members of the Committee as a result of an amendment offered in Committee and reflects a compromise suggested by a Democratic Senator.

Section 1703A(i) would direct VA to establish a procedure to monitor the quality of care provided through the agreements. Section 1703A(j) would direct VA to establish procedures for providers to present disputes related to the agreements.

Section 1703A(k) would provide that this section would sunset 2 years after enactment of the Jason Simcakoski Memorial Act.

Section 461(b) of the Committee bill would direct VA to promulgate an interim final rule to carry out this section no later than 1 year after the date of enactment.

Section 461(c) of the Committee bill would make a clerical change to add section 1703A to the table of contents for chapter 17 of title 38, U.S.C.

It is the Committee's intent that a Veterans Extended Care Agreement will not be considered a "contract" or "contract-like instrument" as those terms are defined in Executive Order 13658 and its implementing regulations (29 C.F.R. Part 10). Any Veterans Extended Care Agreement will not be treated as a Federal contract or subcontract for the acquisition of goods or services and will not be subject to any provision of law governing Federal contracts or subcontracts for the acquisition of goods or services. This section intends to ensure veterans' access to high-quality extended care if that care is not available directly from VA while ensuring providers are subject to robust terms and conditions that address the quality of care for veterans, oversight of the provision of such care, and protections for taxpayers.

Sec. 462. Modification of authority to enter into agreements with State homes to provide nursing home care.

Section 462 of the Committee bill, which is derived from S. 2000, would amend section 1745 of title 38, U.S.C., to provide that VA may enter into agreements to provide nursing home care and those agreements may be entered into without regard to any law that would require VA to use competitive procedures in selecting the party with which to enter into the agreement. Generally, a State home in carrying out that agreement would not be subject to any law that Medicare providers are not subject to.

Background. Currently, VA may enter into contracts or agreements with State Veterans Homes to provide extended care services to certain veterans; however, those contracts or agreements would need to be FAR-based contracts. FAR-based agreements re-

quire reporting of employee and applicant data and demographics that would be burdensome to State Veterans Homes. Medicare and Medicaid providers are not considered to be Federal contractors by regulations developed by the Department of Labor; however, a State Veterans Home agreement or contract with VA would be a FAR-based agreement.

Committee Bill. Section 462 of the Committee bill would amend section 1745 of title 38, U.S.C., to modify how VA enters into agreements exempt from certain provisions of law with State Veterans Homes. Section 462(a) of the Committee bill would amend section 1745(a) of title 38, U.S.C., by replacing language to provide VA the authority to enter into agreements with State Veterans Homes. Section 462(b) of the Committee bill would further amend such section to exempt the agreements from any law that would require competitive contracting procedures. Section 462(c) of the Committee bill would direct that section 1745, as amended, would apply to agreements entered into 30 days after the date of enactment.

It is the Committee's intent that an agreement made under this section will not be considered a "contract" or "contract-like instrument" as those terms are defined in Executive Order 13658 and its implementing regulations (29 C.F.R. Part 10). Any agreement entered into will not be treated as a Federal contract or subcontract for the acquisition of goods or services and will not be subject to any provision of law governing Federal contracts or subcontracts for the acquisition of goods or services. This section intends to ensure veterans' access to high-quality extended care services if that care is not available directly from VA while ensuring providers are subject to robust terms and conditions that address the quality of care for veterans, oversight of the provision of such care, and protections for taxpayers.

TITLE V—OTHER MATTERS

Sec. 501. Extension of temporary increase in number of judges on United States Court of Appeals for Veterans Claims.

Section 501 of the Committee bill, which is derived from S. 1754, continues the expansion of the United States Court of Appeals for Veterans Claims from seven to nine authorized judges through January 1, 2021.

Background. The Veterans Court is a national court of record established under Article I of the Constitution that reviews appeals from decisions rendered by VA's Board of Veterans' Appeals. Under section 7253(a) of title 38, U.S.C., the Veterans Court was originally authorized to be composed of not more than seven judges. In 2001, the Veterans Court was temporarily expanded from seven to nine authorized judges for the period spanning January 2002 through August 2005 by Public Law 107–103. In 2008, the Veterans Court was again expanded from seven to nine authorized judges until January 2013 by Public Law 110–389. By December 2012, a full complement of nine judges had been confirmed by the U.S. Senate. Since then, two judges have retired, leaving the total number of confirmed judges at the time of the writing of this report at seven. Because the most recent temporary expansion of the court has expired, the eighth and ninth judges cannot be replaced. In recent years, the Board of Veterans' Appeals has increased the vol-

ume of decisions it is rendering annually, suggesting there may be a larger volume of incoming appeals ripe for Veterans Court review in the coming years.

Committee Bill. Subsection (a) of section 501 of the Committee bill would amend section 7253 to expand the number of authorized judges at the Veterans Court to nine through January 1, 2021. Subsection (b) of section 501 of the Committee bill would require the chief judge of the Veterans Court to report to Congress not later than June 30, 2020, on the temporary expansion, including an assessment on the effect of the expansion to ensure appeals are handled in a timely manner, a description of the types of ways in which the complexity levels of appeals may vary based on appellants' eras of service, and a recommendation on whether the number of judges should be adjusted at the end of the expansion time.

It is the view of the Committee that allowing the temporary expansion of the court to continue until 2021 will help allow the Veterans Court to address the anticipated surge in incoming appeals. Because the workload of the Veterans Court has varied over the years based on a number of factors, the temporary expansion coupled with the reporting requirement will allow Congress to again assess the appropriate size of the court prior to the expiration of this expansion.

Sec. 502. Repeal inapplicability of modification of basic allowance for housing to benefits under laws administered by Secretary of Veterans Affairs.

Section 502 of the Committee bill, which is an original provision, would repeal section 604(b) of Public Law 113–291 in order to realign the housing allowance provided to VA beneficiaries using Post-9/11 GI Bill benefits so it is paid at the same rate as the Basic Allowance for Housing provided to active duty military personnel in pay grade E–5 at the "with dependents" rate.

Background. Section 604 of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (Public Law 113–291) allowed the Secretary of Defense to change how basic allowance for housing is computed under section 403 of title 37, U.S.C. Specifically, it authorized the Secretary of Defense to reduce the monthly allowance rate by 1 percent of the average national housing costs for each pay grade and dependent status. This provision is similar to section 603 of the legislative proposals for fiscal year 2015 that the Department of Defense transmitted to Congress.

As part of the final language agreed to by the Senate and the House of Representatives, subsection 604(b) of Public Law 113–291 specified that any authorized reductions to the monthly rate under section 403 of title 37, U.S.C., would not apply to benefits paid by the VA Secretary. Instead, that subsection specified that benefits paid by the VA Secretary would be paid according to section 403 of title 37, U.S.C., as that section was written prior to enactment of Public Law 113–291.

Committee Bill. Section 502 of the Committee bill repeals section 604(b) of the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (Public Law 113–291), removing the exception of benefits paid by the Secretary of Veterans Affairs from the new calculation of basic allowance for

housing under section 403 of title 37, U.S.C. The repeal of section 604(b) in the Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act for Fiscal Year 2015 (Public Law 113–291) is made effective January 1, 2016, with the intent that housing allowance rates for benefits under chapters 31 and 33 of title 38, U.S.C., will match those prescribed according to section 403 of title 37, U.S.C., when those rates are adjusted on August 1, 2016.

Sec. 503. Department of Veterans Affairs program of internal audits.

Section 503 of the Committee bill, which is derived from S. 1641, would establish an independent and interdisciplinary office in the Office of the Secretary to regularly conduct internal audits to improve the delivery of benefits and health care to veterans and their families.

Background. In fiscal year 2016, Congress provided VA $71.2 billion in discretionary funding, which is in addition to the $94.5 billion in the Department's mandatory accounts. This funding is vitally important for providing health care and benefits to our nation's veterans. However, the Department does not currently undertake a regular, formal audit process to determine whether its funds are being used for the maximum benefit of veterans and their families, despite the fact that VHA is the largest integrated health system in the country. Many of the nation's largest health systems, such as Emory Health care, have an established internal audit process to identify and evaluate risks to the system as well as to drive efforts at improving the system and protecting institutional resources. The ability to conduct internal audits allows large health care systems to monitor systemic adherence to policies and procedures and to address any pressing concerns within the organization.

In January 2015, GAO added VHA to the GAO High Risk List, a designation that GAO assigns to government operations and programs it has identified as high risk due to vulnerability to fraud, waste, abuse, and mismanagement or the need to transform in order to address economic, efficiency, or effectiveness challenges. GAO concluded it was necessary to place VA on this list because of ambiguous policies and inconsistent processes, inadequate oversight and accountability, information technology challenges, inadequate training for staff, and unclear resource needs and allocation priorities within VHA. If VA is to comply with the recommendations GAO made in order to be removed from the High Risk List, then it will need to prove a sustained ability to allocate resources appropriately in areas of the highest need and to consistently implement policies across the health care system. In order to understand where resources are most needed, VA must have a better understanding of where the biggest problems are and an ability to determine how to address those problems. The ability to self-assess issues through an internal review process would assist VA in addressing any new issues before they rise to the level of threatening VA's ability to deliver health care or benefits.

Section 201 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146) required the commissioning of an Independent Assessment of the Health Care Delivery Systems and Management Processes of the Department of Veterans Affairs

(hereinafter, "Independent Assessment"). The Independent Assessment was reported to the Committee on September 1, 2015, and cost approximately $68 million to complete. This assessment provided an important review of VHA programs, including those that the Committee has held hearings on during the past year, such as construction, the non-VA care program, and the addition of VA to GAO's High Risk List. One of the key findings from the Independent Assessment was the need to take a systemic approach to addressing the challenges at VA that were identified in the Independent Assessment.

Enhanced internal assessment is an important tool for identifying opportunities early—before material weaknesses develop—for improvement of conditions within the Department that can result in financial loss or can affect care. On January 12, 2016, an OIG Audit of Non-VA Medical Care Obligations found VA facilities returned $1.9 billion to the Department of Treasury in fiscal year 2013 because the facilities did not manage their obligations appropriately. OIG found a reduction in the over-obligation of Non-VA Care funds from approximately 29 percent to 10 percent would have allowed an increase in approximately $358 million in direct Non-VA Care services to veterans. A September 28, 2015, OIG Administrative Investigation revealed Senior Executive Service employees were utilizing the relocation program and employee incentives in the Veterans Benefits Administration, including spending $1.8 million for 23 reassignments from fiscal year 2013 to fiscal year 2015. The OIG identified an inadequate approval process and a lack of standardization regarding practices regarding annual salary increases as contributing factors to this excessive spending by VA. The findings in these two reports illustrate systematic failures within VA that might have been prevented before costing the agency millions of dollars in lost or inappropriately used resources. A more robust internal auditing system could uncover problems at an early stage and serve as an alert that intervention is needed in order to preserve resources and avoid fraud, waste, and abuse.

In addition to the work done at GAO and OIG, the Committee plays a vital role in the ongoing oversight of VA. VA's lack of a consistent process and protocol regarding internal auditing and self-assessment impacts many of the topics the Committee's work covers. In fact in 2015, Committee oversight addressed several budget shortfalls, including cost overruns associated with building a new medical center in Denver and the poor financial forecasting that led to a $3.2 billion gap in VHA's non-VA care budget.

Despite the success of the above-mentioned audits, investigations and Congressional inquiries, these alone cannot achieve the type of insight into risks, effectiveness, and planning that is necessary to ensure the Department's smooth provision of benefits and health care to veterans and their families. In order to demonstrate the Department's ability to consistently manage the funding that is provided to it for the care and benefits of veterans and their families, the Committee believes the VA Secretary must engage in regular, independent review across the Department's offices to better monitor the delivery of health care and benefits to veterans and their families.

Committee Bill. Subsection (a) of section 503 of the Committee bill would establish a program of internal audits and self-analysis

at VA. The Committee believes this program will improve the delivery of benefits and health care to veterans and their families. The newly-established program would be an independent, interdisciplinary office within the Office of the Secretary tasked with conducting periodic risk assessments. These risk assessments would then be utilized to develop a plan to conduct internal audits.

The VA Secretary would be required to audit no fewer than five covered administrations or their functions, staff organizations, or staff offices each year. In determining which risk assessments to undertake, the VA Secretary would be required to prioritize administrations, such as VHA or the Veterans Benefits Administration and their functions, such as mental health and compensation and pension. Audits of staff organizations, including the Office of Acquisition, Logistics, and Construction, the Board of Veterans' Appeals, and the Office of Regulation Policy and Management, and staff offices, including the Office of the Assistant Secretary for Congressional and Legislative Affairs, the Office of the Assistant Secretary for Information and Technology, and the Office of Management would also be authorized.

Subsection (b) of section 503 of the Committee bill would require the VA Secretary to complete the first required risk assessment within 180 days of enactment. When the VA Secretary completes an audit under the program, the VA Secretary would be required to submit a report on the audit to the Senate and House Committees on Veterans' Affairs, the Senate and House Committees on Appropriations, the Senate Committee on Homeland Security and Governmental Affairs, and the House Committee on Oversight and Government Reform within 90 days of completion of the audit. The submitted report would include a summary of the audit, the findings in the report, the recommendations for legislative or administrative action to improve the furnishing of benefits and health care to veterans and their families and the plans, including timelines, to carry out the recommendations that the VA Secretary can complete without legislative action.

Finally, the VA Secretary would be required to submit to the Senate and House Committees on Veterans' Affairs, the Senate and House Committees on Appropriations, the Senate Committee on Homeland Security and Governmental Affairs, and the House Committee on Oversight and Government Reform by September 1 of each year a plan for risk assessments and audits to be conducted in the next fiscal year.

Sec. 504. Improvement of training for managers.

Section 504 of the Committee bill, which is derived from S. 1856, would require VA to provide periodic training to its managers.

Background. On June 24, 2015, the Committee held a legislative hearing to consider certain benefits and health care legislation pending before the Committee. The Partnership for Public Service (hereinafter, "Partnership")—a nonpartisan, non-profit organization dedicated to revitalizing the Federal civil service and transforming the way government works—testified at the hearing. In its testimony, the Partnership mentioned that "the biggest contributor to the performance problems at the VA is the quality of the manage-

ment, rather than the quality of the system."[22] The Partnership also mentioned that "the process for removing or disciplining a Federal employee is daunting in terms of the time and effort required, and this discourages some managers from taking appropriate action."[23] According to the Partnership, often managers are not trained in handling disciplinary actions and administrative support to take action.[24] The importance of training was also stressed during the Committee's legislative hearing on September 16, 2015, by Donald F. Kettl, a professor at the School of Public Policy at the University of Maryland. In his testimony in support of S. 1856, Professor Kettl discussed how S. 1856 would significantly advance the nation's efforts to care for its veterans for it places training at the center of the Department's career development network.[25] In his testimony, Professor Kettl mentioned that training is the most essential component, for the Committee is not only trying to solve the serious problems that plague the Department today, but the Committee is also building the foundation on which its future service to veterans depends. According to Professor Kettl, "[t]he only effective way to avoid future crises is to build—now—the capacity the Department will need tomorrow."[26] To bring greater accountability to the Department, and to build the capacity the Department will need in the future, the Department must invest in providing regular training to its managers.

Committee Bill. Section 504 would require VA to provide each employee who is in a managerial position with periodic training on the following: (1) the rights of whistleblowers and how to address a report by an employee of a hostile work environment, reprisal, or harassment; (2) how to effectively motivate, manage, and reward the employees who report to the manager; and (3) how to effectively manage employees who are performing at an unacceptable level and access assistance from the VA Office of Human Resources Management and the Office of General Counsel with respect to those employees.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the Congressional Budget Office (hereinafter, "CBO"), estimates that enactment of the Committee bill would, relative to current law, decrease direct spending by $4.1 billion over 10 years and increase discretionary spending by $3.5 billion over 5 years. Enactment of the Committee bill would not affect the budget of state, local, or tribal governments.

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

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[22] Testimony of Max Stier, President and CEO of the Partnership for Public Service, during a hearing entitled, "Pending Health and Benefits Legislation," before the Senate Committee on Veterans' Affairs, June 24, 2015, available at http://www.veterans.senate.gov/imo/media/doc/PPS%20Stier%20Testimony%206.24.15.pdf.

[23] Id.

[24] Id.

[25] Testimony of Donald F. Kettl, Professor, School of Public Policy University of Maryland, during a hearing entitled, "Pending Health and Benefits Legislation," before the Senate Committee on Veterans' Affairs, September 16, 2015, available at http://www.veterans.senate.gov/imo/media/doc/D%20Kettl%20Testimony%2009.16.2015.pdf.

[26] Id.

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, September 9, 2016.

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

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 425, the Veterans Homeless Programs, Caregiver Services, and Other Improvements Act of 2015.

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

Sincerely,

KEITH HALL,
Director.

Enclosure.

S. 425—Veterans Homeless Programs, Caregiver Services, and Other Improvements Act of 2015

Summary: Enacting S. 425 would reduce benefits provided under certain education programs administered by the Department of Veterans Affairs (VA) while expanding eligibility under those programs for some beneficiaries. The bill also would increase the amount of the pension paid to Medal of Honor recipients. On net, those changes would decrease direct spending by $4.1 billion over the 2017–2026 period.

In addition, S. 425 would make a number of changes to VA's health care programs, including expanding the caregivers program, improving benefits for homeless veterans, and increasing pay for medical staff. In total, CBO estimates that implementing those provisions would cost $3.5 billion over the 2017–2021 period, subject to appropriation of the necessary amounts.

Pay-as-you-go procedures apply because enacting the legislation would affect direct spending. Enacting the bill would not affect revenues. CBO estimates that enacting S. 425 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

S. 425 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA) and would benefit public entities, including educational institutions and health care providers, that provide services to veterans. Any costs those entities might incur would be incurred as conditions of participating in a voluntary federal program.

Estimated cost to the Federal Government: The estimated budgetary effect of S. 425 is shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Table 1.—Estimated Budgetary Effects of S. 425, The Veterans Homeless Programs, Caregiver Services, and Other Improvements Act of 2015

	By fiscal year, in millions of dollars—					
	2017	2018	2019	2020	2021	2017–2021
DECREASES IN DIRECT SPENDING [a]						
Estimated Budget Authority	-13	-151	-300	-426	-453	-1,345
Estimated Outlays	-13	-151	-300	-426	-453	-1,345
INCREASES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	40	162	518	1,105	1,902	3,728
Estimated Outlays	33	143	482	1,040	1,808	3,507

Note: Details do not add to totals because of rounding.
[a] Enacting S. 425 would have effects beyond 2020. CBO estimates that under the bill, direct spending would decrease by $4.1 billion over the 2017–2026 period.

Basis of estimate: For this estimate, CBO assumes that S. 425 will be enacted at the start of fiscal 2017, that the estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for affected programs.

Direct spending

S. 425 would reduce the amounts paid for certain education and rehabilitation benefits provided by VA and expand eligibility for those programs. It also would increase the amount of the pension the department pays to Medal of Honor recipients. On net, those changes would decrease direct spending by $4.1 billion over the 2017–2026 period (see Table 2).

REDUCED HOUSING ALLOWANCES. Under the Post-9/11 GI Bill (Chapter 33), VA provides monthly housing allowances to certain beneficiaries while they are in school. Those allowances are set at the amount of the housing allowance paid by the Department of Defense (DOD) to enlisted servicemembers with dependents and a rank of E–5. Additionally, VA provides some disabled veterans enrolled in education and training for rehabilitation with a monthly stipend at that same rate. Section 502 would reduce those payments.

Table 2.—Estimate of the Effects of S. 425 on Direct Spending

	By fiscal year, in millions of dollars—											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016	2017–2021	2017–2026
CHANGES IN DIRECT SPENDING												
Reduced Housing Allowances												
Estimated Budget Authority	-8	-137	-269	-373	-387	-408	-429	-450	-468	-481	-1,174	-3,410
Estimated Outlays	-8	-137	-269	-373	-387	-408	-429	-450	-468	-481	-1,174	-3,410
Transferred Education Benefits												
Estimated Budget Authority	-10	-24	-42	-64	-80	-91	-102	-117	-131	-151	-220	-812
Estimated Outlays	-10	-24	-42	-64	-80	-91	-102	-117	-131	-151	-220	-812
Restoration of Education Benefits												
Estimated Budget Authority	3	3	4	4	5	5	5	5	6	6	19	46
Estimated Outlays	3	3	4	4	5	5	5	5	6	6	19	46
Credit for Time in Medical Care												
Estimated Budget Authority	0	3	3	3	4	4	4	4	4	5	13	34
Estimated Outlays	0	3	3	3	4	4	4	4	4	5	13	34
Fry Scholarships												
Estimated Budget Authority	2	2	2	2	3	3	3	3	3	3	11	26
Estimated Outlays	2	2	2	2	3	3	3	3	3	3	11	26
Medal of Honor Pensions												
Estimated Budget Authority	0	2	2	2	2	2	2	1	1	1	6	14

Table 2.—Estimate of the Effects of S. 425 on Direct Spending—Continued

	By fiscal year, in millions of dollars—											
	2017	2018	2019	2020	2021	2022	2023	2024	2025	2016	2017–2021	2017–2026
Estimated Outlays	0	2	2	2	2	2	2	1	1	1	6	14
Total Changes in Direct Spending												
Estimated Budget Authority	-13	-151	-300	-426	-453	-485	-517	-554	-585	-617	-1,345	-4,102
Estimated Outlays	-13	-151	-300	-426	-453	-485	-517	-554	-585	-617	-1,345	-4,102

Note: Details do not add to totals because of rounding.

The Department of Defense sets its housing allowances on the basis of average housing costs for each locality. The Congress, in the National Defense Authorization Act for Fiscal Year 2016 (Public Law 114–92), authorized the department to reduce those allowances by up to 5 percent below the average. DOD has cut that allowance by 2 percentage points to 98 percent of the average for 2016. CBO expects that DOD will phase in the rest of the reduction by 1 percentage point a year through 2019. Under current law, VA's housing allowances are exempt from those reductions. Section 502 would strike VA's exemption, resulting in a decrease in the allowances provided by VA.

Based on current enrollment data, CBO estimates that about 800,000 people will use Chapter 33 benefits in 2017, and that the housing allowance per beneficiary will average about $7,800 in that year. (Many beneficiaries are not eligible to receive a housing allowance from VA, and most of those who do only receive the allowance during the 9-month academic year; thus, the average payment is significantly less than the approximately $19,500 in housing allowance that an E–5 with dependents would receive in 2017.) On that basis, and accounting for growth in the eligible population and incorporating annual inflation, CBO estimates that enacting section 502 would reduce direct spending for Chapter 33 benefits by about $3.2 billion over the 2017–2026 period.

About 27,000 disabled veterans enrolled in college, apprenticeship programs, or on-the-job training through VA's rehabilitation services receive the same housing stipend as that provided to Chapter 33 beneficiaries. Those stipends would be similarly affected by section 502. CBO estimates that cutting the stipends as described above would reduce direct spending for rehabilitative benefits by about $170 million over the 2017–2026 period.

In total, enacting section 502 would reduce direct spending by $3.4 billion over the 2017–2026 period.

TRANSFERRED EDUCATION BENEFITS. Servicemembers who earn benefits under the Post-9/11 GI Bill can use those benefits themselves or transfer them to their dependents. Section 202 would modify the authorities under which servicemembers may make such transfers. On net, those changes would reduce direct spending by about $800 million over the 2017–2026 period, CBO estimates.

Housing Allowance. Section 202 would reduce by half the monthly housing allowance paid to children who use transferred benefits. That reduction would apply to benefits that are transferred to children180 days or more after the bill is enacted. Based on current payment levels and adjusting for the effect of section 502 as discussed above and for expected inflation, CBO estimates that the annual payment for the housing allowance under the Post-9/11 GI

Bill will average about $7,600 in 2017 and $8,500 over the 2017–2026 period. (That annual payment may represent an academic years' worth of benefits for one student or portions of an academic year for two or more students.)

Based on data from DOD, CBO estimates that about 38,000 servicemembers will transfer their education benefits to their children each year. Less than 10 percent of children who receive transferred benefits will be college-aged at the time of the transfer and only half will reach college age during the subsequent 10-year period. Thus, the reduction in the housing allowance would affect a small number of annual payments initially—about 1,700 in 2017. The number of reduced payments would increase over time to about 40,000 annual payments in 2026. CBO estimates that the number of annual payments that would be cut in half under section 202 would total roughly 210,000 over the 2017–2026 period, reducing direct spending by $940 million.

Conditions for Transferring Benefits. Section 202 also would change the terms under which servicemembers may transfer Chapter 33 benefits to their spouses and children. Under current law, members must serve at least 6 years and agree to serve another 4 years to be eligible to transfer their benefits. Spouses are able to begin using those transferred benefits immediately, while children must wait until the member has completed 10 years of service. Under section 202, members would have to serve at least 10 years, and agree to serve an additional 2 years in order to transfer benefits. Spouses and children could begin using benefits as soon as they are transferred by the member.

CBO expects that those changes would cause some servicemembers who, under current law, would choose to transfer benefits, to instead leave the military and use their benefits themselves. Because servicemembers would have to wait four more years before committing to additional military service, they would have more opportunities to leave the armed forces. Also, spouses would have to wait an additional 4 years to use transferred benefits, somewhat reducing their value to the spouse. Finally, the length of service required from the member would increase from 10 years to 12 years.

Based on the rate at which personnel leave the military between their 6th and 10th years of service, CBO estimates that each year about 1,800 members who would have committed to additional service in order to transfer benefits under current law would, under this provision, leave the military and retain those benefits for their own use. That change would have several offsetting effects that would, on net, increase direct spending by $125 million over the 2017–2026 period, CBO estimates. Those effects include:

- Increased costs of $520 million for an additional 17,000 servicemembers who would separate and use additional benefits;
- Increased costs of $40 million for the roughly 1,400 additional recruits who would replace some of those separating servicemembers and then later separate and use education benefits near the end of the budget window;
- Decreased costs of $245 million because spouses who do receive transferred benefits would have to wait an additional 4 years to use them, reducing the total number of spouses who attend school over the next 10 years by about 5,500;

• Decreased costs of $90 million because about 3,700 fewer spouses would receive transferred benefits; and
• Decreased costs of $100 million because about 14,000 fewer children would receive transferred benefits, about 1,700 of whom would have reached college age during the next 10 years.

RESTORATION OF EDUCATION BENEFITS. Section 201 would increase the education benefits that VA provides under the Post-9/11 GI Bill by restoring some of those benefits to students who attend institutions that permanently close during an academic term.

Under current law, VA pays educational institutions at the start of the academic term for beneficiaries' tuition and fees. It then reduces the months of education benefits available to those students by the duration of that term. If a school permanently closes during the term, students will have been charged for use of the benefit, but may not have received academic credit. Additionally, VA discontinues payment of the monthly housing allowance to students at the time the school closes. Military personnel earn 36 months of Chapter 33 benefits if they serve on active duty after September 11, 2001; however, beneficiaries may have fewer than 36 months available if servicemembers transfer a portion of the benefit to dependents or use education benefits under a different VA education program. The bill would direct VA to restore lost months of education benefits to students who do not receive credit for a term as a result of school closures occurring in 2015 or thereafter.

Restoring benefit months would increase VA's payments only for those students who would otherwise use every month of education benefit currently available to them. In addition, those new costs would not begin to accrue for a beneficiary until that individual had used each month of eligibility available to them under current law and continued on to use months newly available under this provision. Thus, CBO expects that additional costs resulting from closures in a particular year would occur over several subsequent years.

On the basis of data from VA regarding usage rates for its education programs, CBO expects that roughly 900 students using the Post-9/11 GI Bill will be affected by school closures each year and that about half of those beneficiaries will use every month of education benefit available to them under the current program. Thus, CBO estimates that under section 201, about 450 beneficiaries a year would receive about 5 months of restored eligibility that they would use over the succeeding years. CBO further estimates that the average cost of that additional usage would be $6,300 in 2017 and would increase with inflation in subsequent years. On that basis, restoring benefits under section 201 would increase direct spending by $28 million over the budget window, CBO estimates.

Section 201 also would require VA to continue to pay the monthly housing allowance to beneficiaries affected by school closures for the lesser of 4 months or the remainder of the cancelled term. Under that requirement, CBO estimates that 900 students a year would receive an average of three additional months of housing allowance at a cost of $1,900 per person in 2017. After incorporating annual inflation, those additional payments would increase direct spending by a total of $18 million over the 2017–2026 period, CBO estimates.

In total, enacting section 201 would increase direct spending by $46 million over the 2017–2026 period.

CREDIT FOR TIME IN MEDICAL CARE. Section 210 would allow the time a reservist serves on active duty while receiving medical care or undergoing a medical evaluation to count as qualifying service for accruing education benefits under the Post-9/11 GI Bill. To qualify for full benefits under Chapter 33, veterans must serve 36 months on active duty or receive a disability retirement. Reduced benefits, between 40 percent and 90 percent of the full benefit, are available to veterans who serve less than 36 months but at least 90 days.

On the basis of historical data from the Department of Defense regarding activations for medical evaluations or care, CBO estimates that about 1,000 reservists will be called to active duty for those reasons annually, and spend an average of 7 months in that status. That additional qualifying service would increase benefit payments for those reservists who would not qualify for full Chapter 33 benefits under current law. That change would apply to benefits used after 2017. On the basis of average benefits, CBO estimates that those reservists who would receive an additional $2,600 in benefits in 2018. That amount would increase annually to reflect the increased cost of higher education.

Based on personnel data from DOD, CBO estimates that under section 210, about 25 percent of the reservists who are activated for medical care would receive and use additional benefits as a result of that service. Because beneficiaries typically attend school over several years, approximately 1,000 people would receive a larger benefit each year. In total, the additional payments from VA for those benefits would increase direct spending by $34 million over the 2017–2026 period, CBO estimates.

FRY SCHOLARSHIPS. The Marine Gunnery Sergeant John David Fry Scholarship provides 36 months of education benefits under the Post-9/11 GI Bill to spouses and children of servicemembers who died on active duty at any time after September 11, 2001. Section 209 would allow recipients of the Fry scholarship to receive additional benefits under the Yellow Ribbon GI Education Enhancement Program (YRP). As part of the Post-9/11 GI Bill, that program provides additional payments for some students—such as those at certain private schools and out-of-state students attending public schools—who face tuition and fees above what VA will typically cover. Institutions participating in the YRP agree to cover a portion of the difference between the tuition charged and the amount that VA would otherwise pay. VA then matches that financial assistance, thereby reducing or eliminating students' out-of-pocket expenses.

In 2014, VA made payments averaging $5,700 for 4 percent of the students who were eligible for the Yellow Ribbon Program. About 5,600 people with Fry Scholarships will attend school each year, CBO estimates. Assuming the same percentage of students with Fry Scholarships get similar YRP benefits (incorporating annual inflation), those additional payments would increase direct spending by $26 million over the 2017–2026 period, CBO estimates.

MEDAL OF HONOR PENSIONS. Effective 1 year from the date of enactment, section 102 would increase the special monthly pension

rate paid to Congressional Medal of Honor recipients from $1,299 per month to $3,000 per month, and adjust it annually thereafter for inflation. As of 2015, there were 79 individuals receiving a special monthly pension for the Medal of Honor. While CBO estimates that, on average, one new living recipient will receive a Metal of Honor and thus a special monthly pension each year, expected mortality rates for the existing population will cause the total number of recipients to decline gradually over the coming years. After accounting for projected mortality, new recipients, and inflation, CBO estimates that section 102 would increase direct spending for those pensions by $14 million over the 2018–2026 period.

Spending subject to appropriation

S. 425 contains a number of provisions that would enhance the support services provided to homeless veterans. Other provisions would modify VA's administration of its health care programs and expand eligibility and benefits for caregivers. In total, CBO estimates that implementing the bill would cost $3.5 billion over the 2017–2021 period, assuming appropriation of the necessary amounts (see Table 3).

HEALTH CARE ADMINISTRATION. Title IV would modify certain aspects of VA's health care program. In total CBO estimates implementing the provisions under title IV would cost $3.4 billion over the 2017–2021 period.

Expansion of Caregivers Program. The Family Caregivers program provides stipends, health insurance, respite care, training, and other forms of support to caregivers of eligible veterans who are enrolled in the program. Eligible veterans are those who require assistance in daily activities such as bathing, eating, or grooming as a result of injuries incurred during military service on or after September 11, 2001. Section 451 would open that program, in two stages, to eligible veterans of any era, and would expand the benefits offered under the program to include legal and financial planning services. In total, CBO estimates that implementing this section would cost $2.9 billion over the 2017–2021 period.

Table 3.—Estimated Effects of S. 425 on Spending Subject to Appropriation

	By fiscal year, in millions of dollars—					
	2017	2018	2019	2020	2021	2017–2021
Health Care Administration						
Expansion of Caregivers Program						
Estimated Authorization Level	10	12	310	969	1,768	3,069
Estimated Outlays	9	12	278	895	1,673	2,867
Overtime for Medical Staff						
Estimated Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Competitive Pay for Physician Assistants						
Estimated Authorization Level	0	16	16	17	17	66
Estimated Outlays	0	14	16	17	17	64
Competitive Pay for Directors						
Estimated Authorization Level	0	19	22	26	27	94
Estimated Outlays	0	17	21	25	27	90
Guidelines for Opioid Therapy						
Estimated Authorization Level	1	7	14	16	17	55
Estimated Outlays	1	6	13	16	17	53
Opioid Safety Measures						
Estimated Authorization Level	18	20	20	21	22	101
Estimated Outlays	16	20	20	21	22	99

Table 3.—Estimated Effects of S. 425 on Spending Subject to Appropriation—Continued

	By fiscal year, in millions of dollars—					
	2017	2018	2019	2020	2021	2017–2021
Pain Management Boards						
Estimated Authorization Level	0	9	9	9	10	37
Estimated Outlays	0	8	9	9	10	36
Assessment of Opioid Therapy						
Estimated Authorization Level	0	1	3	3	3	10
Estimated Outlays	0	1	3	3	3	10
Office of Patient Advocacy						
Estimated Authorization Level	*	*	1	1	1	3
Estimated Outlays	*	*	1	1	1	3
Community Meetings						
Estimated Authorization Level	*	1	1	1	1	4
Estimated Outlays	*	1	1	1	1	4
Complementary and Integrative Health						
Estimated Authorization Level	0	6	7	7	0	20
Estimated Outlays	0	5	7	7	1	20
IT System						
Estimated Authorization Level	1	1	*	*	*	2
Estimated Outlays	1	1	*	*	*	2
Agreements for Extended Care						
Estimated Authorization Level	0	4	10	0	0	14
Estimated Outlays	0	4	9	1	0	14
State Veterans Homes						
Estimated Authorization Level	0	50	80	0	0	130
Estimated Outlays	0	40	80	10	0	130
Subtotal, Health Care Administration						
Estimated Authorization Level	31	147	494	1,071	1,867	3,610
Estimated Outlays	28	130	459	1,007	1,773	3,397
Homeless Veterans						
Dental Care						
Estimated Authorization Level	*	8	15	24	25	72
Estimated Outlays	*	7	14	23	25	69
Homeless Veterans Reintegration Program						
Estimated Authorization Level	4	4	4	4	4	20
Estimated Outlays	*	3	4	4	4	15
Case Management						
Estimated Authorization Level	*	1	1	1	1	4
Estimated Outlays	*	1	1	1	1	4
Legal Services for Homeless Veterans						
Estimated Authorization Level	*	1	1	2	2	6
Estimated Outlays	*	1	1	2	2	6
Subtotal, Homeless Veterans						
Estimated Authorization Level	4	14	21	31	32	102
Estimated Outlays	*	12	20	30	32	94
Other Matters						
Court of Appeals for Veterans Claims						
Estimated Authorization Level	0	*	1	1	1	3
Estimated Outlays	0	*	1	1	1	3
Internal Audits						
Estimated Authorization Level	*	1	2	2	2	7
Estimated Outlays	*	1	2	2	2	7
Training for Managers						
Estimated Authorization Level	*	*	*	*	*	1
Estimated Outlays	*	*	*	*	*	1
Subtotal, Other Matters						
Estimated Authorization Level	*	1	3	3	3	11
Estimated Outlays	*	1	3	3	3	11
Reports, Studies, and Evaluations						
Estimated Authorization Level	5	*	*	*	*	5
Estimated Outlays	5	*	*	*	*	5

Table 3.—Estimated Effects of S. 425 on Spending Subject to Appropriation—Continued

	By fiscal year, in millions of dollars—					
	2017	2018	2019	2020	2021	2017–2021
Total Spending Subject to Appropriation						
Estimated Authorization Level	40	162	518	1,105	1,902	3,728
Estimated Outlays	33	143	182	1,040	1,808	3,507

Note:IT = Information Technology; details do not add to totals because of rounding; * = less than $500,000.

