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HEARING ON PENDING HEALTH CARE LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

JUNE 3, 2015

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PENDING HEALTH CARE LEGISLATION

WEDNESDAY, JUNE 3, 2015

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 2:30 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

Present: Senators Isakson, Moran, Boozman, Rounds, Sullivan, Blumenthal, Murray, Brown, Tester, and Manchin.

OPENING STATEMENT OF HON. JOHNNY ISAKSON, CHAIRMAN, U.S. SENATOR FROM GEORGIA

Chairman ISAKSON. The Committee on Senate Veterans Affairs will come to order. Welcome everybody. We look forward to an active afternoon, and look forward to your testimony, and appreciate Senator Kirk and the others who are going to testify here today.

We will be discussing health care bills currently pending before the Committee. Two draft bills on the agenda are very important. They are all very important, obviously, to the authors, but two I want to point out. One is a bill to allow VA to enter into provider agreements for delivering care to non-VA providers. This is an issue that has been before the VA for some time we are moving forward on and I am happy that we are.

A draft bill to direct VA and DOD to develop a joint formulary for pain and psychiatric drugs. Both the Armed Services Committee and the Veterans' Affairs Committee are very interested in this being a seamless process in terms of formularies and I am glad we are working on that.

Another bill seeks to improve the provision for health care for women veterans and as a Georgian with 50,000 women veterans in my State, and with the issues that are arising with women's participation in our military, I think it is very important that this Committee focus on benefits to our women.

There are also two bills on the agenda that seek to address issues related to veterans' homelessness and the reauthorization of certain veterans' homelessness programs. I look forward to dealing with those and look forward to all the other issues that come before the Committee today. I want to thank the Members that are present for their attendance and I will call on the Ranking Member, Richard Blumenthal.

STATEMENT OF HON. RICHARD BLUMENTHAL, RANKING MEMBER, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman. Thanks for holding this hearing. I, too, very much welcome this profoundly significant discussion of health care issues that challenge our Veterans Administration today and challenge our Nation to do better. I am going to ask, if there is no objection, that I be joined as cosponsor to 207, 297, 425, 471, and 684, all representing a very comprehensive approach to problems relating to women's health care, formularies, veterans reintegration, and access to quality care.

These are a very important step forward. I am going to cut short my remarks because we are here really to hear from the witnesses and I welcome them here today. Thank you, and particularly our colleague, Senator Kirk, whose commitment to our veterans is unquestionable and so very impressive. Thank you, Senator Kirk, for being here.

Chairman ISAKSON. As is the practice here, all of the Members will be able to submit statements for the record at the conclusion of our hearing. We will go in order of questioning based on the attendance of the Members. It is also our tradition to make sure any visiting Senator who is present to speak is recognized first, so, Senator Kirk, we are glad to welcome you.

STATEMENT OF HON. MARK KIRK, U.S. SENATOR FROM ILLINOIS

Senator KIRK. Thank you, Mr. Chairman. I would like to recognize the presence of the world's best ranking member, Mr. Tester, on the VA MILCON Subcommittee of Appropriations. I just want to say that it has been a real joy to work with Jon. We are going to make sure that the Red Horse Squadron in Malmstrom is really taken care of.

I am here to testify on behalf of my bill which is S. 297, the Frontlines to Lifelines Act of 2015 legislation. Let me show you a graphic that really explains what is going on. We now have about 10,000 active-duty corpsmen leaving the active-duty force that creates a need for about 28,000 health care assistants in the VA.

The goal of this legislation is to make sure that the transition between active duty to VA is as seamless as possible knowing that veterans are going to care for veterans better than anybody else.

When you hang around VA, if you talk to somebody and ask, "Where did you serve," and they say, "Hey, I served in this war and this place," you are going to have a lot more confidence in that person that is taking care of you if they are former active-duty.

To make sure we recoup all the training that has come to those corpsmen and the 10,000 that are coming out of the active-duty force. I would say that I have bipartisan support for this legislation, including Mr. Blount, Manchin, Scott, and now Mr. Blumenthal. Thank you for the support. I would say that we want to get this through and that would conclude my statement, Mr. Chairman.

Chairman ISAKSON. Thanks, Senator Kirk. Same here. Thank you for your service to the country and to the U.S. Senate. I noticed Senator Tester is a cosponsor on this, 425. Did you have any comments you wanted to enter about that?

Senator TESTER. We will make some comments later, but I just want to thank Chairman Kirk for his kind remarks. It has been fun working with you on MILCON VA. The problem has been—and I know you do not do this to Senator Blumenthal, but Senator Kirk has side comments that he makes about different issues that come up, and their importance.

Chairman ISAKSON. I have been known to issue an editorial or two.

Senator TESTER. Thank you for being here.

Senator KIRK. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you very much, Senator Kirk. We will be taking the bill up in a markup later on this month and we appreciate your testimony. I think we are going to go to the first panel now.

Our first panel is Thomas Lynch, Assistant Deputy Under Secretary for Health Clinical Operations, Veterans Health Administration, U.S. Department of Veterans Affairs, accompanied by Deputy Chief, Patient Care Services Officer, Veterans Health Administration, U.S. Department of Veterans Affairs, Maureen McCarthy, and Deputy Assistant General Counsel, Office of the General Counsel, the Department of Veterans Affairs, Susan—is that Blauert?

Ms. BLAUERT. Blauert.

Chairman ISAKSON. Thank you. I am sorry I could not get that. Dr. Lynch, thank you very much for being here today. We appreciate your time and we will give you as much time as you need as long as you do not run too long. We normally like to keep it down to 5 minutes, but we know we are commenting on legislation that is before the VA, so what time you need, please take. We are glad to have you.

STATEMENT OF THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MAUREEN McCARTHY, M.D., DEPUTY CHIEF, PATIENT CARE SERVICES OFFICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND SUSAN BLAUERT, DEPUTY ASSISTANT GENERAL COUNSEL, OFFICE OF GENERAL COUNSEL

Dr. LYNCH. Thank you, Mr. Chairman. I will try to keep my comments to 5 minutes. Mr. Chairman, Ranking Member, thank you for inviting us here today to present the Department's views on several bills that would affect VA programs and services.

As you mentioned, I am joined today by Dr. Maureen McCarthy on my right and Mrs. Susan Blauert on my left. Mr. Chairman, we appreciate the Committee's attention to those subjects important to veterans and we support many of the provisions you are considering today.

There are several bills for which we have not been able to prepare views due to time constraints. We will submit those opinions as soon as we can and we will follow up with your staff in the meantime to address any technical concerns.

In beginning, I would like to express VA's appreciation for the recent enactment of Public Law 114–19, which will give VA new flexibility to use the Veterans Choice program—when a veteran

may live within 40 miles of a VA facility, but still face an unusual or excessive burden in getting to that facility. It will expand the different individual circumstances VA can consider in determining eligibility for Veterans Choice beyond simply geography, to include environmental factors and the veteran's medical condition.

This will allow VA to be more responsive to the special challenges faced by individual veterans. Let me add that we also sincerely appreciate placement of the draft purchased care reform bill on the agenda today. We strongly support enactment of the bill which is similar to legislation requested by the Administration to reform VA's authorities for purchasing hospital care, medical services, and extended care. This is a well-crafted measure that is critical to address deficiencies in current law, as well as provide a comprehensive framework for the purchase of non-VA care.

We know this is important as well to a great number of providers with whom VA partners and on whom we depend for the delivery of care to veterans in the community. Mr. Chairman, this measure is absolutely critical to assure timely access to care for veterans. Again, we greatly appreciate your strong support.

Mr. Chairman, you will see VA's detailed discussion on other bills under consideration today in our written testimony, but I would like to take this opportunity to highlight some of our views. S. 297 would, in part, direct the Department to transfer available credentialing data from health care providers to VA when we hire those providers. Credentialing is required to ensure a health care provider has the necessary clinical competence and professional experience.

Consultation with the Department of Defense is necessary before VA can present a position on this provision. We look forward to working with the Department and the Committee on this bill.

S. 425 would provide additional employment services for homeless and at-risk veterans. Employment is a key factor in achieving and maintaining stability and permanent housing. VA believes this bill would be helpful in our efforts to combat homelessness, but we defer to the Department of Labor for their views and cost estimate.

S. 684 has multiple provisions addressing support for homeless veterans. We appreciate the attention to so many aspects of homelessness and the VA's homeless program. As you can see detailed in our written statement, we support many of those provisions. Other provisions we support in concept, but would like to engage with the Committee on technical aspects as well as funding issues.

Mr. Chairman, although we do not present views today on the draft bill that would establish a joint VA/DOD formulary, we understand the importance of the continuity of medical care when a servicemember transitions his or her health care to VA.

Over the past decade, VA has taken concrete steps to ensure medication continuity is a departmental priority. Most recently, VA issued guidance to VA prescribers and pharmacists, reiterating our long-standing practice of continuing mental health and pain medications for transitioning servicemembers.

VA, in fact, analyzed mental health and pain medication use for 2,000 transitioning servicemembers. Of those 2,000, only 21 veterans had medication switched solely due to differences between

the VA and DOD drug formularies. While not acceptable, we believe even these few incidents can be addressed.

A GAO analysis had similar results with a finding that 90 percent of mental health medications and 96 percent of pain medications dispensed by DOD are listed on the VA national formulary. Although the report did not mention it, VA routinely dispenses DOD formulary medications even though they are not listed on the VA national formulary.

We look forward to working with the Committee to ensure there is confidence in the continuity of care for transitioning servicemembers. Thank you, Mr. Chairman, for the opportunity to testify today. My colleagues and I would be pleased to respond to any questions that you or the Members of the Committee may have at this time.

[The prepared statement of Dr. Lynch follows:]

PREPARED STATEMENT OF THOMAS LYNCH, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH CLINICAL OPERATIONS, VETERANS HEALTH ADMINISTRATION (VHA), 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.

S. 207—VETERANS ACCESS TO COMMUNITY CARE ACT OF 2015

S. 207, the Veterans Access to Community Care Act of 2015, would require VA to use specified authorities to purchase non-VA hospital care and medical services for Veterans who reside more than 40 miles driving distance from the closest VA medical facility that can furnish the care sought by the Veteran. The specified authorities are section 1703 of title 38, United States Code (U.S.C.), the authority in section 101 of the recently enacted Veterans Access, Choice, and Accountability Act of 2014 (VACAA) (Public Law 113–146), and any other authority under the laws administered by VA relating to the purchase of hospital care and medical services at non-VA facilities.

We believe the intent of S. 207 is to expand eligibility for the Choice Program to Veterans who meet the threshold eligibility requirements for Choice and reside more than 40 miles driving distance from the closest VA medical facility that can furnish the care sought by the Veteran. However, it is not clear whether the bill as drafted would accomplish this objective. The language of section 2(b)(2), "relating to the furnishing of hospital care and medical services * * * if the veteran is unable to schedule an appointment * * * within the wait-time goals of the Veterans Health Administration," appears to limit the application of the bill's reference to VACAA to Veterans eligible for Choice based on section 101(b)(2)(A) of VACAA, i.e., only those Veterans unable to schedule an appointment within wait time goals.

