

**STATEMENT OF
JANET MURPHY
ACTING DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND
MANAGEMENT
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES**

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Good morning Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services. Joining me today is Elias Hernandez, Chief Officer, Workforce Management and Consulting; Harold Kudler, Chief Consultant for Mental Health Services; and Susan Blauert, Deputy Assistant General Counsel.

The Department of Veterans Affairs (VA) provided views on the majority of bills on the agenda, but we are unable to provide cleared views on sections 103, 501, and Title 3 of the draft legislation, the Promoting Responsible Opioid Management and Incorporating Medical Expertise Act, at this time. We will forward these views to you as soon as they are available.

H.R. 1319 Ask Veterans Act

The proposed bill would require VA to enter into a 5-year contract with a non-government entity to conduct an annual survey of a statistically significant sample of Veterans who reside in the geographic area served by each of VA's medical facilities to determine the nature of the experiences of such Veterans in obtaining hospital care and medical services at each such medical facility. In developing the survey, the contractor would be required to consult with Veterans Service Organizations. The contractor would also be required to submit each of its proposed surveys to the Comptroller General for review and certification before conducting them. Furthermore, VA would be required to make the results of such surveys publicly available on its website within 30 days after their completion.

VA does not support H.R. 1319, as such activities would be duplicative of current efforts already in place and, therefore, the minimal benefit of such additional surveys would be substantially outweighed by their significant costs. The provision that requires contractors to obtain a certification from the Comptroller General prior to a survey also contravenes the separation of powers. In its Survey of Health Experiences of Patient

(SHEP) Program, the Veterans Health Administration (VHA) is already conducting ongoing surveys of Veterans' experiences with hospital care.

VA uses a scientifically designed survey instrument, the Consumer Assessment of Health Providers and Systems (CAHPS), and an external contractor IPSOS. The CAHPS surveys are designed by a scientific community that is sponsored by the Agency for Health Research and Quality. CAHPS surveys are an integral part of the Centers for Medicare and Medicaid Services efforts to improve healthcare in the U.S. For example, some CAHPS surveys are used in quality ratings for Medicare and Medicaid health plans, as well as other CMS initiatives such as Value-Based Purchasing. The surveys have also been endorsed by the National Quality Forum and the National Commission for Quality Assurance. Furthermore, the surveys are widely used by commercial health plans. The scientific properties of CAHPS surveys were examined in peer-reviewed scientific literature, examples of which VA can provide upon request.¹ Because VA utilizes the same scientific survey approach as the private sector, we are also able to compare our performance to non-VA hospitals.

VA utilizes CAHPS surveys in its SHEP program, which currently assesses over one million Veterans annually to obtain valid and precise estimates of performance for each VA medical facility. Our survey provider, IPSOS, has been certified by Medicare as meeting scientific standards for sampling, survey administration, and data validation. Furthermore, our SHEP protocols are approved by the Office of Information and Regulatory Affairs.

VA regularly obtains input from Veterans Service Organizations regarding our SHEP program, and we provide SHEP results annually to them upon request. We also post updated facility-level SHEP results quarterly on our public website.² The SHEP program's surveys are completed anonymously, and all of VA's posted results are fully de-identified, aggregate data. VHA's Office of Analytics and Business Intelligence enthusiastically welcomes the opportunity to provide a more detailed briefing of our SHEP program to Congressional staff.

H.R. 1603 Military Sexual Assault Victims Empowerment Act

H.R. 1603 would amend subsection (b) of section 101 of the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act) to add a provision specifically addressing eligibility for the Veterans Choice Program (Choice Program) for victims of military sexual trauma (MST) described in section 1720D(a)(1) of title 38, United States Code (U.S.C.). The intent of this bill appears to make such victims eligible for the Choice Program regardless of the date they enroll for VA health care and without the need to satisfy the wait-time or residence eligibility criteria.

¹ For a summary of the scientific evidence, see Price et al, "Should health care providers be accountable for patients' care experiences" *Journal of General Internal Medicine* 2015 (Feb); vol 30: pp 253-256. Additional information about CAHPS is available at www.cahps.ahrq.gov

² <http://www.va.gov/qualityofcare/apps/shep/barchart.asp>

New legislation is not needed to exempt MST victims from the Choice Act enrollment date restrictions. The bill does not take into account recent legislative changes to the eligibility provisions for the Choice Act. Specifically, section 4005 of the Surface Transportation and Veterans Health Care Choice Improvement Act of 2015, Public Law 114-41, amended section 101 to remove the August 1, 2014, enrollment date restriction, thereby making all Veterans enrolled in the VA health care system under 38 Code of Federal Regulations (C.F.R.) § 17.36 eligible for the Choice Program if they meet its other eligibility criteria. If the intent of the bill is to make Veterans who meet the requirements of 38 U.S.C. § 1720D eligible for the Choice Program without having to enroll in VA health care, that is not clear, and the bill language would need to be clarified. The proposed amendment would also make Veterans who are victims of MST as described in 38 U.S.C. § 1720D(a)(1) eligible for the Choice Program without regard to the wait-time or place of residence eligibility criteria that apply to other Veterans. VA does not support this provision for a number of reasons.

VA supports the Choice Program, which creates a mechanism for providing timely, local care to eligible Veterans for whom such care would otherwise be inaccessible. The Choice Program provides this same access to otherwise eligible Veterans who experienced MST; under existing authorities, MST survivors already have the option to seek Choice Program care based on the wait-time or place of residence eligibility criteria.