Stage one of this provision would open eligibility for the Family Caregivers program to eligible veterans who were injured during service on or before May 7, 1975. That stage would begin within 2 years of the date of enactment (after VA develops and certifies a new IT system to track benefits, as required under section 452). The second stage would begin 2 years after stage one, and would open the program to the remaining eligible veterans—those injured during service after May 7, 1975, and before September 11, 2001. For the purposes of this estimate, CBO assumes that S. 425 will be enacted by October 2016, that stage one of the proposal will begin in October 2018, and that stage two will begin in October 2020.

In 2015, costs for the Family Caregivers Program totaled $454 million, about $18,300 per participating veteran. Most of that cost resulted from stipends paid to caregivers. To qualify as a caregiver, individuals must be at least 18 years of age and either a member of a veteran's extended family or live with the veteran full time. Stipends are paid monthly and are based on the hours of daily care the veteran requires and the prevailing wage for home health aides. In 2015, stipends paid under the program ranged from $7,700 to $29,000 on an annual basis, and averaged roughly $15,600. Caregivers also are eligible to participate in CHAMPVA, a program run by VA that provides health insurance for dependents and survivors of certain disabled veterans. In addition, the Family Caregiver Program provides up to 30 days a year of respite care, as well as training and other support services. In 2015, costs under the Family Caregivers Program for CHAMPVA and the remaining services averaged about $2,700 per veteran.

CBO's estimate of the cost of expanding the Caregivers program is based on the usage and average costs of the existing program, and the number of veterans with significant, service-connected disabilities in the cohorts that would be newly eligible. However, to account for the advanced age of the newly eligible veterans, our estimate reflects the following findings from a recent RAND study:[1]

- Disabled veterans rely more heavily on assistance for daily activities as they age,
- Older veterans tend to rely on older caregivers, and
- Health care costs for caregivers increase with age.

For stage one, CBO estimates that about 20,000 additional veterans would benefit from the program in 2019, growing to roughly 44,000 by 2021. CBO expects that the youngest members of this co-

[1] Ramchand, Rajeev, Terri Tanielian, Michael P. Fisher, Christine Anne Vaughan, Thomas E. Trail, Caroline Batka, Phoenix Voorhies, Michael Robbins, Eric Robinson and Bonnie Ghosh-Dastidar. *Hidden Heroes: America's Military Caregivers*. Santa Monica, CA: RAND Corporation, 2014.

hort will be in their late 60s. After factoring in a heavier reliance on caregiver assistance for activities of daily living and higher health care costs for caregivers because of advanced age we estimate that the average cost per participant would be about $30,000 in 2019. However, through the General Caregiver Program—which provides limited support services to caregivers of eligible veterans from all eras—VA already provides respite care to assist some caregivers. Accounting for those current benefits in our estimate reduces the average added cost per participant to $29,400. After accounting for gradual implementation and incorporating annual inflation, CBO estimates that stage one of this proposal would cost $2.5 billion over the 2019–2021 period.

In the second stage of expansion we estimate that about 29,000 additional veterans would use the Family Caregivers program in 2021. Because veterans in this group would be younger than those under the initial expansion we expect they would have less reliance on caregiver assistance (lower stipend amount) and the caregivers would be younger (lower CHAMPVA costs). On average, in 2021, we estimate the incremental cost per participant would be $28,000, after accounting for existing benefits under the General Caregiver Program. After factoring in a gradual implementation for the second stage of expansion and incorporating annual inflation, CBO estimates additional costs for the Family Caregivers Program of $367 million in 2021. Those costs would grow to be in the tens of billions of dollars over the 10-year window, CBO estimates.

In addition, under this section CBO estimates that roughly 34,000 caregivers in the current Family Caregivers Program (for veterans injured during service after September 11, 2001) would receive legal and financial support services. On the basis of the resources necessary to provide counseling under the existing program, we estimate an average annual cost of $130 per beneficiary for legal and financial services. CBO estimates it would cost $23 million over the 2017–2021 period to provide those benefits to individuals eligible for the Family Caregivers Program under current law. The costs of providing that additional benefit for individuals newly eligible for the Family Caregivers Program under this provision are included in the above estimates of adding those individuals to the program.

Furthermore, in anticipation of the surge of new applications upon expansion of the Family Caregivers Program, VA would need to hire and train additional staff to manage the program (caregiver support line, outreach activities, and monitoring). On the basis of the overhead costs to manage the existing program of $7 million in 2014 for 19,000 participants and incorporating annual inflation, CBO estimates staffing costs of $400 per participant. To handle roughly 20,000 new beneficiaries starting in 2018, CBO estimates additional overhead costs of $16 million in 2017 and 2018.

Overtime for Medical Staff. Section 412 would allow VA to offer flexible work hours (above or below 80 hours on a biweekly basis) to physicians or physician assistants (PAs) who work for VA on a full-time basis, provided the total work hours in a calendar year did not exceed 2,080. VA reports that the department does not compensate physicians for overtime; however, it does offer overtime pay to PAs at a premium rate of 25 percent of the employee's basic hourly rate.

VA employs roughly 1,800 PAs on a full-time basis. Using the average weekly hours for PAs in the private sector (where overtime pay is offered) of 40.63 hours, we estimate that PAs will work an average of 33 hours over the calendar year at the overtime pay rate (about $14 above their basic hourly rate of $55, which includes the pay increase under section 413). After factoring in the time to prepare regulations, we estimate that implementing the section would cost $5 million over the 2017–2021 period.

Competitive Pay for Physician Assistants. Beginning 1 year after enactment, section 413 would require VA to compensate PAs at rates that are competitive with those paid by health care providers in the private sector. Currently, VA employs about 1,850 physician assistants. On the basis of wages paid by private-sector providers, we estimate that the pay rate for those employees would increase by about 6 percent in 2018 (from $112,000 to $120,000) if VA paid competitive rates.

In addition, we expect that the higher pay level would help ameliorate VA's current difficulties in recruiting and retaining physicians' assistants, and would thus increase the total number of PAs employed by VA. On the basis of data from VA on hiring and retaining nurses, who are paid at competitive rates, CBO estimates that under section 413 VA would employ roughly 2,000 physicians' assistants by 2021 (or an 8 percent increase above the current staffing level). On that basis, CBO estimates that implementing this section would cost $64 million over the 2018–2021 period.

Competitive Pay for Directors. One year after enactment, section 415 would allow VA to offer competitive pay (based on compensation in the private market) to directors of regional and medical facilities at the department. VA employs about 130 directors at an average compensation amount of $220,000 in 2015. On average, compensation for medical directors in the private sector is about $320,000. As a result of the increase in salary, CBO estimates that VA would be able to fully staff the 140 Medical Director positions by 2021. After factoring in a 1-year delay and additional hiring, CBO estimates that implementing this provision would cost $90 million over the 2018–2021 period.

Guidelines for Opioid Therapy. Within 1 year of enactment of this bill, section 421 would require VA and DOD to jointly update their guidelines for managing opioid therapy for chronic pain. The updated guidelines would require VA to expand participation in the state-run Prescription Drug Monitoring Program (PDMPs) to include all VA medical facilities and to conduct both routine and random urine drug tests for patients receiving opioid therapy.

On the basis of information from VA and DOD, we estimate minimal costs to update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

In 2015, the PDMPs cost about $4 million to operate at 64 percent of the VA medical facilities. CBO estimates that increasing the program nationwide would cost an additional $2 million each year. After factoring in a 1-year period to update the guidelines, we estimate expanding the PDMPs would cost $9 million over the 2017–2021 period.

According to VA, about 255,000 (or 77 percent) of the 333,000 patients being treated for pain had at least one urine drug screening in 2015. After accounting for the growth in the number of such pa-

tients, we estimate about 100,000 additional urine tests would need to be completed each year at an average cost of about $110 per test to meet the updated requirements. After factoring in the necessary time to update the guidelines, we estimate that conducting urine tests would cost $44 million over the 2017–2021 period.

In total, CBO estimates that implementing this section would cost $53 million over the 2017–2021 period.

Opioid Safety Measures. Section 422 would require VA to expand its safety measures by improving training on providing pain management and prescribing opioids, establishing pain management teams at each medical facility, and improving patient tracking through electronic reports.

This provision would create pain management teams throughout the VA health care system. According to VA, each medical facility currently has its own methods to manage and oversee pain therapy; however, they do not always have designated pain management teams. Under this provision, VA would be required to implement a protocol for such teams. Based on information from VA, we expect that establishing and implementing such protocols at roughly 1,000 medical facilities would require very little additional work and would have an annual cost of roughly $6,500 per facility. On that basis, CBO estimates that establishing the pain management teams nationwide would cost $33 million over the 2017–2021 period.

Section 422 also would require VA to expand the nationwide availability of certain treatments such as Naloxone kits for opioid overdose. According to VA, it currently has roughly 55,000 patients with opioid-use disorder and roughly 28,000 Naloxone kits in its inventory. CBO estimates that it would cost roughly $14 million each year to ensure the availability of kits (at a cost of about $400 per kit) for those 55,000 patients who have the greatest potential risk of overdose. On that basis, CBO estimates it would cost $66 million over the 2017–2021 period to expand the availability of such treatments.

This section also would require VA to enhance the ability of the electronic Opioid Therapy Risk Report (OTRR) to access information on prescribed drugs through the Prescription Drug Monitoring Programs. According to VA, such modifications to the OTRR would require minimal analyst and programming support. CBO estimates that implementing that requirement would cost less than $500,000 over the 2017–2021 period.

In total, CBO estimates that implementing section 422 would cost $99 million over the 2017–2021 period.

Pain Management Boards. One year after enactment of this bill, section 424 would require VA to establish Pain Management Boards in each of the 21 VA health care regions to do the following:

- Consult with patients and family members,
- Oversee use of best practices in managing pain and issue recommendations for treating difficult cases, and
- Host educational and public events.

Under this provision, CBO expects that the regional boards—whose members might be spread across multiple states—would usually hold regular board meetings via phone or virtual conferencing. However, face-to-face meetings may be needed on occasion; thus, CBO estimates annual per diem and travel costs of $250 for

315 individuals (based on 15 board members in each of the 21 VA health care regions). CBO also expects VA would hire roughly 60 support staff (or 3 support staff per board) with an average compensation of $120,000. After factoring in a 1-year delay, CBO estimates that implementing this section would cost $36 million over the 2017–2021 period.

Assessment of Opioid Therapy. Under section 425, within 2 years of enactment of the bill, VA would be required to enter into a contract with an independent entity to assess and report on opioid prescribing practices at VA medical facilities. Beginning no later than 1 year after enactment, this section also would require VA to collect and analyze data on prescription rates of opioids and usage of opioid therapy at all VA medical facilities and to provide annual reports to the Congress on those matters. CBO estimates that implementing those requirements would cost about $1 million each year for data collection and coordination at all medical facilities.

On the basis of information from VA and independent entities who worked on similar studies, CBO estimates an independent review would take 3 years and cost $2 million each year, beginning in 2019. In total, CBO estimates it would cost $10 million over the 2017–2021 period to implement section 425.

Office of Patient Advocacy. Within a year of enactment, section 431 would establish a new Office of Patient Advocacy under the Undersecretary of Health at VA. According to VA, the department has already established a Client Services Response Team (CSRT) that reports directly to the Undersecretary of Health's office. We expect this provision would mostly codify existing practice; however, we think VA would hire two additional support staff and a director (with an average compensation level of $200,000 for each new employee) to assist the CSRT's efforts. After factoring in the time to hire the new staff, we estimate it would cost $3 million over the 2017–2021 period to implement this section.

Community Meetings. Section 432 would require VA Medical Centers and Community Based Outpatient Clinics to host community meetings on an annual and quarterly basis, respectively. Those meetings would be open to the public. VA currently hosts town hall meetings to get feedback from veterans, their family members and other community stakeholders. On the basis of information from VA, CBO estimates that VA would need to hold an additional 500 such meetings a year to meet the requirements of this provision.

Based on costs in the private sector, we estimate VA would spend roughly $1,500 per meeting for audio visual equipment, staff time, and supplies. In total, CBO estimates implementing this provision would cost $4 million over the 2017–2021 period.

Complementary and Integrative Health. Section 442 would require VA to operate a 3-year program at 15 VA Medical Centers to assess the feasibility of integrating complementary and alternative medicine with traditional care. On the basis of VA's implementation of other pilot programs of similar scope (such as using meditation for veterans with Post Traumatic Stress Disorder), CBO expects that developing and operating the program would require two additional medical practitioners at each of the 15 facilities to provide nontraditional care, as well as two additional employees at

each facility to engage in research, training, and assessment of the program.

The use of complementary and alternative medicine also would partially displace the use of traditional care (emergency care, primary care, and physical therapy) but would lead to greater use of medical services on balance, than under current law. Specifically, CBO estimates that the net cost to deliver medical services, after adjusting for the expected reduction in usage of traditional health care services would be roughly $66,000 per medical provider, resulting in costs of roughly $2 million annually during the 3-year pilot program.

On the basis of information from VA, CBO further estimates that the annual cost per person for the research and training personnel was $127,000 in 2015. Thus, in total, implementing section 442 would cost $20 million over the 2018–2021 period, CBO estimates.

IT System. By December 31, 2016, section 452 would require VA to develop and implement an IT system to track and assess data of the Family Caregiver Program. VA reports that it is currently working on enhancing its existing IT system, the Caregivers Application Tracker system, to allow for an easier application process, as well as tracking stipend awards and other benefits. As a result, we estimate this requirement would mostly codify existing practice and would have no budgetary effect. However, the provision also includes assessment and reporting requirements that CBO estimates would cost $2 million over the 2017–2021 period.

Agreements for Extended Care. Section 461 would temporarily—through 2019—exempt VA from the requirements of the Federal Acquisition Regulation (FAR) for the purposes of entering into agreements to provide long-term care to veterans in private facilities. The FAR is a set of rules that governs the conditions under which most federal agencies may purchase goods and services. VA has faced continuing challenges securing access to certain long-term care facilities because of the high cost of the contractual requirements (mostly related to reporting, compensation, and fringe benefits) under the FAR. Under this provision, CBO expects that VA will be able to contract for long-term care for more veterans than is possible under current law. This section also would require VA to develop a system, similar to that used by Medicare, to monitor the care provided to veterans in such extended care facilities.

According to VA, there are a total of 150 extended care facilities that have terminated their contracts with VA due to the strict requirements of the FAR. After factoring in the time for VA to place veterans, CBO estimates that by 2018 VA would enter into non FAR agreements with about 30 of those facilities. Based on information from VA, we estimate that, on average, veterans would occupy three beds at each of those facilities at a per diem rate of $280—with an average length of stay of 113 days. Based on information from the department, we expect that after the authority provided under this section expires in 2019, VA would lose access to the extended stay facilities under non FAR agreements, and would therefore have to place veterans in facilities with existing contracts. Thus, we estimate no additional costs after 2019.

CBO also estimates that VA would incur administrative costs of $1 million each year to increase its monitoring of care provided to veterans in extended care facilities by expanding its use of existing

data gathered by the states and the Centers for Medicare and Medicaid on extended care facilities. In total we estimate discretionary costs of $14 million over the 2017–2021 period.

State Veterans' Homes. Section 462 would temporarily—through 2019—waive the requirements of the FAR for contracts and agreements that VA enters into with state-run nursing homes for veterans. Under current law, the state veterans' homes (SVHs) are required to fill 75 percent of their beds with veterans. VA is required to pay SVHs the full cost of care for veterans with a service-connected disability (SCD) rating of 70 percent or more, under a contract or agreement. For all other veterans, VA pays SVHs a grant based on a fixed daily allowance.

According to VA, in 2015 the Department used such agreements to reimburse state-run nursing homes at a daily rate of $380 for each veteran with a SCD of 70 percent or more—at an annual cost of roughly $350 million (or 37 percent of the total reimbursements to SVHs). However, those agreements do not comply with the FAR, and VA does not expect to be able to enter into FAR agreements with any of the SVHs. In the absence of this legislation, CBO expects that VA will gradually phase out the use of such agreements as those veterans who are currently under that payment structure die or leave the SVHs. We expect those veterans would be replaced by veterans under the lower daily allowance rate of roughly $100 per patient. By allowing VA to enter into non FAR agreements, CBO estimates that this proposal would nearly triple VA's reimbursements to SVHs for veterans with severe SCDs.

As a result, after factoring in a gradual phase out of using non FAR agreements, CBO estimates that enacting this provision would cost $130 million over the 2018–2021 period. The additional costs from waiving the FAR requirements would begin in 2017. However, appropriations have already been provided for such agreements in 2017, so we estimate no additional funding would be necessary in that year.

HOMELESS VETERANS. Title III would authorize VA to expand benefits provided to homeless veterans, such as dental care, employment assistance, and legal services. In total, CBO estimates implementing those requirements would cost $94 million over the 2017–2021 period.

Dental Care. One year after enactment of the bill, section 303 would expand eligibility for dental care to veterans receiving certain forms of housing assistance. Under current law, veterans who receive short-term housing assistance through VA may receive limited dental care to alleviate pain, as part of treatment for a more severe periodontal disease, or to aid in getting a job. This section would provide that same out-patient dental care to certain veterans receiving longer-term housing assistance through the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program and transitional housing through a non-VA entity.

Based on an analysis of information from VA, CBO estimates about 3,700 veterans would take advantage of this benefit in 2018, growing to about 10,000 by 2020. At an average cost of about $2,000 per veteran in 2018, and incorporating the effects of medical inflation and a 1-year delay in implementation, CBO estimates that providing dental care to those additional homeless veterans would cost $69 million over the 2018–2021 period.

Homeless Veterans Reintegration Program. Section 304 would expand the eligibility for the Homeless Veterans Reintegration Program (HVRP). HVRP provides grants to agencies and organizations that provide job placement, training, and vocational counseling to homeless veterans.

This section would extend the benefits to veterans receiving longer-term housing assistance through HUD-VASH, newly released veterans who were incarcerated, and certain veterans who are Native Americans. According to VA, roughly 17,000 veterans would become eligible for the HVRP program under this proposal. Based on the current participation levels for HVRP, we estimate that under section 304 about 1,800 new beneficiaries would seek job placement annually at an average cost of $2,000 in 2017. CBO estimates that implementing this provision would cost $15 million over the 2017–2021 period.

Case Management. Within 1 year of enactment of the bill, section 306 would require VA to conduct a pilot program to assess the feasibility of using intensive case management practices for certain homeless veterans who are enrolled in the VA health care system. The pilot program would operate in at least six locations in the VA health care system and would include no fewer than 20 veterans at each location.

Based on the size of the pilot program and information from VA, CBO expects that implementing this provision would require the department to hire six full-time case managers at an average salary of $100,000. After adjusting for projected salary increases for federal workers, CBO estimates a total cost of $4 million over the 2017–2021 period.

Legal Services for Homeless Veterans. Section 308 would allow VA to collaborate with public and private entities to provide legal assistance (in areas such as housing, family law, and criminal defense) to veterans at risk of homelessness. On the basis of existing rates of participation in the Supportive Service Low Income Vets and Families program, which currently provides limited legal services to veterans at risk of homelessness, CBO estimates that roughly 15,000 veterans would take advantage of the proposed legal assistance.

Further, given the number and dollar amount of stipends provided to the health professional trainees (which includes fellows, residents, and students) rotating through VA, CBO estimates that VA would award stipends of $20,000 (incorporating annual inflation) to about 90 legal fellows to provide services to veterans. Because of the time necessary to write regulations and to develop partnerships, CBO expects that this program would not be fully implemented for several years. As a result, CBO estimates that implementing section 308 would cost $6 million over the 2017–2021 period.

OTHER MATTERS. Title V would extend the temporary increase in the number of judges for the Court of Appeals for Veterans Claims, establish a program of internal audits within VA, and provide training to managers throughout VA. CBO estimates that implementing title V would cost $11 million over the 2017–2021 period.

Court of Appeals for Veterans Claims. Section 501 would extend, through January 1, 2021, the authority for the Court of Appeals for Veterans Claims (CAVC) to appoint a new judge to the court

should a position become vacant. Previous legislation allowed for the court to expand from seven judges to nine in order to address the workload of the court. The authority to appoint a new judge to maintain nine judges expired on January 1, 2013.

According to the CAVC, the cost of a judge and his or her chamber is about $1 million per year. CBO expects that one judge will leave or retire over the next several years; thus, under section 501 one new judge would be appointed. Therefore, CBO estimates that implementing section 201 would cost $3 million over the 2017–2021 period.

Internal Audits. Section 503 would establish an office and program of internal audits—independent of other offices within VA—to do periodic risk assessments and analysis of various organizations and staff offices within the department. Based on information from VA, CBO expects that VA would hire 10 additional support staff and a director (with an average compensation level of $200,000 per staff member) to carry out the internal audits. After factoring in the time to hire the new staff, we estimate that implementing this provision would cost $7 million over the 2017–2021 period.

Training for Managers. Section 504 would require VA to provide training to managers in several areas. Such training would cover: ensuring rights of whistleblowers, effectively managing and motivating employees, and managing employees who are performing at an unacceptable level. According to VA, while managers are currently required to undergo training similar to that required by section 504, the agency would need to add new and updated content to meet all the requirements of the bill. On the basis of VA's current practices, CBO expects that VA would enter into a contract with a private entity to implement those changes at a cost of $1 million over the 2017–2021 period.

REPORTS, STUDIES, AND EVALUATIONS. The bill would require VA to produce a total of 13 reports on matters such as opioid therapy, patient advocacy, and benefits to caregivers of injured veterans. It also would require a study by the Government Accountability Office of programs offered to homeless veterans. Based on the costs of similar studies and reports, CBO estimates that meeting those requirements would cost a total of $5 million over the 2017–2021 period.

Pay-As-You-Go Considerations: The Statutory Pay-As-You-Go Act of 2010 establishes budget-reporting and enforcement procedures for legislation affecting direct spending or revenues. The net changes in outlays that are subject to those pay-as-you-go procedures are shown in the following table.

Table 4.—CBO Estimate of Pay-As-You-Go Effects for S. 425 as ordered reported by the Senate Committee on Veterans' Affairs on December 9, 2015

	By fiscal year, in millions of dollars—												
	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026	2016–2021	2016–2026
NET INCREASE OR DECREASE (-) IN THE DEFICIT													
Statutory Pay-As-You-Go Impact	0	-13	-151	-300	-426	-453	-485	-517	-554	-585	-617	-1,345	-4,102

Increase in Long-Term Direct Spending and Deficits: CBO estimates that enacting S. 425 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2026.

Intergovernmental and private-sector impact: S. 425 contains no intergovernmental or private-sector mandates as defined in UMRA and would benefit public entities, including educational institutions and health care providers, that provide services to veterans. Any costs those entities might incur would be incurred as conditions of participating in a voluntary federal program.

Previous cost estimates: On June 3, 2015, CBO transmitted a cost estimate for S. 1376, the National Defense Authorization Act for Fiscal Year 2016, as ordered reported by the Senate Committee on Armed Services on May 19, 2015. Section 605 of that bill is similar to section 502 of S. 425. The estimates differ because other legislation has been enacted in the interim that changed costs under current law and because VA provided additional information on how it would implement the provision.

On November 19, 2015, CBO transmitted a cost estimate for H.R. 3016, the Veterans Employment, Education, and Healthcare Improvement Act, as ordered reported by the House Committee on Veterans' Affairs on September 17, 2015. Section 301 of that bill is similar to section 202 of S. 425. The costs of section 202 are higher because of interactive effects with other provisions of the bill. Section 302 of that earlier bill also would increase benefits under the Fry Scholarships in a more expansive manner than would section 209 of S. 425, thus, the costs in this estimate are lower. Section 210 of S. 425 is similar to section 307 of H.R. 3016 and section 103 of H.R. 475 the GI Bill Processing Improvement and Quality Enhancement Act of 2015, as ordered reported by the House Committee on Veterans' Affairs on May 21, 2015. Section 210 would credit military service before the date of enactment of the bill; the previous bills would not. However, the estimate for the proposal has been updated for new information. Thus, on net, the cost of section 210 is less than the previous estimates.

On May 4, 2016, CBO transmitted a cost estimate for H.R. 4063, the Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act, as ordered reported by the House Committee on Veterans' Affairs on February 25, 2016. Sections 102 and 201 of that bill are similar to sections 422 and 432 respectively of S. 425, and the estimated costs for those provisions are the same. Section 302 of H.R. 4063 is similar to section 442 of S. 425, but would be effective 1 year later. The estimated costs for those provisions differ only because of that timing effect.

Estimate prepared by: Federal Costs: Ann E. Futrell, David Newman, and Dwayne M. Wright; Impact on State, Local, and Tribal Governments: Jon Sperl; Impact on the Private Sector: Paige Piper/Bach.

Estimate approved by: H. Samuel Papenfuss, Deputy Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in

carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7(b) of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its December 9, 2015, meeting. One amendment by Senator Isakson was adopted by voice vote; Senator Brown and Senator Hirono requested to be recorded as voting no on the amendment. S. 425 as amended, and as subsequently amended during the Committee meeting, was agreed to by voice vote, without dissent, and ordered favorably reported to the Senate.

AGENCY REPORT

On May 13, 2015, David R. McLenachen, Acting Deputy Under Secretary for Disability Assistance, Veterans Benefits Administration; on June 3, 2015, Dr. Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration; on June 24, 2015, Dr. Rajiv Jain, Assistant Deputy Under Secretary for Health for Patient Care Services, Veterans Health Administration; on September 16, 2015, Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration; on October 6, 2015, Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration; and on November 18, 2015, Curtis L. Coy, Deputy Under Secretary for Economic Opportunity, Veterans Benefits Administration, from the Department of Veterans Affairs appeared before the Committee on Veterans' Affairs and submitted testimony on various bills incorporated into the Committee bill. In addition, on July 15, 2015; September 4, 2015; and December 8, 2015, VA provided views on various bills incorporated into the Committee bill. Excerpts from these statements are reprinted below:

STATEMENT OF DAVID R. MCLENACHEN, ACTING DEPUTY UNDER SECRETARY FOR DISABILITY ASSISTANCE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good afternoon, Mr. Chairman and Members of the Committee. I am pleased to be here today to provide the views of the Department of Veterans Affairs (VA) on pending legislation affecting VA's programs, including the following: S. 270, S. 602, S. 627, the "21st Century Veterans Benefits Delivery Act," the "Veterans' Compensation Cost-of-Living Adjustment Act of 2015," and a draft bill concerning VA small business contracting, Veterans benefits, and burial matters. We will separately provide views on the following bills: S. 681; sections 202, 203 and 206 of the "21st Century Veterans Benefits Delivery Act;" the bill associated with legislative proposals from the Report of the Military Compensation and Retirement Modernization Commission; the bill associated with legislative proposals from the Department of Defense (DOD); and sections 201 and 206 of the consolidated bill related to bills from the 113th Congress. Accompanying me this afternoon is Renée Szybala, Assistant General Counsel.

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S. 602

S. 602, the "GI Bill Fairness Act of 2015," would amend the term "active duty" under chapter 33 of title 38, to include certain time spent receiving medical care from DOD as qualifying active duty service performed by members of the Reserve and National Guard. Under this bill, individuals ordered to active duty under section 12301(h) of title 10, United States Code, to receive authorized medical care; to be medically evaluated for disability or other purposes; or to complete a required DOD health care study, would receive credit for this service under the Post-9/11 GI Bill.

S. 602 would apply as if it were enacted immediately after the enactment of the Post-9/11 Veterans Educational Assistance Act of 2008, Public Law 110–252.

VA defers to DOD regarding the change to qualifying active duty service under the Post-9/11 GI Bill, with the observation that a similar proposal was submitted by the Administration for inclusion with the 2016 NDAA, with an exception that this bill would be retroactive. Currently, individuals with qualifying active duty service of at least 30 continuous days who are honorably discharged due to a service-connected disability become eligible for 100 percent of the Post-9/11 GI Bill benefit. Because service under 10 U.S.C. § 12301(h) does not meet the current definition of active duty, Guard and Reserve members with such service who are discharged under these circumstances do not automatically qualify for 100 per-

cent of the benefit. If enacted, this change would allow for an increase in benefits from the 40–90 percent benefit tier up to the 100 percent level, and the change would be retroactive to as early as August 1, 2009.

The proposed change to the eligibility criteria under the Post-9/11 GI Bill would require VA to make changes to the type of data that are exchanged between DOD and VA through the VA/DOD Identity Repository (VADIR) and displayed in the Veteran Information System (VIS). In addition, new rules would need to be programmed into the Post-9/11 GI Bill Long Term Solution (LTS) in order to calculate eligibility based on service under section 12301(h) and to allow for benefit payments retroactive to 2009. VA estimates that it would need 1 year from enactment of S. 602 to complete these changes.

VA estimates that administrative cost requirements associated with the enactment of S. 602 would be insignificant. The Department is still evaluating benefit and resource costs related to this legislation.

STATEMENT OF THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning 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 benefits programs and services. Joining us today is Maureen McCarthy, M.D., VHA's Deputy Chief Patient Care Services Officer and Susan Blauert, Deputy Assistant General Counsel in VA's Office of General Counsel.

We do not yet have cleared views on sections 2 and 4 of S. 297, S. 471, the draft bill on Joint VA-DOD formulary for pain and psychiatric medications, and the draft bill Veterans Health Act of 2015. We will forward the views to the Committee as soon as they are available.

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S. 425, HOMELESS VETERANS' REINTEGRATION PROGRAMS REAUTHORIZATION ACT OF 2015

S. 425 would extend the authorization of appropriations for the Department of Labor's Homeless Veteran Reintegration Programs (HVRP) and the Homeless Women Veterans and Homeless Veterans with Children Reintegration Grant Program from 2015 to 2020. The bill would further expand the population eligible to receive services under HVRP to include not only homeless Veterans but also Veterans who are participating in the Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH) program, receiving assistance under the Native American Housing Assistance and Self-Determination Act of 1996, or transitioning from incarceration.

VA defers to the Department of Labor for views and costs on S. 425; however, we offer that this bill would provide additional

services for homeless and at-risk Veterans in the critical area of employment, which is a key factor in achieving and maintaining stability in permanent housing. Veterans transitioning from incarceration often face multiple barriers to successful reentry, and expanding HVRP eligibility to this population would help address the employment-related needs of a population of Veterans who are often at high risk of becoming homeless. It would also be especially helpful for Veterans transitioning from incarceration who may not be eligible for VA services.

S. 684, HOMELESS VETERANS PREVENTION ACT OF 2015

Section 2 of S. 684 would amend 38 U.S.C. § 2012(a)(2) to increase the per diem payments for Veterans who are participating in the VA's Homeless Provider Grant and Per Diem (GPD) Program through a "transition in place" (TIP) grant. The per diem payments under GPD TIP would be increased to 150 percent of the VA State Home rate for domiciliary care, compared to the current payment which is the lesser of 100 percent of the VA State Home rate for domiciliary care or the daily cost of care minus other sources of payments to the per diem recipient for furnishing services to homeless veterans.

VA supports section 2. This new provision would facilitate and provide support for Veterans moving from transitional to permanent housing. Supporting Veterans' transition from homelessness to permanent housing is a strategy VA believes will be effective in our efforts to end homelessness among Veterans. By allowing Veterans to "transition in place" to permanent housing, the Department would provide a valuable alternative for Veterans who may not need or be interested in participating in the HUD-VASH program.

Section 3 would amend 38 U.S.C. § 2012(a) to permit a grantee receiving per diem payments under the GPD Program to use part of these payments for the care of a dependent of a homeless Veteran who is receiving services covered by the GPD grant. This authority would be limited to the time period during which the Veteran is receiving services under the grant.

VA supports the intent of section 3, conditioned on the availability of additional resources to implement this provision. We feel that this authority is needed to fully reach the entire homeless population. However, full implementation of the legislation would require additional funding to avoid diminished services in VA's full complement of programs for homeless Veterans.

Section 4 would authorize the Secretary to enter into partnerships with public or private entities to provide general legal services to Veterans who are homeless or at risk of homelessness. The language further specifies that VA is only authorized to fund a portion of the cost of legal services.

VA supports section 4 as legal services remain a crucial but largely unmet need for homeless and at-risk Veterans, but respectfully recommends technical amendments to the bill language. The Supportive Services for Veteran Families Program currently allows for grantees to enter into partnerships with legal service providers to address legal needs that pose barriers to housing stability. However, this is not a required service under the SSVF regulations and,

therefore, is not provided to Veterans through all SSVF programs. Rather than authorizing VA to enter into "partnerships," section 4 should authorize VA to provide grants to ensure the language reflects a funding mechanism that VA could use to execute it. Furthermore, VA recommends removing the phrase "a portion of" from the proposed section 2022A(a). This change would allow VA to fund a portion or the entirety of the legal services provided under the partnership, thereby providing VA greater flexibility to support these efforts. Finally, VA would like to work with the Committee to make additional minor improvements to section 4.

Section 5 would extend dental benefits under 38 U.S.C. § 2062 to a Veteran enrolled in the VA health care system who is also receiving for a period of 60 consecutive days assistance under the HUD-VASH program, or care under title 38 authority in one of the following settings: a domiciliary, therapeutic residence, community residential care, or a GPD program. For purposes of the 60-day requirement, it would permit breaks in the continuity of assistance or care for which the Veteran is not responsible.

VA appreciates the intent of section 5 to expand eligibility for VA dental care, but cannot support it under a realistic assumption of future funding availability. VA believes these services would be especially valuable for this group of Veterans, and we welcome further discussion with the Committee.