We also note that S. 207 would not amend section 101 of VACAA. Consequently, it is not clear how the requirements of section 101 would apply to care provided under the authority in section 2(b)(2) of the bill. If enacted as drafted, we would interpret S. 207 in conjunction with section 101 by, for example, applying the provider eligibility requirements and payment rates set forth in VACAA. Similarly, sections 2(b)(1) and (3) do not amend section 1703 or VA's sharing agreement authorities, but we would apply the requirements of those existing authorities to care provided under S. 207. Because the bill does not actually alter distance-based eligibility under the Veterans Choice Program, it creates significant ambiguities, funding questions and legal issues which we would be glad to discuss with Committee staff.

When VA analyzed the cost impact of providing care under the Veterans Choice Program based on the distance between a Veteran's residence and the closest VA medical facility that provides the needed care, we concluded that this change would

have a significant budgetary impact, leading to total Choice Program costs for those eligible Veterans more than 40 driving miles that could range from $5 billion to $34 billion annually; this estimate assumes that participation in the Veterans Choice Program is not limited to only those Veterans enrolled as of August 1, 2014, as is required under the current law. We have briefed your staff, as well as representatives from the Congressional Budget Office, on that range of estimates, including their underlying assumptions. VA cannot reconcile the resource requirements that would be posed by S. 207 with any realistic view regarding the resources that will be available to VA under the framework reached in the budget resolution recently approved by both the Senate and House. Therefore, VA does not support S. 207.

As VA testified on May 12 before this Committee, VA has taken steps to improve the Veterans Choice Program, including expanding access by publishing a second interim final rule changing the way we measure distance for purposes of determining eligibility based on residence from a straight-line measure to a driving distance measure. VA was glad to see this change also carried out in legislation, H.R. 2496, the Construction, Authorization and Choice Improvement Act, just signed into law by President Obama on May 22nd. This change has approximately doubled the number of Veterans eligible for the Veterans Choice Program based on the distance criteria, and we are glad to have eliminated one significant source of frustration and confusion for Veterans. H.R. 2496 also will provide VA greater flexibility within VACAA to consider factors unrelated to geographic challenges that impact a Veteran's ability to travel to access care. Enactment of this change allows us to mitigate the impact of distance and other hardships, including the Veteran's medical condition, for many Veterans, and enable more Veterans to receive health care closer to home.

VA is committed to continuing to work with the Committee to improve Veterans' timely access to care, within the Veterans Choice Program and outside of it.

S. 297—FRONTLINES TO LIFELINES ACT OF 2015

Section 3(a) of the Frontlines to Lifelines Act of 2015 would direct the Secretary of Defense to transfer to the Secretary of Veterans Affairs the credentialing data of a covered health care provider who has been hired by VA, upon receiving a request from VA for the Department of Defense's (DOD) credentialing data related to such health care provider.

Section 3(b) would define a "covered health care provider" as a health care provider who is or was employed by the Secretary of Defense, provides or provided health care related services as part of such employment, and was credentialed by the Secretary of Defense.

Section 3(c) would require the Secretaries of Veterans Affairs and Defense to establish policies and promulgate regulations as may be necessary to carry out this section.

Section 3(d) would define the term "credentialing" to mean the systematic process of screening and evaluating qualifications and other credentials, including licensure, required education, relevant training and experience, and current competence and health status.

Credentialing is required to ensure a health care provider has the necessary clinical competence, professional experience, health status, education, training and licensure to provide specified medical or other patient care services. VA understands the goals of section 3, and the sharing of credentialing data between departments would facilitate VA's credentialing process and the appointment of only qualified, covered health care providers to the VA facility's medical staff. However, as this provision places requirements upon DOD, consultation with DOD is necessary before VA can present a position on this provision.

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 Vet-

erans 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 Healthcare 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 forward 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 two 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.

ADDITIONAL VIEWS FROM ROBERT A. MCDONALD, SECRETARY,
U.S. DEPARTMENT OF VETERANS AFFAIRS

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.

JUNE 3, 2015 AGENDA

S. 471, WOMEN VETERANS ACCESS TO QUALITY CARE ACT OF 2015

Section 2 of S. 471 would require VA to establish standards to ensure that all VA medical facilities have the structural characteristics necessary to adequately meet the gender-specific health care needs, including privacy, safety, and dignity, of Vet-

erans at these facilities. VA would be required to promulgate regulations within 180 days of the date of enactment to carry out this section. Within 270 days of the date of the enactment of the Act, VA would be required to integrate these standards into the prioritization methodology used by VA with respect to requests for funding of major medical facility projects and major medical facility leases. Not later than 450 days after the date of the enactment of the Act, VA would be required to report to the Committees on Veterans' Affairs of the House and Senate on the standards established under this section, including a list of VA medical facilities that fail to meet the standards; the minimum total cost to ensure that all VA medical facilities meet such standards; the number of projects or leases that qualify as a major medical facility project or major medical facility lease; and where each such project or lease is located in VA's current project prioritization.

VA appreciates the intent of section 2 of S. 471, but we do not believe it is necessary given other actions we are already taking. For example, in 2012, VA developed and published a Space Planning Criteria Chapter for Women Veterans Clinical Service, which provides standards for Women Veterans Clinical services within VA. A standard examination room plan for Women Veterans Clinics was developed including access to bathroom facilities directly connected to the examination room. VA's Medical/Surgical Inpatient Units and Intensive Care Nursing Units Design Guide, developed in 2011 and 2012, addresses the gender-specific needs of women Veterans. These standards are available online at: www.cfm.va.gov/TIL. Moreover, it is unclear why VA would need to promulgate regulations for this section. Absent the requirement in the bill, VA would not need to promulgate regulations. VA's construction standards have been established through policy for years, and revising our standards through this process is less resource intensive and faster than formal regulations.

Section 3 of S. 471 would require the Secretary to use health outcomes for women Veterans furnished hospital care, medical services, and other health care by VA in evaluating the performance of VA medical center directors. It would also require VA to publish on an Internet Web site information on the performance of directors of medical centers with respect to health outcomes for women Veterans, including data on health outcomes pursuant to key health outcome metrics, a comparison of how such data compares to data on health outcomes for male Veterans, and explanations of this data to help the public understand this information.

We do not support section 3 of S. 471. Many important health outcomes, such as mortality and readmission, are normally not reported by gender in hospitals. The inherent problem relates to the difficulty of measurement at individual facilities where numbers of outcome events for women Veterans may be few, which would mean that any findings would not be statistically significant or reliable. VA could report outpatient experience by gender, but to obtain valid results at the facility level, we would need to implement over-sampling of women Veterans for the Survey of Healthcare Experiences of Patients (SHEP). This would be costly and is likely to be perceived as burdensome on women Veterans.

Furthermore, the Institute of Medicine (IOM), in its report "Vital Signs: Core Metrics for Health and Health Care Progress" (2015), has raised concerns about the increasing burden on providers posed by the proliferation of performance measures. Valid and actionable metrics are difficult and costly to develop and implement. Flawed measures, however well-intentioned, can produce programmatic distortions such as an overly narrow focus on measured activities rather than what is most important to the patient (IOM, p 19). VA already monitors gender-specific performance system wide and has other mechanisms in place, such as site surveys, to ensure equitable provision of care. For these reasons, we do not support inclusion of gender-based outcome measures for evaluating the performance of medical center directors.

Section 4 of S. 471 would seek to increase the number of obstetricians and gynecologists employed by VA. Paragraph (a) of this section would require, not later than 540 days after the date of the enactment of this Act, that VA ensure that every VA medical center have a full-time obstetrician or gynecologist.

VA supports the intent of section 4(a) and is already taking steps to expand access to gynecological care throughout VA. Currently, approximately 78 percent of VA medical centers have a gynecologist on staff, and we plan to add this service at roughly another 20 facilities. This will ensure that all facilities with a surgical complexity of intermediate or complex will have a gynecologist on staff. At facilities with a surgical complexity designation of standard or less, we do not believe that there is sufficient patient demand to support a full-time gynecologist or obstetrician. For Veterans needing these services at these facilities, VA uses its authorities for care in the community to ensure these Veterans are able to access care. Moreover, in some areas of the country, particularly in smaller or more rural areas, VA faces re-

cruitment challenges in hiring new staff, and we anticipate we would face similar challenges if this legislation were enacted.

Paragraph (b) of section 4 of S. 471 would require VA, within 2 years of the enactment of this Act, to carry out a pilot program in not less than three Veterans Integrated Service Networks (VISN) to increase the number of residency program positions and graduate medical education positions for obstetricians and gynecologists (OB-GYN) at VA medical facilities.

VA supports the intent of paragraph (b) of section 4, and is already using authority Congress has previously provided to recruit residents in these fields. Currently, VA funds over 25 OB-GYN residency positions across 32 sites. While gynecologic services are widely available throughout VA, the limited patient population and scope of services at some sites makes broad-based national increases in these residency positions difficult. Additionally, section 301(b) of the Veterans Access, Choice, and Accountability Act of 2014 ("the Choice Act," Public Law 113–146) allows the Secretary to support primary care, mental health, and other specialty residency positions as appropriate. VA is using the authority and resources from the Choice Act to increase OB-GYN residency positions in locations demonstrating significant access issues for Women Veterans, as long as these sites can also demonstrate sufficient educational infrastructure such as faculty supervision and space, and willing educational program partners. We do not have costs at this time.

Section 5 of S. 471 would require VA to develop procedures to share electronically certain information with State Veterans agencies to facilitate the furnishing of assistance and benefits to Veterans. The information would include military service and separation data, a personal email address, a personal telephone number, and a mailing address. Veterans would be able to prevent their information from being shared with State Veterans agencies by using an opt-out process developed by VA. VA would be required to ensure that the information shared with State Veterans agencies is only shared by such agencies with county government Veterans service offices for such purposes as VA would determine for the administration and delivery of assistance and benefits.

We believe strong relationships with State Veterans agencies, as well as outreach to Veterans, are critical. However, VA does have concerns with this section. The information required, we believe, would have Privacy Act implications. Also, managing opt-out requests would require additional resources, although the amount cannot be projected with specificity. We would be glad to discuss with the Committee VA's collaborative efforts with State Veterans agencies on outreach, and how the goals of section 5 could be fulfilled while avoiding the concerns expressed above.

Finally, section 6 of S. 471 would direct the Comptroller General to carry out an examination of whether VA medical centers are able to meet the health care needs of women Veterans. The examination would include the wait times for women Veterans for appointments; whether the medical centers have a clinic that specializes in the treatment of women Veterans; the number of full-time obstetricians or gynecologists; the number of health professionals trained in women's health; the extent to which the medical center conducts regular training on issues specific to women's health and sensitivity training; the differences in health outcomes between men and women Veterans; the security and privacy measures used in registration, clinical, and diagnostic areas; the availability of gender-specific equipment or procedures; the extent to which VA's Center for Women Veterans advises and engages with medical centers in providing health care to women Veterans; the extent to which the medical centers implement directives from the Center for Women Veterans; the outreach conducted by VA to women Veterans in the community; the collaboration between VA medical centers and providers in the community to meet the health care needs of women Veterans; and the effectiveness of the Patient Aligned Care Teams in meeting the health care needs of women Veterans. The Comptroller General would be required, within 270 days of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on this examination.