There is, however, no clearly identifiable clinical advantage or benefit to MST survivors, in terms of quality of care or patient outcomes, to allow MST survivors to elect Choice Program care as a first-option preference, rather than as a secondary-option based on need under existing non-VA care authorities. As noted in VA's annual report to Congress, required by 38 U.S.C. § 1720D(e), care for MST-related conditions is available through every VA medical facility and Vet Center, and all VA health care facilities have sufficient staffing capacity to meet the MST-related care needs of their local Veteran populations. As such, there is no clear need to create an exception to the existing Choice Program eligibility criteria on the basis of the availability of MST-related care in VA facilities.

There are also some advantages to viewing VA as the first-option provider of MST-related care whenever wait-time and place of residence are not an issue. VA has the authority and infrastructure to ensure that its providers have received training on evidence-based psychotherapies for trauma-related disorders, and specifically on provision of care to MST survivors. Currently all VA mental health and primary care providers must complete mandatory training on MST as specified by VHA Directive 2012-004. VA also offers a range of continuing education opportunities for staff interested in furthering their level of MST expertise. There are few checks to ensure that private providers have the specialized training to offer a standard of evidence-based care to match care available in a VA facility.

Further, it is not uncommon for Veterans who experienced MST to have multiple health concerns and comorbidities and, within VA, to receive care from a range of medical and mental health clinics. As a single umbrella provider, VA is well positioned to provide this type of coordinated, tailored care that ensures the Veteran's history of

MST is considered in all treatment provided. VA providers are familiar with internal resources available to address new or emergent treatment needs, and can provide timely internal referrals as needed. Every VA health care system has a designated MST Coordinator whose role includes assisting MST survivors with accessing needed services and facilitating coordination of care. Given the considerable clinical benefit to MST survivors of coordinated, trauma-sensitive, evidence-based care, and the need to direct Choice Program resources towards addressing accessibility gaps where they exist, VA maintains that VA MST-related care should be considered the first-option treatment standard whenever wait-time and place of residence are not an issue.

It is not possible to estimate costs for this bill without further study to determine how many Veterans would choose to seek Choice Program care under this new authority.

H.R. 1904 Wounded Warrior Workforce Enhancement Act

H.R. 1904, the Wounded Warrior Workforce Enhancement Act, would direct VA to establish two grant award programs. Section 2 of the bill would require VA to award grants to institutions to: (1) establish a master's or doctoral degree program in orthotics and prosthetics, or (2) expand upon an existing master's degree program in those areas. This section would require VA to give a priority in the award of grants to institutions that have a partnership with a VA medical center or clinic or a Department of Defense (DoD) facility. Grant awards under this provision must be at least \$1 million and not more than \$1.5 million. Grant recipients must either be accredited by the National Commission on Orthotic and Prosthetic Education in cooperation with the Commission on Accreditation of Allied Health Education Programs, or demonstrate an ability to meet such accreditation requirements if receiving a grant. VA would be required to issue a request for proposals for grants not later than 90 days after the date of enactment of this provision.

In addition to the two purposes noted above, grantees would be authorized to use grants under this provision to train doctoral candidates and faculty to permit them to instruct in orthotics and prosthetics programs, supplement the salary of faculty, provide financial aid to students, fund research projects, renovate buildings, and purchase equipment. Not more than half of a grant award may be used for renovating buildings. Grantees would be required to give a preference to Veterans who apply for admission in their programs.

VA does not support the enactment of section 2 of this bill. We believe VHA has adequate training capacity to meet the requirements of its health care system for recruitment and retention of orthotists and prosthetists. VA offers one of the largest orthotic and prosthetic residency programs in the Nation. In fiscal year (FY) 2015, VA allocated \$877,621 to support 20 Orthotics/Prosthetics residents at 10 VA medical centers. The training consists of a year-long post masters residency, with an average salary of \$44,000 per trainee. In recent years, VA has expanded the number of training

sites and the number of trainees. Moreover, recruitment and retention of orthotists and prosthetists has not been a challenge for VA. Nationally, VA has approximately 312 clinical orthotic and prosthetic staff.

VA offers in-house orthotic and prosthetic services at 79 locations across VA; however, much of the specialized orthotic and prosthetic capacity of VA is met through contract mechanisms. VA contracts with more than 600 vendors for specialized orthotic and prosthetic services. Through both in-house staffing and contractual arrangements, VA is able to provide state-of-the-art, commercially-available items ranging from advanced myoelectric prosthetic arms to specific custom fitted orthoses.

We also note certain aspects of the bill that would make its implementation problematic. First, the bill would not require grant funded programs to affiliate with VA or send their trainees to VA as part of a service obligation. Also, section 2, subsection (e) would authorize appropriations (\$15 million) in only one fiscal year, FY 2014 – which we presume the drafters intended to be FY 2016, consistent with the language in section 3(e) – and specify that the funding would expire as of September 30, 2016. This subsection contemplates that unobligated funds would be returned to the General Fund of the Treasury immediately upon expiration. Under 31 U.S.C. § 1552(a), expired accounts are generally available for 5 fiscal years following expiration for the purpose of paying obligations incurred prior to the account's expiration and adjusting obligations that were previously unrecorded or under recorded. If the unobligated balance of these funds were required to be returned to the Treasury immediately upon expiration, then VA would be unable to make obligation adjustments to reflect unrecorded or under recorded obligations. A bookkeeping error could result in an Antideficiency Act violation. Lastly, we also note that 90 days after the date of enactment of this provision would not be enough time for VA to promulgate regulations and a request for proposals (RFP) for these grants.