VA supports section 6, which would provide permanent authority for VA's Veterans Justice Outreach (VJO) and Health care for Reentry Veterans (HCRV) Programs. VJO's goal is to avoid the unnecessary criminalization of mental illness and extended incarceration among Veterans by ensuring that eligible Veterans involved with the criminal justice system have timely access to VA's mental health and substance use services when clinically indicated, and other VA services and benefits as appropriate. Similarly, designed to address the community reentry needs of incarcerated Veterans, HCRV's goals are to prevent homelessness, reduce the impact of medical, psychiatric, and substance abuse problems upon community readjustment, and decrease the likelihood of re-incarceration for those leaving prison. This permanent authority would recognize the crucial role these programs play in preventing and ending Veteran homelessness.

Section 7 would amend 38 U.S.C. § 2044(e) to authorize the use of $500 million from VA's FY 2016 Medical Services appropriation for the Supportive Services for Veteran Families (SSVF) Program, and to extend the existing $1 million appropriation authority for training and technical assistance to SSVF grantees through FY 2015.

While the $500 million level of this authorization is above the level proposed in VA's budget, we nevertheless support an authorization level that provides flexibility should VA determine that additional funding is necessary and the Department is in a position to dedicate higher amounts to the program. VA thus supports the intent of section 7, but believes that in order to ensure the provision of quality services to Veteran families and the efficient execution of such additional funds; this increased flexibility should be accompanied by an increased proportional authorization in technical assistance for SSVF providers.

Section 8 would require the Secretary to assess and measure the capacity of programs receiving grants under 38 U.S.C. § 2011, or per diem payments under 38 U.S.C. § 2012 or 2061.

VA believes the intent of section 8 is satisfied by existing VA's Homeless Providers Grant and Per Diem Program monitoring practices. VA's GPD Program regularly monitors capacity and performance in grantees' programs, so section 8 would impose a new and potentially duplicative reporting requirement. Although VA expects that compliance with section 8 would require time and effort from VA employees, the reporting requirements are not unduly burdensome and would result in minimal costs to VA. Therefore, VA does not object to section 8.

Section 9 would require the U.S. Comptroller General to conduct an assessment of VA programs serving homeless Veterans to determine whether these programs are meeting Veterans' needs, and recent efforts to improve the privacy, safety, and security of female Veterans receiving assistance under these programs. VA supports the intent of section 9, but believes its goals have been accomplished by recent reviews of VA homeless programs conducted by the Government Accountability Office and by VA's annual assessment of homeless Veterans' service needs and the availability of responsive VA and community services. Since its inception in 1994, VA's Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) has surveyed participants (homeless and formerly homeless Veterans, as well as VA and community service providers) on the needs of homeless Veterans in their local communities, and the extent to which these are addressed by existing VA and community services. The results not only drive the development of new local partnerships, but also generate a national picture of male and female homeless Veterans' met and unmet service needs, as identified by homeless Veterans themselves and the service providers who work with them directly.

Section 10 would remove the requirement that VA report to the Senate and House of Representatives Committees on Veterans' Affairs on the activities of the Department during the calendar year preceding the report under programs of the Department for the provision of assistance to homeless veterans.

VA supports section 10. Removing this time consuming reporting function would free up VA resources that could be better used to internally asses the programs and implement changes to enhance the benefits and services provided to homeless Veterans. Furthermore, VA remains committed to providing timely data reporting to the Committees upon request. Removing this annual reporting requirement would recognize that VA, on its own initiative, conducts ongoing data analysis of VA homeless programs.

DRAFT BILL—DEPARTMENT OF VETERAN AFFAIRS PURCHASED HEALTH CARE STREAMLINING AND MODERNIZATION ACT

This draft bill is similar to legislation requested by the Administration to reform the authorities VA uses to purchase hospital care, medical services, and extended care when that care is not feasibly available at a VA facility, or through contracts or sharing agreements entered into under other authorities. We sincerely appreciate the Committee placing it on the agenda today, and look for-

ward to working with you on this critical aspect of ensuring Veterans' timely access to health care.

Section 2 would amend chapter 17 of title 38, U.S.C., by adding a new section, "1703A. Veterans Care Agreements with certain health care providers."

Subsection (a) of 1703A would provide that if VA is not feasibly able to furnish hospital care, medical services, or extended care within the Department or through the exercise of other authority to enter into contracts or sharing agreements, VA may enter into "Veterans Care Agreements" (VCA) with eligible providers who are certified under subsection (c) of the new 1703A. Eligibility for care would be determined in the same manner as if the care or services were furnished directly by a VA facility.

Subsection (b) would define eligible providers to include Medicare and Medicaid providers; an Aging or Disability Resource Center, an area agency on aging, or a State agency as defined in section 102 of the Older Americans Act; a center for independent living as defined in section 702 of the Rehabilitation Act; and other providers the Secretary determines to be appropriate.

Subsection (c) would require the Secretary to establish a process for the certification and re-certification of eligible providers. This process must include procedures for screening providers according the risk of fraud, waste, and abuse and must require the denial of applications from providers excluded from certain Federal programs. VA notes that this provision would require VA to certify all eligible providers, including those participating in Medicare or Medicaid. In VA's legislative proposal, VA would establish a separate certification process for those eligible providers that are not under the certification regimes of Medicare and Medicaid. VA suggests this approach to avoid subjecting providers to duplicative certification processes, which could dissuade providers from entering VCAs.

Subsection (d) would require the inclusion of specific terms in VCAs, including payment rates that are, to the extent practicable, in accordance with the rates paid by the United States in the Medicare program. Other requirements of VCAs would include restricting care to that authorized by VA, prohibiting third-party billing by providers, and submitting medical records to the Department.

Subsection (e) would specify the terms and conditions under which VA or the provider may terminate a VCA.

Subsection (f) would require the Secretary to review VCAs of material size every 2 years to determine whether it is feasible or advisable to provide the necessary care at facilities of the Department or through contract or sharing agreements entered into under other authorities.

Subsection (g) would specify that VCAs under section 1703A are exempt from certain provisions of law governing Federal contracting. Specifically, VCAs would be awarded without regard to competitive procedures and would not subject an eligible provider to certain laws that providers and suppliers of health care services through the Medicare program are not subject to. Providers entering into VCAs would be subject to all laws regarding integrity, ethics, fraud, or that subject a person to civil or criminal penalties, as well as all laws prohibiting employment discrimination on the basis

of race, color, national origin, religion, gender, sexual orientation, gender identity, disability, or status as a Veteran.

Subsection (h) would require the Secretary to establish a system or systems to monitor the quality of care and services provided to Veterans under section 1703A and to assess the quality of care and services for purposes determining whether to renew a VCA.

Subsection (i) would require the Secretary to establish administrative procedures for providers to present disputes arising under or related to VCAs. It would further require that providers exhaust these administrative procedures before seeking judicial review under the Contract Disputes Act.

Subsection (j) would direct the Secretary to prescribe regulations to carry out section 1703A.

Section 3 of the draft bill would amend 38 U.S.C. § 1745 to permit VA to enter into agreements with State Veterans Homes that are exempt from certain provisions of law governing Federal contracting. Specifically, an agreement could be awarded without regard to competitive procedures and would not subject a State Home to certain laws that providers and suppliers of health care services through the Medicare program are not subject to. An agreement would be subject to all laws regarding integrity, ethics, fraud, or that subject a person to civil or criminal penalties, as well as all laws prohibiting employment discrimination on the basis of race, color, national origin, religion, gender, sexual orientation, gender identity, disability, or status as a Veteran. In addition, subsection (c) would establish a separate effective date for the amendments made by section 3 based on the effective date of implementing VA regulations.

Although section 3 would eliminate the word "contract" in section 1745, it would authorize VA to enter into "agreements" which VA believes would include contracts based on the Federal Acquisition Regulation (FAR) contracts. VA thus does not interpret this amendment to prohibit VA from using FAR-based contracts if a State home requests it.

Similar to the legislation proposed by the Administration, the draft bill would not result in additional costs and thus would be budget neutral.

This bill is a critical reform that will address deficiencies in current law, as well as provide a comprehensive framework and foundation for the purchase of non-VA care in those circumstances where it is not feasibly available from VA or through contracts or sharing agreements. We strongly support its enactment, which we believe is essential to maintaining Veterans' access to care in every part of the country.

Mr. Chairman, thank for the opportunity to present the Department's views on these bills and we will be glad to respond to the Committee's questions.

STATEMENT OF DR. RAJIV JAIN, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning 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 benefits programs and services. Joining us today is Catherine Mitrano, Deputy Assistant Secretary for Resolution Management, and Jennifer Gray, Staff Attorney in VA's Office of General Counsel.

We do not yet have cleared views on the Draft Biological Implant Tracking and Veteran Safety Act of 2015 or on S. 1117, the Ensuring Veteran Safety Through Accountability Act of 2015. Additionally, we do not have cleared views on sections 203, 205, 208, and 209(b) of S. 469, sections 3 through 8 of S. 1085, section 2 of the draft bill referred to on the agenda as "Discussion Draft" or sections 101–106, 204, 205, 403 and 501 of The Jason Simcakoski Memorial Opioid Safety Act. We will be glad to work with the Committee on prioritization of those views and cost estimates not included in our statement.

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S. 1085, MILITARY AND VETERAN CAREGIVER SERVICES IMPROVEMENT ACT OF 2015

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

Section 2 of S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015, would remove "on or after September 11, 2001" from the statutory eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers, and thereby expand eligibility under the program to Veterans of all eras who otherwise meet the applicable eligibility criteria. Family caregivers could not receive assistance under this expanded eligibility until Fiscal Years 2016, 2018, or 2020 depending on the monthly stipend tier for which their eligible Veteran qualifies. Section 2 would also add "or illness" to the statutory eligibility criteria, and thereby expand eligibility to include those Veterans who require a caregiver because of an illness incurred or aggravated in the line of duty. In addition, the bill would expand the bases upon which a Veteran could be deemed to be in need of personal care services, to include "a need

for regular or extensive instruction or supervision without which the ability of the Veteran to function in daily life would be seriously impaired."

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

Section 2 of S. 1085 would also authorize VA, in providing assistance under the Program of Comprehensive Assistance for Family Caregivers, to "enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private, nonprofit, and other entities" in certain circumstances. It would expand the definition of family member to include a non-family member who does not provide care to the Veteran on a professional basis, and it would amend the definition of "personal care services." The bill would also end the Program of General Caregiver Support Services on October 1, 2020, but would ensure that all of its activities are carried out under the Program of Comprehensive Assistance for Family Caregivers. Finally, the bill would amend the annual reporting requirements for the Program of Comprehensive Assistance for Family Caregivers.

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

In the report, however, VA noted difficulties with making reliable projections of the cost effect of opening the Program of Comprehensive Assistance for Family Caregivers to eligible Veterans of all eras, but estimated a population range of 32,000 to 88,000 additional Veterans in the first year (estimated for FY 2014), at a cost of $1.8 billion to $3.8 billion in the first year (estimated for FY 2014). After VA provided this report to Congress, the RAND Corporation published a report titled, "Hidden Heroes: America's Military Caregivers," which estimates a significantly larger eligible population (1.5 million) that may be eligible if the program were expanded to caregivers of pre-9/11 Veterans. VA's estimates in the 2013 report did not account for expansion to eligible Veterans with

an illness incurred or aggravated in the line of duty, other Veterans who would become eligible for the program based on the amendments in section 2 of S. 1085, or the additional assistance that would become available to primary family caregivers under the bill.

VA cannot responsibly provide a position in support of expanding the Program of Comprehensive Assistance for Family Caregivers without a realistic consideration of the resources necessary to carry out such an expansion, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. That consideration includes the budget levels included in the fiscal year 2016 budget resolution adopted by Congress, S. Con. Res 11, as well as the fiscal year 2016 Military Construction/VA appropriations measures passed in the House and awaiting action in the Senate (H.R. 2029). This is especially true as VA presses to strengthen mental health services and ensure the fullest possible access to care across the system.

While VA has not provided views on section 7 of S. 1085, the Department of Justice advises that it has constitutional concerns with that provision, which it will provide to the Committee under separate cover.

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

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DRAFT LEGISLATION—JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

Section 201 would establish within the Office of the Under Secretary for Health an office to be known as the "Office of Patient Advocacy." The Office would carry out the Patient Advocacy Program of VA. This section would also establish the responsibilities of patient advocates at VA medical facilities.

VHA currently has a Patient Advocacy program established to ensure that all Veterans and their families served in VHA facilities and clinics have their complaints addressed in a convenient and timely manner. The program operates under a philosophy of Service Recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall services to Veterans.

As health care continues to evolve, so does the role of the Patient Advocate. The role of the advocate in VHA has traditionally been more reactive, i.e. responding to issues as they arise, hearing and reacting to patient complaints as they bring them forward. With a heightened awareness of the importance of a positive, patient experience, VHA is on the pathway to transform the program including the role of the Patient Advocate to focus on a more proactive ap-

proach by all staff that would result in a more positive patient experience.

Earlier this month, to maintain the highest standard for responding to patient issues while continually improving the advocacy program, VHA established the Client Services Response Team (CSRT), reporting directly to the Office of the Under Secretary for Health. The CSRT is charged to centralize and streamline internal processes to improve VHA's overall responsiveness to the concerns of Veterans, employees and other key stakeholders.

The proposed bill reflects the existing Patient Advocacy program but does not account for the strategy to transform the Patient Advocate role to keep pace with private sector advances in patient experience. The model has been successfully demonstrated in VHA pilots and private sector health care systems [27] and is consistent with VA's vision of providing world-class customer service. This vision will engage staff from across the organization as well as Veterans to be actively involved in the transformation process. VA is thus very supportive of the concept in section 201, but has concerns that detailed statutory directives could restrict the evolution and breadth of the Patient Advocacy program.

VA supports section 202 which would require VA Medical Centers and Community Based Outpatient Clinics to host community meetings, open to the public, on improving health care from the Department. This section is consistent with current practices of hosting Town Hall meetings to hear from Veterans, families, and other stakeholders.

Section 203 would require VA display at each VA medical facility the purposes of the Patient Advocacy Program, contact information for the patient advocate, and the rights and responsibilities of patients and family members. VA supports increasing the awareness of the Patient Advocacy Program and the Rights and Responsibilities of Veterans and family members. This section is consistent with current practices of posting this information in medical facilities and would only require the addition of posting the Patient Advocacy Program's purpose.

VA supports the intent of title III which seeks to expand research, education and delivery of complementary and integrative health (CIH) to Veterans. VA is committed to expanding the research, education and delivery of complementary and integrative health services to Veterans. Aligning with VA's Blueprint for Excellence VHA leadership identified as its number one strategic goal "to provide Veterans personalized, proactive, patient-driven health care." This approach to health care prioritizes the Veteran and their values, and partners with them to create a personalized strategy to optimize their health, healing, and well-being. Many of the strategies that may be of benefit extend beyond what is conventionally addressed or provided by the health system and includes CIH. To this end, VA is establishing the Integrative Health Coordinating Center within the Office of Patient Centered Care and Cultural Transformation (OPCC&CT).

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[27] Merlino, J (2015). *Service fanatics: how to build a superior patient experience the Cleveland Clinic way*. New York, NY: McGraw-Hill Education.

OPCC&CT, along with Patient Care Services, deployed a national survey on CIH to better understand the evolution of how these services are being provided across the system and to advance further implementation. The survey was deployed to all VA parent medical facilities with a 100 percent completion rate. This report is being finalized this month for review by VHA and VA leadership.

VA is preparing the current workforce through a focus on education of the clinical staff. OPCC&CT developed the Whole Health Clinical Education Program which is designed to educate clinicians in providing a proactive, whole person approach. This includes learning how to effectively integrate CIH approaches. This interprofessional training includes VA physicians, nurses, dietitians, chaplains and other clinical staff. The core curriculum was designed and launched in 2014 and targets traditional health care providers across VHA.

The evaluation demonstrated that clinicians had improved attitudes towards Integrative Health, as well as changes in intentions to integrate mindful awareness in interactions with Veterans, encourage the use of self-care strategies, encourage the use of integrative health strategies during clinical encounters, and to co-manage patients with practitioners outside their own medical paradigm.

To implement safe and effective management of pain, VHA's National Pain Program office oversees several work groups and a National Pain Management Strategy Coordinating Committee representing the VHA offices of nursing, pharmacy, mental health, primary care, anesthesia, education, integrative health, and physical medicine and rehabilitation. Working with the field, these groups develop, review and communicate strong pain management practices to VHA clinicians and clinical teams.

VHA has multiple projects, coordinated under the National Pain Program office, to support and educate clinicians and Veterans about safe and effective stepped pain management, including use of opioids. Programs such as the Opioid Safety Initiative (OSI), the Joint Pain Education and Training Project (JPEP) with Department of Defense (DOD), the Tiered Acupuncture Training Across Clinical Settings (ATACS) with DOD, the Pain Mini-residency, Pain Specialty Care Access Network (SCAN ECHO), asynchronous Web-based training, and Community of Practice calls all reach across the VHA to train primary care providers in all settings in the assessment and treatment of pain and in the use of patient education in self-management, the use of multiple modalities such as behavioral, integrative medicine (Complementary and Alternative Medicine, or CAM), and physical therapies and the use of consultant specialists in pain, mental health, and CAM.

For example, on the topic of opioids safety, all the education programs listed above, except ATACS which is focused on acupuncture skill training, have presentations on universal precautions and risk management in opioid therapy for pain, including clinical evaluation, written informed consent, screening such as urine drug monitoring, use of state monitoring programs, and safe tapering. Related specifically to safe opioid prescribing, the VHA has implemented the Opioid Safety Initiative, a mandatory academic detailing program that identifies targets of risky practices (e.g., high

opioid doses, co-prescribed benzodiazepines, use of urine drug screens) and universally monitors these practices in VHA at the provider and facility/VISN level through appointed VISN and facility OSI and Pain Management Point of Contact, or POCs. A POC is a clinician appointed and supported at the VISN level who is an appropriately trained, experienced and credentialed in pain medicine, pain management, or another credential appropriate to the clinical discipline. These individuals identify targets of risky practices through regular monthly and 'on-demand' progress reports, and provide education and counseling for facilities and prescribers whose patterns of prescribing and pain management practices require remediation.

To provide clinical education and resource support to providers and facilities for successful OSI implementation, the National Pain Program office established the interdisciplinary OSI Toolkit Task Force to systematically peer-review and standardize clinical education and patient education materials for distribution throughout VHA. The OSI Toolkit Task force has completed peer-review, revision and approval of the below trainings and materials and meets regularly to peer-review, revise, and publish new "strong practices" that are identified in VHA.

Most recently, in March 2015, the National Pain Management launched the new Opioid Therapy Risk Report tool which provides detailed information on the risk status of Veterans taking opioids to assist VA primary care clinicians with pain management treatment plans. This tool is a core component of a reinvigorated focus on patient safety and effectiveness.

In 2014, VA's Office of Academic Affiliations in conjunction with Physical Medicine and Rehabilitation Services launched a national VA Chiropractic residency program. The VA Chiropractic program has been engaged in chiropractic education and training for a decade. Since 2004 over 1,500 chiropractic students have completed clinical rotations at 24 VA facilities. The VA chiropractic residency program focuses on Integrated Clinical Practice, with training emphasizing the provision of chiropractic care in an integrated health care system, collaborating with primary care Patient Aligned Care Teams (PACTs), specialty care, and other medical and associated health providers and trainees. Individual residencies are administered by the respective local VA facilities. Each VA facility partners with its affiliated Council on Chiropractic Education accredited chiropractic school in conducting the program.

VA Research is actively engaged with the community of scientists in establishing the evidence base for complementary and integrative health treatments for physical and mental conditions, the latter including examining the benefit of CIH therapy for PTSD, suicide prevention, and mood disorders. As these studies are completed, results will be evaluated to determine potential impact on Clinical Practice Guidelines. The VA Evidence-based Synthesis Program in conjunction with OPCC&CT and Patient Care Services has examined the scientific literature on various CAM services and have presented the findings in the form of "evidence maps." An evidence review and map in acupuncture, yoga, Tai Chi and mindfulness has been completed. The findings from these reviews are help-

ing to inform decisions on how to best use CAM within VA and identify areas for further research.

Section 401 would require that as part of the hiring process VA reach out to state medical boards to ascertain whether a prospective employee has any violations over the past twenty years, or has entered into a settlement agreement related to the employee's practice of medicine. VA does not feel that additional legislation is needed to accomplish this. VHA policy, already in place, requires the verification of all current and previously held licenses for all licensed health care providers. At the time of initial appointment all current and previously held licenses are verified with the state licensing board issuing the license. Verification requires querying the state licensing board for not only the issue date and expiration date, but also any pending or previous adverse actions. If an adverse action is identified, the verification requires obtaining all documentation available associated with such action, including but not limited to copies of any agreements. At the time of expiration of a license as well as at the time of reappraisal, VHA policy requires querying the state licensing board to confirm renewal of the license as all as whether or not there have been any new pending or previous adverse actions. If the license is not renewed, VHA policy requires confirmation that the license expired in good standing and if not, what was not in good standing.

At the time of initial appointment, all health care providers are queried through the National Practitioner Data Bank (NPDB). The NPDB is a national flagging system that serves as a resource for hospitals and other health care entities during the provider credentialing process. The NPDB provides information about past adverse actions of health care providers. VHA also enrolls all independent, privileged providers in the NPDB's Continuous Query program for ongoing monitoring of not only adverse actions taken against a credential, but also paid malpractice. VHA receives notification of a new report within 24 hours of the report being filed with the NPDB.

Additionally, at the time of initial appointment, all physicians are queried through the Federation of State Medical Boards (FSMB) Federation Physician Data Center, a nationally recognized system for collecting, recording and distributing to state medical boards and other appropriate agencies data on disciplinary actions taken against licensees by the boards and other governmental authorities. The report returned from the FSMB Physician Data Center not only identifies if there are any adverse actions recorded against a physician's license but also lists all of the physician's known licenses, current or previously held, serving as double-check that the physician reported all licenses during the credentialing process. In addition, the licenses of all physicians are monitored through a contract with the FSMB's Disciplinary Alert Service (DAS). Through this contract, all physicians are enrolled in the DAS which offers ongoing monitoring of physician licensure. If a new action against a physician's license is reported to the FSMB DAS, VHA receives a notification of the report within 24 hours. The staff at the physician's facility then contacts the reporting state licensing board to obtain the details of the action.

If the facility learns of an adverse action taken against a provider license, the staff at the facility must obtain information from the provider against whom the action was taken and consider it as well as the information obtained from the state licensing board. This review is documented to include the reasons for the review, the rationale for the conclusions reached, and the recommended action for consideration and appropriate action by the facility.

Section 402 would require VA to provide the relevant state medical board detailed information about any health care provider of VA that has violated a requirement of their medical license. We also believe in this case additional legislation is not required. VA has broad authority to report to state licensing boards those employed or separated health care professionals whose behavior or clinical practice so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients. The authority to report those professionals is derived from VA's long-standing statutory authority, contained in 38 U.S.C. 7401–7405, which authorizes the Under Secretary for Health, as head of VHA, to set the terms and conditions of initial appointment and continued employment of health care personnel, as may be necessary, for VHA to operate medical facilities. This authority includes requiring health care professionals to obtain and maintain a current license, registration, or certification in their health care field.

The Veterans Administration Health-Care Amendments of 1985, Public Law 99–166, and Part B of Title IV of Public Law 99–660, the Health Care Quality Improvement Act of 1986, are Acts require VHA to strengthen quality assurance and reporting systems to promote better health care. Pursuant to section 204 of Public Law 99–166, VA established a comprehensive quality assurance program for reporting any licensed health care professional to state licensing boards who:

(1) Was fired or who resigned following the completion of a disciplinary action relating to such professional's clinical competence;

(2) Resigned after having had such professional's clinical privileges restricted or revoked; or

(3) Resigned after serious concerns about such professional's clinical competence had been raised, but not resolved.

The statutory provisions of 38 U.S.C. 7401–7405, augmented by Public Laws 99–166 and 99–660, provide VHA ample authority to make reports to state licensing boards when exercised consistent with Privacy Act requirements for release of information. VHA policy requires the VA medical facility Director to ensure that within seven calendar days of the date a licensed health care professional leaves VA employment, or, information is received suggesting that a current employee's clinical practice has met the reporting standard, an initial review of the individual's clinical practice is conducted to determine if there may be substantial evidence that the individual so substantially failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients.

Usually this review is conducted and documented by first and second level supervisory officials. When the initial review suggests

that there may be substantial evidence that the licensed health care professional so failed to meet generally-accepted standards of clinical practice as to raise reasonable concern for the safety of patients, the medical facility Director is responsible for immediately initiating a comprehensive review to determine whether there is, in fact, substantial evidence that this reporting standard has been met. This review involves the preparation of a state licensing board Reporting File. VHA policy defines the process for collecting evidence; notifying the provider of the intent to report which affords the provider the opportunity to respond in writing to the allegations; and then the review process to assure that VHA has complied with the Privacy Act prior to reporting.

It is VA's policy to cooperate whenever possible with an inquiry by a state licensing board. VA medical facilities must provide reasonably complete, accurate, timely, and relevant information to a state licensing board in response to appropriate inquiries.

Mr. Chairman, thank you for the opportunity to present our views on the legislation today and we will be glad to answer any questions you or other Members of the Committee may have.

STATEMENT OF THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

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 benefits programs and services. Joining me today are Robert Worley, Director of the Education Service in the Veterans Benefits Administration, Catherine Mitrano, Deputy Assistant Secretary for Resolution Management, and Susan Blauert and Kim McLeod, who are both Deputy Assistant Counsels in VA's Office of General Counsel

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S. 1450, DEPARTMENT OF VETERANS AFFAIRS EMERGENCY MEDICAL STAFFING RECRUITMENT AND RETENTION ACT

S. 1450 would allow VA to arrange flexible physician and physician assistant work schedules to allow for the hiring and full implementation of a hospitalist physician system and to accommodate the unusual work schedule requirements for Emergency Medicine (EM) Physicians.

VA supports increased flexibility for critical medical personnel. Hospitalist physicians and EM physicians specialize in the care of patients in the hospital, often working irregular work schedules to accommodate the need for continuity of efficient hospital care. VA believes that increased scheduling flexibility would align VA practice with the private sector, facilitating the recruitment, retention of emergency physicians and the recruitment, retention and operation of a hospitalist physician system at VA medical centers (VAMC). We note concerns that the Office of Personnel Management will provide in its statement for the record with respect to

certain of the bill's provisions. The Administration looks forward to working with the Congress and our agency partners to finalize language on these provisions.

VA believes S. 1450 would be cost neutral in terms of impact on salaries as it merely authorizes flexibility in physician and physician assistant work schedules to allow for the hiring and full implementation of a hospitalist physician system and improvements in EM physician coverage and enhanced ability to recruit EM trained and experienced physicians.

S. 1451, VETERANS' SURVIVORS CLAIMS PROCESSING AUTOMATION ACT OF 2015

S. 1451, the "Veterans' Survivors Claims Processing Automation Act of 2015," would authorize VA to pay benefits to a survivor of a Veteran who has not filed a formal claim if the record contains sufficient evidence to establish the survivor's entitlement to such benefits. The bill would specify that the date on which a survivor notifies VA of the Veteran's death would be treated as the date of receipt of the survivor's application for benefits. S. 1451 would be applicable to claims based on a death occurring on or after the date of enactment of this legislation.

VA supports S. 1451. The Department submitted a similar legislative proposal for the Fiscal Year (FY) 2016 Budget. Under 38 U.S.C. 5101(a), a claimant must file a formal claim as a condition of receiving benefits. However, when a survivor of a Veteran files a claim for VA benefits based upon the Veteran's death, the information and evidence necessary to decide the claim is often contained in the Veteran's claims file. As a result, it is not necessary from a practical standpoint for a claimant to file a formal claim in such circumstances. Elimination of the formal-claim requirement would automate the delivery of uninterrupted benefits to qualifying survivors.

VA has one technical comment. VA would prefer to change the language from "the date on which a survivor of a Veteran notifies the Secretary of the death of the Veteran," to "the date on which the Secretary is notified of the Veteran's death." The modified language would allow VA to be more liberal when providing benefits in instances where the survivor is not the individual notifying VA of the Veteran's death.

VA estimates that there would be no benefit or general operating expenses (GOE) associated with S. 1451.

S. 1460, FRY SCHOLARSHIP ENHANCEMENT ACT OF 2015

S. 1460 would allow recipients of the Marine Gunnery Sergeant John David Fry Scholarship to be eligible for the Yellow Ribbon program under the Post-9/11 GI Bill. The Yellow Ribbon program is currently available to Veterans and most transfer-of-entitlement recipients receiving Post-9/11 GI Bill benefits at the 100 percent benefit level attending institutions of higher learning. The program provides payment for up to half of the tuition-and-fee-charges that are not covered by the Post-9/11 GI Bill, such as charges that exceed an academic year cap or out-of-state charges, if the institution enters into an agreement with VA to pay or waive an equal amount of the charges that exceed Post-9/11 GI Bill coverage. This bill

would take effect for the academic year (August 1) beginning after the date of enactment.

VA does not object to S. 1460, subject to Congress identifying acceptable offsets for the additional benefit costs. VA would need to make modifications to its existing information technology (IT) systems to implement this legislation. Specifically, VA would need to modify the Benefits Delivery Network (BDN), the VA-Online Certification of Enrollment (VA-ONCE), and the Post-9/11 GI Bill Long-Term Solution (LTS), to calculate eligibility and award Yellow Ribbon program payments for Fry Scholarship beneficiaries. VA estimates that it would require 1 year from the date of enactment to make the IT system changes necessary to implement the proposed legislation.

VA estimates the benefit costs associated with enactment of the bill to be $492,000 in FY 2016, $2.7 million over 5 years, and $6.2 million over 10 years. Although VBA administrative costs are estimated to be insignificant, IT costs are estimated to be $5 million. This IT estimate consists of the design, development, testing, and deployment of the new functionality that would be needed to meet the requirements of this legislation.

S. 1856, VA EQUITABLE EMPLOYEE ACCOUNTABILITY ACT OF 2015

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Section 6 of S. 1856 would require VA to provide all managers with periodic training on whistleblower rights and managing and motivating employees. VA already offers managers the training discussed in section 6. Moreover, some training, such as whistleblower rights and protections, is already required for all managers. Nevertheless, VA is committed to the principles of section 6 of S. 1856 and supports this section.

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S. 1938, CAREER READY STUDENT VETERANS ACT OF 2015

S. 1938, the "Career-Ready Student Veterans Act of 2015," would amend title 38, United States Code, to improve the approval of certain VA programs of education for purposes of educational assistance.

This bill would amend 38 U.S.C. 3676(c), pertaining to the approval of non-accredited courses, by adding new requirements to the criteria that must be met for State approving agencies to approve institutions' written applications for approval of non-accredited courses. First, in the case of a program designed to prepare an individual for licensure or certification in a State, the program would need to meet any instructional curriculum licensure or certification requirements of that State. Second, in the case of a program designed to prepare an individual for employment pursuant to standards developed by a board or agency of a State in an occupation that would require approval or licensure, the program would need to be approved or licensed by such board or agency of the State.

The bill also would add subsection (f) to section 3676 to permit VA to waive the aforementioned requirements in the case of a pro-

gram of education offered by an educational institution if VA determined:

- The educational institution was accredited by an agency or association recognized by the Department of Education;
- The program did not meet the requirements at any time during the 2-year period preceding the date of the waiver;
- The waiver furthers the purposes of the educational assistance programs administered by VA or would further the education interests of individuals eligible for assistance under such programs;
- The educational institution does not provide any commission, bonus, or other incentive payment based directly or indirectly on success in securing enrollments or financial aid to any persons or entities engaged in any student recruiting or admission activities or in making decisions regarding the award of student financial assistance, except for the recruitment of foreign students residing in foreign countries who are not eligible to receive Federal student assistance.

Subsection (d) of the proposed legislation would add a new subsection to section 3679 of title 38 to require VA to disapprove a non-accredited course of education designed to prepare an individual for licensure or certification in a State or for employment pursuant to standards developed by a board or agency of a State in an occupation that requires approval or licensure, if the educational institution providing the course of education does not publicly disclose any conditions or additional requirements, including training, experience, or exams, required to obtain the license, certification, or approval for which the course of education is designed to provide preparation.

Subsection (e) of this bill would amend section 3672(b)(2)(A)(i) to include the new approval requirements for non-accredited courses in the approval requirements for "deemed approved" accredited programs.

The bill would also amend 38 U.S.C. 3675, to apply the new requirements in section 3676(c), to the approval conditions for accredited courses offered by private for-profit institutions.

VA supports the intent behind this bill. However, we do not support the bill as currently drafted for a number of reasons.

If enacted, the bill would ensure that non-accredited courses pursued by GI Bill beneficiaries meet all of the State requirements for licensure or certification in a given occupation or career field and would be approved by the State board or agency that developed the standards. VA does not oppose the concept of additional criteria for the approval of non-accredited courses. However, we note that, as written, the bill would not allow the Secretary to waive the requirement for non-accredited courses, as the institution must be accredited in order to meet the criteria for a waiver. VA is unclear as to the reason why an accreditation requirement would be inserted in the approval criteria for non-accredited programs. In general, an institution's accreditation applies to all of the courses offered by the institution, and accredited courses have different approval requirements.

Additionally, the bill would ensure that accredited courses at private, for-profit institutions meet all State requirements for certification and licensure. VA supports efforts to ensure that Veterans

and other GI Bill beneficiaries are well-trained and adequately equipped to obtain employment and achieve economic success. However, we note that the proposed licensure and certification requirements would not be applied to similar programs at public and private, not-for-profit institutions. Consequently, the bill does not ensure that all Veterans and beneficiaries would receive all of the training required for licensure or certification in their chosen occupational fields.

VA also has concerns about the language in the new section 3679(d), which would require the disapproval of waived programs if the educational institution does not publicly disclose the additional conditions or requirements needed in order to meet licensing or certification requirements. VA believes "the Secretary or the appropriate State approving agency" should be substituted for "the Secretary," as the State approving agencies are responsible for the approval of non-accredited courses. As State employees, they have subject matter expertise with regard to the specific State requirements for licensure or certification and, consequently, are better-positioned to determine the gaps in training or conditions that must be publicized. In addition, to be consistent with approval authorities in other sections of chapter 36, VA believes that both the Secretary and the SAA should have this authority.

VA is unclear as to the intent underlying the proposed amendment to 3672(b)(2)(A)(i). As written, it could be interpreted to include non-accredited programs in a "deemed approved" category. However, if the intent is to make the proposed paragraphs (14) and (15) of section 3676(c) apply to accredited programs at public and proprietary not-for-profit institutions of higher learning as well, then it should be reworded to read, "Subject to paragraphs (14) and (15) of section 3676(c) of this title, an accredited." In addition, we note that, as currently drafted, the licensure and certification requirements could not be waived for these programs. VA believes that the waiver authority should apply to accredited programs at public and proprietary not-for-profit institutions of higher learning as well as to accredited courses at private, for-profit institutions and non-accredited programs.

VA estimates that there would be no additional mandatory or discretionary cost requirements associated with the enactment of this bill.