We defer to the U.S. Government Accountability Office (GAO) on this provision.

DRAFT BILL, VETERANS HEALTH ACT OF 2015

Section 4 would extend by one year, until December 31, 2016, VA's authority to transport persons to and from VA facilities and other places in connection with vocational rehabilitation, counseling required under chapter 34 or 35 of title 38, or for the purpose of examination, treatment, or care. Section 4(b) would authorize appropriations of $4 million for FY 2016 and 2017, and section 4(c) would require a report to Congress within 1 year of the date of the enactment of this Act on VA's transpor-

tation program, the use of the program by Veterans, and the feasibility and advisability of continuing the program beyond December 31, 2016.

VA has no objection to the reporting requirement under section 4(c).

Section 5 would require VA to make available on an Internet Web site data files that contain information on research of the Department, a data dictionary on each data file, and instructions for how to obtain access to each data file for use in research. It would also require, within 18 months of the date of the enactment of this Act, that any final, peer-reviewed manuscript prepared for publication that uses data gathered or formulated from research funded by the Department be submitted to the Secretary for deposit in a digital archive. VA would be required to establish this archive within 18 months of the date of the enactment of the Act or to partner with another executive agency to compile such manuscripts in a digital archive. The digital archive would have to be publicly available on an Internet Web site, and each manuscript would have to be available through the archive within 1 year of the official date on which the manuscript is published. VA would also be required, within 1 year of making manuscripts available and annually thereafter, to report to Congress on the implementation of this section. Finally, within 1 year of the date of the enactment of this Act, the VA-Department of Defense (DOD) Joint Executive Committee would be required to submit to the VA and DOD Secretaries options and recommendations for the establishment of a program for long-term cooperation and data sharing between the two Departments.

VA is still analyzing this section and would be glad to provide views at a later time.

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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.

JUNE 3, 2015

S. 297—FRONTLINES TO LIFELINES ACT OF 2015

Section 2 of S. 297 would require VA to revive the Intermediate Care Technician Pilot Program of the Department of Veterans Affairs (VA) that was carried out between January 2013 and February 2014. VA would be required to expand the pilot program to include not less than 250 intermediate care technicians in the pilot program. It would also permit VA to assign any intermediate care technician hired under this program to a VA medical facility, with the Secretary giving priority to facilities at which Veterans have the longest wait times for appointments for the

receipt of hospital care or medical services. The pilot would be authorized during the 3-year period beginning on the date of the enactment of this Act.

As we explained in a response to a question from Senator Rounds at the hearing, we are currently working to expand the program beyond emergency services, most notably to increase support in podiatry and surgical clinics given the qualifications of those participating in the earlier pilot program. We do not require additional legislation for this expansion of the program, and consequently, VA does not support section 2 of this bill because we are already moving ahead with a permanent program, rather than a pilot program.

Section 4(a) of S. 297 would give discretion to the Secretary to authorize "covered nurses" to practice independently, without supervision or direction of others, under a set of privileges approved by the Secretary. Such authority would be notwithstanding any provision of state law and regardless of the state in which the covered nurse would be employed by VA. Section 4(b) would define a "covered nurse" as an advanced practice registered nurse (APRN) who is employed by VA in any of the following specializations: Nurse Midwife, Clinical Nurse Specialist (with respect to the provision of mental health care), and Nurse Practitioner.

VA supports the intent of section 4, but we offer four recommendations for technical revisions to the legislation. First, we recommend adding a reference to state of licensure in section 4(a). This would enable the Secretary to standardize the practice of APRNs throughout VA's health care system, regardless of the state(s) in which they are licensed and/or employed by VA. This technical revision would facilitate the provision of additional health care services in medically-underserved areas, thereby increasing access to high quality health care for all Veterans.

Second, we recommend that the phrase "under a set of privileges approved by the Secretary" be deleted from section 4(a), as unnecessary. To practice professionally, all health care providers must be granted a scope of practice or clinical privileges by the medical facility where they work.

Third, we recommend that the word "Licensed Certified" be added to the titles of Nurse Midwife, Clinical Nurse Specialist, and Nurse Practitioner.

Fourth, we recommend that Section 4 contain a new subsection (c) to clarify that covered nurses may prescribe controlled substances provided they are authorized by their state licensure to do so and comply with the limitations and restrictions on that prescribing authority.

DRAFT BILL—ESTABLISHING A JOINT UNIFORM FORMULARY FOR SYSTEMIC PAIN AND PSYCHIATRIC DRUGS

The draft bill establishing a joint uniform formulary for systemic pain and psychiatric drugs, would require the Secretaries of Defense and Veteran Affairs to establish (and periodically update) a joint strategic, evidence-based, uniform formulary for systemic pain and psychiatric drugs that are critical for individuals receiving health care services furnished by DOD who are transitioning to health care services furnished by VA.

While this draft bill is narrower in scope than other legislation being considered by the Congress, VA still believes the proposed legislation is unnecessary and has the potential to undermine VA's formulary process. First, as documented by a U.S. Government Accountability Office (GAO) report, DOD and VA Health Care: Medication Needs during Transitions May Not Be Managed for All Servicemembers (November 2012), VA's formulary already lists 90 percent of mental health and 96 percent of pain medication DOD currently dispenses (p. 17–18). Second, VA and DOD already collaborate to conduct extensive reviews of medications available to transitioning Servicemembers on their respective formularies. Furthermore, VA has a longstanding policy of promoting continuity of care between DOD and VA and existing policies to manage Servicemember transition from DOD to VA. For example, an Information Letter (IL 10–2014–15) from the Under Secretary for Health in July 2014 stated, "The medication therapy needs of recently discharged Veterans who choose VA for their medical care should also be carefully evaluated by VA health care providers and unless medical conditions warrant a change, existing medication therapies should be continued." Additionally, in August 2014, as part of the President's executive actions to address the mental health needs of Servicemembers and Veterans, VA announced a new policy to ensure that transitioning Servicemembers can maintain access to mental health medication absent specific safety or clinical reasons to make a change. VA has implemented this policy through Veterans Health Administration (VHA) Directive 2014–02, Continuation of Mental Health Medications Initiated by Department of Defense Authorized Providers, which states that it is VHA policy not to discontinue mental health medications initiated

by a DOD authorized provider solely because of differences between the VA and DOD drug formularies.

VA's formulary process is evidence-based and not automatic or based on prescriber preferences. This process involves VA clinical subject matter experts, who perform clinical reviews and provide recommended guidelines, and recommendations and decisions by VA's Medical Advisory Panel and the Veterans Integrated Service Network Pharmacy Executive Committee. VA's current formulary methodology enables clinical staff to use discretion to exclude drugs from VA's formulary when there is the belief that certain pharmaceuticals pose safety risks or have unknown safety risks and/or offer no clinical benefit over existing formulary drugs. For example, between 1997 and 2011, 31 FDA-approved drugs were removed from the U.S. market, primarily for safety reasons, yet only 2 of these drugs were on VA's formulary. Despite the language in the proposed legislation aimed at preserving DOD and VA's authority to maintain their own unique formularies, VA does not see how the proposed legislation reconciles the differences between DOD and VA's formulary processes for purposes of a joint formulary, even of limited scope, and believes the current proposal may actually undermine VA's formulary process. Finally, VA believes implementing such a proposal could result in increased cost to VA with no corresponding clinical benefit for Veterans.

Of note, DOD has similarly noted concerns regarding establishment of a joint formulary in response to recent recommendations of the Military Compensation and Retirement Modernization Commission. DOD noted that it works with VA to ensure that medications can be maintained for transitioning Servicemembers but believes that sufficient authorities exist today to do so.

VA is unable to estimate the cost of this bill because it cannot be known, at this time, what medications would be included in the formulary.

DRAFT BILL—VETERANS HEALTH ACT OF 2015

Section 2 of the draft bill, "Veterans Health Act of 2015," would amend the definition of "preventive health services" in 38 United States Code (U.S.C.) 1701(9) to include immunizations against infectious diseases, including each immunization on the recommended adult immunization schedule at the time such immunization is indicated by the Advisory Committee on Immunization Practices established by the Secretary of Health and Human Services and delegated to the Centers for Disease Control and Prevention. It would also modify the requirements of the annual report to Congress on preventive health services by including a requirement to report on VA's programs to provide Veterans each immunization on the recommended adult immunization schedule at the time such immunization is indicated. Finally, section 2 would require VA, within 2 years of enactment of the Act, to submit to Congress a report on the development and implementation of quality measures and metrics, including targets for compliance, to ensure Veterans receiving medical services receive each immunization on the recommended adult immunization schedule at the time such immunization is indicated.

VA strongly supports preventive care measures, including making a wide range of immunizations available at VA medical facilities. However, because we believe VA is already satisfying the purpose of this bill, we do not support this legislation. Under current policy, VA already provides preventive immunizations at no cost to the Veteran. In addition, VHA is represented as an ex-officio member of the Advisory Committee on Immunization Practices (ACIP), and VA develops clinical preventive services guidance statements on immunizations in accordance with ACIP recommendations. All ACIP-recommended vaccines are available to Veterans at VA medical facilities. These vaccines currently include: hepatitis A, hepatitis B, human papillomavirus, influenza, measles/mumps/rubella, meningococcal, pneumococcal, tetanus/diphtheria/pertussis, tetanus/diphtheria, varicella, and zoster. As the ACIP recommendations change, VHA policy reflects those changes.

The delivery of preventive care, including vaccinations, has been well established in the VHA Performance Measurement system for more than 10 years with targets that are appropriate for the type of preventive service or vaccine. VA updates the performance measures to reflect changes in medical practice over time.

Section 3 would require VA to carry out a program to provide chiropractic care and services to Veterans through VA medical facilities at not fewer than two VA medical centers in each VISN by not later than 2 years after the date of the enactment of this Act, and at not fewer than 50 percent of all VA medical centers in each VISN by not later than 3 years after the date of the enactment of this Act. It would also modify 38 U.S.C. 1701 to amend the definition of "medical services" to include chiropractic care and would amend the definition of "preventive health services" to include periodic and preventive chiropractic examinations and services.

VA supports the intent of section 3 of this bill, conditioned on the availability of additional resources to implement this provision. Expanding the number of VA medical facilities providing on-station chiropractic care would serve the needs of Veterans in expanding the availability of evidence-based treatment for musculoskeletal pain conditions that are highly prevalent in Veterans. Chiropractic treatment has been shown to be clinically effective, cost effective, and in high demand by Veterans. Patients who have access to chiropractic care are less likely to receive opiate medications and spinal surgeries. Just this year, The Joint Commission added chiropractic care to its pain management standards.

Additionally, VA has already been expanding access to chiropractic services for Veterans. In fiscal year (FY) 2014, VA provided on-station chiropractic care to 26,395 Veterans, an increase of 14 percent from FY 2013. As of May 2015, 52 VA medical centers have chiropractic clinics, up from 47 in FY 2014. Nevertheless, VA continues to face significant variation in access to chiropractic care across the country. Therefore, expanding the minimum number of chiropractic clinics per VISN will facilitate providing these services to Veterans in a more equitable manner.