Section 3 of H.R. 1904 would require VA to award a \$5 million grant to an institution to: (1) establish the Center of Excellence in Orthotic and Prosthetic Education (the Center); and (2) improve orthotic and prosthetic outcomes by conducting evidence-based research on orthotic and prosthetic education. Under the bill, grant recipients would be required to have a robust research program; offer an education program that is accredited by the National Commission on Orthotic and Prosthetic Education in cooperation with the Commission on Accreditation of Allied Health Education Programs; be well recognized in the field of orthotics and prosthetics education; and have an established association with a VA medical center or clinic and a local rehabilitation hospital. This section would require VA to give priority in the grant award to an institution that has, or is willing and able to enter into: (1) a memorandum of understanding with VA, DoD, or other appropriate government agency; or (2) a cooperative agreement with an appropriate private sector entity. The memorandum of agreement would provide resources to the Center and/or assist with the Center's research. VA would be required to issue a request for proposals for grants not later than 90 days after the date of enactment of this provision.

VA does not support section 3 because VA would not have oversight of the Center and there would be no guarantee of any benefit to VA or Veterans. Further, we believe that a new Center is unnecessary. DoD has an Extremity Trauma and Amputation Center of Excellence, and VA and DoD work closely to provide care and conduct scientific research to minimize the effect of traumatic injuries and improve outcomes of wounded Veterans suffering from traumatic injury. VA also has five Research Centers of Excellence that conduct research related to prosthetic and orthotic interventions, amputation, and restoration of function following trauma:

1. Center of Excellence for Limb Loss Prevention and Prosthetic Engineering in Seattle, WA.
2. Center of Excellence in Wheelchairs and Associated Rehabilitation Engineering in Pittsburgh, PA.
3. Center for Functional Electrical Stimulation in Cleveland, OH.
4. Center for Advanced Platform Technology in Cleveland, OH.
5. Center for Neurorestoration and Neurotechnology in Providence, RI.

These centers provide a rich scientific environment in which clinicians work closely with researchers to improve and enhance care. They are not positioned to confer terminal degrees for prosthetic and orthotic care/research but they are engaged in training and mentoring clinicians and engineers to develop lines of inquiry that will have a positive impact on amputee care. Finally, the requirement to issue a request for proposals within 90 days of enactment would be very difficult to meet as VA would first need to promulgate regulations prior to being able to issue the RFP.

VA estimates that, if section 2(e)(1) referred to FY 2016, instead of FY 2014, sections 2 and 3 of H.R. 1904 would cost \$150,000 in FY 2016 and \$21.6 million over 5 years.

H.R. 2639 Marriage and Family Therapists for Veterans Act

H.R. 2639, the “Marriage and Family Therapists for Veterans Act,” would amend the qualification standards for Marriage and Family Therapists (MFT), prescribed under 38 U.S.C. § 7402(b)(10).

Under current qualification standards, MFTs must meet two requirements: (1) hold a master’s degree in marriage and family therapy, or a comparable degree in mental health, from a college or university approved by the Secretary; and (2) be licensed or certified to independently practice marriage and family therapy in a state.

H.R. 2639 would add a third prerequisite to the qualification standards for MFTs, which would require that an MFT have passed a marital and family therapy examination administered by the Association of Marital and Family Therapy or an examination for a marriage and family therapy license given by a state board of behavioral sciences or its equivalent.

H.R. 2639 would also amend the first requirement in the qualification standards to allow an MFT to fulfill that prerequisite if he or she obtained a master's degree in marriage and family therapy, or a comparable degree in mental health, from a regionally accredited college or university. VA has a number of policy concerns about the amendment to this requirement and consequently cannot support the bill.

Under current law, the Secretary has discretion to approve colleges and universities that have master's degree programs in marriage and family therapy. This discretion allows VA to require that MFTs graduate from schools with programs accredited by the national accrediting body for MFTs, the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). COAMFTE is a specialized accrediting body that accredits master's degree, doctoral degree, and post-graduate degree clinical training programs in Marriage and Family Therapy throughout the United States and Canada and, since 1978, has been recognized by the U.S. Department of Education as the national accrediting body for the field of Marriage and Family Therapy.

Requiring a Marriage and Family Therapist to have a COAMFTE accredited degree ensures that the MFT has completed a course of professional preparation that meets specific standards established by the discipline's accrediting body and that the individual has been trained in the appropriate knowledge and skill areas required of the profession. The requirement that MFTs graduate from a program accredited by COAMFTE is similar to the requirements imposed on other core mental health disciplines (e.g., Psychology, Psychiatry, Social Work, Nursing, Licensed Professional Mental Health Counseling, and Marriage and Family Therapy), in that individuals in these disciplines must also graduate from programs that are accredited by a recognized body.

Requiring that an MFT graduate with a master's degree in marriage and family therapy or a comparable degree in mental health, from a college or university that is regionally accredited, is problematic because regional accrediting bodies accredit academic institutions but do not examine the quality of education provided in a specific program. In 2013, the American Association of Marriage and Family Therapy and COAMFTE identified a number of regionally accredited universities with marriage and family therapy programs. However, after reviewing the academic curricula for the programs, COAMFTE staff determined that many of these programs would not be eligible for COAMFTE accreditation since the programs were unable to demonstrate they actually trained their students in marriage and family therapy.