DRAFT BILL REGARDING IMPROVEMENTS IN EDUCATIONAL ASSISTANCE

Section 1 of the proposed legislation would add a new section (3326) under subchapter III of chapter 33, title 38 U.S.C. Specifically, this section proposes to recodify the provisions of Public Law (Pub. L.) 110–252, section 5003(c), to bring those requirements into title 38, and it proposes a few amendments to those requirements.

The Post-9/11 GI Bill (or chapter 33) requires individuals to relinquish eligibility to some other VA education benefit, as applicable, in order to receive the chapter 33 benefits.

Subsection (a) of the proposed 38 U.S.C. 3326 would define the eligibility requirements for individuals to elect chapter 33 educational benefits. Individuals would be able to elect to receive chapter 33 benefits if, as of August 1, 2009, they were entitled to the MGIB-AD, MGIB-Selected Reserve (SR), or the Reserve Edu-

cational Assistance Program, and had some or all of their entitlement remaining under those programs. Individuals would be able also to elect chapter 33 if they are making contributions to receive MGIB-AD, or previously declined participation in the MGIB-AD program.

Subsection (b) of the proposed 38 U.S.C. 3326 would call for the cessation of contributions toward MGIB-AD if an individual elects to receive chapter 33 while still making contributions to MGIB-AD. The obligation to make contributions would cease the first month after the individual elects chapter 33 benefits.

Subsection (c) of the proposed 38 U.S.C. 3326 would address the revocation of remaining entitlement transferred to a dependent under MGIB-AD, if the individual who transferred the benefit elects to receive chapter 33 benefits instead. The proposed legislation would allow the transferor to revoke any unused benefits that have been transferred to a dependent. If the transferor revoked the transferred benefits from his or her dependent, then the remaining entitlement would be available for the transferor to use under chapter 33. If the transferor did not elect to revoke the transferred MGIB-AD benefits, then those benefits would remain available to the dependent under MGIB-AD.

Subsection (d) of the proposed 38 U.S.C. 3326 would state that individuals who make an election would be eligible for benefits under chapter 33, rather than under the relinquished benefit. It also would state that if individuals elected to receive chapter 33 in lieu of MGIB-AD, and had previously used entitlement under MGIB-AD, they would have eligibility under chapter 33 for the number of months of entitlement that were remaining under MGIB-AD, plus any entitlement that was revoked from a dependent in accordance subsection (c).

Subsection (e) of the proposed 38 U.S.C. 3326 would allow individuals who elect to receive educational assistance under chapter 33 to receive payments at the rate available under the relinquished benefit if their educational pursuit is authorized under the relinquished benefit, but not under chapter 33. Any entitlement used would be charged against chapter 33 in the same manner as it would be charged against the relinquished benefit.

Subsection (f) of the proposed 38 U.S.C. 3326 would outline additional chapter 33 assistance for members who made contributions toward the MGIB-AD program. A refund of MGIB-AD contributions would be issued to a qualifying Veteran as an increase to the last monthly housing stipend when benefit entitlement is exhausted. The amount of the refund would be calculated by taking the remaining months of entitlement under MGIB-AD, at the time of the chapter 33 election, plus the number of months, if any, of entitlement under chapter 30 that were revoked by the individual and dividing that number by 36. The result would be multiplied by the dollar amount that the Veteran contributed toward the MGIB-AD, and the resulting amount would be issued in conjunction with the final monthly housing stipend. This proposed legislation would also change the corresponding language currently contained in section 5003(c) of Pub. L. 110–252 by also authorizing refunds to individuals pursuing programs at non-degree granting institutions.

Subsection (g) of the proposed 38 U.S.C. 3326 would provide for continued entitlement to additional assistance for critical skills, specialty, and/or service (i.e., a college fund or kicker) to which an individual was entitled under MGIB-AD or MGIB-SR prior to relinquishing one of those benefits and establishing eligibility under chapter 33. The additional assistance would be paid in conjunction with the individual's monthly housing stipend.

Subsection (h) of the proposed 38 U.S.C. 3326 would provide VA with the authority to make an alternative election for an individual if the election submitted by the applicant is not in his or her best interest. If an individual elected to receive a benefit that would be clearly not in his or her best interest on or after January 1, 2016, VA would be able to change the election and would be required to notify the individual of the change within 7 days. The individual would be allowed 30 days from the date he or she received the VA notification to modify or revoke the election made by VA. In addition, VA would notify the individual of the change of election by electronic means whenever possible. These provisions are not included in section 5003(c) of Pub. L. 110–252; therefore, they would constitute a new authority.

Subsection (i) of the proposed 38 U.S.C. 3326 would provide that any election made under section 3326 would be irrevocable.

Finally, this section would repeal subsection (c) of section 5003 of the Post-9/11 Veterans Educational Assistance Act of 2008 (Pub. L. 110–252; 38 U.S.C. 3301 note).

VA does not object to (a) through (g) of the proposed 38 U.S.C. 3326 because these provisions are, generally, identical to those that were enacted in section 5003(c) of Pub. L. 110–252, with the exception of one minor change in the proposed section 3326(f), which would also authorize refunds of MGIB-AD contributions to individuals receiving monthly stipend payments for pursuit of non-degree programs under 38 U.S.C. 3313(g).

However, VA has concerns with subsection (h) of the proposed 38 U.S.C. 3326, which would allow VA to make an alternative election on behalf of the Veteran that VA determines is in his or her best interests. As individuals' situations are different, elections made in the best interest of a Veteran would be highly subjective. While one claims examiner might view an election option as being the best, another might disagree. Therefore, VA recommends specific criteria for an election be added to the legislation that would eliminate subjectivity. For example, in some instances, a Veteran elects to relinquish MGIB-AD to receive chapter 33 benefits when he or she has only a few months of MGIB-AD entitlement remaining. If the individual has more than one qualifying period of service, it may be in that individual's best interest to finish 36 months of entitlement under MGIB-AD before beginning to receive chapter 33 benefits—the individual could then receive up to 12 months of entitlement under chapter 33. If this situation met the criteria in the legislation as enacted, the Veteran's claim would be processed under the chapter 30 program until his or her entitlement under that program ends.

VA also recommends that the proposed legislation include language to allow VA to make an election in cases where a Veteran or Servicemember applies for chapter 33 benefits and does not elect

to relinquish any benefit. This would allow VA to maximize automation, improve processing times, and obviate the need to contact the Veteran for an election.

Further, VA has concerns with the impact this subsection would have on the automation of original claims using LTS. If VA has to make an alternative election under chapter 33 when a Veteran is eligible for more than one benefit, claims' examiners would have to review the majority of chapter 33 original claims. The need for this review would limit the number of original claims that could be automated through LTS without human intervention, increasing the length of time that Veterans would be waiting to receive their benefits.

VA estimates the cost of this section would be insignificant because subsections (a) through (g) of the proposed 38 U.S.C. 3326 are provisions that are already in place under section 5003(c) of Pub. L. 110–252 and, therefore, would result in no additional cost. In some cases, subsection (h) may result in a Veteran receiving a better benefit that would increase costs to VA. However, due to VA's current outreach efforts, such as the GI Bill Comparison Tool, and the amount of information available to assist Veterans in making informed decisions on education benefits, VA does not anticipate making a significant number of alternative elections. Therefore, anticipated costs to the readjustment benefits account are insignificant.

Section 2 would amend 38 U.S.C. 3684(a) to define the term "educational institution" to include a group, district, or consortium of separately accredited educational institutions located in the same State, and which are organized in a manner that facilitates the centralized reporting of their enrollments. This legislation would also amend section 3684(a) to include individuals enrolled under chapters 32 and 33.

The proposed legislation would apply to any reports of enrollment submitted on or after the date of enactment.

VA supports section 2. This legislation would allow each institution in a district/consortium to certify a student's enrollment regardless of where the student is matriculated. Furthermore, since school certifying officials at "District" institutions have access to student records and all courses have universal numbering, VA compliance visits could be done at any institution and records would be available for students who attend any of the institutions included in the group, district, or consortium.

There would be no additional cost for implementing this provision because the reporting fees would be paid to the school that is certifying the enrollment, regardless of the location of the institution.

Section 3 would amend subsection 38 U.S.C. 3313(c)(1)(A) to limit the benefits paid for pursuit of certain degree programs at a public institution of higher learning (IHL). It would limit the amount of tuition and fees payable for certain programs at IHLs, specifically those that involve a contract or agreement with an entity (other than another public IHL) to provide a program of education or a portion of a program of education, to the same amount per academic year that applies to programs at private or foreign IHLs. This section would be effective the first day of a quarter, se-

mester, or term (whatever is applicable) after the legislation's enactment.

VA supports legislation that would limit the amount of tuition and fee payments at public IHLs that involve contracted training. VA is concerned about high tuition and fee payments for enrollment in degree programs involving flight training at public IHLs. Education benefit payments for these types of programs have increased tremendously with the implementation of P.L. 111–377, and in some cases, public institutions seem to be targeting Veterans for their flight-related training programs.

There has been a significant increase in flight training centers, specifically those that offer helicopter training, that have contracted with public IHLs to offer flight-related degrees. Sometimes these programs charge higher prices than those that would be charged if the student had chosen to attend the vocational flight school for the same training.

Additionally, VA has also noticed a growing number of VA beneficiaries are taking flight courses as electives. VA allows for "rounding out," whereby non-required courses may be taken to bring a student's course load up to full-time status in the student's last term. Based on anecdotal evidence, some schools are enrolling students in these very expensive flight courses when "rounding out" is applicable. In most cases, these courses are not specifically required for the Veteran's degree.

VA is still determining the costs associated with this provision.

Section 4 would add a new section 3699 to title 38, U.S.C., requiring VA to make available to educational institutions information about the amount of educational assistance to which a Veteran or other individual is entitled under chapter 30, 32, 33, or 35. This information would be provided to the educational institution through a secure information technology system accessible by the educational institution and updated regularly to reflect any amounts used by the Veteran or other individual.

VA supports the intent behind providing educational institutions with the number of months of educational assistance to which a Veteran is entitled. Currently, VA provides the amount of a Veteran's entitlement (original and remaining) and other information (i.e., the delimiting date) to the educational institution through the VA Online Certification of Enrollment (VA-ONCE) system. The educational institution in which the student is enrolled can view this information for individuals training under chapters 30, 1606, and 1607 after VA processes an award for education benefits. This functionality is not currently available for Veterans or other individuals training under chapters 32, 33, or 35; therefore, VA would need to make programming changes to VA-ONCE in order to make this information available as well.

VA recommends removing the requirement to provide information for individuals training under chapter 32 from the proposed legislation. Chapter 32 usage has decreased from 560 beneficiaries in FY 2008 to 2 beneficiaries for fiscal year 2015 through June 30, 2015. Because eligibility for chapter 32 ends 10 years after an individual's release from active duty, the majority of those with remaining entitlement are likely also eligible for benefits under chapter 33.

VA estimates the administrative costs for developing the functional requirements of this section to be $500,000, and the information technology (IT) costs associated with this section to be $5 million to make enhancements to VA-ONCE to provide newly required information to educational institutions.

Section 5 would amend 38 U.S.C. 3672(b)(2)(A) to authorize State Approving Agencies (SAA) to determine if a program of education is deemed to be approved for purposes of this chapter if the program is one of the following:

- An accredited standard college degree program offered at a public or not-for-profit proprietary educational institution that is accredited by an agency or association recognized for that purpose by the Secretary of Education.
- A flight training course approved by the Federal Aviation Administration (FAA) that is offered by a certified pilot school that possesses a valid FAA pilot school certificate.
- An apprenticeship program registered with the Office of Apprenticeship, Employment Training Administration, Department of Labor; or a State apprenticeship agency recognized by the Office of Apprenticeship pursuant to the Act of August 16, 1937 (popularly known as the "National Apprenticeship Act;" 29 U.S.C. 50, et seq.).
- A program leading to a secondary school diploma offered by a secondary school approved in the state in which it is operating.
- A licensure test offered by a Federal, state, or local government.

This legislation also would amend 38 U.S.C. 3675(a)(1) to substitute "A State approving agency, or the Secretary when acting in the role of a State approving agency" for "the Secretary or a State approving agency." Further, this legislation proposes to amend section 3675 to expand the approval of other courses by authorizing an SAA, or the Secretary when acting in the role of a SAA, to approve accredited programs (including non-degree accredited programs) not covered by section 3672 of title 38.

VA supports the clarification of the approval requirements codified in 38 U.S.C. 3672(b)(2)(A), as detailed in section 2(a) of the proposed legislation. To be "deemed approved," accredited programs must meet the requirements of a number of provisions in chapter 36 of title 38. Consequently, compliance with those provisions must be verified, which the proposed change will make more explicit. However, to be consistent with approval authorities in other sections of chapter 36, VA believes that both the Secretary and the SAA should have approval authority.

VA also supports the proposed change to 38 U.S.C. 3675 in section 5(b) of the bill, to make those approval provisions apply to accredited non-degree programs at public and private non-profit IHLs that are not covered by section 3672 or by any of the approval requirements currently contained in chapter 36 of title 38. However, VA does not support modifying the current language that grants approval authority to both the Secretary and the SAA. The Secretary was granted authority under P.L. 111–377 to approve those programs, if necessary. While VA has no plans to take over approvals of all educational programs, it does appreciate this flexibility of authority.

VA estimates there are no costs associated with this section.

Section 6 would amend 38 U.S.C. 3676(c)(14) as it pertains to the criteria used to approve non-accredited courses. Under the proposed legislation, VA, in consultation with the SAA and pursuant to regulations, would determine if additional criteria may be deemed necessary for the SAA to approve an institution's written application for a course of education. VA and the SAA must treat public, private, and private for-profit educational institutions equitably.

The legislation would also amend 38 U.S.C. 3675(b)(3) to include this requirement as part of the approval conditions for accredited courses offered by private for-profit institutions.

This change would apply with respect to criteria developed pursuant to 38 U.S.C. 3676(c)(14) on or after January 1, 2013, and an investigation conducted under 38 U.S.C. 3676(c) that is covered by a reimbursement of expense paid by VA to a state, pursuant to 38 U.S.C. 3674, on or after October 1, 2015.

While VA agrees with the intent underlining section 6, that the approval requirements for non-accredited courses should be applied equitably regardless of the type of institution providing the training, VA does not believe that it should be interjected into the SAA approval requirements applicable to educational institutions located in the state over which the SAA has jurisdiction. VA is not aware of any widespread concerns regarding unfair practices or unequal treatment with respect to additional SAA approval requirements. VA is concerned about the amount of resources that could potentially be involved in regulating the process, reviewing the SAA requirements, and making determinations regarding necessity and equity. In this instance, VA would have to coordinate with all 50 States, territories, and institutions of higher learning regarding policy and procedure changes. At this time, VA cannot quantify the level of effort required for coordination of this scope. Consequently, VA recommends adding the requirement that any additional criteria treat public, private, and proprietary for-profit educational institutions equitably, without requiring a formal process and a VA decision on each additional requirement. This would ensure the consistent application of additional SAA approval requirements, allow states to promulgate additional requirements for educational institutions located within their borders, and avoid the potentially burdensome administrative process proposed in this section.

At this time, VA cannot quantify the costs and level of effort required for coordination of this scope.

Section 7 would amend 38 U.S.C. 3693 by inserting a new subsection (a) that would require VA to conduct an annual compliance survey of educational institutions and training establishments offering one or more courses approved for enrollment of eligible Veterans or individuals, if at least 20 such Veterans or individuals are enrolled. VA would be responsible for:

- Designing the compliance surveys to ensure that such institutions or establishments, as the case may be, and approved courses are in compliance with all applicable provisions of chapters 30 through 36 of title 38;
- Surveying each of these educational institutions and training establishments not less than once during every 2-year period; and

• Assigning not fewer than one education compliance specialist to work on compliance surveys in any year for each 40 compliance surveys required to be made under this section for such year.

Additionally, VA, in consultation with the SAAs, would annually determine the parameters of the surveys, and not later than September 1 of each year, make available to the SAAs a list of the educational and training establishments that would be surveyed during the fiscal year following the date of making such list available.

VA supports this section as it would improve the compliance survey process. VA recognizes the importance of compliance work in ensuring timely and accurate payments to Veterans and their families. As such, VA and the National Association of State Approving Agencies formed a joint committee, the Compliance Survey Redesign Working Group, to streamline and enhance the compliance survey process.

Currently, there are approximately 16,000 approved domestic and international IHLs and non-college degree institutions. Of the 16,000 institutions, there were 11,260 active institutions in calendar year 2013. During FY 2013 and FY 2014, VA and SAAs completed well over 10,000 surveys, with just over 5,000 surveys completed in FY 2014. VA anticipates completing a similar number of reviews in 2015. This work will be split roughly in half between VA and SAAs, as it has been for the last few years.

The statute requires VA to conduct annual surveys at 100 percent of schools with greater than 300 beneficiaries and non-college degree programs. Schools with high numbers of beneficiaries are more likely to have one or more full-time school certifying officials and may not need a visit annually. Institutions with a smaller number of beneficiaries are more likely to have school certifying officials who have other duties, and these institutions may not be as well-versed in school certifying official requirements, especially as they relate to the Post-9/11 GI Bill program.

This section would also create a new provision that would require the Secretary to consult with SAAs when determining the parameters of which institutions would receive a compliance survey each year. VA believes this provision is unnecessary as VA already consults with SAAs when determining where surveys will be conducted. With the implementation of section 203 of P.L. 111–377 (Post-9/11 Veterans Educational Assistance Improvements Act of 2010), VA was granted the authority to utilize SAAs to assist VA in conducting compliance surveys at GI Bill-approved institutions. Although VA can use the services of SAAs, VA continues to be ultimately responsible for conducting compliance surveys.

There are no mandatory costs associated with section 7, and there would be only minimal administrative costs associated with this provision.

Mr. Chairman, thank you for the opportunity to present our views on the legislation today and we will be glad to answer any questions you or other members of the Committee may have.

STATEMENT OF THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

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 benefits programs and services. Joining me today are Vince Kane, Special Assistant to the Secretary and Jennifer Gray, Staff Attorney in VA's Office of General Counsel

We do not have cleared views on sections 5 and 8 of S. 1885. We also do not have cleared views on S. 1676, a bill to increase the number of graduate medical education positions treating veterans, to improve the compensation of health care providers, medical directors, and directors of Veterans Integrated Service Networks, and for other purposes. We will be glad to work with the Committee on prioritization of those views and cost estimates not included in our statement.

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S. 1754, VETERANS COURT OF APPEALS SUPPORT ACT OF 2015

S. 1754 would amend section 7253(a) of title 38, United States Code, by permanently increasing the maximum number of judges presiding over the United States Court of Appeals for Veterans Claims (Veterans Court) from seven to nine. Because the bill would primarily affect the Veterans Court and would not affect the operation of VA, we defer to the Veterans Court as to whether S. 1754 should be enacted.

S. 1885, VETERAN HOUSING STABILITY ACT OF 2015

Section 2 of S. 1885 would expand the definition of "homeless Veteran" to include those Veterans fleeing domestic violence and interpersonal violence (DV/IPV), aligning VA's definition with that of the Department of Housing and Urban Development (HUD). VA supports section 2. Since Veterans fleeing from DV/IPV are considered at high risk for homelessness, they are already served in VA's homeless programs when it is clinically appropriate.

Section 3 would require VA to create a new program to provide intensive case management interventions to homeless Veterans in at least six locations selected by VA based on criteria which is described in the bill. VA would also be required to prepare a report for Congress on the outcomes of the program. VA does not believe section 3 is necessary, as VA is already authorized to provide intensive case management through the HUD-VASH program. HUD-VASH is similarly already authorized to provide flexible team-based care management and thus does not require the proposed program to provide such services.

Section 4 would require VA to award grants for the provision of case management services for Veterans who are transitioning to permanent housing and those who are at risk for homelessness. This would help address a current gap in case management service delivery. The Homeless Providers Grant and Per Diem (GPD) pro-

gram, for example, lacks the authority to provide funding for case management services once a Veteran exits a GPD-funded transitional housing program. However, such services may be currently provided by grantees in VA's Supportive Services for Veteran Families (SSVF) program.

Section 4 would also require the Secretary to prioritize for grant funding those organizations that would voluntarily stop receiving per diem payments under the GPD program (38 U.S.C. Section 2012) or Special Need awards (38 U.S.C. Section 2061), and be willing to use their transitional housing facility for permanent housing. VA supports this section of the bill. Currently there are nearly 9,000 transitional housing beds developed through VA investment of capital in partnership with community organizations. As the number of homeless Veterans decreases, the need for some of this transitional housing will diminish, but there will be a continued need for permanent housing interventions like rapid re-housing and permanent supportive housing. This grant funding could enable VA to help fill this need for permanent housing interventions, consistent with the VA's Housing First approach to assisting homeless Veterans.

VA supports section 6, which would require VA and HUD to collaboratively provide outreach to public housing authorities, tribally designated housing entities, realtors, landlords, property management companies, developers, and other relevant audiences to educate them about the housing needs of Veterans and encourage them to rent to Veterans. VA and HUD currently collaborate on such efforts.

VA supports section 7, which would codify the role of the VA National Center on Homelessness Among Veterans as a center of research, evaluation, and dissemination of best practices regarding services for homeless Veterans.

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S. 2022, SPECIAL PENSION OF MEDAL OF HONOR RECIPIENTS

S. 2022 would amend section 1562(a) of title 38, United States Code, by increasing the monthly rate for the Medal of Honor Pension to $3,000. VA administers the Medal of Honor Pension, a special pension benefit that is not based on income level, need, or disability, to recipients of the Medal of Honor. For reference, the monthly Medal of Honor Pension rate established pursuant to 38 U.S.C. § 1562 is currently $1,299.61.

The bill would be effective either (1) 180 days after the date of enactment, or (2) if the date 180 days after the date of enactment does not fall on the first day of a month, the first day of the first month beginning after the date that is 180 days after the date of enactment. If the increased rate for the Medal of Honor Pension is effective prior to December 1, 2016, the monthly rate would not be increased by a cost of living adjustment (COLA) for FY 2017. Annual COLA increases would resume beginning on December 1, 2017.

VA supports S. 2022, subject to Congress identifying acceptable offsets for the additional benefit costs. This legislation would be consistent with Congress' original intent for the Medal of Honor

Pension, which was to serve as a "recognition of superior claims on the gratitude of the country" and to "reward * * * in a modest way startling deeds of individual daring and audacious heroism in the face of mortal danger when war is on."

VA estimates that benefit costs to the appropriation for compensation and pension would be $788,000 in FY 2016, $7.2 million over 5 years, and $16.1 million over 10 years.

STATEMENT OF CURTIS L. COY, DEPUTY UNDER SECRETARY FOR ECONOMIC OPPORTUNITY, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning, Mr. Chairman and Members of the Committee. I am pleased to be here today to provide the views of the Department of Veterans Affairs (VA) on pending legislation affecting VA's programs, including the following: S. 2106, S. 2134, S. 2170, S. 2253, and a draft bill regarding whistleblower complaints. At this time, VA is unable to develop cost estimates for the "Department of Veterans Affairs Veterans Education Relief and Restoration Act of 2015;" however, we will provide these to you as soon as they are available. Accompanying me this morning are Maureen McCarthy, Acting Assistant Deputy Under Secretary for Health for Patient Care Services, Veterans Health Administration and Meghan Flanz, Deputy General Counsel, Legal Operations & Accountability.

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S. 2134

S. 2134, the "Grow Our Own Directive: Physician Assistant Employment and Education Act of 2015," would establish a pilot program to provide educational assistance to certain former members of the Armed Forces for education and training as physician assistants within the VA. While VA supports the concept, the cost associated with the legislation would cause concern within our available resources.

S. 2134 would require the Secretary to provide information on the pilot program to eligible individuals. An eligible individual would be defined as an individual who: (1) has medical or military health experience while serving as a member of the Armed Forces; (2) has received a certificate, associate degree, baccalaureate degree, master's degree, or post-baccalaureate training in a science related to health care; (3) has participated in the delivery of health care services or related medical services; and (4) does not have a degree of doctor of medicine, doctor of osteopathy, or doctor of dentistry.

S. 2134 would also require the Secretary to select no less than 250 eligible individuals to participate in the program with a minimum of 35 scholarship participants per year. Priority would be given to: individuals who participated in the Intermediate Care Technician Pilot Program of the Department that was carried out by the Secretary between January 2011 and February 2015, and individuals who agree to be employed as a physician assistant for

VHA in a community designated as a medically underserved population and in a State with a per capita Veteran population of more than 9 percent. Although VA supports the minimum requirement of scholarship participants, VA is concerned that the applicant pool of eligible individuals may be insufficient to meet the required number.

S. 2134 would also require the Secretary, in carrying out the pilot program, to provide educational assistance to individuals participating in the program to cover the costs to the individuals of obtaining a master's degree in physician assistant studies or a similar master's degree. The legislation would call for the use of the Health Professionals Educational Assistance Program (HPEAP) and other educational assistance programs the Secretary considers appropriate, to administer a 5-year pilot program.

S. 2134 would also require each individual participating in the pilot program to enter into an obligated service agreement with the Secretary to be employed as a physician assistant with VHA for a period of time that is either specified in the HPEAP or other educational assistance program or, if the individual is participating through a program where an obligated service period is not specified, a period of at least 3 years or such other period as the Secretary considers appropriate.

The bill would also provide that where an individual who participates in the pilot program fails to satisfy the period of obligated service, he or she shall be liable to the United States, in lieu of the obligated service, for the amount that has been paid or is payable to or on behalf of the individual under the pilot program, reduced by the proportion that the number of days the individual served for completion of the period of obligated service years to the total number of days in the period of obligated service of such individual.

The bill would also require the Secretary to ensure that a physician assistant mentor or mentors are available for individuals participating in the pilot program at each facility of VHA at which a participant in the pilot program is employed.

The bill would require the Secretary to seek to partner with not less than

15 institutions of higher education that offer a master's degree program in physician assistant studies or a similar area of study accredited by the Accreditation Review Commission on Education for the Physician Assistant. These institutions would also agree to guarantee seats in such master's degree program for pilot program participants, and to provide pilot program participants with information on admissions criteria and process. VA recommends that it be granted flexibility with the final number of partnerships/affiliates as less than 15 institutions may be sufficient to meet these requirements.

The bill would also require four new employees to administer the pilot program: a Deputy Director of Education and Career Development of Physician Assistants; a Deputy Director of Recruitment and Retention; a recruiter; and an administrative assistant. All positions would be aligned with VHA's Office of Physician Assistant Services.

This pilot program would require scholarship recipients to complete a service obligation at a VA health care facility after gradua-

tion and licensure/certification. VHA has had difficulty recruiting and retaining physician assistants for several years. Additionally, VHA Workforce Succession Strategic Plan and Reports have listed physician assistants in the top ten critical occupations, and VA's Office of Inspector General's Critical Occupation Staffing Shortage Report has listed physician assistants in the top five most critical occupations shortages.

The total cost of the Health Professional Scholarship Program for 450 awards over 5 years would be $56,573,810.

The total cost associated with administering the pilot program over 5 years would be $2,764,667.

The total cost associated with establishment of pay grades for physician assistants and the requirement of providing competitive pay would be $374,921,436 over 10 years

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S. 2253—DEPARTMENT OF VETERANS AFFAIRS VETERANS EDUCATION RELIEF AND RESTORATION ACT OF 2015

This bill would amend title 38, U.S.C., to provide Veterans affected by school closures with certain relief and restoration of education benefits. The bill would add a new subsection (d) to section 3312 of title 38, U.S.C., to allow for the restoration of entitlement to educational assistance and provide other relief for Veterans affected by a school closure. More specifically, no payment of educational assistance would be charged against an individual's entitlement to educational assistance under the Post-9/11 GI Bill, or counted against the aggregate period for which an individual may receive educational assistance under two or more programs, if VA finds that the individual was forced to discontinue a course or courses as a result of a permanent school closure and did not receive credit, or lost training time, toward completion of the program of education being pursued at the time the school closed.

S. 2253 also would amend section 3680(a) of title 38, U.S.C., authorizing VA to prescribe regulations allowing VA to continue a monthly housing allowance stipend under the Post-9/11 GI Bill during a temporary school closure or for a limited period following a permanent school closure. The housing allowance would be payable until the end of the term, quarter, or semester during which the school closure occurred, or 4 months after the date of the school closure, whichever is sooner.

VA supports S. 2253, as it would allow VA to restore entitlement and continue monthly housing allowance stipend payments to Post-9/11 GI Bill beneficiaries impacted by school closures. While VA currently has authority to continue payments to beneficiaries when schools are temporarily closed due to an emergency or under an established policy based on an Executive Order of the President, there is no similar statutory authority upon which to continue benefit payments in the event of a permanent school closure. Furthermore, regardless of whether a school closure is temporary or permanent, there is no statutory authority that allows VA to restore entitlement for a term, quarter, or semester for which a beneficiary fails to receive credit toward program completion due to such a closure. VA would interpret the bill to apply only to a course or

courses in which an individual was enrolled in FY 2015, and all current or future enrollments. VA would also interpret the bill as currently written to provide that the portion of a course or courses that a beneficiary has participated in through the time of the school's closure (e.g., the portion of an incomplete college semester that has already passed at the time of a school closure) is not charged against the beneficiary's entitlement. We note that there appears to be a discrepancy between the new subsection (d)(2), which applies to an individual who meets the criteria of both (A) and (B) of that subsection, and the applicability provision in section 2(a)(2) of the bill, which describes new subsection (d) as applying if the criteria of either paragraph (A) or paragraph (B) of subsection (d)(2) are met.

The closure of educational institutions while GI Bill beneficiaries are actively pursuing approved programs of education or training negatively impacts Veterans and eligible dependents in a number of ways. First, their monthly housing benefits are suddenly and unexpectedly discontinued in the middle of the term. In many cases, these payments are the primary (or sole) source of funds for paying for housing, food, utilities, and other basic necessities while attending school. Second, while VA can pay benefits for the term, quarter, or semester up to the time of the school's closure, the student is still charged entitlement for that period, even though he/she does not earn any credit toward program completion. In some instances, this could result in a beneficiary exhausting his/her entitlement before being able to complete his/her program at another institution.

We will be pleased to provide for the record an estimate of the cost of enactment of this bill.

DEPARTMENT OF VETERANS AFFAIRS,
Washington, DC, July 15, 2015.

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

DEAR MR. CHAIRMAN: The agenda for the Senate Committee on Veterans' Affairs' June 3, 2015, and June 24, 2015, legislative hearings included a number of bills that the Department of Veterans Affairs (VA) was unable to address in our testimony. We are aware of the Committee's interest in receiving our views and cost estimates for those bills.

By this letter, we are providing the following remaining views and cost estimates for the following bills from the June 3, 2015, legislative hearing: S. 471, the Women Veterans Access to Quality Care Act of 2015; and sections 4(b)-(c) and 5 of the draft Veterans Health Act of 2015.

We are also providing views and costs on the following bills from the June 24, 2015, legislative hearing: the Draft Biological Implant Tracking and Veteran Safety Act of 2015; on S. 1117, the Ensuring Veteran Safety Through Accountability Act of 2015; sections 203, 205, 208, and 209(b) of S. 469, the Women Veterans and Families Health Services Act of 2015; sections 3 through 8 of S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015;

section 2 of the draft bill referred to on the agenda as "Discussion Draft;" and sections 101–106, 204, 205, 403 and 501 of the draft Jason Simcakoski Memorial Opioid Safety Act.

In the time requested for transmittal of follow up views, VA was not able to include in this letter the following views: sections 2 and 4 of S. 297, the Frontlines to Lifelines Act of 2015; the draft bill on establishing a joint VA-Department of Defense (DOD) formulary for systemic pain and psychiatric medications; sections 2, 3, and 5 of the draft Veterans Health Act of 2015, sections 203, 208, and 209(b) of S. 469, the Women Veterans and Families Health Services Act of 2015; sections 4(b) and 8 of S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015; and sections 105, 205, 403, and 501 of the Jason Simcakoski Memorial Opioid Safety Act. The remaining views can be forwarded in a separate and final follow-up views letter.

We appreciate this opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

ROBERT A. MCDONALD,
Secretary.

Enclosure.

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S. 1085, MILITARY AND VETERAN CAREGIVER SERVICES IMPROVEMENT ACT OF 2015

Section 3 of this bill proposes to add a new section 3319A to title 38 to authorize individuals who are eligible for and participating in a program of comprehensive assistance for family caregivers under 38 U.S.C. 1720G(a) the opportunity to transfer their unused Post-9/11 GI Bill education benefits to their dependents. Veterans may complete the transfer of entitlement any time during the 15-year period beginning on the date of their last discharge or release from active duty. Transferees would be subject to the same rules in place for individuals who receive transferred benefits under 38 U.S.C. 3319. However, there is no length of service requirement, and the monthly rate of educational assistance would be the same rate payable to the individual making the transfer. The Secretary would be authorized to prescribe regulations to carry out this section.

Currently, DOD determines eligibility for transfer of entitlement. If enacted, the proposed legislation would require VA to develop procedures to receive requests to transfer entitlement for certain individuals, determine eligibility, and award benefits for the transfer of entitlement program. Because the transfer of entitlement provisions of the Post-9/11 GI Bill were established as a recruitment and retention tool for the uniformed services, VA defers to DOD on this section of the bill. However, VA notes that Congress would need to identify appropriate offsets for the cost of this legislation, which we are unable to estimate at this time.

Section 4(a) would amend 37 U.S.C. 439, providing for special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday liv-

ing, by amending the definition of covered members to include those Servicemembers who have a serious injury or illness that was incurred or aggravated in the line of duty, are in need of personal care services as a result of the injury, and who would require hospitalization, nursing home care, or other residential care in the absence of such personal care services. Section 4(b) would further amend section 439 by requiring VA to provide family caregivers of a Servicemember in receipt of monthly special compensation assistance available to family caregivers of eligible veterans under 38 U.S.C. 1720G(a)(3)(A), other than the monthly caregiver stipend. VA would provide assistance under this subsection in accordance with a memorandum of understanding (MOU) between VA and DOD, and an MOU between VA and the Secretary of Homeland Security. Section 4(c) would define the term "serious injury or illness," which would replace the term "catastrophic injury or illness," to mean an injury, disorder, or illness that (1) renders the afflicted person unable to carry out one or more activities of daily living; (2) renders the afflicted person in need of supervision or protection due to the manifestation by such person of symptoms or residuals of neurological or other impairment or injury; (3) renders the afflicted person in need of regular or extensive instruction or supervision in completing two or more instrumental activities of daily living; or (4) otherwise impairs the afflicted person in such manner as the Secretary of Defense or Homeland Security prescribes.

VA defers to DOD and the Department of Homeland Security regarding amendments sections 4(a) and 4(c).

VA is still analyzing section 4(b) and would be glad to provide views at a later time.

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

VA defers to OPM on this section.

Section 6 would amend the Public Health Service Act (42 U.S.C. 300ii), which governs lifespan respite care, to amend the definition of "adult with special need" to include a veteran participating in the family caregiver program under 38 U.S.C. 1720G. It would also amend the definition of "family caregiver" to include family caregivers under 38 U.S.C. 1720G. Furthermore, in awarding grants or cooperative agreements to eligible State agencies to furnish lifespan respite care, the HHS would be required to work in cooperation with the interagency working group on policies relating to caregivers of Veterans established under section 7 of this bill. Section 6 would also authorize appropriations of $15 million for fiscal years 2016 through 2020 for these grants.