We offer two recommendations for technical revisions to the legislation. First, we recommend removing the reference to clinics in the proposed amendment to section 204(c) of Public Law 107–135. This change would focus the language on VA medical centers and would not result in confusion over whether clinic referred to a service at a medical center or an independent clinic at another location. Second, we recommend the legislation not amend the definition of preventive health services in section 1701(9). Chiropractic services are provided as part of the medical benefits package and are administered based on clinical need, similar to all other medical care. It would be inconsistent with the professional standards for other medical disciplines and inappropriate to provide "periodic and preventative chiropractic examination and services" when there are no clinical indications that such care is needed.

We estimate that VA would need to add chiropractic services at five facilities to meet the requirement to operate the program at not fewer than two VA medical centers in each VISN within 2 years of the date of the enactment of this Act, and at another 23 facilities to meet the requirement that these services be available at not fewer than 50 percent of all VA medical centers in each VISN within 3 years of the date of the enactment of this Act. We estimate that the cost to hire these additional staff would be $3.67 million per year after the requirements of section 3 are fully phased in.

Section 5 would require VA to make available on an Internet Web site data files that contain information on research of the Department, a data dictionary on each data file, and instructions for how to obtain access to each data file for use in research. It would also require, within 18 months of the date of the enactment of this Act, that any final, peer-reviewed manuscript prepared for publication that uses data gathered or formulated from research funded by the Department be submitted to the Secretary for deposit in a digital archive. VA would be required to establish this archive within 18 months of the date of the enactment of the Act or to partner with another executive agency to compile such manuscripts in a digital archive. The digital archive would have to be publicly available on an Internet Web site, and each manuscript would have to be available through the archive within 1 year of the official date on which the manuscript is published. VA would also be required, within 1 year of making manuscripts available and annually thereafter, to report to Congress on the implementation of this section. Finally, within 1 year of the date of the enactment of this Act, the VA/DOD Joint Executive Committee would be required to submit to the VA and DOD Secretaries options and recommendations for the establishment of a program for long-term cooperation and data sharing between the two Departments.

VA supports the goal of this bill and is already taking action to achieve its objectives. Public access to research has been an increasingly important topic among Federal research agencies over the past several years. As a result, most of what is required in this bill has already been accomplished or is in process. On February 22, 2013, the White House Office of Science and Technology Policy (OSTP) directed each Federal agency with over $100 million in annual expenditures for the conduct of research and development to develop a plan to support increased public access to the results of research funded by the Federal Government, including any results published in peer-reviewed scholarly publications that are based on research that directly arises from Federal funds. The bill's requirement to make information on VA research publicly available on an Internet Web site is nearly identical to requirements established by OSTP. Similarly, VA has already taken steps to satisfy the bill's requirement that VA ensure public access to manuscripts on VA-funded research. All VA-funded investigators are required to place their published manuscripts on the National Institutes of Health (NIH) PubMed, which provides manu-

scripts free to the public. Use of PubMed ensures that texts and their associated content will be stored in non-proprietary and/or widely-distributed archival, machine readable formats; provide access to persons with disabilities in accordance with Section 508 of the Rehabilitation Act of 1973; enable interoperability with other Federal public access archival solutions and other appropriate archives; and ensure that attribution to authors, journals, and original publishers will be maintained. VA also currently requires, and will continue to require, that the results of applicable VA-funded clinical trials must be provided to the public through the ClinicalTrials.gov archive, which provides access to the results of clinical trials involving products regulated by the Food and Drug Administration. Additionally, VA is working with DOD to develop data sharing agreements, and several such agreements are already in place.

We are concerned that the bill, as written, would greatly increase costs to the Department and may inadvertently limit the public availability of manuscripts. As stated, VA is currently making much of this information public, but through other mechanisms, such as PubMed or ClinicalTrials.gov. Requiring VA to develop its own Web site would require additional expenses with no net benefit in terms of the availability of information. Additionally, creating a separate repository for this information from PubMed or ClinicalTrials.gov would spread information among several Federal Web sites, making it more difficult for users to find information. VA is unable to offer a cost estimate at this time because we cannot determine the information technology (IT) costs associated with these requirements.

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Chairman ISAKSON. Thank you, Dr. Lynch. I have a comment and a question. You made favorable statements about the language providing for provider agreements, is that correct?

Dr. LYNCH. Yes, Senator.

Chairman ISAKSON. VA has had input into that language in terms of non-VA health care, is that correct?

Dr. LYNCH. Yes, Senator.

Chairman ISAKSON. And those provisions are merged with another provision that Senator Hoeven introduced to allow VA nursing home vouchers be accepted by private providers, is that correct?

Dr. LYNCH. Senator, I would have to defer to Ms. Blauert on that.

Ms. BLAUERT. Yes, the veterans care agreements would be available to be used for extended care services, so purchasing nursing home care from community providers.

Chairman ISAKSON. And there is no objection from the VA on any of those provisions, is that correct?

Ms. BLAUERT. Specifically, we are in favor of being able to purchase extended care services through a mechanism like a veterans care agreement.

Chairman ISAKSON. For the benefit of the Members, one of the burdens of chairmanship is from time to time you are asked to make commitments on the floor of the Senate that you wish you had waited to make. I committed to Senator Hoeven that we would not object to a UC (unanimous consent) on provider agreements in terms of nursing home facilities. Subsequently, that information was merged, as I understand it, with provider language for all non-VA provider contracts, both hospitalization as well as physicians, is that correct?

Ms. BLAUERT. Yes. The Administration bill that was presented on May 1st included hospital care medical services and extended care services.

Chairman ISAKSON. So, the Members are fully appraised, if a UC is offered on the floor prior to us doing a markup on that bill, I am not going to object to that UC. I wanted you all to all hear from

the VA that they have no objection to the provider agreement language, which is, I think, what the lawyer said.

Chairman ISAKSON. Am I right, Tom?

Dr. LYNCH. Yes, sir.

Chairman ISAKSON. Senator Blumenthal, is that right?

Senator BLUMENTHAL. That is absolutely correct, Mr. Chairman, and I want to thank you personally for your understanding on behalf of myself, and I think I speak for Senator Hoeven. Our staffs have worked very closely and well on merging these two pieces of legislation that essentially deal with providing alternative opportunities for care to our veterans, and I want to thank the VA for being cooperative as well.

Chairman ISAKSON. Thank you, Senator Blumenthal. Senator Blumenthal, do you have a question?

Senator BLUMENTHAL. I just want to ask you, Dr. Lynch, very quickly about the formulary issue. I do not know whether you have had a chance to read Mr. Medina's written testimony telling of his struggle to obtain medication that his doctor previously found to work well for him and to manage chronic symptoms from his Traumatic Brain Injury. It is a very powerful and compelling story.

I understand that after learning of Mr. Medina's attempt to testify today, the VA reached out to him offering to cover the medication that was originally prescribed by DOD, but, in effect, denied by the VA.

I am very pleased and thankful that the VA seems to be taking action to remedy the problems of a prior policy, and my feeling is that the VA, or perhaps more directly veterans treatment options, should not be determined by whether or not they have an opportunity to speak in front of Congress.

Earlier this year, the VA issued a directive meant to prevent transitioning soldiers like Mr. Medina from having to stop treatment that has proven effective simply because it is not in the VA's formulary. I welcome that directive or policy change.

Can you discuss whether you have seen any other improvements? Obviously Mr. Medina's situation has improved since the implementation of this policy.

Dr. LYNCH. The only reference I would have, Senator, is that when we did look at a series of 2,000 veterans, we saw a small percentage who did have a problem as they related to the VA/DOD formulary issue. We have been very aggressive in getting communications to the field. VA feels strongly that there needs to be an appropriate transfer of medications.

The single qualification would be that there is a certain clinical judgment that has to occur at the time of transfer and there may be some changes under those circumstances. But otherwise, I think it is important, as the veteran transitions, that we do not change medications if clinically appropriate.

Senator BLUMENTHAL. And that the approach be, in effect, evidence-based and that it be consistent with patient safety?

Dr. LYNCH. That has been the VA's approach to our formulary as we have developed the formulary. It has been evidence-based, it has been focused on patient safety, it has used the best available information to determine what drugs to place on that formulary, absolutely.

Senator BLUMENTHAL. Thank you. Thanks, Mr. Chairman.
Chairman ISAKSON. Senator Moran.

HON. JERRY MORAN, U.S. SENATOR FROM KANSAS

Senator MORAN. No questions.
Chairman ISAKSON. Senator Tester.

HON. JON TESTER, U.S. SENATOR FROM MONTANA

Senator TESTER. Well, thank you, Mr. Chairman, and I want to say thank you for holding this hearing. We have focused mainly on oversight of this Committee, which is very, very important, so it is good to get some good policies out, too. So, I thank you for that, Mr. Chairman and Ranking Member Blumenthal.

Just a question for you, Mr. Lynch—Dr. Lynch, I am sorry. The VA——

Dr. LYNCH. It is only important to my mother.

Senator TESTER [continuing]. Launched a veterans transportation service initiative which began providing funds to local VA facilities to help them better meet the transportation needs of our veterans out there. Since that time, this funding has been used in Montana and elsewhere to hire staff, transportation staff, and purchase vehicles.

I think the program is working and there is a reauthorization proposal here today. I think it is in the fifth group down, which is a compilation of bills that is Number 172, but I think a long-term authority is important. I just want to get your perspective on the transportation bill and transportation perspective.

Does this program so far do what it was intended to do and that is connect veterans with rehab counseling and medical care that they need?

Dr. LYNCH. Absolutely. This has been a tremendous program. It has helped us get veterans to services that they need in a convenient fashion. It is being expanded. Interestingly, one of my responsibilities is spinal cord injury. Our spinal cord injury physicians are beginning to explore the use of this service to move those veterans to care as well. I think it is very well formed. I think it is a good program. I think it needs to continue.

Senator TESTER. Now, the VA has estimated that a longer-term authorization could potentially save the taxpayers about $206 million, a little over that, almost $207 million over 5 years.

Dr. LYNCH. Yes, sir.

Senator TESTER. Would you agree with that estimate? I assume that is because of additional travel costs, staying overnight, all that kind of stuff.

Dr. LYNCH. That would be my assumption, sir.

Senator TESTER. OK, good. So, there are some areas where it has been tough to find drivers, to be quite frank with you, and I will just give you an example. Like Fort Peck Indian Reservation where we have a high number of veterans, yet, tough to get qualified drivers for a number of reasons, and they are all real.

Is there some way—do you have the ability now in cases like that—and this is not with this bill particularly, just overall—to be able to contract with other transportation services out there that already exist?

Dr. LYNCH. Senator, I cannot answer that question specifically. I would like to get back to you with an answer that I am confident with, if that would be permissible.

Senator TESTER. That would be very good because I think it may serve some purpose down the line, so if you could do that, that would be great.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JON TESTER TO THOMAS LYNCH, M.D., U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. For the purpose of delivering healthcare, the VA may contract transportation services for certain eligible Veterans, other persons traveling with an eligible Veteran or in certain circumstances when transport is required to provide a complete hospital or medical services.

Title 38 U.S.C. 111 provides authority to make payment to or for certain persons for travel in relation to VA examination, treatment or care. This authority is limited to the eligibility criteria of the authority and determined under the regulations prescribed at 38 CFR Part 70.