H.R. 3234 Failing VA Medical Center Recovery Act

H.R. 3234, the “Failing VA Medical Center Recovery Act,” would establish an Office of Failing Medical Center Recovery (OFMCR) within VA. Under the bill, OFMCR would manage day-to-day operations for VA medical centers (VAMC) that are ranked as “failing” key health metrics. VA has legal and policy concerns about H.R. 3234 as outlined below.

Determining a VAMC’s ranking

H.R. 3234 would require the Secretary to publish a quarterly list of key health metrics for each VAMC. This quarterly list would also include rankings for each VAMC as either “excellent,” “satisfactory,” “poor,” or “failing,” based on Strategic Analytics Improvement and Learning (SAIL) data. SAIL data is a web-based balanced scorecard model that VA developed to measure, evaluate, and benchmark quality and efficiency at VAMCs. VA designed SAIL for internal benchmarking within VHA to spotlight the successful strategies of VA’s top performers to promote high-quality, safety, and value-based health care across all of its VAMCs. SAIL is available on the VHA Intranet website and accessible to all VA staff members who have network access. In support of VA Transparency Program, VA published SAIL benchmark tables for each medical facility on the Internet in October 2014 to ensure public accountability and spur continuous improvements in health care delivery.

Overlap of OFMCR with activities performed by VHA

The bill would require that VAMCs ranked as “failing” be transferred by the Secretary from VHA to the newly established OFMCR. OFMCR would then manage the day-to-day operation of the “failing” VAMC until the VAMC can achieve a ranking of “satisfactory” or better under the key health metrics for three consecutive quarters, at which time the VAMC would be restored back to VHA. Once the Secretary ranks a VAMC as “failing,” the head of OFMCR, the Under Secretary for Failing Medical Center Recovery (the Under Secretary), would assume all the duties, responsibilities, and authority held by the director of the “failing” VAMC. Once the “failing” VAMC is under the control of the OFMCR Under Secretary, he or she would retain the use of all resources and services that would otherwise be made available to the covered “failing” medical center and would operate the center independently from its respective Veterans Integrated Service Network (VISN).

A number of OFMCR activities are already performed by VHA. For example, VHA already monitors performance in VHA facilities based on SAIL data which encompasses 28 measures – 27 quality measures, which are organized into 9 domains: acute care mortality; avoidable adverse events; cause mortality register 30-Day mortality and readmission rate; length of stay; performance measures; customer satisfaction; ambulatory care sensitive condition hospitalizations; access; and mental health – and an additional measure to assess overall efficiency. Based on the SAIL data, VA facilities are benchmarked on individual measures and domains, and using

10th, 30th, 70th, 90th percentile cut-offs of overall quality score, each facility is designated a 1- to 5-star rating for overall quality.

We are deeply concerned that this bill proposes to use percentile-based ranking to identify “failing” medical centers. Applying a percentile-based ranking schema ensures that there will always be a certain number of medical centers that are certified as “failing” irrespective of how high their scores might be on the SAIL metrics. This would perpetuate a continuous need for the OFMCR to seize control of various medical centers even if SAIL scores were to collectively improve across all medical centers. We therefore propose that a specific SAIL score threshold be established and used to identify “failing” VAMCs.

Based on SAIL data, VHA sends teams of subject matter experts out to facilities to provide on-site consultative training to help facilities in areas specific to their needs. In FY 2014, there were a total of 62 consultative trainings that were provided. In FY 2015, VHA provided at least 133 trainings. During these trainings, facilities were provided with areas where they have improvement opportunities, recommendations for improvement strategies, and points of contact from VA medical centers where there are strong practices they can borrow from. VHA provides follow-up consultation to facilities within 30-60 days of the training. In FY2015, nearly 45% of VA medical centers improved their overall performance from one year ago. For VHA as a whole, significant improvements were found on patient outcome measures such as mortality, length of stay, hospital readmission rate, ambulatory care sensitive condition hospitalizations, are healthcare acquired infections. All of these measures are considered significant quality indicators that are publically reported by agencies such as Centers for Medicare and Medicaid Services.

Authority of the Under Secretary for Failing Medical Center Recovery

The Under Secretary would be directly responsible for the operation of OFMCR. Under the bill, the Under Secretary can appoint individuals in OFMCR using direct-hire authority in 5 U.S.C. § 3304(a)(3) and can pay these individuals at a prevailing rate that is 125 percent of the rate of pay for the employee’s position. OFMCR employees who serve for 2 or more years with that office would also be entitled to receive preferential treatment for promotion and advancement within VA. VA is extremely concerned with establishing a new Under Secretary position to manage and lead this office as it removes authority vested in the Under Secretary for Health and moves it to what appears to be a non-medical position. This would make it harder for the Under Secretary for Health to manage Veteran medical care when his authorities are being shifted out of the administration. A realignment of VHA functions for failing medical centers under a new Under Secretary position would create costly and duplicative functions at the national, regional and local levels. Furthermore, VA does not believe a separate Under Secretary and organization would be successful in achieving improved outcomes and care.

The bill does not address funding for OFMCR or whether the preferential treatment for OFMCR employees in applying for promotions and advancement within VA trumps Veterans' preference.