VA defers to HHS on this section.

Section 7 would establish an interagency working group on policies relating to caregivers of Veterans and Servicemembers. The working group would be composed of a chair selected by the President, and representatives from VA, DOD, HHS (including the Centers for Medicare & Medicaid Service), and the Department of Labor. The working group would be authorized to consult with

other advisors as well. The working group's duties would include regularly reviewing policies relating to caregivers of Veterans and Servicemembers, coordinating and overseeing the implementation of policies relating to these caregivers, evaluating the effectiveness of such policies, developing standards of care for caregiver and respite services, and others. Not later than December 31, 2015, and annually thereafter, the working group would be required to submit to Congress a report on policies and services relating to caregivers of Veterans and Servicemembers.

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

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

Section 8(a) would require VA to conduct a longitudinal study on Servicemembers who began their service after September 11, 2001. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. Within 1 year of the date of the enactment of the Act, VA would be required to submit to the Committees on Veterans' Affairs a plan for the conduct of the study. Not later than October 1, 2019, and not less frequently than once every 4 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of the study. Section 8(b) would require VA to provide for the conduct of a comprehensive study on Veterans who have incurred a serious injury or illness and individuals who are acting as caregivers for Veterans. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. The study would be required to include the health of the Veteran and the impact of the caregiver on the health of the Veteran, the employment status of the Veteran and the impact of the caregiver on that status, the financial status and needs of the Veteran, the use by the Veteran of VA benefits, and any other information VA considers appropriate. Not later than 2 years after the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of this study.

VA is still analyzing this section and would be glad to provide views at a later time.

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DRAFT BILL, THE JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

Section 101 would require, within 1 year of the date of the enactment of the Act, VA and DOD to jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. The guidelines would have to include guidelines for safely prescribing opioids for the treatment of chronic, non-cancer pain in outpatient settings; enhanced guidance with respect to ab-

solute contraindications for opioid therapy; enhanced guidance with respect to the treatment of patients with behaviors or comorbidities, or a history of substance abuse or addiction, that require consultation or co-management of opioid therapy with one or more specialists; enhanced guidance with respect to the conduct by health care providers of an effectiveness assessment for patients receiving opioid therapy; requirements that each VA and DOD provider, before initiating opioid therapy, use VA's Opioid Therapy Risk Report tool to assess the risk for adverse outcomes; guidelines to govern the methodologies used by VA and DOD providers to taper opioid therapy when adjusting or discontinuing opioid therapy; guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient settings; enhanced recommendations on the use of routine and random urine drug tests for all patients before and during opioid therapy; and guidance that health care providers discuss with patients before initiating opioid therapy other options for pain management therapies. Before updating these guidelines, VA and DOD would be required to jointly consult with the working group on pain management and opioid therapy established under section 3 of this bill. Within 1 year of the date of enactment of this Act, GAO would be required to submit to the Committees on Veterans' Affairs a report on the implementation of the updated guidelines by each VA medical facility and the compliance of each medical facility with these guidelines.

VA appreciates the intent of this thoughtful and comprehensive bill, and agrees that more needs to be done to support clinicians with clearer guidance and training on prescribing medications for pain management. VA, because of its central role in training physicians across the country, can provide leadership by training clinicians in pain management and supporting a team approach to care. There are cases where the use of opioids is clinically indicated, albeit closely controlled and monitored, to control pain when nothing else does. We have a number of recommendations to improve the bill, and would be glad to meet with the Committee to discuss these further. For example, the requirement in section 101(b) that VA and DOD jointly consult the working group on pain management and opioid therapy established in section 103 of the bill would be redundant, as the VA/DOD Health Executive Council (HEC) already has a Pain Management Work Group whose focus is on improving pain management practices in the two Departments.

Section 102(a) would require VA, within 180 days of enactment, to expand the Opioid Safety Initiative to include all VA medical facilities.

Section 102(b) would require VA to ensure all providers responsible for prescribing opioids to receive education and training on pain management and safe opioid prescribing practices. The education and training would have to cover a number of identified areas, and in providing the training, VA would be required to use the Interdisciplinary Chronic Pain Management Training Team Program.

Section 102(c) would require each VA medical facility to identify and designate a pain management team of health care profes-

sionals responsible for coordinating and overseeing therapy at the facility for patients experiencing acute and chronic pain that is not related to cancer. Each VISN Director would be responsible for establishing protocols for the designation of a pain management team at each VA medical facility in the VISN, and the protocols would need to ensure that any health care provider without expertise in prescribing analgesics or who has not completed required training not prescribe opioids, with limited exceptions. Within 1 year of enactment of this Act, each VA medical facility would be required to submit to the VISN Director a report identifying the health care professionals that have been designated as members of the pain management team at the facility.

Section 102(d) would require, within 18 months of the date of the enactment of the Act, that VA provide for real time tracking and access to data on the use of opioids and prescribing practices. VA also would be required to ensure access by VA health care providers to information on controlled substances prescribed by community providers through State prescription drug monitoring programs. Within 180 days of the enactment of this Act, VA would be required to submit to Congress a report on the implementation of these improvements.

Section 102(e) would require VA to increase the availability of opioid receptor antagonists, such as naloxone, to veterans and for use by VA health care providers treating Veterans. Within 90 days of enactment of this Act, VA would be required to equip each VA medical facility with opioid receptor antagonists approved by FDA. VA notes that other opioid receptor antagonists approved by FDA exist, but only one type (naloxone) is approved for overdose reversal. This section also directs VA to enhance training of providers on distributing such antagonists, and to expand the Overdose Education and Naloxone Distribution program to ensure all Veterans in receipt of health care who are at risk of opioid overdose (as defined by the bill) have access to opioid receptor antagonists and training on their proper administration. Within 120 days of the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on compliance with this requirement.

Section 102(f) would require that VA include in the Opioid Therapy Risk Report tool information on the most recent time the tool was accessed by a VA health care provider with respect to each Veteran and information on the results of the most recent urine drug test for each Veteran. VA would also be required to determine if a provider prescribed opioids without checking the information in this tool first.

Section 102(g) would require VA to modify VA's Computerized Patient Record System (CPRS) to ensure that any health care provider that accesses the record of a Veteran will be immediately notified whether the Veteran is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose, has a history of opioid abuse, or is at risk of becoming an opioid abuser.

VA agrees that additional training for providers is necessary. Clinicians want to help Veterans and Servicemembers, but often do not have the skills and resources to do so. A well-trained physician and clinical team will know how to evaluate comprehensively a pa-

tient with pain, including making clinical diagnoses and how to develop a goal oriented management plan for pain, as well as how to engage the particular resource needs of each patient. Regarding other parts of section 102, VA is currently taking steps to fulfill the intent of many of these provisions. For example, section 102(e) would require VA to increase the availability of opioid receptor antagonists approved by the FDA, and VA is currently exploring ways to increase the availability of these life-saving medications. Similarly, section 102(g) would require VA to modify the Computerized Patient Record System to ensure providers will be immediately notified about opioid risks for each patient. VA's electronic health record already has real-time mechanisms in place to alert VA health care providers of existing opioid prescriptions to prevent prescribing of additional opioids to Veterans who receive all their healthcare and prescriptions through the VA system. These mechanisms include real-time order checks that alert providers of prescriptions with potential problems with duplication, drug interactions, and doses in excess of the maximum recommended amount. In some facilities, VA health care providers also can check the State Prescription Drug Monitoring program databases to determine if a Veteran has an opioid prescription outside of VA.

Section 103 would establish within the VA-DOD Joint Executive Committee (JEC) a working group on pain management and opioid therapy for individuals receiving health care from either VA or DOD. The working group would cover the prescribing practices of health care providers in both Departments, the ability of each Department to manage acute and chronic pain, the use of complementary and integrative health in treating such individuals, the concurrent use of opioids and prescription drugs to treat mental health disorders, the practice of prescribing opioids, the coordination in coverage and consistent access to medications for patients receiving care from VA and DOD, and the ability of each Department to identify and treat substance use disorders. The working group would be required to coordinate with other working groups established under 38 U.S.C. 320, consult with other Federal agencies, and review and comment on the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. The Secretaries of VA and DOD would be required to jointly ensure that the working group is able to consult meaningfully with respect to the updated guideline required by section 101 of this bill within 1 year of the date of the enactment of this Act.

As noted previously, the VA-DOD HEC already has a pain management work group, so to that extent, we think VA and DOD are already meeting the intent of section 103.

Section 104 would add a new section 7309A to title 38, which would require VA to establish in each VISN a Pain Management Board. These Boards would have a series of defined duties, including consulting with health care professionals and other VA employees in the VISN about resources and best practices for pain management, overseeing compliance and providing oversight of professionals using pain management practices, and carrying out educational forums and public hearings on best practices on pain management. The Boards would be able to provide treatment recommendations for patients in some situations. Each Board would

be required to submit an annual report to the Under Secretary for Health on pain management practices within the VISN and recommended best practices. VA would be required to submit an annual report to Congress that contains comprehensive information from the reports submitted by the Boards.

VA appreciates the intent of this provision, but is concerned that the time it would take to participate in this admittedly very important activity would be time these professionals are not able to furnish direct clinical care and treat patients. In particular, the clinicians who would be best qualified to serve on such boards are also those likely to be treating the most complex patients. If additional resources were available to ensure that patient care would not suffer as a result of implementing these Boards, this concern would be alleviated. We note that the bill is unclear in terms of the appointment of non-Federal employees to the Pain Management Boards and the implications of such appointments under other laws.

Section 105 would require VA to conduct a study on the feasibility and advisability of carrying out a pharmacy lock-in program under which veterans at risk for abuse of prescription drugs would be permitted to receive prescription drugs only from certain specified VA pharmacies. VA would be required to report to the Committees on Veterans' Affairs within 1 year on this study.

VA is still analyzing this section and would be glad to provide views at a later time.

Section 106 would require the Comptroller General, within 2 years of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs, a report on the Opioid Safety Initiative and the opioid prescribing practices of VA health care professionals. The report would include recommendations for improvement, and VA would be required to report to the Committees on Veterans' Affairs on a quarterly basis on the actions taken by VA to address any outstanding findings and recommendations from the Comptroller General.

We defer to GAO on this provision.

Section 106 would also require VA to conduct an annual report and investigation on opioid therapy, and to submit this report to the Committees on Veterans' Affairs. This report would include information on patient populations and prescribing patterns for opioids. Facilities that are among the top 10 percent in prescription rates would be subject to a full investigation by the Office of the Medical Inspector, and VA would be required to notify the Committees on Veterans' Affairs and the senators and representatives from the area in which the facility is located.

Section 204 would require the Comptroller General to submit to the Committees on Veterans' Affairs a report on VA's Patient Advocacy Program, including recommendations and proposals for modifying the program and other information the Comptroller General considers appropriate.

We defer to GAO on this provision.

Section 205 would require VA, within 180 days of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs a report on the transitions undergone by Veterans in receiving health care in different health care settings. The report would

have to include an evaluation of VA's standards for facilitating and managing the transitions undergone by veterans in receiving health care in different settings, an assessment of the case management services that are available, an assessments of the coordination in coverage of and consistent access to medications, and such recommendations to improve transitions, including coordination of drug formularies between VA and DOD.

VA is still analyzing this section and would be glad to provide views at a later time.

Section 403 would require, within 2 years of the date of the enactment of this Act, VA to submit a report on its compliance with VA's policy to conduct a review of each health care provider who transfers to another VA medical facility or leaves VA to determine whether there are any concerns, complaints, or allegations of violations relating to the medical practice of the health care provider, and to take appropriate action with respect to any such concern, complaint, or allegation.

VA is still analyzing this section and would be glad to provide views at a later time.

Section 501 would add a new section 527A to title 38 requiring VA to carry out a program of internal audits and self-analysis to improve the furnishing of benefits and health care to veterans and their families. The Secretary would be required to establish an office within the Office of the Secretary to carry out these audits. The office would conduct periodic risk assessments, develop plans in response to these assessments, and conduct internal audits. At least five covered administrations, staff organizations, or staff offices would have to be audited each year. Within 90 days of completing an audit, the Secretary would be required to submit to Committees on Veterans' Affairs, the House Committee on Oversight and Government Reform, and the Senate Committee on Homeland Security and Government Affairs a report on the audit. The first audit would have to be completed within 180 days of the date of the enactment of this Act.

VA is still analyzing this section and would be glad to provide views at a later time.

Overall, VA understands the bill is a well-intentioned effort to combat a national public health problem, as outlined in a 2011 study by the Institute of Medicine (IOM).

DEPARTMENT OF VETERANS AFFAIRS,
Washington, DC, September 4, 2015.

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

DEAR MR. CHAIRMAN: The agenda for the Senate Committee on Veterans' Affairs' June 3, 2015, and June 24, 2015, legislative hearings included a number of bills that the Department of Veterans Affairs (VA) was unable to address in our testimony or in our prior correspondence with you on July 15, 2015. By this letter, we are providing the final remaining views and cost estimates on the following bills from the June 3, 2015, legislative hearing: sections 2

and 4 of S. 297, the Frontlines to Lifelines Act of 2015; the draft bill on establishing a joint VA-Department of Defense (DOD) formulary for systemic pain and psychiatric medications; and sections 2, 3, and 5 of the draft bill, Veterans Health Act of 2015.

We are also providing the final remaining views and cost estimates on the following bills from the June 24, 2015, legislative hearing: sections 203, 208, and 209(b) of S. 469, Women Veterans and Families Health Services Act of 2015; sections 4(b) and 8 of S. 1085, Military and Veteran Caregiver Services Improvement Act of 2015; and sections 105, 205, 403, and 501 of the Jason Simcakoski Memorial Opioid Safety Act.

We appreciate this opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

ROBERT A. MCDONALD,
Secretary.

Enclosure.

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S. 1085, MILITARY AND VETERAN CAREGIVER SERVICES IMPROVEMENT ACT OF 2015

Section 4(b) of S. 1085 would amend 37 U.S.C. 439 by requiring VA to provide family caregivers of a Servicemember in receipt of monthly special compensation assistance under 37 U.S.C. 439(a) the assistance that is currently provided to family caregivers of eligible Veterans under 38 U.S.C. 1720G(a)(3)(A), other than the monthly caregiver stipend. VA would provide assistance under this subsection in accordance with a memorandum of understanding (MOU) between VA and DOD and an MOU between VA and the Secretary of Homeland Security.

VA does not support section 4(b). DOD already provides many of the services and supports available under VA's Program of Comprehensive Assistance for Family Caregivers including health care coverage, mental health services, and respite care. Requiring VA to furnish these services as well would result in a duplication of benefits.

Section 8(a) would require VA to conduct a longitudinal study on Servicemembers who began their service after September 11, 2001. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. Within 1 year of the date of the enactment of the Act, VA would be required to submit to the Committees on Veterans' Affairs a plan for the conduct of the study. Not later than October 1, 2019, and not less frequently than once every 4 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of the study. Section 8(b) would require VA to provide for the conduct of a comprehensive study on Veterans who have incurred a serious injury or illness and individuals who are acting as caregivers for Veterans. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. The study would be required to include the health of the Veteran and the impact of the

caregiver on the health of the Veteran; the employment status of the Veteran and the impact of the caregiver on that status; the financial status and needs of the Veteran; the use by the Veteran of VA benefits; and any other information VA considers appropriate. Not later than 2 years after the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of this study.

We do not believe this section is necessary. Currently, VA researchers are seeking new ways to address the mental health issues of Iraq and Afghanistan Veterans, including PTSD. They are also researching Traumatic Brain Injury (TBI) and its treatment and are developing and testing prostheses that will allow Veterans with amputations or other issues to live as independently as possible. One major effort is the Marine Resiliency Study (MRS), involving some 2,600 Marines who deployed to Iraq and Afghanistan. Beginning in 2008, the research team conducted clinical interviews on Marine bases and collected psychological, social, and biological data before deployment and then multiple times after deployment. Researchers are analyzing the data to identify risk and resilience factors for combat-related PTSD. The team recently published two articles in *JAMA Psychiatry*. One shows deployment-related brain injury to be a significant risk factor for PTSD. Another implicates high levels of inflammation in the body as a PTSD risk factor. VA is also conducting a longitudinal study of the neuropsychological and mental outcomes of Veterans of the Iraq war (CSP #566). VA will soon have large datasets to characterize health status and changes over time for Vietnam, Iraq, and Afghanistan Veterans, which will be a rich resource for researchers.

In addition, VA researchers are already studying the impact of caregivers on the health of Veterans. For example, one recently initiated randomized study is examining the effectiveness of an innovative caregiver skills training program and whether it can help Veterans to have increased days at home, reduced total health care costs, and higher satisfaction with VHA health care compared to Veterans in usual care; it will also examine if caregivers in the program have lower depressive symptoms than caregivers who do not receive the training. Another ongoing project is studying an intervention aimed at dementia patients with pain, assessing whether it decreases incidence of aggression, pain, caregiver burden, injuries, use of antipsychotic medication, and nursing home use. Another study is seeking to understand better how war-related psychiatric symptoms of Operation Enduring Freedom/Operation Iraqi Freedom Veterans may interfere with family reintegration and negatively affect family functioning; this study is testing whether difficulties with family reintegration account for the impact of psychiatric symptoms on overall family functioning over time. Another current study is examining whether a brief, inexpensive intervention to foster end-of-life preparation and completion improves quality of life and health utilization for Veterans with serious illness and improves outcomes for caregivers of these Veterans at the end of life.

Additionally, VA works closely with other Federal research agencies to ensure effective use of scarce taxpayer resources in executing its research mission. We carry out joint programmatic re-

views with DOD and NIH to ensure that our research efforts are complementary and not duplicative. Under the auspices of the President's National Research Action Plan, VA has worked with DOD to create two research consortia for TBI and PTSD, at a combined investment of $107 million over 5 years. This tight coordination has become routine for all three agencies, with benefits that accrue to Veterans and the American public at large.

DRAFT BILL, THE JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

Section 105 would require VA to conduct a study on the feasibility and advisability of carrying out a pharmacy lock-in program under which Veterans at risk for abuse of prescription drugs would be permitted to receive prescription drugs only from certain specified VA pharmacies. VA would be required to report to the Committees on Veterans' Affairs within 1 year on this study.

VA has numerous concerns with section 105. We believe a pharmacy lock-in program, under which Veterans at risk for abuse of prescription drugs are permitted to receive prescription drugs only from certain specified VA pharmacies, will lead to negative patient outcomes. For example, Veterans who are traveling or require emergent/urgent medical care from a VA facility may need to receive a prescription from another VA facility's pharmacy to treat the Veteran's emergent/urgent condition. The pharmacy lock-in program would prevent medically-necessary drugs from being dispensed to Veterans. VA health care providers receive duplicate order checks from other VA facilities at the point of prescribing. These duplicate order checks would notify the provider and pharmacist in real-time that the Veteran is receiving similar medications at another VA facility. Therefore we do not believe a study on a pharmacy lock-in program would yield useful information.

Section 205 would require VA, within 180 days of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs a report on the transitions undergone by Veterans in receiving health care in different health care settings. The report would have to include an evaluation of VA's standards for facilitating and managing the transitions undergone by Veterans in receiving health care in different settings, an assessment of the case management services that are available, an assessments of the coordination in coverage of and consistent access to medications, and such recommendations to improve transitions, including coordination of drug formularies between VA and DOD.

VA does not support Section 205 because its requirements would duplicate multiple GAO investigations regarding the health care transition of Servicemembers and Veterans, most notably a November 2012 report, *Recovering Servicemembers and Veterans: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits.* In response, DOD and VA are enhancing care coordination and case management to improve transitions across health care settings, including the development of an Interagency Comprehensive Plan for Servicemembers and Veterans requiring complex care coordination as well as a Lead Coordinator to align and standardize care coordination processes, roles, and responsibilities and to reduce confusion, duplication, and frustration.

In addition, GAO is currently conducting a study, *Engagement on Care Transitions and Medication Management for Post-Traumatic Stress Disorder and Traumatic Brain Injury* (GAO code 291282). GAO is interviewing DOD and VA officials, as well as staff in the field. Thus far, GAO has conducted interviews at the Washington, DC VA Medical Center, at Fort Hood, Texas, and at Fort Carson, Colorado. VA looks forward to their objective, third-party assessment.

Section 403 would require VA, within 2 years of the date of the enactment of this Act, to submit a report on its compliance with VA's policy to conduct a review of each health care provider who transfers to another VA medical facility or leaves VA to determine whether there are any concerns, complaints, or allegations of violations relating to the medical practice of the health care provider and to take appropriate action with respect to any such concern, complaint, or allegation.

VA does not support section 403 because reporting systems are already in place. VA has broad authority to report employed or separated health care professionals to state licensing boards when their behavior or clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. VA medical facility Directors are required to ensure that a review is conducted of the clinical practice of a licensed health care professional who leaves VA employment or when information is received suggesting that a current employee's clinical practice has met the reporting standard. VA has established a comprehensive quality assurance program for reporting any licensed health care professional to state licensing boards who was fired or resigned following the completion of a disciplinary action relating to such professional's clinical competence, resigned after having had such professional's clinical privileges restricted or revoked, or resigned after serious concerns about such professional's clinical competence had been raised but not resolved. When a report is made to a state licensing board, a copy of that letter is also forwarded to VA Central Office. VA would be happy to provide this information upon request, but we do not believe a statutory requirement to submit this information is warranted.

Section 501 would add a new section 527A to title 38 requiring VA to carry out a program of internal audits and self-analysis to improve the furnishing of benefits and health care to Veterans and their families. The Secretary would be required to establish an office within the Office of the Secretary to carry out these audits. The office would conduct periodic risk assessments, develop plans in response to these assessments, and conduct internal audits. At least five covered administrations, staff organizations, or staff offices would have to be audited each year. Within 90 days of completing an audit, the Secretary would be required to submit to the Committees on Veterans' Affairs, the House Committee on Oversight and Government Reform, and the Senate Committee on Homeland Security and Governmental Affairs a report on the audit. The first audit would have to be completed within 180 days of the date of the enactment of this Act.

VA understands the intent of this section, but is concerned about creating an entirely new structure that would in essence duplicate

efforts of other organizations, such as the Inspector General or the Office of the Medical Inspector. We are also concerned that legislation directing VA to create certain offices or functions could produce conflict with the Department-wide restructuring effort underway through the MyVA initiative. VA recommends against further consideration of this section until VA's MyVA restructuring plans are more advanced so we can ensure that any new offices and functions are properly aligned and do not overlap with the missions of other organizations.

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, December 8, 2015.

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

DEAR MR. CHAIRMAN: By this letter, we are providing the remaining views and cost estimates for the following bills from the Committee's October 6, 2015, legislative hearing: S. 1676 and sections 5 and 8 of S. 1885.

We appreciate this opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

ROBERT A. MCDONALD.

Enclosure.

S. 1676, DELIVERING OPPORTUNITIES FOR CARE AND SERVICES FOR VETERANS ACT OF 2015

Section 101 of S. 1676 would amend the Social Security Act to direct the Secretary of Health and Human Services to not take into account any resident within the field of allopathic or osteopathic medicine who counts towards the obligation of the Secretary of Veterans Affairs under section 301 (b)(2) of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 38 United States Code (U.S.C.) 7302 note) (VACAA) when applying the limitations regarding the total number of full-time equivalent residents in a hospital's approved medical residency training program. The Secretary would disregard such residents for cost reporting periods beginning on or after July 1, 2016.

VA appreciates this effort to increase VA's ability to expand graduate medical education (GME), including expanding into underserved communities by allowing other community partners to assist in GME development. Since VA does not sponsor its own physician residency programs, it relies on its academic affiliates to select and sponsor residents who then receive a portion (typically around a quarter of their time) of their clinical training in a VA facility. This arrangement can help ensure that residents receive a well-rounded educational experience. The current cap on residency positions funded by the Centers for Medicare & Medicaid Services (CMS) limits the ability of potential partners to sponsor new VACAA residency positions in collaboration with VA.

This provision, however, would have a budget impact on CMS and VA that could be significant, which makes support for this provision contingent on the availability of resources for both CMS and VA for its implementation. Still, however, VA believes that a partnership with CMS on the VA GME Expansion could assist with addressing known inequities in physician workforce, including the increasing specialization of physicians and the geographic maldistribution. VA's GME Expansion specifically targets Primary Care and Mental Health, and focuses on GME development in smaller and rural communities. A partnership with CMS on this initiative could create significant and beneficial change in the physician workforce for the nation.

Section 102 would amend section 301 (b) of the VACAA to extend from 5 years to 10 years the time period provided for the Secretary of Veterans Affairs to increase the number of GME residency positions to 1,500; and extend by 5 years the time period during which the Secretary must file annual reports to Congress on residency positions at VA medical facilities. VA supports section 102. This legislation would provide additional time for VA to build the infrastructure needed to successfully create the required new residency positions. VA estimates that enactment of section 102 would be cost neutral.

Section 103(a) would require the Secretary of Veterans Affairs and the Secretary of Health and Human Services to jointly conduct a 6-year pilot program to establish not less than three GME residency programs in behavioral medicine in underserved areas in the United States. Section 103(b) would require each residency program to provide participating residents the opportunity to work with diverse patient populations through rotations between medical facilities of VA, the Indian Health Service, and facilities participating under the Medicare program; provide education in the field of behavioral medicine; be carried out in a manner consistent with other residency programs supported and funded by VA and the Department of Health and Human Services; and be located in a community that is designated as a medically under-served area under 42 U.S.C. 254b(b)(3)(A), in a state with a per capita population of Veterans of more than 9 percent according to the National Center for Veterans Analysis and Statistics and the United States Census Bureau, and be within 100 miles of a Reservation as defined in 25 U.S.C. 1452.

Section 103(c) would require the Secretary of Veterans Affairs and Secretary of Human Health and Services to provide to Congress at least annually a joint report containing certain specified elements regarding implementation of the pilot program.

VA appreciates the goals behind section 103 but does not support these provisions. The extremely narrow criteria for the location of the three pilot sites would make the pilot program difficult to implement. For example, large states such as California and New York would be disqualified from consideration because of the per capita Veteran population requirement. Also, the requirement that each pilot site be located within 100 miles of a reservation would exclude many VA facilities from participation. In addition, the extremely limited residency training opportunities within the Indian Health Service would create a challenge when seeking to provide

residents rotations through the Indian Health Service. Finally, the requirement for detailed annual joint reports from the Secretary of Veterans Affairs and the Secretary of Health and Human Services would be unduly burdensome given the relatively small portion of the GME workload these pilot sites would represent. VA estimates that the reporting requirement in section 103(c) would cost $260,000 annually and $1.56 million over the course of the pilot program.

Section 104(a) would require the Secretary of Veterans Affairs to include in the education and training program required under section 7302(a)(1) of title 38 U.S.C., education and training of marriage and family therapists (MFT) and licensed professional mental health counselors (LPMHC). VA supports the goal behind section 104(a) but does not believe that section 104(a) is necessary as VA is presently providing this training and will continue to do so.

Section 104(b) would require the Secretary to apportion funding equally among the professions included in the education and training program. VA does not support section 104 and has a technical concern. It is unclear to which professions the requirement for equal apportionment of funding would apply. If the intent is to require equal funding among all professions, VA does not support such a requirement. Presently, trainee funding is allocated in accordance with future hiring needs and capacity to support training programs at VA facilities. If the intent is to provide equal funding for LPMHC and MFT training programs, this would be problematic as well. VA has attempted to provide equal funding for these two professions. Nonetheless, internships are conducted in partnership with academic affiliate programs and under principles ensuring a quality educational experience and in the context of state licensing laws governing the credentials of supervisors. We have been able to rapidly expand LPMHC internships, but for the MFT internships, the supervisory requirements do not allow equally rapid expansion. A legislative requirement for equal funding might actually result in curtailing training for one profession, so that training for one profession does not exceed funding for another.

Section 105 would amend section 7402(b)(11)(A) of title 38 to expand eligibility for appointment within VA as a LPMHC to specifically include persons who hold a doctoral degree. VA supports section 105. VA estimates that there would be no cost associated with implementation of section 105.

Section 201 would amend section 7451(a)(2) of title 38 to include physician assistants as "covered positions" to which the competitive pay provisions of that section apply. Presently, only registered nurses and certain positions as the Secretary may determine upon recommendation of the Under Secretary for Health are covered positions under section 7451.

While VA supports the intent of Section 201, VA's support is conditioned on Congress providing the additional funding necessary to support these costs. VA also believes that the following health care professionals should also be added as "covered positions" to this section of the law to apply these same competitive pay provisions to physical therapists, occupational therapists, physical therapy assistants, and occupational therapy assistants.

Recruitment and retention of physical and occupational therapy professionals has been a longstanding challenge for VA. A major recruitment and retention barrier for these disciplines is the significant pay disparity between private sector market pay and VA pay schedules for these therapies. Although special pay rate authority exists at the local medical center level to address these disparities, such authority is not consistently utilized and is ineffective in many cases because special salary rates are below the full performance level salary.

VA estimates that the cost of enactment of section 201 for PAs would be $33.2 million in FY 2016, $129 million over 5 years, and $241 million over 10 years. In addition, VA estimates that expansion of the cost of applying the competitive pay provisions of section 7511 to physical therapists, occupational therapists, physical therapy assistants, and occupational therapy assistants would be $42.8 million in FY 2016, $220 million over 5 years, and $458 million over 10 years.

Section 202 would amend section 7681 of title 38 to require that not less than 30 percent of the amount of debt reduction payments paid under the Education Debt Reduction Program (EDRP) each year be paid to individuals who practice medicine in a rural area or highly rural area or demonstrate a commitment to practice medicine in such an area. Section 202 would define "highly rural area" to mean an area located in a county or similar community that has less than seven individuals residing in that county or community per square mile, "rural area" to mean an area that is not an urbanized area or a highly rural area, and "urbanized area" to have the meaning given that term by the Director of the Bureau of the Census. VA does not support section 202. VA recognizes the intent of the legislation is to ensure use of EDRP for recruitment and retention in rural and highly rural areas. However, the proposed legislation would negatively impact the ability of local facilities to effectively use EDRP by restricting the flexibility that exists in the current process and seriously misaligning funding with respect to relative representation of clinical staff and vacancies.

EDRP is designed for recruitment and retention of health care providers who are in difficult to recruit/retain health care positions and who are providing direct patient care services or services incident to direct patient care. Local facilities prioritize hard-to-recruit-and-retain occupations based on facility needs. Each VA medical facility receives EDRP funding allocation to recruit and retain health care providers. Many VA facilities, including both urban and rural facilities, are in fierce competition with the private sector. In fact, some of the hardest to recruit/retain facilities are in urban areas where the cost of living is extremely high and where VA has a harder time competing with the salaries offered by the private sector.

Currently, the percentage of EDRP funding is on par with the percentage of rural and highly rural facilities and providers at those facilities. Rural and highly rural facilities make up 12.6 percent of VA facilities, and employ only 6 percent of VA's clinical providers and support staff. In FY 2015, 11 percent of facilities receiving EDRP were rural or highly rural, and employees at those facilities received 8 percent of the total EDRP funds distributed, com-

mensurate with their representation in the workforce. Furthermore, a review of current recruitment activity rates indicates that only 5.4 percent of clinical vacancies are in rural and highly rural facilities.

Requiring 30 percent of all EDRP funding be awarded to rural facilities would create a significant disparity in overall program funding for other sites, preventing facilities with critical provider shortages from filling EDRP-eligible positions. Restricting usage of nearly one-third of all EDRP funding for rural areas would negatively impact the flexibility afforded to local facilities to determine their specific health care provider needs. Finally, past efforts to set aside EDRP funds for various hiring initiatives have indicated that funds set aside for special uses, such as this, are frequently underused because the employees hired at those sites or for those positions simply do not have eligible student loan debt. It is imperative that flexibility not be restricted for use of these funds in a way that has unintended consequences, and potentially limits the use of the funding all together. VA estimates that there would be no cost associated with implementation of section 202.

Section 203(a) would require the Secretary of Veterans Affairs to submit to Congress a report on the medical workforce of the Department not later than 120 days after the date of enactment of the Act. Section 203(b) would require the report to include specific elements. Specifically, section 203(b)(1) would require the report to include how many LPMHCs and MFTs are enrolled in the mental health professionals trainee program of the Department; how many are expected to enroll in the mental health professionals trainee program of the Department during the 180-day period beginning on the date of submittal of the report; a description of the eligibility criteria for such counselors and therapists compared to other behavioral health professions in the Department; a description of the objectives, goals, and timing of the Department regarding increasing the representation of such counselors and therapists in the behavioral health workforce of the Department; and a description of the actions taken by the Secretary, in consultation with the Director of the Office of Personnel Management (OPM), to create an occupational series for such counselors and therapists and a timeline for the creation of such an occupational series.

Section 203(b)(2) would require the report to include a specific breakdown of spending by the Department in connection with EDRP, as well as descriptions of how the Department prioritizes such spending and the actions taken by the Secretary to increase the effectiveness of such spending for the purposes of recruitment of health care providers. Section 203(b)(3) would require the report to include a description of any impediments to the delivery of telemedicine services to Veterans and any actions taken by the Department to address such impediments, including with respect to certain specified issues.

Section 203(b)(4) would require the report to include an update on the efforts of the Secretary to offer training opportunities in telemedicine to medical residents in medical facilities of the Department that use telemedicine, consistent with medical residency program requirements established by the Accreditation Council for Graduate Medical Education, as required by the Honoring Amer-

ica's Veterans and Caring for Camp Lejeune Families Act of 2012 (Public Law 112–154; 38 U.S.C. 7406 note). Section 203(b)(5) would require the report to include an assessment of the development and implementation by the Secretary of succession planning policies to address the prevalence of vacancies in the Veterans Health Administration (VHA) of more than 180 days, including development of an enterprise position management system to more effectively identify, track, and resolve such vacancies.

Section 203(b)(6) would require the report to include a description of the actions taken by the Secretary, in consultation with the Director of OPM, to address any impediments to the timely appointment and determination of qualifications for Directors of Veterans Integrated Service Networks (VISN) and Medical Directors of the Department.

VA does not believe that the reporting requirements in section 203 are necessary and the actions and initiatives addressed by section 203 are already deployed or being pursued within VHA. VA estimates that the costs associated with enactment of section 203 would not be significant.

Section 301 would amend section 7306(a)(4) of title 38 to add VISN Directors to the list of personnel who comprise the VA Office of the Under Secretary for Health and remove the requirement that Medical Directors be doctors of medicine, dental surgery, or dental medicine.

Section 302 would amend chapter 74 of title 38 to add a new subchapter VII and section 7481 regarding compensation for Medical Directors and VISN Directors. Section 302 would establish the elements of pay for Directors appointed under section 7306(a)(4) of title 38 to include basic pay as determined under section 7404(a) of title 38 and market pay as determined under the new section 7481. Section 302 would require the Secretary to evaluate the amount of market pay payable to a Director not less frequently than once every 2 years and may adjust market pay as a result of such evaluation. Section 302 require the Secretary not less than once every 2 years to set forth a Department-wide total annual pay minimum and maximum which must be published in the Federal Register. Section 302 would prohibit the Secretary from delegating the authority to determine the Department-wide minimum and maximum total annual pay.