Title 38 U.S.C. 7301(b) has been interpreted to provide the transportation for the transfer of a patient between VA facilities and/or Non-VA facility at VA expense when; the initial transferring VA facility is incapable of providing the necessary treatment, care or examination, The transfer is necessary for the continuation of services, A VA facility has accepted for admission a patient receiving emergency care at a non-VA facility at VA expense under 38 U.S.C. 1728 or who is otherwise eligible for travel benefits under 38 U.S.C. 111.

The majority of our transportation contracts consists of ambulance and wheelchair transport services, but may include such services as taxi when appropriate. VA facilities typically do not have these types of vehicles and the staff needed to provide transport or those that do cannot meet the volume of service required. Although not always possible, the VA attempts to enter into Transportation service contracts to reduce costs to the government when the facility has insufficient assets to meet the demand for transporting our Veterans to ensure they have access to care.

When VA must utilize a contract for transportation services the role of the contracting officer is to ensure that a contract is appropriate and complies with all terms of both Federal and VA Acquisition Regulations prior to and upon award.

Realizing these services are very costly to the government the Veteran Transportation Program continues to look for ways to offset the cost. One such program is our Veteran Transportation Service that works with facilities to implement their own transportation services. Other initiatives involve developing transportation partnerships within the local community.

Regardless of the methods used, transportation contracts, VA owned and operated services or community transportation services, all efforts are focused on providing our Veterans timely access to care.

Senator TESTER. Immunizations are kind of the low-hanging fruit out there from my perspective. I think it is very, very fast and effective for prevention of disease and health and death.

As many as 70,000, according to CDC, adults deaths are from vaccine preventable diseases. Dr. Lynch, as you may know, many of our veterans are in a high-risk category of contracting such diseases. To what extent does the VA—if you want to defer this you certainly can. To what extent does the VA place a priority on immunizations?

Dr. LYNCH. Number 1, VA places a high priority. I am not going to defer it. I am going to pass it off to Dr. McCarthy who actually has been looking at this very carefully over the past couple days in preparation.

Dr. MCCARTHY. Thanks for this question. VA takes the need for immunization extremely seriously and we have one of our chief consultants, actually an ex officio member on the national committee about immunizations.

Senator TESTER. OK.

Dr. MCCARTHY. We take what is the from the Committee and have a very proactive approach.

Senator TESTER. Now, the CDC has recommended that adult immunization schedules be periodically reviewed and revised. Do you do that?

Dr. MCCARTHY. Yes, we do.

Senator TESTER. OK. To what extent does the VA follow immunization recommendations of the CDC?

Dr. MCCARTHY. We follow the recommendations to the letter of the law in terms of what we recommend to veterans in terms of the immunizations that we would expect them to take. There are choices involved from the veteran perspective.

Senator TESTER. As you look at the protocol that is out there for administering vaccinations to veterans, do you see any improvements that could be made?

Dr. MCCARTHY. We look at this often. What is it that we are doing right, what could we do better. When we think, in particular—let us take flu vaccine, for instance. We seized the moment in terms of the Ebola crisis for people to have a lot of education about it, you know, in this country. There was a very significantly increased risk of death from influenza, and how important it was for our veterans to be vaccinated with influenza.

We had a very large education campaign about that. Some of our facilities set up drive-in clinics for flu shots and everything else. You know, what we could to better, perhaps, is make it even more convenient for veterans. That is where our focus has been.

Senator TESTER. Thank you. Thank you all for being here today and I may have some questions for the record on homelessness. Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Rounds.

HON. MIKE ROUNDS, U.S. SENATOR FROM SOUTH DAKOTA

Senator ROUNDS. Thank you, Mr. Chairman, I would also like to echo the comments earlier. It is good to see the Committee taking up discussions on these different pieces of legislation. I have appreciated the evaluation which you have expressed on the legislation which is before us today.

I guess my first question would be, if there was an order of importance with regard to the items found within it and that we are looking at today, could you give me the most important bill or the most important piece of legislation that would help you deliver health care to our veterans?

Dr. LYNCH. I think from VA's standpoint, it would be the development of a non-FAR model for obtaining purchased care in the community for our veterans.

Senator ROUNDS. Specifically, to one of the pieces of legislation here today?

Dr. LYNCH. Specifically, it is the draft legislation. Let me make sure I have the name correct here.

Ms. BLAUERT. It is the draft version of the Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act.

Senator ROUNDS. As I have said, I appreciate your review of the other legislation involved. If I could, just on S. 297, I did have just

a question with regard to Section 3 and Section 4 of that and your analysis. How do you lay out, in terms of the health care provider, how broad were you looking at or anticipating your review of who would be included as a health care provider for the pilot project?

Dr. LYNCH. VA has already had a pilot project with respect to intermediate care technicians. It concluded recently. It involved about 15 different sites. It included 45 individuals. Services were predominantly in the emergency department. It was wildly successful. VA is moving forward actively to expand the program and to expand it beyond emergency services.

Senator ROUNDS. Do you include the other allied health professions? I am just curious as to how broad the project is or how broad you could look at it in terms of the different professional services being provided.

Dr. LYNCH. Dr. McCarthy.

Dr. MCCARTHY. I can say that the initial thought was perhaps the best fit would be in emergency departments, but as time evolved, it seemed to support in podiatry and surgical clinics were a very good fit for the people that were part of the pilot for the transition. We are looking in the health care arena and what might be a good fit and it is a win-win.

Senator ROUNDS. You would be open to expanding the pilot project to other allied health professions that may not be involved in your pilot project today? What I am thinking about is, in South Dakota, we do not necessarily have—in a lot of our rural areas, we are served by allied health professionals. I just want to make sure that if we are looking at a pilot project like this, that we be as broad as possible. If there is a concern with regard to one profession versus another, I am just curious if you could share any concerns like that you might have.

Dr. MCCARTHY. I can say a little bit about the development of the pilot and the people in the different kinds of professions that were represented.

Senator ROUNDS. Please.

Dr. MCCARTHY. It included physicians, physician assistants, nursing staff of various professional degrees, in particular. I do not know that we had any representative from lab, but that is the kind of thing that we would embrace, yes.

Dr. LYNCH. I think we would be interested in exploring with your office any opportunities to expand that program and work with you to make a more effective program.

Senator ROUNDS. Very good.

Dr. LYNCH. It has been very successful. I think it is a great opportunity. It is win-win for the veteran and it is win-win for the VA.

Senator ROUNDS. Thank you. Mr. Chairman, I yield back.

Chairman ISAKSON. Thank you, Senator Rounds.

Senator Manchin.

HON. JOE MANCHIN, U.S. SENATOR FROM WEST VIRGINIA

Senator MANCHIN. Thank you, Mr. Chairman, and thank all of you. I am going to switch topics to something that is really devastating to my State. It is the opioids, prescription of these opioids, painkillers, and I am sure you all are very much aware of it. We

are being devastated in my State. It is the number 1 killer. We have a mortality rate and it is because of prescription drug abuse.

I am finding that the VA does not always have or offer good alternatives. For example, just in the Beckley VA medical center, there are zero alternative treatments available, and at Clarksburg we only have one.

So, my question would be, how do you plan on using funds provided under the Choice Act to establish alternative treatment methods at facilities like these?

Dr. LYNCH. Dr. McCarthy.

Dr. MCCARTHY. Sure, I will be happy to start. I used to be chief of staff at the Salem, Virginia, VA medical center and we treated many veterans from Beckley and we had a pain program in which some of the veterans from Beckley actually came and received some non-pharmacologic interventions for their pain.

They may not be provided right at Beckley, but there was access to those veterans, for instance, at Salem.

Senator MANCHIN. Yes.

Dr. MCCARTHY. Not perfect, I know,

Senator MANCHIN. Well, let me ask, for areas where we do not have the proper treatment, with the Choice Act, are you all allowing them to find different providers, private providers, that might be able to provide the services they need which would help them versus trying to find something within the VA system that is not even practical for them to go to?

Dr. MCCARTHY. Let us just talk about providers in general if we could, for a minute. We could talk about chiropractors. We could talk about pain specialists. We could talk about acupuncture. OK. Under the Choice program, indeed, chiropractors are included and pain specialists are included in terms of those that people are referred to.

I am not aware of the integrative complementary and alternative medicine specialties like, for instance, acupuncture. I would have to take that one for the record and get back to you.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOE MANCHIN TO MAUREEN MCCARTHY, M.D., U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Many Complementary and Integrative Health (CIH) practices are in use within VHA and CIH practices that are offered by licensed practitioners could be offered by non-VA providers through the Choice program. Two common CIH practices offered by licensed CIH practitioners are acupuncture and massage therapy. Recently Congress amended the Original Choice Act to include these providers in their provider network so that these resources may be available to Veterans if they are needed and cannot be provided by their local facilities. The VA Community Care office is working on contract modifications to include integrative health services in the current contracts VA has for non-VA care.

Dr. LYNCH. Senator, I would just add that the VA has established, over the last 12 to 18 months, a very aggressive opioid safety initiative program which is looking at our use of opioids. Part of that program, as we are looking at the use of opioids and the prescriptions for opioids across the system, is also looking at how we can incorporate complementary and alternative therapies into more VA medical centers, realizing this is going to be a critical part of treating veterans with chronic pain.

Senator MANCHIN. Well, let me just tell you what is hard. In my little State of West Virginia, from 2007 to 2012, over 200 million

pills, opioids, have been shipped to my State; 200 million. Our veterans are being affected by this. We have double the mortality rate as far as opioid overdoses in military VA than the national average. So, we know we have a problem with the VA.

We have got, basically, people who are not trained at dispensing or taking time to educate a veteran who is needing this—PTSD or whatever it may be—that are getting a concoction. They are taking things that are just lethal.

Dr. MCCARTHY. Yes. We could talk to you a little bit about the opioid safety initiative that we have going on.

Senator MANCHIN. How are you tracking your doctors who are over-prescribing?

Dr. MCCARTHY. We have tracking of prescriptions. We are tracking all of the opioids in terms of the morphine equivalent doses. We are actually expecting trends downward. We are tracking people that are on opiates as well as benzodiazepines, which is not a great——

Senator MANCHIN. Are we trying any alternatives? The reason I am saying that, if we as a Nation—you know, 5 percent of the population of the world is what we have in the United States of America, yet, we use 80 percent of the opioids that are produced in the world. Five percent of the world population consuming 80 percent of painkillers. Something is wrong.

Dr. MCCARTHY. Yes.

Senator MANCHIN. Now, you tell me that is not a big money scheme from pharma that is basically putting out pills that we do not need and putting out more of them than we ever could consume or should consume. Something is wrong there. So, I am saying, we have got to go to alternative pain methods. Are you all trying anything different?

Dr. MCCARTHY. Go ahead, Dr. Lynch.

Dr. LYNCH. I think we are. I mean, I would need to get back to you with the specifics, but as part of our opioid safety initiative, we are beginning to engage complementary and alternative therapies as part of the program. We do, in fact, give veterans informed consent before we provide opioids at this point.

We give them a discussion of what the risks and what the benefits of the treatment are. And we are making active efforts to get people off of high doses of opioids and on to alternative medications and therapies.