The bill allows the Under Secretary to hire individuals as employees of VHA at "failing" VAMCs; pay an employee at a "failing" VAMC at a prevailing rate that is 125 percent of the rate of the employee's position; and carry out adverse actions, including transfers or reassignments for all employees at a "failing" VAMC.

By allowing the Under Secretary to appoint individuals at "failing" VAMCs as employees of VHA, the bill fails to consider the possible repercussions such appointments would have on VHA's budget, which is typically managed by the Under Secretary for Health. Indeed, the possible budgetary impact on VHA would be significant as the Under Secretary can pay these employees or other employees at "failing" VAMCs at a prevailing rate that is 125 percent of the rate of the employee's position.

With regard to paying an employee at a "failing" VAMC or OFMCR at 125 percent of the employee's rate of pay, the bill does not address statutory limits on employee pay linked to the Executive Schedule, which would, for example, cap a Registered Nurse at Level IV of the Executive Schedule. The bill also does not consider pay retention for employees paid at 125 percent of their pay rate. That is, whether an employee who has been paid at 125 percent of their rate of pay would be allowed to retain that pay increase if they leave the "failing" VAMC or OFMCR, or, if the employee continues to work at the "failing" VAMC, once the VAMC is no longer designated as "failing" by the Secretary. VA is also concerned that this flexibility to pay an employee at the 125 percent rate would be limited to hospitals that are deemed "failing" and not all facilities that face hiring challenges and other difficulties.

The bill also would allow the Under Secretary to designate any employee of a "failing" VAMC as an employee covered by 38 U.S.C. § 713, for purposes of removal, even if that employee is not a senior executive. This provision would have broad implications on VA's personnel system as any employee of a "failing" VAMC, regardless of grade, pay level, or direct patient-care responsibilities, could be removed under a section intentionally limited to VA senior executives.

Limiting the appeal rights for employees who are removed at these "failing" VAMCs would also create a two-tier system of employment in VA. That is, employees at "failing" VAMCs would have fewer appeal rights if they are terminated under 38 U.S.C. § 713 than their counterparts at other VAMCs and the rest of the Federal Government. To that extent, high-performing employees at VAMCs, who through no fault of their own, are employed at VAMCs that the Secretary has designated as "failing," may be reluctant to remain employed at those facilities, when they can have better removal appeal rights at other VAMCs or Federal agencies, or greater pay by joining the private sector. Because VA is already hard-pressed to compete with the private sector, especially in positions involving health care, the inclusion of a provision

curtailing employee removal appeal rights would be detrimental to Veteran care and the operation of the impacted VAMCs.

Ultimately, the inclusion of this provision would make conditions of employment in VA significantly less attractive than in other Federal agencies or in the private sector, and as a result, would discourage outstanding VA employees from remaining in VA and dramatically impair VA's ability to recruit top talent, including Veterans. In addition, we understand that the Department of Justice believes that the political affiliation restriction for the Under Secretary raises Appointments Clause concerns.

The Office of Personnel Management (OPM) may also have views on H.R. 3234, as the bill would adversely impact the treatment of VA employees under Title 5 personnel authorities administered by OPM.

VA is unable to determine the costs of H.R. 3234 at this time.

H.R. 3471 Veterans Mobility Safety Act of 2015

H.R. 3471 would amend 38 U.S.C. § 3903 to require the Secretary to ensure that, to the extent practicable, eligible individuals are given the opportunity to make personal selections related to automobiles or other conveyances provided under chapter 39 of title 38, U.S.C. The bill would also set forth minimum standards for adaptive equipment modification services – requiring the providers of such services to be certified by a certification organization or the manufacturer of the adaptive equipment. Individuals performing adaptive equipment modification services on an automobile would also be required to meet these certification requirements or be licensed or certified by the state in which the modification service is performed if the service is within the scope of practice. Under the bill, providers of automobiles, adaptive equipment, or modification services would be required to adhere to chapter 126 of title 42 (the Americans with Disabilities Act of 1990), and to the “make inoperative mandates” of the Department of Transportation National Highway Traffic Safety Administration (NHTSA) Federal Motor Vehicle Safety Standards prescribed pursuant to section 30122 of title 49. The bill would define the terms “certification organization” and “modification services.”

H.R. 3471 would also amend 38 U.S.C. §§ 1718 and 3104 to specify that if the Secretary provides adaptive equipment in providing rehabilitative services or a rehabilitation program under chapters 17 or 31 of title 38, U.S.C., respectively, the equipment must meet the minimum standards prescribed under 38 U.S.C. § 3903(d)(2), as amended by the bill. No later than 1 year after enactment, VA would be required to prescribe regulations to carry out these amendments.

VA does not support H.R. 3471, as VA defers to the NHTSA on safety compliance issues. NHTSA prescribes safety standards for adaptive equipment and develops criteria to assist not just Veterans, but all citizens, when selecting a modifier and/or alterer to modify their vehicles (49 U.S.C. § 30111; 49 C.F.R. Parts 571 and

567). VA does not manufacture or install adaptive equipment on a beneficiary's vehicle. Rather, VA pays for automobile adaptive equipment that accommodates beneficiaries' driving and/or passenger needs as identified by a VHA certified Drivers Rehabilitation Specialist.