VA supports sections 301 and 302, and the latter provision matches a proposal put forward in February 2015 in VA 's Fiscal Year 2016 budget submission. VA believes that there are three primary factors that warrant a separate compensation system for Medical Directors and VISN Directors. First, existing pay compression within the current Senior Executive Service (SES) pay system and the closely proximate rates of pay for direct reports to Medical Center Directors and VISN Directors have resulted in declining Director applicant pools. Second, a high number of existing (an estimated 84 percent by FY 2018) Directors are or will soon be eligible for retirement. Third, private sector pay for health care leadership positions is highly competitive.

In addition, there are limited pay incentives for experienced Medical Center Directors and VISN Directors to voluntarily move to fill more demanding positions. Due to the SES pay compression

between experienced Medical Center Directors and VISN Directors, the small pay raise, if any, that VHA is able to offer in a reassignment may cause the candidate to be disadvantaged financially. The most significant cost disparities occur due to housing costs and in some cases, higher tax rates (e.g., New York, California). With current executive pay authorities, a move for the good of the organization most of the time means a move to the financial detriment of the Director and their family. On average, it has taken over 6 months to fill Medical Center Director and VISN Director positions, with many being re-announced multiple times for positions in both rural and major metropolitan areas. The reluctance on the part of these senior leaders to relocate is understandable. It is imperative that VHA have the ability to implement pay to retain eligible leaders, reward mobility, and ensure knowledge transfer to the next generation of Medical Center Directors and VISN Directors. VA estimates that enactment of section 301 would involve no cost and that enactment of section 302 would cost $8.8 million in FY 2016, $46 million over 5 years, and $93.2 million over 10 years.

Section 401(a) would require the Secretary, not later than 1 year after the date of enactment of the Act, to conduct a 2-year pilot program to assess the feasibility and advisability of implementing in rural areas and highly rural areas with a large percentage of Veterans a nurse advice line to furnish to Veterans medical advice, appointment and cancellation services, and information on the availability of benefits from VA.

Section 401(b) would require the pilot program to establish a nurse advice line that operates free of charge, is based on and improves upon the Department of Defense TRICARE advice line, complies with call center requirements set forth by URAC, uses a process for determinations of caller eligibility, allows for information sharing between VA and the nurse advise line, and maintains quality controls to ensure calls are answered by a customer service representative within 30 seconds with an abandonment rate of less than 5 percent.

Section 401(c) would require the nurse advice line to provide an array of services including: medical advice from licensed registered nurses who assess the caller's symptoms using a proprietary clinical algorithm meeting specified criteria, information to address basic questions regarding eligibility for VA benefits, and use of an appointment clerk to facilitate scheduling of appointments for health care from the Department.

Section 401(d) would require, not later than 120 days after the date of completion of the pilot program, the Secretary to submit to Congress a report providing specified information regarding the pilot program.

VA does not support section 401 as VA already provides telephone services for clinical care. Specifically, VHA Directive 2007–033, Telephone Service for Clinical Care, requires telephone services for clinical care to be made available to all Veterans receiving care at VHA facilities to include 24/7 telephone access to clinical staff trained to provide health care advice and information. Each facility is responsible for providing access for Veteran clinical concerns consistent with VHA Directive 2007–033. Veteran telephone access to clinical care during business hours is facility based, man-

aged, and resourced. Veterans are able to call their local facility and speak with clinical staff to address and manage their concerns. VA staff members working with Veterans are responsible for following evidence-based guidance including during in-person and telephone contact. VA estimates that enactment of section 401 would cost $75 million in FY 2016, $385 million over 5 years, and $770 million over 10 years.

S. 1885, VETERANS HOUSING STABILITY ACT OF 2015

Section 5 of S. 1885 would amend section 2041 of title 38 U.S.C. to expand eligibility for the services provided under that section as well as the scope of services provided. Under section 2041, VA may enter into agreements to sell, lease, or donate real property acquired by the Secretary as a result of a default on a loan made, insured, or guaranteed by VA to qualified nonprofit organizations or state or local governments that agree to use the properties to shelter homeless Veterans and their families. Section 5 would permit such entities to continue assisting homeless Veterans and their families, as under current section 2041, but would also expand section 2041 to include Veterans and their families who are at risk of becoming homeless and very low-income Veteran families (as defined in section 2044(f) of title 38). Rather than limiting the entities' assistance to shelter, as is currently the case, the entities would also be able to assist such Veterans and their families in acquiring and transitioning to permanent housing, and in maintaining occupancy in permanent housing. Section 5 would also require the entity to expand the range of services it provides to the Veterans that it houses by ensuring that such Veterans receive referrals for the benefits and services to which the Veterans may be entitled or eligible under title 38.

VA does not object to section 5 but has a technical concern. Section 5(a)(2)(C) would amend subsection (a)(3)(B) of section 2041 to strike "solely as a shelter primarily for homeless Veterans and their families" and insert "to provide permanent or transitional housing for Veterans and families described in paragraph (1)." By striking "shelter," section 5(a)(2)(C) would require the entity to agree to use the property in a manner more narrow than the overall purpose of the bill as expressed in section 5(a)(2)(A), which includes assisting eligible individuals "in acquiring shelter." Therefore, VA recommends that line 2 of page 12 of the draft bill be revised to include "shelter or" before "permanent or transitional housing." VA estimates that enactment of section 5 would result in new benefit loan subsidy costs of $16.6 million for FY 2016. The provision would expire at the end of 2016. VA estimates that enactment would not increase general operating expenses costs.

Section 8 would amend section 2012 of title 38 to require VA to annually review each Homeless Provider Grant and Per Diem (GPD) program grant recipient and eligible entity that received a per diem payment and evaluate each grantee's success in assisting Veterans to obtain, transition into, and retain permanent housing and increasing Veteran income through obtaining employment or income-related benefits. VA would only be able to continue providing per diem to the grantee if VA determines that the grantee's performance merits continuation of the per diem. Section 8 would

also require VA to establish uniform performance targets for all GPD grantees in order to conduct its review and evaluation.

VA supports section 8 and has a minor technical concern. Currently, the GPD program has in place an annual inspection protocol which includes an evaluation of certain performance metrics established by VA. When grantees fail to meet the annual inspection requirements the GPD program begins corrective action process that can lead to stopping per diem if corrections are not implemented. VA believes the current annual inspections process could be changed to incorporate the criteria specified in, and new uniform performance targets required by, section 8. These changes would further help VA to tie continued per diem payment to grantee performance. VA's minor technical concern relates to lines 5 and 6 of page 16 of the bill, which state that VA would evaluate performance with respect to success "in assisting Veterans obtain, transition into, and retain permanent housing." VA recommends inserting the word "to" before the word "obtain." VA estimates that the enactment of section 8 would be cost neutral.

On May 13, 2015, Anthony Kurta, Deputy Assistant Secretary of Defense, Military Personnel Policy, Department of Defense, appeared before the Committee on Veterans' Affairs and submitted testimony on various bills incorporated into the Committee bill. An excerpt from that testimony is reprinted below:

STATEMENT OF ANTHONY KURTA, DEPUTY ASSISTANT SECRETARY OF DEFENSE, MILITARY PERSONNEL POLICY, U.S. DEPARTMENT OF DEFENSE

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and esteemed members of the Committee. I am pleased to appear before you today to discuss pending benefits legislation.

Per the agenda for today's hearing, the committee requested the Department of Defense's view on a series of bills and proposals. Since both funding and administration of the Post-9/11 GI Bill fall under the purview of the Department of Veterans Affairs, I will focus my comments only on those proposals that will affect the Department of Defense and generally defer to the Departments of Labor and Veterans Affairs to provide responses on those with no significant DOD impacts. This statement will follow the order on the printed agenda.

S. 602, GI BILL FAIRNESS ACT OF 2015

The committee asked for comments on S. 602, "GI Bill Fairness Act of 2015," a bill that would consider active duty performed under the authority of title10, United States Code, section 12301(h), as qualifying active duty for the purposes of Post-9/11 GI Bill Education Benefits. Reserve component members wounded in combat are often given orders to active duty under this provision to receive authorized medical care; to be medically evaluated for disability; or to complete a required health care study. However, as currently written, section 3301(1)(B), of title 38, United States Code, does not include active duty performed under 12301(h) as qualifying active duty for purposes of Post-9/11 GI Bill educational assistance.

Currently, when a member of the Reserve Component on active duty sustains an injury due to military operations, the Servicemember is not discharged, but remains in the Selected Reserve on active duty under 12301(h), title 10, United States Code. None of the time spent in recovery under this status is qualifying time for purposes of the Post-9/11 GI Bill. In this case, the Servicemember would return to Selected Reserve status with less qualifying time than those who served an entire period of active duty without an intervening injury. As a result, the Servicemember would not receive an educational benefit equivalent to the other members of his or her cohort. In effect, the Servicemember is being penalized for having being wounded or injured in theater. This legislation would correct this inequity by simply extending eligibility for the Post-9/11 GI Bill to service under 12301(h).

DOD recognizes the inequity of not including this active duty time for purposes of Post-9/11 GI Bill benefits, and has included a provision similar to this bill in our FY 2016 legislative proposal package as section 514. However, the DOD proposal would include

only active duty performed after enactment. In contrast, S. 602 would be retroactive; categorizing all duty performed under 12301(h) since September 11, 2001, as qualifying active duty for purposes of the Post-9/11 GI Bill. We estimate that approximately 5,000 Reserve Component members performed active duty under 12301(h) each year since September 11, 2001. Accordingly, we believe that S. 602 would generate an additional cost to the Department of Veterans Affairs. Given that both the funding and administration of the Post-9/11 GI Bill fall under the purview of the Department of Veterans Affairs, we would defer to that agency to determine the costs and effects of the bill on their Department.

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On October 6, 2015, Hon. Lawrence B. Hagel, Chief Judge of the U.S. Court of Appeals for Veterans Claims submitted the following written testimony:

STATEMENT OF HON. LAWRENCE B. HAGEL, CHIEF JUDGE, U.S. COURT OF APPEALS FOR VETERANS CLAIMS

Mr. Chairman and Distinguished Members of the Committee: Thank you for the opportunity to comment on S. 1754, a bill that would amend 38 U.S.C. § 7253(a), to make permanent the authorization for an increase in the number of judges on the U.S. Court of Appeals for Veterans Claims (Court), from seven to nine. Succinctly stated, the Court supports this legislation and urges its passage.

The decision by Congress several years ago to expand the Court temporarily to nine judges came in response to a significant increase in the Court's caseload, and a perception that the rise was not simply a spike but in fact a trend. Effective December 31, 2009, authorization permitted the Court to grow to nine active judges, and we reached that full complement in December 2012. We were fortunate to operate with nine judges for almost three years until the retirement of one of our colleagues one month ago. With full staffing the Court has been able to conduct effective, efficient, and expeditious judicial review. Your support in providing the resources to handle our heavy caseload is very much appreciated.

Under current law we will operate with eight judges until the next retirement, and then we revert to seven judges, our current permanent authorization. The reality is that two judges' terms expire within days of each other in December 2016, so absent legislation the Court will dip to six judges at that time. With the unpredictability of the judicial nomination and appointment process, and another retirement likely in 2017, there is a very real possibility that the Court will shrink to five judges just two years from now. Passage of S. 1754 would permit a judicial appointment now to bring us back up to nine judges, and would prevent the Court from dropping to a critically low number of judges in the near future.

Since its creation in 1988, the Court has become one of the Nation's busiest Federal courts based on the numbers of appeals filed and decided per judge. Up until about ten years ago the Court received roughly 2,200 appeals annually. That number began to rise significantly starting in FY 2005, reaching over 4,700 appeals filed in FY 2009. Since that time, annual appeals filed have not fallen below 3,500 and although we are still tabulating FY 2015 numbers, we estimate that over 4,400 appeals were filed. This is double the number of appeals filed annually during the Court's first 15 years from 1989 to 2004.

For cases decided, the Court terminated in the neighborhood of 4,400 appeals in FY 2015. That is in addition to acting on nearly 3,000 applications for attorney fees, hundreds of petitions for extraordinary relief, and thousands of procedural motions. We continue to be one of the busiest national courts, but we are efficiently handling this formidable caseload. Generally speaking, appeals

filed at the Court come from veterans who are dissatisfied with a decision of the Board of Veterans' Appeals (Board). Much emphasis and financial support has been placed toward increasing the numbers of personnel at the Department of Veterans Affairs, and toward improving claims processing times. Up from 41,910 decisions in FY 2013, the Board issued 55,532 decisions in FY 2014, and the Board estimates that it will decide at least the same number in FY 2015. Although it is difficult to predict with certainty what our caseload will be in the future, it seems likely, considering the number of claims filed annually with VA and the increased productivity by the Board, that the number of appeals filed at the Court will also rise further and stay high.

Over the past several years the Court has striven to create efficiencies in how we conduct judicial review of veterans' appeals. We have adopted an electronic case filing and management system. We are constantly improving our pre-briefing mediation program to resolve cases earlier in the process, to hone the issues on appeal, and to stretch our judicial resources to the greatest extent possible. We have an active bar, and we engage frequently with our practitioners to discuss ways to further improve our process. Everyone involved in judicial review of veterans' appeals shares a common goal of wanting to honor our veterans and provide full, fair, and prompt decisions on their appeals. Authorization for nine active judges would be a significant factor in furthering that goal.

In closing, on behalf of the Court, I express my appreciation for your past and continued support, and for the opportunity to provide this statement.

SUPPLEMENTAL VIEWS OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, HON. PATTY MURRAY, HON. BERNIE SANDERS, HON. SHERROD BROWN, HON. JON TESTER, AND HON. MAZIE K. HIRONO

On December 9, 2015, the Senate Committee on Veterans' Affairs (hereinafter, "the Committee") voted, by voice vote, to approve S. 425, as amended, a bill to provide for a five-year extension to the homeless veterans reintegration programs of the Department of Veterans Affairs (hereinafter, "VA" or "Department") and to provide clarification regarding eligibility for services under such programs. We strongly support the Committee's intent, expressed on December 9, 2015 that employment discrimination on the basis of race, color, religion, sex, sexual orientation, gender identity, national origin, disability, veteran status, or other protected category or activity has no place in the health care that VA provides. We reaffirm in these supplemental views our expectation that all entities providing health care to veterans will meet the highest standards of nondiscrimination, civil rights protections and equality of employment opportunity.

Section 461(a) of the bill would add a new § 1703A to 38 U.S.C. chapter 17. That section includes a provision, § 1703A(h)(2)(A), which was modified during the Committee meeting to fully exempt extended-care providers that enter into "Veterans Extended Care Agreements" from laws to which providers under Medicare are not subject. Similarly, § 462(b) of the bill adds a new subparagraph 4(B) to 38 U.S.C. § 1745(a), which ensures similar status for state veterans homes that provide nursing-home care by agreement with VA. The Veterans Extended Care Agreements authorized by this bill arrange for eligible extended-care providers to provide direct health care services for veterans for which VA will reimburse the providers for those services. This is distinct from the arrangement under Medicare and Medicaid, where the Federal Government provides financial assistance to the individuals to whom health-care providers furnish services. It is also different from the arrangement used by the Department of Defense (hereinafter, "DOD") through the TRICARE health system, whereby health-care providers do not directly contract with DOD but rather are part of health-care networks administered by Managed Care Support Contractors.

This bill exempts extended-care providers from complying with the Vietnam Era Veterans' Readjustment Assistance Act of 1974, as amended, section 4212 of title 38 U.S.C. (hereinafter, "VEVRAA"). VEVRAA is the only Federal statute that promotes employment opportunities for protected veterans who work for or apply to work for covered Federal contractors and subcontractors that have at least $150,000 in contracts. The VEVRAA regulations provide explicit, comprehensive protection from discrimination in all aspects of the employment relationship—including advertising

and recruitment, the application process and initial hiring, training opportunities, performance evaluations, promotions, benefits, compensation, discharge, and all other terms and conditions of employment. For Federal contractors that have at least 50 employees, VEVRAA also requires that they measure progress toward achieving equal employment opportunity for veterans against an established benchmark, periodically review their personnel processes to ensure that they do not stereotype protected veterans in a way that limits their access to all jobs for which they are qualified; and periodically assess any qualification standards that tend to screen out qualified veterans to ensure the standards are job-related for the position in question and consistent with business necessity. The Office of Federal Contract Compliance Programs (hereinafter, "OFCCP") within the Department of Labor (hereinafter, "DOL") enforces VEVRAA. If OFCCP finds that a covered contractor has engaged in unlawful discrimination against a protected veteran, it can require the contractor to provide "make-whole relief" to the veteran, including back pay and an offer of employment. A covered contractor that refuses to comply with the statute and its regulations may be subject to disbarment from future contracts.

A consequence of enactment of this bill would mean extended-care providers who enter into agreements during the two years for which they are authorized will not have to file annual Federal Contractor Veterans' Employment Reports. The information from these reports is valuable for contractors, the public, and policymakers who want to assess contractors' progress in hiring veterans. In 2012, Congress amended VEVRAA in 2012 to require DOL to make this data public further indicating the value of this information. As DOL has explained in its *Annual Report from Federal Contractors in 2014*——

> Information on the total number and proportion of protected veterans employed and newly hired in Federal contractor workforces from year to year will show trends in the employment of protected veterans, and analyses of those trends can be used to assess the extent to which Federal contractors are providing employment opportunities to protected veterans.

In addition to VEVRAA, two other key civil rights protections would no longer protect employees who work for providers with Veterans Extended Care Agreements under this bill:

- Executive Order (hereinafter, "E.O.") 11246, which prohibits contractors with more than $10,000 in Federal contracts from discriminating against employees or applicants because of race, color, religion, sex, sexual orientation, gender identity, or national origin, or because they inquired about, discussed or disclosed information about compensation, and requires contractors to take affirmative action to ensure equal employment opportunity; and
- Section 503 of the Rehabilitation Act of 1973 ("Section 503"), which prohibits contractors with more than $10,000 in Federal contracts from discriminating in employment on the basis of disability and requires them to take affirmative action to ensure equal employment opportunity for individuals with disabilities.

Like VEVRAA, these two laws and their implementing regulations were adopted to ensure that Federal dollars establish reasonable standards for contractors by requiring not only that they not discriminate in their employment practices, but also that they take positive steps to ensure equal employment opportunity. These requirements include assigning responsibility and accountability for the implementation of equal employment opportunity to an official who has the authority, resources, support of and access to top management to ensure effective implementation; sending notices of contractors' equal employment opportunity obligations to each labor union with which they have a collective bargaining agreement; and reviewing personnel activity to eliminate unnecessary causes of disparities.

Section 503 requirements are particularly useful for veterans with disabilities as they require contractors with 50 or more employees and a contract of $50,000 or more to undertake appropriate outreach activities that are reasonably designed effectively to recruit qualified individuals with disabilities. These activities include reaching out to the Veterans' Service Organizations and the disabled veterans' outreach program specialists in the American Jobs Center nearest the contractor's establishment. This bill would exempt the extended-care providers who often provide health care and rehabilitation services to veterans with disabilities *so that they can return to the civilian workforce*, from having to take at least the same steps to employ veterans with disabilities who are able to work as other Federal contractors do.

E.O. 11246 and Section 503 are important because they provide protection from discrimination on the bases of race, religion, sex, sexual orientation, gender identity, national origin, and disability. Indeed, the commitment to civil rights protections that they embody is consistent with VA's long history of embracing the diversity that has made our Nation great.

OFCCP plays a vital role and unique role in combating unlawful employment discrimination by Federal contractors on the basis of sex, race, national origin, color, sexual orientation, gender identity and disability; as well as requiring non-discrimination and affirmative action for special and disabled veterans of war in which a campaign badge has been authorized. Notably, no other applicable anti-discrimination law requires contractors to ensure they have a workforce that includes protected veterans and qualified individuals with disabilities. No other Federal law explicitly makes it unlawful for employers to discriminate in employment on the basis of sexual orientation. Finally, no other anti-discrimination law carries with it the possibility—albeit remote—that a contractor will be debarred from future Federal contracts if it engages in ongoing, repeated, and egregious discrimination.

We are gravely concerned that claims made about the burdens of compliance, suggesting it will undermine the ability of providers that enter into Veterans Extended Care Agreements to deliver high-quality, timely, and efficient care to veterans, are devoid of evidence-based data. Many health-care facilities, including extended-care facilities, have been subject to these laws for years and have succeeded in complying with them. Despite these concerns, we support the temporary use of Veterans Extended Care Agreements

under this bill as an interim step to promote quick delivery of much-needed extended health care to veterans as VA and Congress work together to reform care delivered by VA. However, more permanent contractual agreements that VA enters into with healthcare providers should restore employee protections unless the concerns, outlined in these Supplemental Views, are alleviated by a strong showing using fact-based evidence that the costs of complying with VEVRAA, Section 503, and E.O. 11246 would make it impossible for extended care providers to provide care to veterans unless they were exempted from these laws.

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CHANGES IN EXISTING LAW

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

Title 38. Veterans' Benefits

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Part I. General Provisions

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Chapter 5. Authority and Duties of The Secretary

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SUBCHAPTER I. GENERAL AUTHORITIES

Sec.

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SUBCHAPTER II. SPECIFIED FUNCTIONS

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527. Evaluation and data collection.
527A. Program of internal audits.

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Subchapter II. Specified Functions

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SEC. 527A. PROGRAM OF INTERNAL AUDITS

(a) PROGRAM REQUIRED.—(1) The Secretary shall carry out a program of internal audits and self-analysis to improve the furnishing of benefits and health care to veterans and their families.

(2) The Secretary shall carry out the program required by paragraph (1) through an office the Secretary shall establish for purposes of the program within the office of the Secretary that is interdisciplinary and independent of—

(A) the other offices within the office of the Secretary; and

(B) the covered administrations (or functions of such administrations), staff organizations, and staff offices identified under subsection (b)(1)(A).

(b) PROGRAM REQUIREMENTS.—(1) In carrying out the program required by subsection (a), the Secretary shall—

(A) conduct periodic risk assessments of the Department to identify those covered administrations (or functions of such administrations), staff organizations, and staff offices of the Department the audit of which would lead towards the greatest improvement in the furnishing of benefits and health care to veterans and their families;

(B) develop plans that are informed by the risk assessments conducted under paragraph (1) to conduct internal audits of the covered administrations (or functions of such administrations), staff organizations, and staff offices identified under subparagraph (A); and

(C) conduct internal audits in accordance with the plans developed pursuant to subparagraph (B).

(2) The Secretary shall carry out under the program required by subsection (a) an audit of not fewer than five covered administrations (or functions of such administrations), staff organizations, or staff offices of the Department each year.

(3) In identifying covered administrations (or functions of such administrations), staff organizations, and staff offices of the Department under paragraph (1)(A), the Secretary shall accord priority to the covered administrations and functions of such administrations.

(4)(A) For purposes of this subsection, the covered administrations of the Department are the following:

(i) The National Cemetery Administration.

(ii) The Veterans Benefits Administration.

(iii) The Veterans Health Administration.

(B) For purposes this subsection, the covered staff organizations of the Department are the following:

(i) The Office of Acquisition, Logistics, and Construction.

(ii) The Advisory Committee Management Office.

(iii) The Board of Veterans' Appeals.

(iv) The Center for Faith-Based and Neighborhood Partnerships.

(v) The Center for Minority Veterans.

(vi) The Center for Women Veterans.

(vii) The Office of General Counsel.

(viii) The Office of Regulation Policy and Management.

(ix) The Office of Employment Discrimination Complaint Adjudication.

(x) The Office of Interagency Care and Benefits Coordination.

(xi) The Office of Small and Disadvantaged Business Utilization.

(xii) The Office of Survivors Assistance.

(xiii) The Veterans' Service Organizations Liaison.

(C) For purposes of this subsection, the covered staff offices of the Department are the following:

(i) The office of the Assistant Secretary for Congressional and Legislative Affairs.

(ii) The office of the Assistant Secretary for Human Resources and Administration.

(iii) The office of the Assistant Secretary for Information and Technology.

(iv) The Office of Management.

(v) The office of the Assistant Secretary for Operations, Security, and Preparedness.

(vi) The office of the Assistant Secretary for Policy and Planning.

(vii) The office of the Assistant Secretary for Public and Intergovernmental Affairs.

(c) REPORTS.—(1)(A) Not later than 90 days after completing an audit under the program required by subsection (a), the Secretary shall submit to the appropriate committees of Congress a report on the audit.

(B) Each report submitted under subparagraph (A) with respect to an audit shall include the following:

(i) A summary of the audit.

(ii) The findings of the Secretary with respect to the audit.

(iii) Such recommendations as the Secretary may have for legislative or administrative action to improve the furnishing of benefits and health care to veterans and their families.

(iv) Plans to carry out the recommendations submitted under clause (iii), including timelines for completion of such plans.

(2)(A) Not later than September 1 of each year, the Secretary shall submit to the appropriate committees of Congress a report on the administration of this section.

(B) Each report submitted under subparagraph (A) shall include the following:

(i) A detailed description of each matter for which a recommendation was submitted under clause (iii) of paragraph (1)(B) and with respect to which plans that were submitted under clause (iv) of such paragraph have not been completed.

(ii) A plan for the conduct of audits under this section during the first fiscal year beginning after the fiscal year in which the report is submitted, which shall include the following:

(I) A description of any risk assessments the Secretary plans to conduct in such fiscal year.

(II) A summary of each audit the Secretary plans to conduct in such fiscal year, including a description of the subject matter of the audit and identification of the administration, office, or function to be audited.

(3) In this subsection, the term "appropriate committees of Congress" includes—

(A) the Committee on Veterans' Affairs, the Committee on Appropriations, and the Committee on Homeland Security and Governmental Affairs of the Senate; and

(B) the Committee on Veterans' Affairs, the Committee on Appropriations, and the Committee on Oversight and Government Reform of the House of Representatives.

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Part II. General Benefits

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Chapter 15. Pension for Non-Service-Connected Disability or Death or for Service

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Subchapter IV. Army, Navy, Air Force, and Coast Guard Medal of Honor Roll

SEC. 1562. SPECIAL PROVISIONS RELATING TO PENSION

(a) The Secretary shall pay monthly to each living person whose name has been entered on the Army, Navy, Air Force, and Coast Guard Medal of Honor Roll, and a copy of whose certificate has been delivered to the Secretary under subsection (d) of section 1134a of title 10, a special pension at the rate of **[**$1,000**]** *$3,000*, as adjusted from time to time under subsection (e), beginning as of the date on which the person's name is entered on the Army, Navy, Air Force, and Coast Guard Medal of Honor Roll under subsection (b) of such section.

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

SUBCHAPTER I. GENERAL

Sec.

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1703. Contracts for hospital care and medical services in non-Department facilities.
1703A. Veterans Extended Care Agreements with certain health care providers.

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Subchapter I. General

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SEC. 1703A. VETERANS EXTENDED CARE AGREEMENTS WITH CERTAIN HEALTH CARE PROVIDERS

(a) AGREEMENTS TO FURNISH EXTENDED CARE.—(1) In addition to the authority of the Secretary under this chapter to furnish extended care at facilities of the Department and under contracts or sharing agreements entered into under authorities other than this section, the Secretary may furnish extended care through the use of agreements entered into under this section. An agreement entered into under this section may be referred to as a "Veterans Extended Care Agreement".

(2) The Secretary may enter into agreements to furnish extended care under this section with eligible providers that are certified under subsection (d) if the Secretary is not feasibly able to furnish extended care at facilities of the Department.

(3) An eligible provider, at its discretion, may opt to enter into an agreement under this section instead of a contract or sharing agreement under authorities other than this section.

(b) RECEIPT OF EXTENDED CARE.—(1) Eligibility of a veteran for extended care under this section shall be determined as if such care were furnished in a facility of the Department and provisions of this title applicable to veterans receiving extended care in a facility of

the Department shall apply to veterans receiving such care under this section.

(2) In carrying out this section, the Secretary—

(A) may not direct veterans seeking extended care to health care providers that have entered into contracts or sharing agreements under authorities other than this section; and

(B) shall ensure that veterans have the option to determine whether to receive extended care from a health care provider described in subparagraph (A) or an eligible provider that has entered into an agreement under this section.

(c) ELIGIBLE PROVIDERS.—For purposes of this section, an eligible provider is one of the following:

(1) A provider of services that has enrolled and entered into a provider agreement under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)).

(2) A physician or supplier that has enrolled and entered into a participation agreement under section 1842(h) of such Act (42 U.S.C. 1395u(h)).

(3) A provider of items and services receiving payment under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or a waiver of such a plan.

(4) A provider that is—

(A) an Aging and Disability Resource Center, an area agency on aging, or a State agency (as defined in section 102 of the Older Americans Act of 1965 (42 U.S.C. 3002)); or

(B) a center for independent living (as defined in section 702 of the Rehabilitation Act of 1973 (29 U.S.C. 796a)).

(5) Such other health care providers as the Secretary considers appropriate for purposes of this section.

(d) CERTIFICATION OF ELIGIBLE PROVIDERS.—(1) The Secretary shall establish a process for the certification of eligible providers under this section that shall, at a minimum, set forth the following.

(A) Procedures for the submittal of applications for certification and deadlines for actions taken by the Secretary with respect to such applications.

(B) Standards and procedures for approval and denial of certification, duration of certification, revocation of certification, and recertification.

(C) Procedures for assessing eligible providers based on the risk of fraud, waste, and abuse of such providers similar to the level of screening under section 1866(j)(2)(B) of the Social Security Act (42 U.S.C. 1395cc(j)(2)(B)) and the standards set forth under section 9.104 of title 48, Code of Federal Regulations, or any successor regulation.

(2) The Secretary shall deny or revoke certification to an eligible provider under this subsection if the Secretary determines that the eligible provider is currently—

(A) excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))) under section 1128 or 1128A of the Social Security Act (42 U.S.C. 1320a–7 and 1320a–7a); or

(B) identified as an excluded source on the list maintained in the System for Award Management, or any successor system.

(e) TERMS OF AGREEMENTS.—Each agreement entered into with an eligible provider under this section shall include provisions requiring the eligible provider to do the following:

(1) To accept payment for extended care furnished under this section at rates established by the Secretary for purposes of this section, which shall be, to the extent practicable, the rates paid by the United States for such care to providers of services and suppliers under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) To accept payment under paragraph (1) as payment in full for extended care furnished under this section and to not seek any payment for such care from the recipient of such care.

(3) To furnish under this section only the extended care authorized by the Department under this section unless the eligible provider receives prior written consent from the Department to furnish extended care outside the scope of such authorization.

(4) To bill the Department for extended care furnished under this section in accordance with a methodology established by the Secretary for purposes of this section.

(5) Not to seek to recover or collect from a health-plan contract or third party, as those terms are defined in section 1729 of this title, for any extended care for which payment is made by the Department under this section.

(6) To provide medical records for veterans furnished extended care under this section to the Department in a time frame and format specified by the Secretary for purposes of this section.

(7) To meet such other terms and conditions, including quality of care assurance standards, as the Secretary may specify for purposes of this section.

(f) TERMINATION OF AGREEMENTS.—(1) An eligible provider may terminate an agreement with the Secretary under this section at such time and upon such notice to the Secretary as the Secretary may specify for purposes of this section.

(2) The Secretary may terminate an agreement with an eligible provider under this section at such time and upon such notice to the eligible provider as the Secretary may specify for purposes of this section, if the Secretary—

(A) determines that the eligible provider failed to comply substantially with the provisions of the agreement or with the provisions of this section and the regulations prescribed thereunder;

(B) determines that the eligible provider is—

(i) excluded from participation in a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))) under section 1128 or 1128A of the Social Security Act (42 U.S.C. 1320a–7 and 1320a–7a); or

(ii) identified as an excluded source on the list maintained in the System for Award Management, or any successor system;

(C) ascertains that the eligible provider has been convicted of a felony or other serious offense under Federal or State law and determines that the continued participation of the eligible pro-

vider would be detrimental to the best interests of veterans or the Department; or

(D) determines that it is reasonable to terminate the agreement based on the health care needs of a veteran or veterans.

(g) PERIODIC REVIEW OF CERTAIN AGREEMENTS.—(1) Not less frequently than once every two years, the Secretary shall review each Veterans Extended Care Agreement of material size entered into during the two-year period preceding the review to determine whether it is feasible and advisable to furnish the extended care furnished under such agreement at facilities of the Department or through contracts or sharing agreements entered into under authorities other than this section.

(2)(A) Subject to subparagraph (B), a Veterans Extended Care Agreement is of material size as determined by the Secretary for purposes of this section.

(B) A Veterans Extended Care Agreement entered into after September 30, 2016, is of material size if the purchase of extended care under the agreement exceeds $1,000,000 annually. The Secretary may adjust such amount to account for changes in the cost of health care based upon recognized health care market surveys and other available data and shall publish any such adjustments in the Federal Register.

(h) EXCLUSION OF CERTAIN FEDERAL CONTRACTING PROVISIONS.—(1) An agreement under this section may be entered into without regard to any law that would require the Secretary to use competitive procedures in selecting the party with which to enter into the agreement.

(2)(A) Except as provided in subparagraph (B) and unless otherwise provided in this section or regulations prescribed pursuant to this section, an eligible provider that enters into an agreement under this section is not subject to, in the carrying out of the agreement, any law that providers of services and suppliers under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) are not subject to.

(B) Notwithstanding subparagraph (A), an eligible provider that enters into an agreement under this section shall be subject to all laws regarding integrity, ethics, fraud, or that subject a person to civil or criminal penalties as if such laws were incorporated into its provider agreements.

(i) QUALITY OF CARE.—The Secretary shall establish through regulation a system or systems for—

(1) monitoring the quality of extended care furnished to veterans under this section; and

(2) assessing the quality of extended care furnished by an eligible provider under this section prior to the renewal of a Veterans Extended Care Agreement with the eligible provider.

(j) DISPUTE RESOLUTION.—(1) The Secretary shall establish administrative procedures for eligible providers with which the Secretary has entered an agreement under this section to present any dispute arising under or related to the agreement.

(2) Before using any dispute resolution mechanism under chapter 71 of title 41 with respect to a dispute arising under an agreement under this section, an eligible provider must first exhaust the ad-

ministrative procedures established by the Secretary under paragraph (1).

(k) SUNSET.—The Secretary may not furnish extended care through the use of an agreement entered into under this section after the date that is two years after the date of the enactment of the Jason Simcakoski Memorial Act.

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

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SEC. 1720G. ASSISTANCE AND SUPPORT SERVICES FOR CAREGIVERS

(a) PROGRAM OF COMPREHENSIVE ASSISTANCE FOR FAMILY CAREGIVERS.—(1)(A) The Secretary shall establish a program of comprehensive assistance for family caregivers of eligible veterans.