Senator MANCHIN. I am just saying, if we, as in the sense of the Senate, the sense of Congress, basically said, We believe that our Medicare, Medicaid, and VA, which is probably the largest group of medical providers in the world, if we could do that which we have influence over, it could basically change the direction of how we treat chronic pain or pain relief, if you will, and not just going to the opioids immediately, but going to alternative uses. Would it be something accepted by the VA?

Dr. MCCARTHY. I think it is a multifactorial approach. I think we need to not start people as much on them and we need to be very careful about the use of them and the mixing of them. Could I just add one other statement?

Senator MANCHIN. I am sorry, Mr. Chairman.

Dr. MCCARTHY. We are now dispensing opiate safety kits, which are the Naloxone kits, that reverse over-doses. I know that a lot of people are carrying them like first responders, police, and fire departments, but I did want you to know that we are actually dispensing them to veterans, and we have had over 55 people's lives saved by the veterans or their loved ones using it.

Senator MANCHIN. How many times do you dispense it to the same user?

Dr. MCCARTHY. I do not have the numbers on that.

Senator MANCHIN. If you could get numbers for me, I would like to know. Because there is another problem coming with that.

Dr. MCCARTHY. OK.

Senator MANCHIN. Two, three, four, five, six, seven, eight? Life support?

Dr. MCCARTHY. Right. I have not heard, but I would not be able to definitively say anything about the number of repeats. What I will say is we have veterans that are reaching out to their communities and saving those that are not veterans.

Senator MANCHIN. I am sorry, Mr. Chairman. I have used up my time, but this is such an important——

Dr. MCCARTHY. Yes, I would agree.

Senator MANCHIN [continuing]. Such an important topic.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. JOE MANCHIN TO MAUREEN MCCARTHY, M.D., U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. From June 19, 2014 to June 5, 2015, VA has received 72 reported reversals from the use of the opioid safety kits. Eleven Veterans have reported more than 1 reversal.

Providing another naloxone kit to a Veteran ensures the Veteran continues to have a means for their life to be saved should another overdose occur. This is similar to prescribing practices for other medications used in emergency situations, such as glucagon for hypoglycemia in diabetics and epi-pens for patients with severe allergies. It is recommended to use a naloxone prescription renewal request as an opportunity to determine the circumstances and base decisions to renew any prescriptions for opioids upon reassessment of the risks and benefits for that patient. It also presents the opportunity to engage the patient, provide re-education about overdoses, consider opioid risk mitigation strategies, and modify treatment plans.

Dr. MCCARTHY. Thank you.

Senator MANCHIN. Thank you.

Chairman ISAKSON. It is a welcome topic and your focus is welcome. You are talking about statistics in terms of 200 million pills to West Virginia?

Senator MANCHIN. Just in my State. In a 5-year period—I only have 1.85 million people in my State.

Chairman ISAKSON. A recent report turned out that there were enough opioids prescribed last year in the United States to provide 15 percent of the American population with a pill a day for the entire year. It is obviously an epidemic, not just in the military.

Senator MANCHIN. This did not happen when we were youth. OK?

Chairman ISAKSON. No.

Senator MANCHIN. It has just changed. It has changed within the last two to three decades, that some of these doctors are putting them out for severe pain, and this never happened unless you came off of a very severe operation, but we are giving them out. If you have got a toothache, you can get a month or 2 months supply.

This is something, but we can control this and we can help the veterans and it might change the whole trend of what we are doing in the country.

Chairman ISAKSON. You are right on track.

Senator MANCHIN. We are working on it.

Dr. LYNCH. Senator, we would be happy to work with your office providing some technical support for legislation.

Senator MANCHIN. Thank you.

Chairman ISAKSON. Senator Boozman.

HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and again, I appreciate the Senator from West Virginia bringing this up. The other problem we have is that as people get onto this, because of cost, the next step is heroin. It is epidemic right now and it is increasing all of the time, again, in the sense that it is the same, but it is much cheaper.

All of this stuff really does go together and we do appreciate your work on trying to get it under control. It is a situation that is not just a problem with the VA, but a problem across the board through society right now because of over-prescribing in the past.

I really do not have any questions. Senator, I would like to thank you for including the S. 425, the Boozman-Tester, Homeless Veterans Reintegration program. What we are trying to do there is get this reauthorized. Then again, you know, you get in a situation where you have benefits based on being homeless and then you get into housing and things like that and you start losing benefits, which makes no sense at all.

I mean, that is really where we need to double down. These are people that have admitted that they need help and we are doing the right thing. But the idea of providing them some help and then all of a sudden you start cutting benefits, which puts them in these Catch–22 situations. So, we are trying to get all of that sorted out and we do appreciate your help.

Thank you. I yield back, Mr. Chairman.

Chairman ISAKSON. And for your benefit, Senator Boozman, as well as the others on the Committee, we unfortunately had to move the June 24 markup to July 14, so that markup will take place on the bills we are hearing today and we will be bringing up at subsequent meetings.

Senator Murray.

HON. PATTY MURRAY, U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Mr. Chairman, first let me start by thanking you for the commitment to list a number of really critical bills at your next legislative hearing later this month. Those bills are sponsored and supported by a number of Members on this Committee, and I know it includes my Women's Veterans and Fertility Treatment bill which is extremely important, my legislation to help family caregivers, and I understand Senator Baldwin's legislation to improve opioid safety that Senator Manchin was just referring to as well.

I really appreciate that. You and I have worked on a lot of critical legislation over many years and I look forward to working with you on getting those bills done. Thank you.

To this panel, Dr. Lynch, I wanted to ask you about the Women Veterans Access to Quality Care Act. I was really pleased to work with Senator Heller on this legislation, and as I am sure you all know, the population of women veterans is increasing dramatically. It has actually doubled since 2001. This bill will require all VA medical centers to have at least one full-time OB/GYN. I wanted to ask you today, how long will it take the VA to meet that standard and does the Department usually struggle to recruit OB/GYNs?

Dr. LYNCH. Right now VA has GYN specialists in 78 percent of our facilities, about 118. There are plans to add additional GYN providers by directive to, I think, around 20 more facilities as part of our operative complexity model. The VA has a model of operative complexity that looks at a certain infrastructure required to support surgical services at facilities.

The mandate would be that all of our complex and intermediate facilities would have a GYN provider. Some of the smaller facilities, and unfortunately, Senator, I do not have the exact count for you, would have difficulty supporting a full-time GYN provider, and in some of those cases, care is provided through community contract.

Senator MURRAY. If you do not have an OB/GYN, do you contract out to a community OB/GYN?

Dr. LYNCH. The expectation would be yes, that we would provide those services in the community if we could not provide them at the VA.

Senator MURRAY. So, you can meet the needs of this bill?

Dr. LYNCH. Dr. McCarthy, would you like to——

Dr. MCCARTHY. I believe that we could meet the intent, which is to do what Dr. Lynch said in terms of based on the surgical complexity, that there would be a plan to hire for all the facilities at a certain level of complexity and higher. But for the facilities, the smaller facilities, there is the expectation that there would be access to care either in the community by contract or by having someone actually come into the facility.

Senator MURRAY. Do you have a timeline on how long that would take?

Dr. MCCARTHY. No, ma'am, I do not. Some of our facilities are in areas where it may be a challenge to recruit, and so I could not give you an absolute timeline. I am sorry.

Senator MURRAY. OK. Well, if you could give me an estimate, I would really appreciate it.

Dr. MCCARTHY. Would you be OK if I took that for the record?

Senator MURRAY. Yes, you may do it for the record.

Dr. MCCARTHY. OK.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO MAUREEN MCCARTHY, M.D., U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Obstetrician-Gynecologist (Ob/Gyn) providers play a critical role in the VA health care system by providing reproductive specialty care. Currently not all VA health care systems have an Ob/Gyn on-site. However, all VA health care systems have access to basic gynecology on-site through Designated Women's Health Primary Care Providers and all sites have access to specialty gynecology care by an Ob/Gyn through non-VA care if not available on-site. VA is committed to having Ob/Gyn care on site at each health care system and the recruitment of these specialists

will be affected by availability in surrounding areas. We are working with onsite facility leadership to address Ob/Gyn availability at sites with no Ob/Gyn. To allow time for recruitment and hiring, this requirement can be met by the end of Fiscal Year 17.

Senator MURRAY. Dr. Lynch, one provision of the Homeless Veterans Prevention Act would allow the grant and per diem program to provide payments for dependents who are accompanying homeless veterans. This is an important change to consider as the number of veterans with dependents, especially women, is rising.

Now, VA has stated that they support the intent of this part of the legislation, but it raised concerns about the need for additional resources to meet the needs of the veterans that would be served. If this unmet need is still there, why did the VA ask for cuts to the grant and per diem program in the budget request?

Dr. LYNCH. Senator, I would have to get back to you with the specifics on that. I cannot answer it. I know that we certainly do support the Homeless Veterans Prevention Act. We do support the increase in per diem for veterans participating in the grant and per diem program and the transition in place. I cannot comment specifically on the budget issues that you were speaking to right now.

Senator MURRAY. OK. Well, if you could get an answer back to me that is really an important question.

Dr. LYNCH. We will do that.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO THOMAS LYNCH, M.D., U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. VA acknowledges the unique needs of Veterans with dependent children. The Grant and Per Diem (GPD) program is not currently authorized to provide services or per diem payments for dependents who may accompany homeless Veterans.

In FY 2016, in order to work within its prescribe budgetary parameters VA made the strategic decision to reduce the FY 2016 funding request for the Grant and Per Diem (GPD) program. This funding adjustment was necessary to preserve VA's full continuum of comprehensive care for homeless Veterans within the budget constraints. It also allowed for the continue support of programs with the greatest capability of providing services to families of homeless Veterans including HUD-VA Supportive Housing and Supportive Services for Veteran Families (SSVF). GPD was able to carefully manage this funding reduction without adversely impacting services to homeless Veterans by fully utilizing its FY 2015 funds to initiate grant agreements that fund a portion of FY 2016 per diem expenditures. The FY 2017 budget request for the GPD program restores program funding at the fully authorized level.

• VA continues its commitment to serve homeless Veterans with dependents and women Veterans. Although HUD-VASH does not track dependent children in the program, during FY 2015, 12 percent of the persons served by HUD-VASH were women. Additionally, in FY 2015, of the 157,416 served by SSVF, 34,636 (15 percent) were dependent children. The proportion of children served in prevention services within SSVF is even higher at 29 percent.

Senator MURRAY. Finally, Dr. Lynch, it is really essential that we make sure our veterans have seamless transition from DOD to VA's health care system, but there are still a lot of barriers out there for our servicemembers and veterans. One frequent problem for new veterans is having to switch medications when they leave the military and come into the VA because the Departments do not carry the same medications. What are the differences in how the VA and DOD decide which medications to carry?

Dr. LYNCH. Do you want to take that, Dr. McCarthy?

Dr. MCCARTHY. Yes. Thanks for that question, Senator Murray. The VA formulary is one that is based on published evidence of

drug safety and effectiveness. There is a process of consideration once a drug is approved by the Food and Drug Administration, whether it be included in the pharmacy.

The DOD formulary is one that is statutory, that anything approved by the FDA is part of the DOD formulary. The VA's formulary is one that has a second-level review for evidence-bases, efficacy, safety and so forth. Our formulary process has been reviewed by Inspector General, Institute of Medicine, multiple people, and what they say is our formulary process is actually a model for the Federal Government.