We note that H.R. 3471 may be too restrictive and cause undue hardship for small businesses that are not members of a certified organization and/or certified by the state in which the modification service is performed. This, in turn, may restrict the access and choice Veterans have when selecting a modifier or alterer for adapting their personal vehicles. Further, we note that there are no systematic issues regarding automobile adaptive equipment safety (as authorized in chapter 39 of title 38, U.S.C.) being reported across VA. Therefore, the amendments in H.R. 3471 would provide no added value to support Veterans and Servicemembers who are eligible to receive automobile adaptive equipment under chapter 39 of title 38, U.S.C.

We do not expect H.R. 3471 to directly impact the provision of benefits to Veterans by VA. Therefore, no benefit costs or savings would be associated with this bill. Any administrative costs associated with this bill would be minimal.

As a technical matter, we would read 38 U.S.C. § 1718(h), as added by section 2(b) of the bill, as applying only to automobile adaptive equipment, and note that this amendment would tend to clarify VA's authority to provide automobile adaptive equipment under chapter 17.

H.R. 3549 VA Billing Accountability Act

H.R. 3549 would add a new section 1709C to title 38, U.S.C., that would require VA to notify Veterans of their copayment requirements no later than 120 days after the date of care or services provided at VA medical facilities, and no later than 18 months after the date of care or services provided at non-VA facilities. If VA does not provide such notice, VA could not collect the copayment, including through a third-party entity, unless VA provides the Veteran: (1) information on applying for a waiver and establishing a payment plan, and (2) an opportunity to make a waiver or establish a payment plan. The Secretary would be authorized to waive the copayment requirement in cases where notification to the Veteran was delayed because of an error committed by VA, a VA employee, or a non-VA facility (if applicable), and the Veteran received notification beyond the specified timeframes. H.R. 3549 would also require VA, no later than 180 days after enactment, to review and improve its copayment billing internal controls and notification procedures, including pursuant to the provisions of the bill.

VA supports the intent of H.R. 3549 to prevent delays in the release of copayment charges due to operational error, avoid undue burden to Veterans, and improve VA's copayment billing procedures. However, the 120-day time period proposed in the bill is not reflective of the timeline of normal business

operations. Further, it is not clear what specific copayment billing issues the bill would address.

We note that copayments are automatically generated by VA's integrated billing system. Moreover, VA ensures that every Veteran is given the notice of rights and the opportunity to request a waiver or compromise, and to establish a repayment plan for copayment charges. This information is included with every copayment billing statement that VA sends to a Veteran. As a service to Veterans, VA holds copayment bills until a Veteran's other health insurance (OHI) is billed and either pays or denies the claim. This allows VA to potentially offset the Veteran's copayment charges with payment received from the OHI, reducing the Veteran's liability. When a Veteran has OHI, the copayment charge is placed on hold for 90 days while the OHI is billed. If no payment is received within 90 days, the charges will automatically be released and a statement generated to the Veteran. If a balance remains after an OHI payment is applied to the copayment debt, the bill for the remaining balance is released to the Veteran and he or she receives it within a variable timeframe that ranges from 70 to 150 days depending on when the OHI payment is made – a timeframe that can exceed the proposed 120-day standard in H.R. 3549. VA financial policy for medical care debts specifies that Veterans who do not have OHI should have the opportunity to satisfy copayment obligations at the Agent Cashier's office prior to leaving the medical facility. Otherwise, the record of service is prepared and the copayment is released for billing on the Veteran's next scheduled monthly billing statement, which is normally received anywhere from 14 to 42 days after the date of service.

Copayment bills may also be generated following income verification under 38 U.S.C. § 5317, which authorizes VA to validate certain Veterans' reported income with the Internal Revenue Service (IRS) and Social Security Administration information. This validation begins 18 months after the calendar year in which that income is reported due to receipt of data, upon completion of tax processing, from the IRS. If VA identifies unreported income, VA has authority to generate copayment billings as a result of this verification process. VA also refunds copayments, when appropriate, as a result of this income verification process. The timeframe associated with this process exceeds the 120-day standard proposed in H.R. 3549. We also note that private sector billing industry standards allow for billing up to 12 to 18 months after services are rendered – also exceeding the proposed 120-day timeframe.

H.R. 3549 does not specify what constitutes an error, what would justify a waiver, and whether the waivers and payment plans authorized under the bill would differ from those currently authorized in applicable statutes and regulations. VA has existing procedures under 38 U.S.C. § 5302 to waive collection in cases where the Secretary determines that recovery would be against equity and good conscience. In these instances, an application for relief must generally be made 180 days from the date of notification of the indebtedness.

As a technical matter, we note that the bill does not define the term “third-party entity” or specify how this language would be applied. Further, we note that VA copayment requirements under 38 U.S.C. § 1710(f)-(g), 38 U.S.C. § 1722A, and 38 U.S.C. § 1710B (which is not referenced in H.R. 3549, but requires copayments of certain Veterans for extended care services) apply regardless of whether the care or services was provided in a VA facility or authorized by VA in a non-VA facility. Therefore, the 120-day timeframe that would be added in section 1710(f)(3)(G)(ii) and section 1722A(c)(2) by the bill may be read as applying to care or services in both VA and non-VA facilities. If copayments billings delayed beyond 120 days from date of service are waived, VA estimates a 5-year revenue loss of \$365.6 million and a 10-year revenue loss of \$695.2 million from the First Party Inpatient/Outpatient and Pharmacy Medical Care Collection Fund.