(B) * * *

(2) * * *

(A) * * *

[(B) has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001; and**]**

(B) for assistance provided under this subsection—

(i) before the date on which the Secretary submits to Congress a certification that the Department has fully implemented the information technology system required by section 452(a) of the Jason Simcakoski Memorial Act, has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001;

(ii) during the two-year period beginning on the date specified in clause (i), has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service—

(I) on or before May 7, 1975; or

(II) on or after September 11, 2001; or

(iii) after the date that is two years after the date specified in clause (i), has a serious injury (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service; and

(C) * * *

(i) * * *

(ii) a need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury**[**; or**]** *;*

(iii) a need for regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired; or

(iv) **[**(iii)**]** such other matters as the Secretary considers appropriate.

(3)(A) * * *

(i) * * *

* * * * * * *

(ii) * * *

* * * * * * *

(IV) medical care under section 1781 of this title[; and]*;*

(V) a monthly personal caregiver stipend[.] *; and*

(VI) through the use of contracts with, or the provision of grants to, public or private entities—

(aa) financial planning services relating to the needs of injured veterans and their caregivers; and

(bb) legal services, including legal advice and consultation, relating to the needs of injured veterans and their caregivers.

(C)(i) * * *

* * * * * * *

(iii) In determining the amount and degree of personal care services provided under clause (i) with respect to an eligible veteran whose need for personal care services is based in whole or in part on a need for supervision or protection under paragraph (2)(C)(ii) or regular instruction or supervision under paragraph (2)(C)(iii), the Secretary shall take into account the following:

(I) The assessment by the family caregiver of the needs and limitations of the veteran.

(II) The extent to which the veteran can function safely and independently in the absence of such supervision, protection, or instruction.

(III) The amount of time required for the family caregiver to provide such supervision, protection, or instruction to the veteran.

(iv) [(iii)] If personal care services are not available from a commercial home health entity in the geographic area of an eligible veteran, the amount of the monthly personal caregiver stipend payable under the schedule required by clause (i) with respect to the eligible veteran shall be determined by taking into consideration the costs of commercial providers of personal care services in providing personal care services in geographic areas other than the geographic area of the eligible veteran with similar costs of living.

(D) In providing instruction, preparation, and training under subparagraph (A)(i)(I) and technical support under subparagraph (A)(i)(II) to each family caregiver who is approved as a provider of personal care services for an eligible veteran under paragraph (6), the Secretary shall periodically evaluate the needs of the eligible veteran and the skills of the family caregiver of such veteran to determine if additional instruction, preparation, training, or technical support under those subparagraphs is necessary.

* * * * * * *

(5) For each application submitted jointly by an eligible veteran and family member, the Secretary shall evaluate *(in collaboration*

with the primary care team for the eligible veteran to the maximum extent practicable)—

* * * * * * *

(11)(A) In providing assistance under this subsection to family caregivers of eligible veterans, the Secretary may enter into contracts, provider agreements, and memoranda of understanding with Federal agencies, States, and private, nonprofit, and other entities to provide such assistance to such family caregivers.

(B) The Secretary may provide assistance under this paragraph only if such assistance is reasonably accessible to the family caregiver and is substantially equivalent or better in quality to similar services provided by the Department.

(C) The Secretary may provide fair compensation to Federal agencies, States, and other entities that provide assistance under this paragraph.

* * * * * * *

(d) DEFINITIONS.—In this section:

* * * * * * *

(4) * * *

(A) Assistance with one or more [independent] activities of daily living.

(B) Supervision or protection based on symptoms or residuals of neurological or other impairment or injury.

(C) Regular or extensive instruction or supervision without which the ability of the veteran to function in daily life would be seriously impaired.

(D) [(B)] Any other non-institutional extended care (as such term is used in section 1701(6)(E) of this title).

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Subchapter V. Payments to State Homes

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SEC. 1745. NURSING HOME CARE AND MEDICATIONS FOR VETERANS WITH SERVICE-CONNECTED DISABILITIES

(a)(1) The Secretary shall enter into [a contract (or agreement under section 1720(c)(1) of this title)] *an agreement* with each State home for payment by the Secretary for nursing home care provided in the home, in any case in which such care is provided to any veteran as follows:

* * * * * * *

(2) Payment under each [contract (or agreement)] *agreement* between the Secretary and a State home under paragraph (1) shall be based on a methodology, developed by the Secretary in consultation with the State home, to adequately reimburse the State home for the care provided by the State home under the [contract (or agreement)] *agreement*.

(3) * * *

(4)(A) An agreement under paragraph (1) may be entered into without regard to any law that would require the Secretary to use competitive procedures in selecting the party with which to enter into the agreement.

(B)(i) Except as provided in clause (ii) and unless otherwise provided in this section or regulations prescribed pursuant to this section, a State home that enters into an agreement under paragraph (1) is not subject to, in the carrying out of the agreement, any law that a provider described in subparagraph (C) is not 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.) or the Medicaid program under title XIX of such Act (42 U.S.C. 1396 et seq.).

(ii) Notwithstanding clause (i), a State home that enters into an agreement under paragraph (1) shall be subject to all laws regarding integrity, ethics, fraud, or that subject a person to civil or criminal penalties as if such laws were incorporated into its provider agreements.

(C) A provider described in this subparagraph is one of the following:

(i) A provider of services that has enrolled and entered into a provider agreement under section 1866(a) of the Social Security Act (42 U.S.C. 1395cc(a)).

(ii) A physician or supplier that has enrolled and entered into a participation agreement under section 1842(h) of such Act (42 U.S.C. 1395u(h)).

(iii) A provider of items and services receiving payment under a State plan under title XIX of such Act (42 U.S.C. 1396 et seq.) or a waiver of such a plan.

(5) The Secretary may not furnish nursing home care under an agreement entered into under paragraph (1) after the date that is two years after the date of the enactment of the Jason Simcakoski Memorial Act.

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Chapter 20. Benefits for Homeless Veterans

SUBCHAPTER I. PURPOSE; DEFINITIONS; ADMINISTRATIVE MATTERS

Sec.

* * * * * * *

SUBCHAPTER II. COMPREHENSIVE SERVICE PROGRAMS

2011. Grants.

2012. Per diem payments.

2013. Program to improve retention of housing by formerly homeless veterans and veterans at risk of becoming homeless.

2014 ⟦2013⟧. Authorization of appropriations.

SUBCHAPTER III. TRAINING AND OUTREACH

* * * * * * *

2022. Coordination of outreach services for veterans at risk of homelessness.

2022A. Partnerships with public and private entities to provide legal services to homeless veterans and veterans at risk of homelessness.

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SUBCHAPTER VII. OTHER PROVISIONS

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Subchapter I. Purpose; Definitions; Administrative Matters

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SEC. 2002. DEFINITIONS

In this chapter:

(1) The term "homeless veteran" means a veteran who is homeless (as that term is defined [in section 103(a) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302(a))] *in subsection (a) or (b) of section 103 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11302)*).

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Subchapter II. Comprehensive Service Programs

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SEC. 2012. PER DIEM PAYMENTS

(a) PER DIEM PAYMENTS FOR FURNISHING SERVICES TO HOMELESS VETERANS.—(1) Subject to the availability of appropriations provided for such purpose *and except as otherwise provided in this section*, the Secretary, pursuant to such criteria as the Secretary shall prescribe, shall provide to a recipient of a grant under section 2011 of this title (or an entity eligible to receive a grant under that section which after November 10, 1992, establishes a program that the Secretary determines carries out the purposes described in that section) per diem payments for services furnished to any homeless veteran—

* * * * * * *

(2)(A) [The rate] *Except as otherwise provided in subparagraph (B), the rate* for such per diem payments shall be the daily cost of care estimated by the grant recipient or eligible entity adjusted by the Secretary [under subparagraph (B). In no case may the rate determined under this paragraph exceed the rate authorized for State homes for domiciliary care under subsection (a)(1)(A) of section 1741 of this title, as the Secretary may increase from time to time under subsection (c) of that section.] *under subparagraph (C).*

(B)(i) Except as provided in clause (ii), in no case may the rate determined under this paragraph exceed the rate authorized for State homes for domiciliary care under subsection (a)(1)(A) of section 1741 of this title, as the Secretary may increase from time to time under subsection (c) of that section.

(ii) In the case of services furnished to a homeless veteran who is placed in housing that will become permanent housing for the veteran upon termination of the furnishing of such services to such veteran, the maximum rate of per diem authorized under this section is 150 percent of the rate described in clause (i).

(C) [(B)] The Secretary shall adjust the rate estimated by the grant recipient or eligible entity under subparagraph (A) to exclude other sources of income described [in subparagraph (D)] *in subparagraph (E)* that the grant recipient or eligible entity certifies to be correct.

(D) [(C)] Each grant recipient or eligible entity shall provide to the Secretary such information with respect to other sources of income as the Secretary may require to make the adjustment [under subparagraph (B)] *under subparagraph (C)*.

(E) [(D)] The other sources of income referred to [in subparagraphs (B) and (C)] *in subparagraphs (C) and (D)* are payments to the grant recipient or eligible entity for furnishing services to homeless veterans under programs other than under this subchapter, including payments and grants from other departments and agencies of the United States, from departments or agencies of State or local government, and from private entities or organizations.

* * * * * * *

(e) REVIEW AND CONDITIONAL RENEWAL.—(1) Each year, the Secretary shall review each grant recipient and eligible entity that received a per diem payment under this section for a service furnished to a veteran during the one-year period preceding the review to evaluate the performance of the grant recipient or eligible entity during that period with respect to—

(A) the success of the grant recipient or eligible entity in assisting veterans to obtain, transition into, and retain permanent housing; and

(B) increasing the income of veterans, whether by helping veterans obtain employment or by helping veterans obtain income-related benefits to which such veterans may be eligible or entitled.

(2) For any grant recipient or eligible entity whose performance was evaluated for a year under paragraph (1), the Secretary may only provide per diem under this section to that grant recipient or eligible entity in the following year if the Secretary determines that such performance merits continued receipt of per diem under this section.

(3) The Secretary shall establish uniform performance targets throughout the United States for all grant recipients and eligible entities that receive per diem payments under this section for purposes of evaluating the performance of each such grant recipient and eligible entity under this subsection.

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SEC. 2013. PROGRAM TO IMPROVE RETENTION OF HOUSING BY FORMERLY HOMELESS VETERANS AND VETERANS AT RISK OF BECOMING HOMELESS

(a) PROGRAM REQUIRED.—The Secretary shall carry out a program under which the Secretary shall provide case management services to improve the retention of housing by veterans who were previously homeless and are transitioning to permanent housing and veterans who are at risk of becoming homeless.

(b) GRANTS.—(1) The Secretary shall carry out the program through the award of grants.

(2)(A) In awarding grants under paragraph (1), the Secretary shall give priority to organizations that demonstrate a capability to provide case management services as described in subsection (a), particularly organizations that are successfully providing or have

successfully provided transitional housing services using amounts provided by the Secretary under sections 2012 and 2061 of this title.

(B) In giving priority under subparagraph (A), the Secretary shall give extra priority to an organization described in such subparagraph that—

(i) voluntarily stops receiving amounts provided by the Secretary under sections 2012 and 2061 of this title; and

(ii) converts a facility that the organization used to provide transitional housing services into a facility that the organization uses to provide permanent housing that meets housing quality standards established under section 8(o)(8)(B) of the United States Housing Act of 1937 (42 U.S.C. 1437f(o)(8)(B)).

(C) In any case in which a facility, with respect to which a person received a grant for construction, rehabilitation, or acquisition under section 2011 of this title, is converted as described in subparagraph (B)(ii), such conversion shall be considered to have been carried out pursuant to the needs of the Department and such person shall not be considered in non-compliance with the terms of such grant by reason of such conversion.

SEC. *2014* [2013]. AUTHORIZATION OF APPROPRIATIONS

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Subchapter III. Training and Outreach

SEC. 2021. HOMELESS VETERANS REINTEGRATION PROGRAMS

(a) IN GENERAL.—Subject to the availability of appropriations provided for such purpose, the Secretary of Labor shall conduct, directly or through grant or contract, such programs as the Secretary determines appropriate to provide job training, counseling, and placement services (including job readiness and literacy and skills training) to expedite the [reintegration of homeless veterans into the labor force.] *reintegration into the labor force of—*

(1) homeless veterans;

(2) veterans participating in the Department of Veterans Affairs supported housing program for which rental assistance is provided pursuant to section 8(o)(19) of the United States Housing Act of 1937 (42 U.S.C. 1437f(o)(19));

(3) Indians who are veterans and receiving assistance under the Native American Housing Assistance and Self Determination Act of 1996 (25 U.S.C. 4101 et seq.); and

(4) veterans who are transitioning from being incarcerated.

* * * * * * *

SEC. 2022A. PARTNERSHIPS WITH PUBLIC AND PRIVATE ENTITIES TO PROVIDE LEGAL SERVICES TO HOMELESS VETERANS AND VETERANS AT RISK OF HOMELESSNESS

(a) PARTNERSHIPS AUTHORIZED.—Subject to the availability of funds for that purpose, the Secretary may enter into partnerships with public or private entities to fund a portion of the general legal services specified in subsection (c) that are provided by such entities to homeless veterans and veterans at risk of homelessness.

(b) LOCATIONS.—(1) The Secretary shall ensure that, to the extent practicable, partnerships under this section are made with entities equitably distributed across the geographic regions of the United

States, including rural communities, tribal lands of the United States, Native Americans, and tribal organizations.

(2) In this subsection, the terms "Native American" and "tribal organization" have the meanings given such terms in section 3765 of this title.

(c) LEGAL SERVICES.—Legal services specified in this subsection include legal services provided by public or private entities that address the needs of homeless veterans and veterans at risk of homelessness, such as the following:

(1) Legal services related to housing, including eviction defense and representation in landlord-tenant cases.

(2) Legal services related to family law, including assistance in court proceedings for child support, divorce, and estate planning.

(3) Legal services related to income support, including assistance in obtaining public benefits.

(4) Legal services related to criminal defense, including defense in matters symptomatic of homelessness, such as outstanding warrants, fines, and driver's license revocation, to reduce recidivism and facilitate the overcoming of reentry obstacles in employment or housing.

(d) CONSULTATION.—In developing and carrying out partnerships under this section, the Secretary shall, to the extent practicable, consult with public and private entities—

(1) for assistance in identifying and contacting organizations described in subsection (c); and

(2) to coordinate appropriate outreach relationships with such organizations.

(e) REPORTS.—The Secretary may require entities that have entered into partnerships under this section to submit to the Secretary periodic reports on legal services provided to homeless veterans and veterans at risk of homelessness pursuant to such partnerships.

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Subchapter VII. Other Provisions

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SEC. 2062. DENTAL CARE

(a) * * *

* * * * * * *

[(b) ELIGIBLE VETERANS.—Subsection (a) applies to a veteran—

[(1) who is enrolled for care under section 1705(a) of this title; and

[(2) who, for a period of 60 consecutive days, is receiving care (directly or by contract) in any of the following settings:

[(A) A domiciliary under section 1710 of this title.

[(B) A therapeutic residence under section 2032 of this title.

[(C) Community residential care coordinated by the Secretary under section 1730 of this title.

[(D) A setting for which the Secretary provides funds for a grant and per diem provider.

[(3) For purposes of paragraph (2), in determining whether a veteran has received treatment for a period of 60 consecutive days, the Secretary may disregard breaks in the continuity of treatment for which the veteran is not responsible.]

(b) ELIGIBLE VETERANS.—(1) Subsection (a) applies to a veteran who—

(A) is enrolled for care under section 1705(a) of this title; and

(B) for a period of 60 consecutive days, is receiving—

(i) assistance under section 8(o) of the United States Housing Act of 1937 (42 U.S.C. 1437f(o)); or

(ii) care (directly or by contract) in any of the following settings:

(I) A domiciliary under section 1710 of this title.

(II) A therapeutic residence under section 2032 of this title.

(III) Community residential care coordinated by the Secretary under section 1730 of this title.

(IV) A setting for which the Secretary provides funds for a grant and per diem provider.

(2) For purposes of paragraph (1), in determining whether a veteran has received assistance or care for a period of 60 consecutive days, the Secretary may disregard breaks in the continuity of assistance or care for which the veteran is not responsible.

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[SEC. 2065. ANNUAL REPORT ON ASSISTANCE TO HOMELESS VETERANS

[(a) ANNUAL REPORT.—Not later than June 15 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the activities of the Department during the calendar year preceding the report under programs of the Department under this chapter and other programs of the Department for the provision of assistance to homeless veterans.

[(b) GENERAL CONTENTS OF REPORT.—Each report under subsection (a) shall include the following:

[(1) The number of homeless veterans provided assistance under the programs referred to in subsection (a).

[(2) The cost to the Department of providing such assistance under those programs.

[(3) The Secretary's evaluation of the effectiveness of the programs of the Department in providing assistance to homeless veterans, including—

[(A) residential work-therapy programs;

[(B) programs combining outreach, community-based residential treatment, and case-management; and

[(C) contract care programs for alcohol and drug-dependence or use disabilities.

[(4) The Secretary's evaluation of the effectiveness of programs established by recipients of grants under section 2011 of this title and a description of the experience of those recipients in applying for and receiving grants from the Secretary of Housing and Urban Development to serve primarily homeless persons who are veterans.

[(5) Information on the efforts of the Secretary to coordinate the delivery of housing and services to homeless veterans with other Federal departments and agencies, including—

[(A) the Department of Defense;

[(B) the Department of Health and Human Services;

[(C) the Department of Housing and Urban Development;

[(D) the Department of Justice;

[(E) the Department of Labor;

[(F) the Interagency Council on Homelessness;

[(G) the Social Security Administration; and

[(H) any other Federal department or agency with which the Secretary coordinates the delivery of housing and services to homeless veterans.

[(6) Any other information on those programs and on the provision of such assistance that the Secretary considers appropriate.

[(c) HEALTH CARE CONTENTS OF REPORT.—Each report under subsection (a) shall include, with respect to programs of the Department addressing health care needs of homeless veterans, the following:

[(1) Information about expenditures, costs, and workload under the program of the Department known as the Health Care for Homeless Veterans program (HCHV).

[(2) Information about the veterans contacted through that program.

[(3) Information about program treatment outcomes under that program.

[(4) Information about supported housing programs.

[(5) Information about the Department's grant and per diem provider program under subchapter II of this chapter.

[(6) The findings and conclusions of the assessments of the medical needs of homeless veterans conducted under section 2034(b) of this title.

[(7) Other information the Secretary considers relevant in assessing those programs.

[(d) BENEFITS CONTENT OF REPORT.—Each report under subsection (a) shall include, with respect to programs and activities of the Veterans Benefits Administration in processing of claims for benefits of homeless veterans during the preceding year, the following:

[(1) Information on costs, expenditures, and workload of Veterans Benefits Administration claims evaluators in processing claims for benefits of homeless veterans.

[(2) Information on the filing of claims for benefits by homeless veterans.

[(3) Information on efforts undertaken to expedite the processing of claims for benefits of homeless veterans.

[(4) Other information that the Secretary considers relevant in assessing the programs and activities.]

* * * * * * *

SEC. 2067. NATIONAL CENTER ON HOMELESSNESS AMONG VETERANS

(a) IN GENERAL.—(1) The Secretary shall establish and operate a center to carry out the functions described in subsection (b).

(2) The center established under paragraph (1) shall be known as the "National Center on Homelessness Among Veterans".

(3) To the degree practicable, the Secretary shall operate the center established under paragraph (1) independently of the other programs of the Department that address homelessness among veterans.

(b) FUNCTIONS.—The functions described in this subsection are as follows:

(1) To carry out and promote research into the causes and contributing factors to veteran homelessness.

(2) To assess the effectiveness of programs of the Department to meet the needs of homeless veterans.

(3) To identify and disseminate best practices with regard to housing stabilization, income support, employment assistance, community partnerships, and such other matters as the Secretary considers appropriate with respect to addressing veteran homelessness.

(4) To integrate evidence-based and best practices, policies, and programs into programs of the Department for homeless veterans and veterans at risk of homelessness and to ensure that the staff of the Department and community partners can implement such practices, policies, and programs.

(5) To serve as a resource center for, and promote and seek to coordinate the exchange of information regarding, all research and training activities carried out by the Department and by other Federal and non-Federal entities with respect to veteran homelessness.

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Part III. Readjustment and Related Benefits

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Chapter 33. Post-9/11 Educational Assistance

SUBCHAPTER I. DEFINITIONS

Sec.

* * * * * * *

SUBCHAPTER III. ADMINISTRATIVE PROVISIONS

* * * * * * *

3326. Election to receive educational assistance.

Subchapter I. Definitions

SEC. 3301. DEFINITIONS

In this chapter:

(1) * * *

(A) * * *

(B) In the case of members of the reserve components of the Armed Forces, service on active duty under a call or order to active duty under section 688, 12301(a), 12301(d), 12301(g), *12301(h),* 12302, or 12304 of title 10 or section 712 of title 14.

* * * * * * *

Subchapter II. Educational Assistance

* * * * * * *

SEC. 3312. EDUCATIONAL ASSISTANCE: DURATION.

* * * * * * *

(d) DISCONTINUATION OF EDUCATION DUE TO CLOSURE OF EDUCATIONAL INSTITUTION.—

(1) IN GENERAL.—Any payment of educational assistance described in paragraph (2) shall not—

(A) be charged against any entitlement to educational assistance of the individual concerned under this chapter; or

(B) be counted against the aggregate period for which section 3695 of this title limits the individual's receipt of educational assistance under this chapter.

(2) DESCRIPTION OF PAYMENT OF EDUCATIONAL ASSISTANCE.—Subject to paragraph (3), the payment of educational assistance described in this paragraph is the payment of such assistance to an individual for pursuit of a course or courses under this chapter if the Secretary finds that the individual—

(A) was forced to discontinue such course pursuit as a result of a permanent closure of an educational institution; and

(B) did not receive credit, or lost training time, toward completion of the program of education being pursued at the time of such closure.

(3) PERIOD FOR WHICH PAYMENT NOT CHARGED.—The period for which, by reason of this subsection, educational assistance is not charged against entitlement or counted toward the applicable aggregate period under section 3695 of this title shall not exceed the aggregate of—

(A) the portion of the period of enrollment in the course or courses from which the individual failed to receive credit or with respect to which the individual lost training time, as determined under paragraph (2)(B), and

(B) the period by which a monthly stipend is extended under section 3680(a)(2)(B) of this title.

* * * * * * *

SEC. 3317. PUBLIC-PRIVATE CONTRIBUTIONS FOR ADDITIONAL EDUCATIONAL ASSISTANCE

(a) ESTABLISHMENT OF PROGRAM.—In instances where the educational assistance provided pursuant to section 3313(c)(1)(A) does not cover the full cost of established charges (as specified in section 3313), the Secretary shall carry out a program under which colleges and universities can, voluntarily, enter into an agreement with the Secretary to cover a portion of those established charges not otherwise covered under section 3313(c)(1)(A), which contribu-

tions shall be matched by equivalent contributions toward such costs by the Secretary. The program shall only apply to covered individuals described [in paragraphs (1) and (2)] *in paragraphs (1), (2), and (9)* of section 3311(b).

* * * * * * *

SEC. 3319. AUTHORITY TO TRANSFER UNUSED EDUCATION BENEFITS TO FAMILY MEMBERS

* * * * * * *

(b) * * *

(1) [six years] *ten years* of service in the Armed Forces and enters into an agreement to serve at least [four more years] *two more years* as a member of the uniformed services; or

* * * * * * *

(g) * * *

(1) * * *

(A) [six years] *ten years* of service in the Armed Forces; or

* * * * * * *

(h) * * *

* * * * * * *

(3) * * *

(A) * * *

(B) in the case of a child, at the same rate as such entitlement would otherwise be payable under this chapter to the individual making the transfer as if the individual were not on active duty, *except that the amount of the monthly stipend described in subsection (c)(1)(B) or (g)(3)(A)(ii) of section 3313, as the case may be, shall be payable in an amount equal to 50 percent of the amount of such stipend that would otherwise be payable under this chapter to the individual making the transfer*.

* * * * * * *

(5) * * *

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(B) Primary caregivers of seriously injured members of the [armed forces] *Armed Forces* and veterans.—

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Subchapter III. Administrative Provisions

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SEC. 3326. ELECTION TO RECEIVE EDUCATIONAL ASSISTANCE

(a) INDIVIDUALS ELIGIBLE TO ELECT PARTICIPATION IN POST–9/11 EDUCATIONAL ASSISTANCE.—An individual may elect to receive educational assistance under this chapter if such individual—

(1) as of August 1, 2009—

(A) is entitled to basic educational assistance under chapter 30 of this title and has used, but retains unused, entitlement under that chapter;

(B) is entitled to educational assistance under chapter 107, 1606, or 1607 of title 10 and has used, but retains unused, entitlement under the applicable chapter;

(C) is entitled to basic educational assistance under chapter 30 of this title but has not used any entitlement under that chapter;

(D) is entitled to educational assistance under chapter 107, 1606, or 1607 of title 10 but has not used any entitlement under such chapter;

(E) is a member of the Armed Forces who is eligible for receipt of basic educational assistance under chapter 30 this title and is making contributions toward such assistance under section 3011(b) or 3012(c) of this title; or

(F) is a member of the Armed Forces who is not entitled to basic educational assistance under chapter 30 of this title by reason of an election under section 3011(c)(1) or 3012(d)(1) of this title; and

(2) as of the date of the individual's election under this paragraph, meets the requirements for entitlement to educational assistance under this chapter.

(b) CESSATION OF CONTRIBUTIONS TOWARD GI BILL.—Effective as of the first month beginning on or after the date of an election under subsection (a) of an individual described by paragraph (1)(E) of that subsection, the obligation of the individual to make contributions under section 3011(b) or 3012(c) of this title, as applicable, shall cease, and the requirements of such section shall be deemed to be no longer applicable to the individual.

(c) REVOCATION OF REMAINING TRANSFERRED ENTITLEMENT.—

(1) ELECTION TO REVOKE.—If, on the date an individual described in paragraph (1)(A) or (1)(C) of subsection (a) makes an election under that subsection, a transfer of the entitlement of the individual to basic educational assistance under section 3020 of this title is in effect and a number of months of the entitlement so transferred remain unutilized, the individual may elect to revoke all or a portion of the entitlement so transferred that remains unutilized.

(2) AVAILABILITY OF REVOKED ENTITLEMENT.—Any entitlement revoked by an individual under this paragraph shall no longer be available to the dependent to whom transferred, but shall be available to the individual instead for educational assistance under chapter 33 of this title in accordance with the provisions of this section.

(3) AVAILABILITY OF UNREVOKED ENTITLEMENT.—Any entitlement described in paragraph (1) that is not revoked by an individual in accordance with that paragraph shall remain available to the dependent or dependents concerned in accordance with the current transfer of such entitlement under section 3020 of this title.

(d) POST–9/11 EDUCATIONAL ASSISTANCE.—

(1) IN GENERAL.—Subject to paragraph (2) and except as provided in subsection (e), an individual making an election under subsection (a) shall be entitled to educational assistance under this chapter in accordance with the provisions of this chapter, instead of basic educational assistance under chapter 30 of this

title, or educational assistance under chapter 107, 1606, or 1607 of title 10, as applicable.

(2) LIMITATION ON ENTITLEMENT FOR CERTAIN INDIVIDUALS.—In the case of an individual making an election under subsection (a) who is described by paragraph (1)(A) of that subsection, the number of months of entitlement of the individual to educational assistance under this chapter shall be the number of months equal to—

(A) the number of months of unused entitlement of the individual under chapter 30 of this title, as of the date of the election, plus

(B) the number of months, if any, of entitlement revoked by the individual under subsection (c)(1).

(e) CONTINUING ENTITLEMENT TO EDUCATIONAL ASSISTANCE NOT AVAILABLE UNDER 9/11 ASSISTANCE PROGRAM.—

(1) IN GENERAL.—In the event educational assistance to which an individual making an election under subsection (a) would be entitled under chapter 30 of this title, or chapter 107, 1606, or 1607 of title 10, as applicable, is not authorized to be available to the individual under the provisions of this chapter the individual shall remain entitled to such educational assistance in accordance with the provisions of the applicable chapter.

(2) CHARGE FOR USE OF ENTITLEMENT.—The utilization by an individual of entitlement under paragraph (1) shall be chargeable against the entitlement of the individual to educational assistance under this chapter at the rate of one month of entitlement under this chapter for each month of entitlement utilized by the individual under paragraph (1) (as determined as if such entitlement were utilized under the provisions of chapter 30 of this title, or chapter 107, 1606, or 1607 of title 10, as applicable).

(f) ADDITIONAL POST–9/11 ASSISTANCE FOR MEMBERS HAVING MADE CONTRIBUTIONS TOWARD GI BILL.—

(1) ADDITIONAL ASSISTANCE.—In the case of an individual making an election under subsection (a) who is described by subparagraph (A), (C), or (E) of paragraph (1) of that subsection, the amount of educational assistance payable to the individual under this chapter as a monthly stipend payable under paragraph (1)(B) of section 3313(c) of this title, or under paragraphs (2) through (7) of that section (as applicable), shall be the amount otherwise payable as a monthly stipend under the applicable paragraph increased by the amount equal to—

(A) the total amount of contributions toward basic educational assistance made by the individual under section 3011(b) or 3012(c) of this title, as of the date of the election, multiplied by

(B) the fraction—

(i) the numerator of which is—

(I) the number of months of entitlement to basic educational assistance under chapter 30 of this title remaining to the individual at the time of the election; plus

(II) the number of months, if any, of entitlement under chapter 30 revoked by the individual under subsection (c)(1); and

(ii) the denominator of which is 36 months.

(2) MONTHS OF REMAINING ENTITLEMENT FOR CERTAIN INDIVIDUALS.—In the case of an individual covered by paragraph (1) who is described by subsection (a)(1)(E), the number of months of entitlement to basic educational assistance remaining to the individual for purposes of paragraph (1)(B)(i)(II) shall be 36 months.

(3) TIMING OF PAYMENT.—The amount payable with respect to an individual under paragraph (1) shall be paid to the individual together with the last payment of the monthly stipend payable to the individual under paragraph (1)(B) of section 3313(c) of this title, or under subsections (2) through (7) of that section (as applicable), before the exhaustion of the individual's entitlement to educational assistance under this chapter.

(g) CONTINUING ENTITLEMENT TO ADDITIONAL ASSISTANCE FOR CRITICAL SKILLS OR SPECIALITY AND ADDITIONAL SERVICE.—An individual making an election under subsection (a)(1) who, at the time of the election, is entitled to increased educational assistance under section 3015(d) of this title, or section 16131(i) of title 10, or supplemental educational assistance under subchapter III of chapter 30 of this title, shall remain entitled to such increased educational assistance or supplemental educational assistance in the utilization of entitlement to educational assistance under this chapter, in an amount equal to the quarter, semester, or term, as applicable, equivalent of the monthly amount of such increased educational assistance or supplemental educational assistance payable with respect to the individual at the time of the election.

(h) ALTERNATIVE ELECTION BY SECRETARY.—

(1) IN GENERAL.—In the case of an individual who, on or after January 1, 2016, submits to the Secretary an election under this section that the Secretary determines is clearly against the interests of the individual, or who fails to make an election under this section, the Secretary may make an alternative election on behalf of the individual that the Secretary determines is in the best interests of the individual.

(2) NOTICE.—If the Secretary makes an election on behalf of an individual under this subsection, the Secretary shall notify the individual by not later than seven days after making such election and shall provide the individual with a 30-day period, beginning on the date of the individual's receipt of such notice, during which the individual may modify or revoke the election made by the Secretary on the individual's behalf. The Secretary shall include, as part of such notice, a clear statement of why the alternative election made by the Secretary is in the best interests of the individual as compared to the election submitted by the individual. The Secretary shall provide the notice required under this paragraph by electronic means whenever possible.

(i) IRREVOCABILITY OF ELECTIONS.—An election under subsection (a) or (c)(1) is irrevocable.

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Chapter 36. Administration of Educational Benefits

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Subchapter I. State Approving Agencies

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SEC. 3672. APPROVAL OF COURSES

(a) * * *

(b)(1) * * *

(2)(A) Subject to sections 3675(b)(1) and (b)(2), 3680A, 3684, and 3696 of this title, [the following programs are deemed to be approved for purposes of this chapter:] *a program of education is deemed to be approved for purposes of this chapter if a State approving agency determines that the program is one of the following programs:*

(i) [An accredited] *Except as provided in subparagraph (C), an accredited* standard college degree program offered at a public or not-for-profit proprietary educational institution that is accredited by an agency or association recognized for that purpose by the Secretary of Education.

* * * * * * *

(C) A course that is described in both subparagraph (A)(i) of this paragraph and in paragraph (14) or (15) of section 3676(c) of this title shall not be deemed to be approved for purposes of this chapter unless—

(i) a State approving agency, or the Secretary when acting in the role of a State approving agency, determines that the course meets the applicable criteria in such paragraphs; or

(ii) the Secretary issues a waiver for such course under section 3676(f)(1) of this title.

* * * * * * *

SEC. 3675. APPROVAL OF ACCREDITED COURSES

(a)(1) [The Secretary or a State approving agency] *A State approving agency, or the Secretary when acting in the role of a State approving agency,* may approve accredited programs (including non-degree accredited programs) [offered by proprietary for-profit educational institutions] *not covered by section 3672 of this title* when—

* * * * * * *

(b) As a condition of approval under this section, [the Secretary or the State approving agency] *the State approving agency, or the Secretary when acting in the role of a State approving agency* must find the following:

(1) The educational institution keeps adequate records, as prescribed by [the Secretary or the State approving agency] *the State approving agency, or the Secretary when acting in the role of a State approving agency*, to show the progress and grades of the eligible person or veteran and to show that satisfactory standards relating to progress and conduct are enforced.

* * * * * * *

(3) The educational institution and its approved courses meet the criteria of paragraphs (1), (2), [and (3)] *(3), (14), (15), and (16)* of section 3676(c) of this title *(or, with respect to such paragraphs (14) and (15), the requirements under such paragraphs are waived pursuant to subsection (f)(1) of section 3676 of this title)*.

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SEC. 3676. APPROVAL OF NONACCREDITED COURSES

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(c) * * *

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(14) In the case of a course designed to prepare an individual for licensure or certification in a State, the course—

(A) meets any instructional curriculum licensure or certification requirements of such State; and

(B) in the case of a course designed to prepare an individual for licensure to practice law in a State, is accredited by an accrediting agency or association recognized by the Secretary of Education under subpart 2 of part H of title IV of the Higher Education Act of 1965 (20 U.S.C. 1099b).

(15) In the case of a course designed to prepare an individual for employment pursuant to standards developed by a board or agency of a State in an occupation that requires approval, licensure, or certification, the course—

(A) meets such standards; and

(B) in the case of a course designed to prepare an individual for licensure to practice law in a State, is accredited by an accrediting agency or association recognized by the Secretary of Education under subpart 2 of part H of title IV of the Higher Education Act of 1965 (20 U.S.C. 1099b).

(16) [(14)] Such additional criteria as may be deemed necessary by the State approving agency *if the Secretary, in consultation with the State approving agency and pursuant to regulations prescribed to carry out this paragraph, determines such criteria are necessary and treat public, private, and proprietary for-profit educational institutions equitably*.