Senator MURRAY. So, how come the DOD has not done that? You are probably the wrong people to ask, but you are here.

Dr. MCCARTHY. You are exactly right about that. We feel very strongly that we want to work with DOD and we want to ease those transitions very much, but I do not know that the answer is to have exactly the same formularies given that theirs is this statutory formulary by regulation and it is everything that is approved.

For us, it makes sense. I believe Senator Blumenthal's proposed legislation talks about the medications related to psychiatric conditions as well as pain. I think that is an important place to start.

In particular, his legislation talks about systemic drugs, not topical meds, which have caused some problems in the past. Some oral meds that we prescribe for psychiatric conditions and pain would be a very important place to start for blending.

Dr. LYNCH. If I could, Senator, I would just repeat from my opening statement, right now 90 percent of mental health medications and 96 percent of pain medications dispensed by DOD are also on the VA formulary. We also mentioned that there was a specific directive sent to the field that veterans will be maintained on their discharge medications from the military when they transfer to the VA if that is clinically appropriate.

I would add that qualification. But we would not take veterans off of medications that they had been receiving from the military if it was felt to be appropriate to continue those medications.

Senator MURRAY. OK.

Dr. LYNCH. I realize there are still, as you will probably hear in the second panel, there are still areas where we have failed. We can do better and we need to do better to make sure that that transition occurs.

Senator MURRAY. OK. We want to make sure there are no barriers, but we also want to make sure people are taking the right medications. I understand the balance, but some attention needs to be really focused on this.

Chairman ISAKSON. Thanks, Senator Murray, for raising that question and I will just make an observation. I am not a pharmacist or a physician, but it does not make a lot of sense to me for the formularies to be different between DOD and the Veterans Administration. I know Senator McCain is working on that same issue and we have expressed our desire to see if we cannot get that worked out. I appreciate you focusing on that issue today.

Dr. Lynch, thank you.

I am sorry. Senator Moran wanted to follow up.

Senator MORAN. Mr. Chairman, thank you very much. In part, I appreciate you recognizing me now so I can thank you for your

help. You and Senator Blumenthal were very instrumental in the Senate passing a fix to the 40-mile rule, if we talk about community and fee-based services, as we did now nearly a week ago, and I wanted to express my gratitude to you.

That bill was scheduled for consideration today and I asked that it be withdrawn from the calendar based upon its unanimous passage by the U.S. Senate. I met today with Chairman Miller and am working to see that the House consider this issue. In case I am talking in riddles, this is the issue of the inability for those who live more than—within 40 miles of a facility, even though that facility does not provide the services the veteran needs, they are being excluded from participation in the Choice Act. So, this legislation makes clear that that is not the intention or it is not the law.

So, Mr. Chairman, Senator Blumenthal, thank you very much for your assistance in accomplishing the passage of that bill and thank you to my colleagues for voting for it.

Chairman ISAKSON. Well, you were heavy, but we got you across the finish line.

Senator MORAN. I appreciate you carrying that load.

Senator BLUMENTHAL. It took two of us to do it.

Senator MORAN. We are not done yet, and we say the finish line, unfortunately, is not the U.S. Senate, but the finish line is the President of the United States.

Senator BLUMENTHAL. I am in total agreement.

Senator MORAN. Thank you both. Dr. Lynch, let me just raise a topic with you. I visited with Deputy Secretary Sloan Gibson yesterday. On your desk is an application for issue that we have been working on in regard to the Department of Emergency Medicine at the Colmery-O'Neil VA Hospital in Topeka, and my understanding is that there is a plan in place to get approval for that emergency room to be reopened.

For my colleagues' understanding, we have been 400 days without an emergency room at one of our VA hospitals because of lack of necessary physician professional providers. The Colmery-O'Neil Hospital has employed five emergency room physicians, a sixth one arriving in July, and it now awaits the approval of Dr. Lynch and the VA at the central office here.

Dr. Lynch, I understand there is a process in place by which that approval could be granted in the near future, and I just wanted to make certain that you were committed to make certain that once those requirements are met, that the approval is given.

Dr. LYNCH. Absolutely, Senator.

Senator MORAN. Thank you very much.

Chairman ISAKSON. Thank you, Senator Moran. Thank you to our panel for being here today and we will pause to reset the table and have our second panel come forward.

I would like to welcome our second panel and appreciate your being here to testify today. We have four distinguished people testifying. Adrian Atizado—is that the correct pronunciation?

Mr. ATIZADO. Yes.

Chairman ISAKSON. Assistant National Legislative Director, Disabled American Veterans; Fred Benjamin, Vice President and Chief Operating Officer, Medicalodges, Inc; Thomas Snee, National Direc-

tor of the Fleet Reserve Association; and Sergeant First Class Victor Medina, U.S. Army, Retired. We welcome all of you and we will start with Mr. Atizado.

ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Mr. ATIZADO. Chairman Isakson, Mr. Moran, Mr. Rounds, Senator Manchin, thank you for inviting DAV to testify at this legislative hearing and present our views on the bills under consideration. As many of you know, DAV is a nonprofit veterans service organization. We are comprised of 1.2 million wartime service-disabled veterans and we are dedicated to imparting veterans to lead high-quality lives with respect and dignity.

While my written testimony discusses DAV's position on all seven measures on today's agenda, for the sake of brevity, my oral statement will only focus on just two. DAV would like to thank Senator Heller and Senator Murray, as well as their dedicated staff, for working with us on S. 471, the Women Veterans Access to Quality Care Act of 2015.

This bill seeks to improve VA health care facilities to better accommodate the needs of women veterans. It would start by setting infrastructure standards to meet gender-specific needs for privacy, safety and dignity, and report those facilities that do not meet those standards.

Section 3 of the bill would require VA to evaluate the performance of VA medical center directors based on the health outcomes for women veterans who use VA medical services.

Section 4 would require a VA medical center to employ a full-time obstetrician or gynecologist. Section 5 would address the need to share veterans' contact information with State veterans agencies in order to facilitate assistance, services, as well as benefits. Veterans would, of course, retain the option of not participating in this information exchange.

Finally, section 6 would instruct the Government Accountability Office to examine whether VA medical centers are able to meet the health care needs of women veterans across a number of specific domains of care. This bill is consistent with DAV Resolution 040 and with key recommendations in DAV's 2014 report, Women Veterans, A Long Journey Home. Thus, the bill carries DAV's full support.

On the draft measure titled, The Department of Veterans Affairs Purchased Healthcare Streamlining and Modernization Act, DAV thanks Senator Blumenthal for introducing this critical measure and for your Committee staff for working with us in its development. This measure would allow VA to use Medicare procedures to enter into provider agreements, to buy care from private sector providers.

Now, these agreements are quite familiar to many community providers and we believe will make VA more appealing to work with in providing medical care and services closer to where veterans live. As you are aware, VA currently buys a broad spectrum of health care and services under specific but fragmented authorities. These authorities have, in some cases, created confusion and

uncertainty among injured veterans as well as private providers in the community.

Moreover, VA's current provider agreement authority is quite limited and, unfortunately, broken. And even with current workarounds, the situation continues to disrupt the continuity of services for many severely ill and injured veterans. It requires arduous work, not only in front line VA personnel, but as well as community providers.

We understand this proposal is not intended to supplant longstanding regional and national contractual and sharing agreements; but rather, to play a supporting role in specific situations when, for a variety of legitimate reasons, needed care services cannot be purchased through existing contracts or sharing agreements. DAV fully supports this measure based on our Resolution Number 163.

We do, however, urge the Committee to improve on the bill's provision for care coordination. It is a key component to delivering integrated health care, which is important to produce positive health outcomes among severely ill and injured veterans and aging veterans with chronic and debilitating conditions.

Mr. Chairman, this concludes my testimony. I would be happy to answer any questions you or other Senators may have.

[The prepared statement of Mr. Atizado follows:]

PREPARED STATEMENT OF ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee: Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing, and to present our views on the bills under consideration. As you know, DAV is a non-profit veterans service organization comprised of 1.2 million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

S. 297, THE FRONTLINES TO LIFELINES ACT OF 2015

This bill would revive and expand a prior Department of Veterans Affairs (VA) pilot program of employing Intermediate Care Technicians in VA facilities; authorize and require Department of Defense (DOD) to transfer credentialing information on health care providers who relocate from DOD to employment in the VA; and, authorize independent practice privileges for certain advance practice nurses in VA.

DAV has no resolution from our membership dealing specifically with these human resource issues. Nevertheless, on the assumption that that these matters if enacted would improve and protect VA care for enrolled veterans, they would be consistent with DAV National Resolution No. 220, to support the provision of comprehensive VA health care services to all enrolled veterans. DAV would offer no objection to their enactment.

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

This bill would extend authority for the VA Homeless Veterans Reintegration Programs (HVRP) and the Homeless Women Veterans and Homeless Veterans with Children Reintegration Grant Program through Fiscal Year 2020. The bill also would clarify eligibility for services under the HVRP to include veterans participating in the VA supported housing program for which rental assistance is provided under the United States Housing Act of 1937; Indians who are veterans receiving assistance under the Native American Housing Assistance and Self Determination Act of 1996; and veterans transitioning from being incarcerated.

DAV is pleased to support S. 425, the Homeless Veterans Reintegration Programs Reauthorization Act of 2015, which is in line with DAV Resolution No. 203, which calls for sustained support and sufficient funding for VA's initiative to eliminate homelessness among veterans and improve its existing supportive programs.

S. 471, WOMEN VETERANS ACCESS TO QUALITY CARE ACT OF 2015

This bill would seek to improve VA health care facilities to better accommodate the needs of women veterans. Section 2 of the measure would direct the VA Secretary to establish standards to ensure that all medical facilities have the structural features necessary to sufficiently meet the gender-specific health care needs of veterans, including those for privacy, safety, and dignity. The bill would require a report to the House and Senate Veterans' Affairs Committees with a list a facilities that fail to meet such standards and the cost for renovations or repairs necessary to meet them.

Section 3 would require the Secretary to evaluate the performance of VA medical center directors by using health outcomes for women veterans who use VA medical services. The VA would be required to publish health outcomes for women veterans on a publicly available Web site including comparisons of the data to male health outcomes, and explanatory information for members of the public to easily understand the differences.

Section 4 would ensure that every VA medical center employs a full-time obstetrician or gynecologist, and mandates a pilot program to increase the number of residency program positions and graduate medical education positions for obstetricians and gynecologists at VA medical facilities, in at least three Veterans Integrated Service Networks.

Section 5 would require the development of procedures to electronically share veterans' military service and separation data; email address; telephone number; and mailing address with State veterans' agencies in order to facilitate the assistance of benefits veterans may need. Under the bill, veterans would retain the option of not participating in this information exchange.

Section 6 would instruct the Government Accountability Office to examine whether VA medical centers are able to meet the health care needs of women veterans across a number of specific dimensions of care, including access, specialization, outcome differences, outreach and other key elements.

The intent of this bill is consistent with DAV's 2014 Report, Women Veterans: The Long Journey Home; thus, the bill carries DAV's full support. The bill is also consistent with DAV Resolution No. 040 to support enhanced medical services and benefits for women veterans, passed by the delegates to our most recent National Convention.