Draft Bill Promoting Responsible Opioid Management and Incorporating Scientific Expertise (PROMISE Act)

In general, this draft bill contains some very appropriate requirements for opioid safety, many of which are already underway in VA. We note, however, that Servicemembers’ opioid use is often initiated by DoD prescribers, and a major shortcoming of this bill is that it lacks requirements for DoD to address opioid use at the beginning of the process and instead focuses on VA interventions after opioid use has been initiated. This problem cannot be resolved in isolation; DoD and VA must both be accountable for opioid use by Servicemembers and Veterans, respectively. To be more effective, this bill should be strengthened so that VA’s requirements are mirrored by requirements for DoD.

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 guideline would have to include common recommended guidelines for safely prescribing opioids for the treatment of chronic, non-cancer pain in outpatient settings as compiled by the Centers for Disease Control and Prevention (CDC); enhanced guidance in certain specified areas; enhanced guidance with respect to the treatment of patients with behaviors or comorbidities such as posttraumatic stress disorder, psychiatric disorders, 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 effective assessment for patients receiving opioid therapy; guidance 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 discriminating opioid therapy; guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient settings; guidelines on appropriate hand-off of case management responsibility for patients receiving opioid therapy who transition from receiving care during active duty

and post-military health care networks; enhanced standards 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 Pain Management Working Group of the VA/DoD Health Executive Council.

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. This bill will, in effect, codify the spirit of the recently released Presidential Memorandum requiring education for all Federal prescribers.³ 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. VA should have the flexibility to develop its own evidence-based prescribing guidelines in partnership with DoD.

In addition, the bill's requirement that VA and DoD health care providers, before initiating opioid therapy to treat a patient, use the VA Opioid Therapy Risk Report tool, including information from the prescription drug monitoring program of each State, is problematic because not every state has a functioning program and not every state allows access by health care providers not licensed in that state. VA has many providers who are not licensed in the state where they work.

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 that 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 professionals responsible for coordinating and overseeing therapy at the facility for patients experiencing acute and chronic pain that is not related to cancer. In consultation with VISN Directors, a consensus on established protocols would have to be adhered to for the designation of a pain management teams at each VA medical facility, and the protocols would need to ensure that any health care provider without expertise in prescribing analgesics or who has not completed required training does not prescribe opioids, with limited exceptions. Within 1 year of enactment

³ Presidential Memorandum-Addressing Prescription Drug Abuse and Heroin Use. White House Office of the Press Secretary. October 21, 2015. Available at <https://www.whitehouse.gov/the-press-office/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin>. Downloaded 11/13/2015

of this Act, each VA medical facility would be required to submit to the Deputy Under Secretary for Health and VISN Director a report identifying the health care professionals that have been designated as members of the pain management team at the facility, and other specified information.

Section 102(d) would require, within 18 months of the date of the enactment of the Act, that VA submit an acquisition and budget plan to create a system that allows 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 (PDMPs). Within 18 months of the enactment of this Act, VA would be required to submit to Congress a report on the implementation of these improvements. As noted above, we recommend that any such requirements also involve DoD. Also, we note that VA already has trending reports available to monitor the key clinical indicators of the Opioid Safety Initiative. In addition, VA health care providers receive real-time order checks on all prescriptions, including opioids. VA likely could not develop the proposed system within 18 months, and the system would offer little value to existing trending reports. Further, it is unclear what the benefit or desired outcome would be to tracking mail-order prescriptions of opioids prescribed to Veterans in real-time.

Section 102(e) would require VA to maximize the availability of opioid receptor antagonists, such as naloxone, to Veterans and ensure their availability 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 the Food and Drug Administration (FDA). VA notes that other opioid receptor antagonists approved by FDA exist, but only one type (naloxone) is approved for overdose reversal. This section would also direct 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 these requirements.

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, and will be compliant with the Presidential Memorandum. 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 patient 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 maximize 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 CPRS to ensure that 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. We note that the Veterans Choice Program also allows VA patients, in certain circumstances, to receive medicines outside of the VA system.

Subparagraphs (A) and (C) of Section 102(d)(2) are duplicative of existing Federal law and regulations, but their general language could cause confusion as to the responsibilities of the Department and its individual providers. More specifically, 38 U.S.C. § 5701(l) required VA to issue regulations authorizing the disclosure of information about Veterans and their dependents to state PDMPs. Accordingly, those regulations were published in 38 C.F.R. § 1.515, which sets forth the specific categories of information that may be disclosed to state PDMPs. Some VA facilities already have policies in place that mandate the querying of state PDMPs regarding patients who are prescribed certain kinds of drugs. If Congress desires to make the disclosure of information to state PDMPs mandatory, rather than permissive, it should consider making that change within 38 U.S.C. § 5701(l), rather than in a separate law.

Section 104 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 of enactment on this study.

VA has numerous concerns with section 104. 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, would lead to negative patient outcomes. For example, Veterans who are travelling 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 105(a) would require the Comptroller General, within 2 years of 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 providers. The report would include recommendations for improvement, and under section 105(b) 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 the Government Accountability Office (GAO) on this provision. However, we note that we would construe the provision not to require VA to implement the Comptroller General's recommendations, due to the separation of powers concerns that would otherwise be presented. See *Bowsher v. Synar*, 478 U.S. 714, 726–27 (1986). We would construe section 105(b) as merely requiring VA to report the actions taken to implement those recommendations, if any.

Section 105(c) would also require VA to conduct an annual report on opioid therapy, and to submit this report to the Committees on Veterans' Affairs. This report would include specified information on patient populations and prescribing patterns for opioids. VA has a number of technical concerns with section 105, and we would be glad to meet with Subcommittee staff to discuss these further.