* * * * * * *

(f)(1) The Secretary may waive the requirements of paragraph (14) or (15) of subsection (c) in the case of a course of education offered by an educational institution (either accredited or not accredited) if the Secretary determines all of the following:

(A) The course did not meet the requirements of such paragraph at any time during the two-year period preceding the date of the waiver.

(B) The waiver furthers the purposes of the educational assistance programs administered by the Secretary or would further the education interests of individuals eligible for assistance under such programs.

(C) The educational institution does not provide any commission, bonus, or other incentive payment based directly or indirectly on success in securing enrollments or financial aid to any persons or entities engaged in any student recruiting or admis-

sion activities or in making decisions regarding the award of student financial assistance, except for the recruitment of foreign students residing in foreign countries who are not eligible to receive Federal student assistance.

(2) Not later than 30 days after the date on which the Secretary issues a waiver under paragraph (1), the Secretary shall submit to Congress notice of such waiver and a justification for issuing such waiver.

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SEC. 3679. DISAPPROVAL OF COURSES

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(d) Notwithstanding any other provision of this chapter, the Secretary or the applicable State approving agency shall disapprove a course of education described in paragraph (14) or (15) of section 3676(c) of this title unless the educational institution providing the course of education—

(1) publicly discloses any conditions or additional requirements, including training, experience, or examinations, required to obtain the license, certification, or approval for which the course of education is designed to provide preparation; and

(2) makes each disclosure required by paragraph (1) in a manner that the Secretary considers prominent.

Subchapter II. Miscellaneous Provisions

SEC. 3680. PAYMENT OF EDUCATIONAL ASSISTANCE OR SUBSISTENCE ALLOWANCES

(a) PERIOD FOR WHICH PAYMENT MAY BE MADE.—**[**Payment of**]** *(1) Except as provided in paragraph (2), payment of* educational assistance or subsistence allowances to eligible veterans or eligible persons pursuing a program of education or training, other than a program by correspondence, in an educational institution under chapter 31, 34, or 35 of this title shall be paid as provided in this section and, as applicable, in section 3108, 3482, 3491, or 3532 of this title. Such payments shall be paid only for the period of such veterans' or persons' enrollment in, and pursuit of, such program, but no amount shall be paid—

(A) **[**(1)**]** to any eligible veteran or eligible person for any period when such veteran or person is not pursuing such veteran's or person's course in accordance with the regularly established policies and regulations of the educational institution, with the provisions of such regulations as may be prescribed by the Secretary pursuant to subsection (g) of this section, and with the requirements of this chapter or of chapter 34 or 35 of this title, but payment may be made for an actual period of pursuit of one or more unit subjects pursued for a period of time shorter than the enrollment period at the educational institution;

(B) **[**(2)**]** to any eligible veteran or person for auditing a course; or

(C) **[**(3)**]** to any eligible veteran or person for a course for which the grade assigned is not used in computing the require-

ments for graduation including a course from which the student withdraws unless—

(i) [(A)] the eligible veteran or person withdraws because he or she is ordered to active duty; or

(ii) [(B)] the Secretary finds there are mitigating circumstances, except that, in the first instance of withdrawal (without regard to withdrawals [described in subclause (A) of this clause] *described in clause (i)*) by the eligible veteran or person from a course or courses with respect to which the veteran or person has been paid assistance under this title, mitigating circumstances shall be considered to exist with respect to courses totaling not more than six semester hours or the equivalent thereof.

[Notwithstanding the foregoing, the Secretary may, subject to such regulations as the Secretary shall prescribe, continue to pay allowances to eligible veterans and eligible persons enrolled in courses set forth in clause (1) of this subsection during periods when schools are temporarily closed under an established policy based on an Executive order of the President or due to an emergency situation. However, the total number of weeks for which allowances may continue to be so payable in any 12-month period may not exceed 4 weeks.]

(2) Notwithstanding paragraph (1), the Secretary may, pursuant to such regulations as the Secretary shall prescribe, continue to pay allowances to eligible veterans and eligible persons enrolled in courses set forth in paragraph (1)(A)—

(A) during periods when schools are temporarily closed under an established policy based on an Executive order of the President or due to an emergency situation, except that the total number of weeks for which allowances may continue to be so payable in any 12-month period may not exceed four weeks; or

(B) solely for the purpose of awarding a monthly housing stipend described in section 3313 of this title, during periods following a permanent school closure, except that payment of such a stipend may only be continued until the earlier of—

(i) the date of the end of the term, quarter, or semester during which the school closure occurred; and

(ii) the date that is 4 months after the date of the school closure.

* * * * * * *

SEC. 3684. REPORTS BY VETERANS, ELIGIBLE PERSONS, AND INSTITUTIONS; REPORTING FEE

(a)(1) Except as provided in paragraph (2) of this subsection, the veteran or eligible person and the educational institution offering a course in which such veteran or eligible person is enrolled under chapter 31, *32, 33,* 34, 35, or 36 of this title shall, without delay, report to the Secretary, in the form prescribed by the Secretary, such enrollment and any interruption or termination of the education of each such veteran or eligible person. The date of such interruption or termination will be the last date of pursuit, or, in the case of correspondence training, the last date a lesson was serviced by a school.

* * * * * * *

(4) For purposes of this subsection, the term "educational institution" may include a group, district, or consortium of separately accredited educational institutions located in the same State that are organized in a manner that facilitates the centralized reporting of the enrollments in such group, district, or consortium of institutions.

* * * * * * *

SEC. 3693. COMPLIANCE SURVEYS

[(a) Except as provided in subsection (b) of this section, the Secretary shall conduct an annual compliance survey of each institution offering one or more courses approved for the enrollment of eligible veterans or persons if at least 300 veterans or persons are enrolled in such course or courses under provisions of this title or if any such course does not lead to a standard college degree. Such compliance survey shall be designed to ensure that the institution and approved courses are in compliance with all applicable provisions of chapters 30 through 36 of this title. The Secretary shall assign at least one education compliance specialist to work on compliance surveys in any year for each 40 compliance surveys required to be made under this section for such year.**]**

(a)(1)(A) Except as provided in subsection (b), the Secretary shall conduct an annual compliance survey of educational institutions and training establishments offering one or more courses approved for the enrollment of eligible veterans or persons if at least 20 such veterans or persons are enrolled in any such course.

(B) The Secretary shall—

(i) design the compliance surveys to ensure that such institutions or establishments, as the case may be, and approved courses are in compliance with all applicable provisions of chapters 30 through 36 of this title;

(ii) survey each such educational institution and training establishment not less than once during every two-year period; and

(iii) assign not fewer than one education compliance specialist to work on compliance surveys in any year for each 40 compliance surveys required to be made under this section for such year.

(2) The Secretary, in consultation with the State approving agencies, shall—

(A) annually determine the parameters of the surveys required under paragraph (1); and

(B) not later than September 1 of each year, make available to the State approving agencies a list of the educational institutions and training establishments that will be surveyed during the fiscal year following the date of making such list available.

(b) The Secretary may waive the requirement in **[**subsection (a) of this section for an annual compliance survey**]** *subsection (a)(1) for a compliance survey* with respect to an **[**institution**]** *educational institution or training establishment* if the Secretary determines, based on the **[**institution's demonstrated record of compliance**]** *record of compliance of such institution or establishment* with all the applicable provisions of chapters 30 through 36 of this title,

that the waiver would be appropriate and in the best interest of the United States Government.

(c) In this section, the terms "educational institution" and "training establishment" have the meaning given such terms in section 3452 of this title.

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Part IV. General Administrative Provisions

Chapter 51. Claims, Effective Dates, and Payments

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Subchapter I. Claims

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SEC. 5101. CLAIMS AND FORMS

(a)(1) [A specific] *(A) Except as provided in subparagraph (B), a specific* claim in the form prescribed by the Secretary (or jointly with the Commissioner of Social Security, as prescribed by section 5105 of this title) must be filed in order for benefits to be paid or furnished to any individual under the laws administered by the Secretary.

(B)(i) The Secretary may pay benefits under chapters 13 and 15 and sections 2302, 2307, and 5121 of this title to a survivor of a veteran who has not filed a formal claim if the Secretary determines that the record contains sufficient evidence to establish the entitlement of the survivor to such benefits.

(ii) For purposes of this subparagraph and section 5110 of this title, the date on which the Secretary is notified of the death of the veteran shall be treated as the date of the receipt of the survivor's application for benefits described in clause (i).

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Part V. Boards, Administrations, and Services

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Chapter 72. United States Court of Appeals for Veterans Claims

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Subchapter I. Organization and Jurisdiction

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SEC. 7253. COMPOSITION

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(i) ADDITIONAL TEMPORARY EXPANSION OF COURT.—(1) * * *

(2) Effective as of [January 1, 2013] *January 1, 2021*, an appointment may not be made to the Court if the appointment would

result in there being more judges of the Court than the authorized number of judges of the Court specified in subsection (a).

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Chapter 73. Veterans Health Administration—Organization and Functions

SUBCHAPTER I. ORGANIZATION

Sec.

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7309A. Pain management boards.
7309B. Office of Patient Advocacy.

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Subchapter I. Organization

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SEC. 7306. OFFICE OF THE UNDER SECRETARY FOR HEALTH

(a) * * *

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(4) Such Medical Directors *and Directors of Veterans Integrated Service Networks* as may be appointed to suit the needs of the Department[, who shall be either a qualified doctor of medicine or a qualified doctor of dental surgery or dental medicine].

* * * * * * *

SEC. 7309A. PAIN MANAGEMENT BOARDS

(a) ESTABLISHMENT.—The Secretary shall establish in each Veterans Integrated Service Network a Pain Management Board (in this section referred to as a "Board").

(b) ACTIVITIES.—(1) Each Board may—

(A) consult with health care professionals and other employees of the Department located in the Veterans Integrated Service Network covered by the Board, patients who are being treated at medical facilities of the Department located in such Veterans Integrated Service Network, and family members of such patients with respect to the pain management resources and best practices of the Department;

(B) oversee compliance by the health care professionals and other employees of the Department with the best practices of the Department, including by issuing recommendations to improve compliance with those best practices;

(C) provide oversight of the pain management practices of the pain management teams of each medical facility of the Department and the health care professionals and other employees of the Department that are located in the Veterans Integrated Service Network covered by the Board;

(D) host educational events, as the Board considers appropriate, for individuals specified in subparagraph (A) on pain management and treatment that may include the sharing of updated research and best practices from medical experts, other

health care systems, and such other Federal agencies as the Board considers necessary to carry out this subparagraph; and

(E) host public events, as the Board considers appropriate, during which health care professionals discuss and share best practices on pain management and complementary and integrative health.

(2)(A) Each Board may provide treatment recommendations for patients with complex clinical pain who are being treated at a medical facility of the Department located in the Veterans Integrated Service Network covered by the Board, and assist in facilitating communication between such patients and their health care providers, regardless of whether such treatment is on an in-patient or out-patient basis, and for whom a request for such recommendations, subject to subparagraph (C), has been made by an individual described in subparagraph (B).

(B) An individual described in this subparagraph is one of the following individuals:

(i) The patient.

(ii) The spouse of the patient.

(iii) A family member of the patient or another individual if such family member or individual has been designated by the patient to make health care decisions for the patient or to receive health care information with respect to the patient.

(iv) A physician of the patient.

(v) An employee of the medical facility of the Department described in subparagraph (A).

(C) An individual described in subparagraph (B) may not request treatment recommendations under subparagraph (A) unless the individual—

(i) has requested treatment recommendations from the pain management team of the medical facility of the Department at which the patient is receiving treatment; and

(ii) has received treatment recommendations from such team and is not satisfied with those treatment recommendations.

(D) Treatment recommendations provided under subparagraph (A) shall assist the patient and health care provider in determining the best treatment plan for the patient and shall not dictate the treatment plan used by the health care provider.

(3) Based on treatment recommendations developed under paragraph (2)(A), consultations conducted under paragraph (1)(A), and educational and public events hosted under subparagraphs (D) and (E) of paragraph (1), each Board may provide to health care professionals of the Department located in the Veterans Integrated Service Network covered by the Board recommendations on the best practices regarding pain management in cases of complex clinical pain.

(4)(A) Not later than January 31 of each year, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report that contains comprehensive information from each Board (with all personally identifiable information of patients redacted) on pain management practices carried out in the Veterans Integrated Service Network covered by the Board.

(B) Each report submitted by the Secretary under subparagraph (A) shall include, for the year preceding the submittal of the report—

(i) a summary and explanation of the treatment recommendations provided under paragraph 2(A) during such year; and

(ii) the recommendations for best practices provided to health care professionals under paragraph (3) during such year.

(5) The Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to any Board.

(c) MEMBERSHIP.—(1) Each Board shall include the following individuals appointed by the Secretary:

(A) A board certified pain medicine specialist.

(B) A trained and qualified member of the primary care team of a medical facility of the Department with experience in pain care, such as a nurse practitioner.

(C) A pain psychologist.

(D) A pain social worker.

(E) A clinical pharmacist.

(F) A pain point of contact for a Veterans Integrated Service Network.

(G) A physician with addiction and psychopharmacology expertise and experience.

(H) An allied health care professional.

(I) A clinician with expertise in complementary and integrative health.

(J) A clinical behavioral therapist.

(K) A patient advocate.

(L) A representative of the labor interests of employees of the Department who are responsible for prescribing drugs.

(M) Two current or former clinical patients who are representative of the demographic of patients served by the Veterans Integrated Service Network covered by the Board.

(N) A family member of a current or former clinical patient who is representative of the demographic of patients served by the Veterans Integrated Service Network covered by the Board.

(2) The Secretary shall determine the terms of service of the members of each Board, taking into consideration the clinical duties of members who are employees of the Department.

(3)(A) Members of each Board shall serve without pay and, except as provided in subparagraph (B), members who are full-time officers or employees of the United States may not receive additional pay, allowances, or benefits by reason of their service on the Board.

(B) Members may receive travel expenses, including per diem in lieu of subsistence, for travel in connection with their duties as members of the Board.

(C)(i) Except as provided in clause (ii), any member who has clinical duties as an officer or employee of the United States shall be relieved of such duties during periods in which such relief is necessary for the member to carry out the duties of the Board.

(ii) The Secretary shall ensure that carrying out the duties of the Board does not prevent any member who has clinical duties as an employee of the Department from furnishing direct clinical care as appropriate to maintain quality patient care.

(d) PARTICIPATION OF CERTAIN MEMBERS.—(1) In carrying out the activities of a Board under subsection (b), any member appointed under subsection (c)(1) solely based on qualifications under subparagraph (K), (L), (M), or (N) of subsection (c)(1)—

(A) may not have access to specific information identifying a patient and other confidential information relating to a patient; and

(B) except as provided in paragraph (2), may not participate in providing treatment recommendations under subsection (b)(2)(A).

(2) In carrying out the activities of the Board under subsection (b), a member appointed under subsection (c)(1) solely based on qualifications under subparagraph (K) of subsection (c)(1) may be present during the provision of treatment recommendations under subsection (b)(2)(A) with the consent and upon the request of the patient for which such treatment recommendations are provided for purposes of representing the interests of the patient.

(e) EMPLOYMENT PROTECTIONS.—No adverse personnel action may be made against an employee of the Department in connection with a communication by the employee with a member of a Board relating to the activities of the Board under subsection (b) and any such communication shall be covered by the employment and whistleblower protections otherwise applicable to communications by employees of the Department.

(f) RESOURCES OF DEPARTMENT.—The Secretary shall make available to each Board the resources and personnel of the Department necessary for the Board to carry out the activities of the Board under subsection (b), including resources and personnel of the General Counsel of the Department.

SEC. 7309B. OFFICE OF PATIENT ADVOCACY

(a) ESTABLISHMENT.—There is established in the Department within the Office of the Under Secretary for Health an office to be known as the "Office of Patient Advocacy" (in this section referred to as the "Office").

(b) HEAD.—(1) The Director of the Office of Patient Advocacy shall be the head of the Office.

(2) The Director of the Office of Patient Advocacy shall be appointed by the Under Secretary for Health from among individuals qualified to perform the duties of the position and shall report directly to the Under Secretary for Health.

(c) FUNCTION.—(1) The function of the Office is to carry out the Patient Advocacy Program of the Department.

(2) In carrying out the Patient Advocacy Program of the Department, the Director shall ensure that patient advocates of the Department—

(A) advocate on behalf of veterans with respect to health care received and sought by veterans under the laws administered by the Secretary;

(B) carry out the responsibilities specified in subsection (d); and

(C) receive training in patient advocacy.

(d) PATIENT ADVOCACY RESPONSIBILITIES.—The responsibilities of each patient advocate at a medical facility of the Department are the following:

(1) To resolve complaints by veterans with respect to health care furnished under the laws administered by the Secretary that cannot be resolved at the point of service or at a higher level easily accessible to the veteran.

(2) To present at various meetings and to various committees the issues experienced by veterans in receiving such health care at such medical facility.

(3) To express to veterans their rights and responsibilities as patients in receiving such health care.

(4) To manage the Patient Advocate Tracking System of the Department at such medical facility.

(5) To compile data at such medical facility of complaints made by veterans with respect to the receipt of such health care at such medical facility and the satisfaction of veterans with such health care at such medical facility to determine whether there are trends in such data.

(6) To ensure that a process is in place for the distribution of the data compiled under paragraph (5) to appropriate leaders, committees, services, and staff of the Department.

(7) To identify, not less frequently than quarterly, opportunities for improvements in the furnishing of such health care to veterans at such medical facility based on complaints by veterans.

(8) To ensure that any significant complaint by a veteran with respect to such health care is brought to the attention of appropriate staff of the Department to trigger an assessment of whether there needs to be a further analysis of the problem at the facility-wide level.

(9) To support any patient advocacy programs carried out by the Department.

(10) To ensure that all appeals and final decisions with respect to the receipt of such health care are entered into the Patient Advocate Tracking System of the Department.

(11) To understand all laws, directives, and other rules with respect to the rights and responsibilities of veterans in receiving such health care, including the appeals processes available to veterans.

(12) To ensure that veterans receiving mental health care, or the surrogate decision makers for such veterans, are aware of the rights of veterans to seek representation from systems established under section 103 of the Protection and Advocacy for Mentally Ill Individuals Act of 1986 (42 U.S.C. 10803) to protect and advocate the rights of individuals with mental illness and to investigate incidents of abuse and neglect of such individuals.

(13) To fulfill requirements established by the Secretary with respect to the inspection of controlled substances.

(14) To document potentially threatening behavior and report such behavior to appropriate authorities.

(e) TRAINING.—In providing training to patient advocates under subsection (c)(2)(C), the Director shall ensure that such training is consistent throughout the Department.

(f) CONTROLLED SUBSTANCE DEFINED.—In this section, the term "controlled substance" has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

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Chapter 74. Veterans Health Administration—Personnel

SUBCHAPTER I. APPOINTMENTS

Sec.

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SUBCHAPTER VII. PAY FOR MEDICAL DIRECTORS AND DIRECTORS OF VETERANS INTEGRATED SERVICE NETWORKS

7481. Pay for Medical Directors and Directors of Veterans Integrated Service Networks.

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Subchapter II. Collective Bargaining and Personnel Administration

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SEC. 7423. PERSONNEL ADMINISTRATION: FULL-TIME EMPLOYEES

(a)(1) Except as provided in paragraph (2), the hours [(a) The hours] of employment in carrying out responsibilities under this title of any employee who is appointed in the Administration under any provision of this chapter on a full-time basis in a position listed in section 7421(b) of this title (other than an intern or resident appointed pursuant to section 7406 of this title) and who accepts responsibilities for carrying out professional services for remuneration other than those assigned under this title shall consist of not less than 80 hours in a biweekly pay period (as that term is used in section 5504 of title 5).

(2) The Secretary may modify the hours of employment for a physician or physician assistant appointed in the Administration under any provision of this chapter on a full-time basis to be more than or less than 80 hours in a biweekly pay period if the total hours of employment for such employee in a calendar year does not exceed 2,080 hours.

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SEC. 7451. NURSES AND OTHER HEALTH-CARE PERSONNEL: COMPETITIVE PAY

(a)(1) * * *

(2) * * *

(A) Registered nurse.

(B) Physician assistant.

(C) [(B)] Such positions referred to in paragraphs (1) and (3) of section 7401 of this title (other than the positions of physician, dentist, [and registered nurse] *registered nurse, and physician assistant)* as the Secretary may determine upon the recommendation of the Under Secretary for Health.

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Subchapter VII. Pay For Medical Directors and Directors of Veterans Integrated Service Networks

SEC. 7481. PAY FOR MEDICAL DIRECTORS AND DIRECTORS OF VETERANS INTEGRATED SERVICE NETWORKS

(a) ELEMENTS OF PAY.—Pay for a Medical Director or Director of a Veterans Integrated Service Network appointed under section 7306(a)(4) of this title (in this section referred to as a "Director") shall consist of basic pay set forth under section 7404(a) of this title and market pay determined under subsection (b).

(b) MARKET PAY.—(1) Each Director is eligible for market pay determined under this subsection.

(2) The amount of market pay payable to a Director under this section shall be determined by the Secretary on a case-by-case basis and shall consist of pay intended to reflect needs of the Department with respect to the recruitment and retention (as determined by the Secretary) of such Director.

(3) In determining the amount of market pay payable to a Director under this section, the Secretary shall—

(A) consult not less than two national surveys on pay for hospital directors, medical facility directors, or other similar positions, whether prepared by private, public, or quasi-public entities, to make a general assessment of the range of potential pay for the Director; and

(B) take into account—

(i) the experience of the Director in managing facilities or program offices of the Department, including the complexity of such facilities or offices;

(ii) the complexity of the facility or facilities to be managed by the Director;

(iii) the labor market, in such geographic area as the Secretary considers relevant, for hospital directors, medical facility directors, and other similar positions;

(iv) the experience of the Director in managing medical facilities for other Federal agencies, private entities, or nonprofit entities; and

(v) such other considerations as the Secretary considers appropriate.

(4)(A) The Secretary shall evaluate the amount of market pay payable to a Director under this section not less frequently than once every two years and may adjust the market pay payable to such Director as a result of such evaluation.

(B) A Director whose market pay is evaluated under subparagraph (A) shall receive written notice of the results of such evaluation.

(c) REQUIREMENTS AND LIMITATIONS ON TOTAL PAY.—(1) Not less frequently than once every two years, the Secretary shall set forth a Department-wide minimum and maximum amount for total annual pay under subsection (a) that may be paid to a Director and shall publish each such amount in the Federal Register.

(2) The minimum and maximum amounts set forth under paragraph (1) shall take effect not earlier than the date that is 60 days after the publication of such amounts under such paragraph.

(3) The sum of the basic pay set forth under section 7404(a) of this title and market pay determined under subsection (b) for a Director for a calendar year—

(A) may not be less than the most recent minimum amount set forth under paragraph (1) before the beginning of such calendar year; and

(B) may not be more than the most recent maximum amount set forth under such paragraph before the beginning of such calendar year.

(4) The total amount of compensation paid to a Director under this title in any calendar year may not exceed the amount of annual compensation (excluding expenses) of the President under section 102 of title 3.

(5) The Secretary may not delegate to an officer or employee of the Department the requirement of the Secretary to set forth a Department-wide minimum and maximum amount under paragraph (1).

(d) TREATMENT OF PAY.—Pay under this section shall be considered pay for all purposes, including retirement benefits under chapters 83 and 84 of title 5 and other benefits.

(e) ANCILLARY EFFECTS OF DECREASES IN PAY.—(1) A decrease in pay of a Director resulting from an adjustment in the amount of market pay of the Director under subsection (b) shall not be treated as an adverse action.

(2) A decrease in the amount of pay of a Director resulting from an involuntary reassignment in connection with a disciplinary action taken against the Director is not subject to appeal or judicial review.

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Carl Levin and Howard P. "Buck" McKeon National Defense Authorization Act For Fiscal Year 2015

(Public Law 113-291; 37 U.S.C. 403 note)

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Division A—Department of Defense Authorizations

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Title VI—Compensation and Other Personnel Benefits

Subtitle A—Pay and Allowances

* * * * * * *

SEC. 604. MODIFICATION OF COMPUTATION OF BASIC ALLOWANCE FOR HOUSING INSIDE THE UNITED STATES.

(a) * * *

[(b) SPECIAL RULE.—Any reduction authorized by paragraph (3) of subsection (b) of section 403 of title 37, United States Code, as amended by subsection (a), shall not apply with respect to benefits paid by the Secretary of Veterans Affairs under the laws administered by the Secretary, including pursuant to sections 3108 and 3313 of title 38, United States Code. Such benefits that are determined in accordance with such section 403 shall be subject to paragraph (3) of such section as such paragraph was in effect on the day before the date of the enactment of this Act.]

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Caregivers and Veterans Omnibus Health Services Act of 2010

(Public Law 111–163; 38 U.S.C. 1720G note)

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Title I. Caregiver Support

SEC. 101. ASSISTANCE AND SUPPORT SERVICES FOR CAREGIVERS.

* * * * * * *

(c) ANNUAL EVALUATION REPORT.—

* * * * * * *

(2) * * *

(A) With respect to the program of comprehensive assistance for family caregivers required by subsection (a)(1) of such section 1720G and the program of general caregiver support services required by subsection (b)(1) of such section—

* * * * * * *

(iv) an assessment of the effectiveness and the efficiency of the implementation of such programs*, including a description of any barriers to accessing and receiving care and services under such programs*; and

* * * * * * *

(B) With respect to the program of comprehensive assistance for family caregivers required by such subsection (a)(1)—

(i) a description of the outreach activities carried out by the Secretary under such program[; and] *;*

(ii) an assessment of the manner in which resources are expended by the Secretary under such program, particularly with respect to the provision of monthly personal caregiver stipends under paragraph (3)(A)(ii)(v) of such subsection (a)[.] *; and*

(iii) an evaluation of the sufficiency and consistency of the training provided to family caregivers under

such program in preparing family caregivers to provide care to veterans under such program.

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Post–9/11 Veterans Educational Assistance Act of 2008

(Public Law 110–252; 38 U.S.C. 3301 note)

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SEC. 5003.

(a) EDUCATIONAL ASSISTANCE AUTHORIZED.—

* * * * * * *

[(c) APPLICABILITY TO INDIVIDUALS UNDER MONTGOMERY GI BILL PROGRAM.—

[(1) INDIVIDUALS ELIGIBLE TO ELECT PARTICIPATION IN POST–9/11 EDUCATIONAL ASSISTANCE.—An individual may elect to receive educational assistance under chapter 33 of title 38, United States Code (as added by subsection (a)), if such individual—

[(A) as of August 1, 2009—

[(i) is entitled to basic educational assistance under chapter 30 of title 38, United States Code, and has used, but retains unused, entitlement under that chapter;

[(ii) is entitled to educational assistance under chapter 107, 1606, or 1607 of title 10, United States Code, and has used, but retains unused, entitlement under the applicable chapter;

[(iii) is entitled to basic educational assistance under chapter 30 of title 38, United States Code, but has not used any entitlement under that chapter;

[(iv) is entitled to educational assistance under chapter 107, 1606, or 1607 of title 10, United States Code, but has not used any entitlement under such chapter;

[(v) is a member of the Armed Forces who is eligible for receipt of basic educational assistance under chapter 30 of title 38, United States Code, and is making contributions toward such assistance under section 3011(b) or 3012(c) of such title; or

[(vi) is a member of the Armed Forces who is not entitled to basic educational assistance under chapter 30 of title 38, United States Code, by reason of an election under section 3011(c)(1) or 3012(d)(1) of such title; and

[(B) as of the date of the individual's election under this paragraph, meets the requirements for entitlement to educational assistance under chapter 33 of title 38, United States Code (as so added).

[(2) CESSATION OF CONTRIBUTIONS TOWARD GI BILL.—Effective as of the first month beginning on or after the date of an

election under paragraph (1) of an individual described by subparagraph (A)(v) of that paragraph, the obligation of the individual to make contributions under section 3011(b) or 3012(c) of title 38, United States Code, as applicable, shall cease, and the requirements of such section shall be deemed to be no longer applicable to the individual.

[(3) REVOCATION OF REMAINING TRANSFERRED ENTITLEMENT.—

[(A) ELECTION TO REVOKE.—If, on the date an individual described in subparagraph (A)(i) or (A)(iii) of paragraph (1) makes an election under that paragraph, a transfer of the entitlement of the individual to basic educational assistance under section 3020 of title 38, United States Code, is in effect and a number of months of the entitlement so transferred remain unutilized, the individual may elect to revoke all or a portion of the entitlement so transferred that remains unutilized.

[(B) AVAILABILITY OF REVOKED ENTITLEMENT.—Any entitlement revoked by an individual under this paragraph shall no longer be available to the dependent to whom transferred, but shall be available to the individual instead for educational assistance under chapter 33 of title 38, United States Code (as so added), in accordance with the provisions of this subsection.

[(C) AVAILABILITY OF UNREVOKED ENTITLEMENT.—Any entitlement described in subparagraph (A) that is not revoked by an individual in accordance with that subparagraph shall remain available to the dependent or dependents concerned in accordance with the current transfer of such entitlement under section 3020 of title 38, United States Code.

[(4) POST–9/11 EDUCATIONAL ASSISTANCE.—

[(A) IN GENERAL.—Subject to subparagraph (B) and except as provided in paragraph (5), an individual making an election under paragraph (1) shall be entitled to educational assistance under chapter 33 of title 38, United States Code (as so added), in accordance with the provisions of such chapter, instead of basic educational assistance under chapter 30 of title 38, United States Code, or educational assistance under chapter 107, 1606, or 1607 of title 10, United States Code, as applicable.

[(B) LIMITATION ON ENTITLEMENT FOR CERTAIN INDIVIDUALS.—In the case of an individual making an election under paragraph (1) who is described by subparagraph (A)(i) of that paragraph, the number of months of entitlement of the individual to educational assistance under chapter 33 of title 38, United States Code (as so added), shall be the number of months equal to—

[(i) the number of months of unused entitlement of the individual under chapter 30 of title 38, United States Code, as of the date of the election, plus

[(ii) the number of months, if any, of entitlement revoked by the individual under paragraph (3)(A).

[(5) CONTINUING ENTITLEMENT TO EDUCATIONAL ASSISTANCE NOT AVAILABLE UNDER 9/11 ASSISTANCE PROGRAM.—

[(A) IN GENERAL.—In the event educational assistance to which an individual making an election under paragraph (1) would be entitled under chapter 30 of title 38, United States Code, or chapter 107, 1606, or 1607 of title 10, United States Code, as applicable, is not authorized to be available to the individual under the provisions of chapter 33 of title 38, United States Code (as so added), the individual shall remain entitled to such educational assistance in accordance with the provisions of the applicable chapter.

[(B) CHARGE FOR USE OF ENTITLEMENT.—The utilization by an individual of entitlement under subparagraph (A) shall be chargeable against the entitlement of the individual to educational assistance under chapter 33 of title 38, United States Code (as so added), at the rate of one month of entitlement under such chapter 33 for each month of entitlement utilized by the individual under subparagraph (A) (as determined as if such entitlement were utilized under the provisions of chapter 30 of title 38, United States Code, or chapter 107, 1606, or 1607 of title 10, United States Code, as applicable).

[(6) ADDITIONAL POST–9/11 ASSISTANCE FOR MEMBERS HAVING MADE CONTRIBUTIONS TOWARD GI BILL.—

[(A) ADDITIONAL ASSISTANCE.—In the case of an individual making an election under paragraph (1) who is described by clause (i), (iii), or (v) of subparagraph (A) of that paragraph, the amount of educational assistance payable to the individual under chapter 33 of title 38, United States Code (as so added), as a monthly stipend payable under paragraph (1)(B) of section 3313(c) of such title, or under paragraphs (2) through (7) of that section (as applicable), shall be the amount otherwise payable as a monthly stipend under the applicable paragraph increased by the amount equal to—

[(i) the total amount of contributions toward basic educational assistance made by the individual under section 3011(b) or 3012(c) of title 38, United States Code, as of the date of the election, multiplied by

[(ii) the fraction—

[(I) the numerator of which is—

[(aa) the number of months of entitlement to basic educational assistance under chapter 30 of title 38, United States Code, remaining to the individual at the time of the election; plus

[(bb) the number of months, if any, of entitlement under such chapter 30 revoked by the individual under paragraph (3)(A); and

[(II) the denominator of which is 36 months.

[(B) MONTHS OF REMAINING ENTITLEMENT FOR CERTAIN INDIVIDUALS.—In the case of an individual covered by subparagraph (A) who is described by paragraph (1)(A)(v), the number of months of entitlement to basic educational as-

sistance remaining to the individual for purposes of subparagraph (A)(ii)(I)(aa) shall be 36 months.

[(C) TIMING OF PAYMENT.—The amount payable with respect to an individual under subparagraph (A) shall be paid to the individual together with the last payment of the monthly stipend payable to the individual under paragraph (1)(B) of section 3313(c) of title 38, United States Code (as so added), or under paragraphs (2) through (7) of that section (as applicable), before the exhaustion of the individual's entitlement to educational assistance under chapter 33 of such title (as so added).

[(7) CONTINUING ENTITLEMENT TO ADDITIONAL ASSISTANCE FOR CRITICAL SKILLS OR SPECIALITY AND ADDITIONAL SERVICE.—An individual making an election under paragraph (1)(A) who, at the time of the election, is entitled to increased educational assistance under section 3015(d) of title 38, United States Code, or section 16131(i) of title 10, United States Code, or supplemental educational assistance under subchapter III of chapter 30 of title 38, United States Code, shall remain entitled to such increased educational assistance or supplemental educational assistance in the utilization of entitlement to educational assistance under chapter 33 of title 38, United States Code (as so added), in an amount equal to the quarter, semester, or term, as applicable, equivalent of the monthly amount of such increased educational assistance or supplemental educational assistance payable with respect to the individual at the time of the election.

[(8) IRREVOCABILITY OF ELECTIONS.—An election under paragraph (1) or (3)(A) is irrevocable.]

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Veterans Access, Choice, and Accountability Act of 2014

(Public Law 113–146; 38 U.S.C. 7302 note)

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Title III. Health Care Staffing, Recruitment, and Training Matters

SEC. 301. TREATMENT OF STAFFING SHORTAGE AND BIENNIAL REPORT ON STAFFING OF MEDICAL FACILITIES OF THE DEPARTMENT OF VETERANS AFFAIRS.

(a) STAFFING SHORTAGES.—

* * * * * * *

(b) INCREASE OF GRADUATE MEDICAL EDUCATION RESIDENCY POSITIONS.—

* * * * * * *

(2) [FIVE-YEAR] *TEN-YEAR* INCREASE.—

(A) IN GENERAL.—In carrying out section 7302(e) of title 38, United States Code, as added by paragraph (1), during

the [5-year period] *10-year period* beginning on the day that is 1 year after the date of the enactment of this Act, the Secretary of Veterans Affairs shall increase the number of graduate medical education residency positions at medical facilities of the Department by up to 1,500 positions.

* * * * * * *

(3) REPORT.—

(A) IN GENERAL.—Not later than 60 days after the date of the enactment of this Act, and not later than October 1 each year thereafter [until 2019] *until 2024*, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on graduate medical education residency positions at medical facilities of the Department.

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