VA supports section 201, which would require VAMCs and community-based outpatient clinics to host community meetings, open to the public, on improving VA health care. This section is consistent with current practices of hosting Town Hall meetings to hear from Veterans, families, and other stakeholders.

Section 202 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.

Section 203 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 204 would require VA, in consultation with DoD, to submit to the Committees on Veterans' Affairs, within 180 days of the date of the enactment of this Act, a report on the transition from DoD to VA health care settings undergone by Veterans in receiving health care. The report would have to include an evaluation of VA's standards for facilitating and managing the transition undergone by Veterans in receiving health care in VA and DoD health care settings, an assessment of the case management services that are available, an assessment of the coordination in coverage of and consistent access to medications, and a study of the sufficiency of VA resources to ensure delivery of quality health care relating to mental health issues among Veterans seeking VA treatment.

VA does not support section 204 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 VAMC; at Fort Hood, Texas; and at Fort Carson, Colorado. VA looks forward to their objective, third-party assessment.

Section 401 would require that as part of the hiring process for health care providers VA reach out to state medical boards to ascertain whether a prospective employee has any violations over the past 20 years, or has entered into a settlement agreement for a disciplinary charge 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 well as whether or not there are any 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 healthcare 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 a 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 boards detailed information about any VA health care provider that has violated a requirement of his or her 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 allows VA to

require 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 requiring 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 that includes 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 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 7 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 the review process to ensure 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.

Section 403 would require VA, within 2 years of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs a report on its compliance with the policy outlined by this Act 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 appropriate 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. As previously noted, 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.

Draft Bill Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act

On May 1, 2015, the Administration transmitted to the Congress a draft bill, the "Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act." We greatly appreciate the Committee placing this measure on today's agenda. The draft bill would clarify VA's authority to purchase care and services in the community when such services are not reasonably available from VA or through contracts or sharing agreements. Accomplishment of this goal is VA's top legislative priority.

VA is developing its plan to consolidate and improve VA purchased care programs in accordance with Public Law 114-41 and will be engaged with the Committee in a far-reaching discussion of this comprehensive plan. While those ideas are being considered, enactment of purchased care reform will provide important

clarifications and improvements that can serve as a cornerstone for further consolidation and streamlining.

Section 2 of the draft bill would amend chapter 17 of title 38, U.S.C., by adding a new section 1703A. Section 1703A, "Agreements with eligible providers; certification processes," would authorize VA to purchase care in certain circumstances through agreements (Veterans Care Agreements or VCA) that are not subject to certain provisions of law governing Federal contracts, so that providers are treated similarly to providers in the Medicare program. The draft bill would provide explicit protections for procurement integrity, provider qualifications, price reasonableness and employment protections while ensuring that VA is able to provide local care to Veterans in a timely and responsible manner.

Specifically, subsection (a) of section 1703A would authorize VA to enter into VCAs with certain providers when the needed care is not feasibly available within VA or through contracts or sharing agreements. Subsection (a) would require VA to review VCAs of a material size every 2 years to determine whether it is practical or advisable to provide the necessary care through VA facilities or contracts or sharing agreements.

Subsection (b) would specify that VCAs are exempt from certain provisions of law governing Federal contracting, specifically, competitive procedures and certain laws to which providers and suppliers of health care services through the Medicare program are not subject. At the same time, it is important that providers entering into these agreements are subject to any law that addresses integrity, ethics, fraud, or civil and criminal penalties, as well as those that ensure equal employment opportunity.

Subsection (c) would clarify that care provided under VCAs is subject to the same terms and conditions as though provided in a VA facility.

Subsection (d) would provide that, to the extent practicable, the rates paid for care under this section shall be in accordance with the rates paid by the United States under the Medicare program.

Subsection (e) would define eligible providers to include: providers, physicians, and suppliers that have enrolled with Medicare and entered a provider agreement or a participation agreement with Medicare; providers participating in Medicaid; and other providers the Secretary determines to be qualified under subsection (f).

Subsection (f) would require the Secretary to establish a process for certification and re-certification of certain providers. This process would include procedures for screening providers according to the risk of fraud, waste, and abuse and must require the denial of applications from providers excluded from certain Federal programs.

Subsection (g) would specify that providers must agree to, among other things, accept the rates and terms of VA payment, provide services only in accordance with VA's authorization, and provide medical records to VA.

Subsection (h) would outline when an agreement may be terminated by VA or the provider.

Subsection (i) would require the Secretary to establish through regulation a mechanism for monitoring the quality of care provided to Veterans under this section.

Subsection (j) would require the Secretary to establish through regulation administrative procedures for providers to present disputes relating to VCAs. Providers would be required to exhaust these administrative procedures before seeking judicial review.

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

Section 3 of the draft bill would make conforming amendments to 38 U.S.C. § 1745 to permit VA to enter into similar agreements with State Veterans Homes. Section 3 would establish a separate effective date for State Veterans Homes.

On continuing review since the time VA transmitted the draft bill to Congress, we believe there are drafting improvements that can be made to clarify aspects of the bill. We note that the Administration strongly supports S. 2179, the "Veteran Care Agreements Rule Enhancement Act", or "the Veteran CARE Act," which was based on this draft bill and provides what we believe is clearer language regarding equal employment opportunities. We'd appreciate the opportunity to discuss those improvements with your staff.

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