S. 684, HOMELESS VETERANS PREVENTION ACT OF 2015

This is a comprehensive bill that would seek to improve services for homeless veterans.

Section 2 would increase per diem payments for transitional housing assistance that becomes permanent for veterans.

Section 3 would authorize per diem payments for furnishing care for a dependent of a homeless veteran while the veteran receives services from a VA grant and per diem recipient.

Section 4 would instruct VA to partner with public and private entities to provide legal services to homeless veterans and veterans at risk of homelessness in an equitably distributed geographic pattern to include rural areas and tribal lands; subject to available funding. The legal services would include those related to housing, including eviction defense and landlord-tenant cases; family law, including assistance with court proceedings for child support, divorce and estate planning; income support, including assistance in obtaining public benefits; criminal defense, including outstanding warrants, fines and driver's license revocation, and to reduce the recidivism rate while overcoming reentry obstacles in employment or housing. The Secretary would require entities that have partnered with VA and provided legal services to homeless veterans to submit periodic reports.

Section 5 would expand the authority of VA to provide dental care to eligible homeless veterans who are enrolled for care, and who are receiving housing assistance under so-called "section 8" for a period of 60 consecutive days; or receiving care (directly or by contract) in a domiciliary; therapeutic residence; community residential care coordinated by the Secretary; or a setting for which the Secretary provides funds for a grant and per diem provider.

Section 6 would make permanent the authority in section 2033, title 38, United States Code, for VA to carry out a program of referral and counseling services for veterans at risk for homelessness who are transitioning from certain institutions.

Section 7 would extend the authority for financial assistance for supportive services for very low-income veteran families in permanent housing.

Section 8 of this bill would require VA to assess and measure the capacity of national and local programs for which entities receive grants under section 2011 of

title 38, United States Code, or per diem payments under section 2012 or 2061 of such title. The following would be assessed:

• 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.

• The amount of capacity that recipients of grants under sections 2011 and 2061 and per diem payments under section 2012 of such title have to provide services for which the recipients are eligible to receive per diem under section 2012(a)(2)(B)(ii) of title 38, United States Code, as added by section 3(5)(B) of this bill.

The Secretary would be required to use the information collected under this section to set specific goals to ensure that VA programs are effectively serving the needs of homeless veterans; assess whether these programs are meeting goals; inform funding allocations for programs described, and improve the referral of homeless veterans to such programs.

The Secretary would be mandated to submit a report to Congress regarding the assessment and recommendations for legislative and administrative action to improve the programs.

Section 9 would require the GAO to complete a study of VA programs that provide assistance to homeless veterans including whether programs are meeting the needs of veterans who are eligible for assistance and a review of recent efforts of the Secretary to improve the privacy, safety, and security of women veterans receiving assistance from such programs.

Section 10 would repeal the requirement for annual reports on assistance to homeless veterans.

DAV is pleased to support this bill, in accordance with DAV Resolution No. 203, which calls for continued support and sustained and sufficient funding for VA's initiative to eliminate homelessness and improve supportive programs. Our resolution also urges Congress to strengthen the capacity of VA's programs to end homelessness by increasing capacity for health care, specialized services for mental health, substance-use disorders as well as vision and dental care.

DRAFT BILL, THE VETERANS HEALTH CARE ACT OF 2015

If enacted, this bill would improve veterans' access to immunizations by including immunizations in the statutory definition of "medical services;" expand the availability of chiropractic care in VA facilities; extend the sunset date of certain VA transportation programs enabling veterans to access VA health care; and open public access to the results of VA research, including research data sharing for specific purposes between VA and the DOD.

VA already conducts a rigorous program of immunizations for influenza, pneumonia, shingles and other disorders prevalent in enrolled veterans. This bill would broaden and regulate immunizations in accordance with Centers for Disease Control and Prevention (CDC) guidelines, and would require VA to provide a one-time report of its conformance to these CDC guidelines within two years of enactment of the legislation. Our DAV members have approved Resolution No. 220, to support the provision of comprehensive VA health care services to all enrolled veterans. We believe a more rigorous national immunization program as contemplated by this bill, and governed by CDC guidelines, would be consistent with DAV's resolution; therefore, DAV supports this provision.

Resolution No. 220 also addresses the topic of chiropractic care, urging its broad availability for appropriate patients enrolled in VA health care. Therefore, DAV also supports the expansion of the existing program of chiropractic care that would be authorized by this bill.

This bill would extend for one year the existing sunset date of December 31, 2015, of the Veterans Transportation Service (VTS) program and authorize $4 million to carry out the purposes of the transportation program, and would require a VA report on the program within one year of enactment.

As this Committee is aware, the DAV National Transportation Network continues to show tremendous growth as an indispensable resource for veterans. Across the Nation, DAV Hospital Service Coordinators operate 200 active programs and have recruited more than 9,000 volunteer drivers. Since we began our free Transportation Network program in 1987, DAV has purchased and donated 2,856 vehicles to the VA, at a cost of 61.8 million dollars. The Ford Motor Company has also donated 192 vehicles at a cost of 4.4 million dollars. So far our vans have carried veterans more than 589 million miles to and from their medical appointments.

DAV believes VTS serves the transportation needs of a special subset of the veteran patient population that the DAV National Transportation Network is unable

to serve—veterans in need of special modes of transportation due to certain severe disabilities. We believe that with a truly collaborative relationship, the DAV National Transportation Network and VTS will meet the growing transportation needs of ill and injured veterans in a cost-effective manner.

Currently, DAV supports this provision; however, our support is based on the progress gained through our collaborative working relationship with VA to resolve weaknesses we have observed in the VTS program. As you may be aware, VTS operates with resources that would otherwise go to direct medical care and services for veterans. These resources should be used carefully for all extraneous programs to ensure veterans are not denied care when they most need it.

This bill would require VA to create a Web site documenting VA research data, providing data dictionaries, and including instructions for users on gaining access to all published VA research data. The bill would also require VA to make publicly available through a digital archive the published manuscripts of all VA-funded research, and would establish a required annual report to Congress detailing implementation of the provision. At our most recent national convention, DAV delegates adopted Resolution No. 206, supporting the VA's medical and prosthetic research programs. This resolution is justified because VA research is one of the strongest underpinnings of VA health care and cements VA's relationships with its affiliated schools of health sciences and academic health centers.

The bill would also require the VA/DOD Joint Executive Committee to submit a report to the respective Secretaries recommending methods to facilitate greater sharing of research between the departments dealing with outcomes of military service on servicemembers, veterans, family members and others. This provision is consistent with our statement of policy, in that its enactment would be helpful to ensure that wounded, injured and ill veterans and their families are better cared for, and their needs are better understood, by both departments. Therefore, we support this provision of the bill.

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

VA purchases a broad spectrum of health care services from private sector providers for veterans, their families and survivors under specific but fragmented authorities. These authorities have in some cases created confusion and uncertainty among ill and injured veterans and private providers in their community.

One example stems from a February 13, 2013 proposed rule in response to Section 105 of the Veterans Health Care, Capital Asset, and Business Improvement Act of 2003 (Public Law 108–170). The rule proposes to amend VA's medical regulations to allow the Department to use Medicare or State procedures to enter into provider agreements to obtain extended care services from non-VA providers. In addition, it proposes to include home health care, palliative care, and non-institutional hospice care services as extended care services, when provided as an alternative to nursing home care. Under this proposed rule, VA would be able to obtain extended care services for veterans from providers who are closer to veterans' homes and communities.

The proposed rule has been stalled with no clear sign if and when a final rule will be made. Because regulations have not been made final, no new provider agreements are being issued by VA and existing provider agreements set to expire are not being renewed, effectively disrupting the continuity of extended care services for many service-connected disabled veterans.

This measure would allow VA to use provider agreements for the purchase of non-VA medical care and services in certain circumstances. The bill appears to preserve key protections found in the contracts based on the Federal and VA Acquisition Regulations including protections against waste, fraud and abuse. It intends to streamline and speed the business process for purchasing care for an individual veteran that is not easily accomplished through a more complex contract with a community provider, and thus be more appealing to solo practitioners and small group practices.

We understand this proposal is not intended to supplant long-standing regional and national contractual and sharing agreements such as those used for VA's Patient-Centered Community Care (PC3) program, which is helping to build VA's Extended Network of community providers. Rather, this authority it intended to play a supporting role in specific situations when, for a variety of legitimate reasons, needed care cannot be purchased through existing contracts or sharing agreements.

We support favorable consideration of this measure based on DAV Resolution No. 163, which calls on VA to establish a non-VA purchased care coordination program that complements the capabilities and capacities of each VA medical facility and in-

cludes care and case management, quality of care, and patient safety standards equal to or better than VA, timely claims processing, adequate reimbursement rates, health records management and centralized appointment scheduling.

VA must fully integrate the care it buys from the community into its health care delivery model by using care coordination to realize the best health outcomes and achieve veterans' health goals. VA also must improve administrative functions and business practices and employ data analytics to ensure the purchases are cost effective, preserve agency interests, and enhance the level of service VA directly provides veterans.

We believe this bill will help VA achieve most of these attributes in community care; however, the bill's provision on care coordination could be improved. Care coordination for severely ill and injured veterans and for aging veterans with chronic conditions is essential when VA buys care from private providers. For example, the contracts used for the PC3 program include numerous provisions outlining VA's responsibility in coordinating outpatient care, inpatient admission/discharges, post-discharge care, and medications. The same intent is outlined in Section 101(a)(3) of the Choice Act: "The Secretary shall coordinate through the Non-VA Care Coordination Program of the Department of Veterans Affairs the furnishing of necessary hospital care, medical services, or extended care under this section to eligible veterans, including by ensuring that an eligible veteran receives an appointment for such care and services within the wait-time goals of the Veterans Health Administration for the furnishing of hospital care, medical services, and extended care."

We ask the Committee to consider including similar requirements to facilitate the integration of care purchased under this authority with the VA health care system, which would produce a positive outcome on the quality of care a veteran receives.

Draft Bill, to require the Secretary of Defense and the Secretary of Veterans Affairs to establish a joint uniform formulary with respect to systemic pain and psychiatric drugs that are critical for the transition of an individual from receiving health care services furnished by the Secretary of Defense to health care services furnished by the Secretary of Veterans Affairs, and for other purposes.

The bill would require the two agencies concerned to establish a process to make available to veterans in transition from DOD to VA health care the same "systemic pain" and "psychiatric" drugs that are appropriate and effective in caring for such individuals in transition. The bill would exempt this joint process for transitioning servicemembers from the standing requirements of DOD's pharmacy benefits program, and would not interfere with each agency's maintenance of its own formulary for other purposes. The bill would require a joint report by DOD and VA to Congress on the establishment of the new process.

While DAV has not received an approved national resolution from our membership on the specific topic addressed by this bill (a joint formulary), this bill is fully consistent with the intent of Public Law 97–174, the Veterans Administration and Department of Defense Health Resources Sharing and Emergency Operations Act, enacted in 1982, as well Subtitle C of Title VII of the Bob Stump National Defense Authorization Act for Fiscal Year 2003, enacted in 2002. Among many other purposes, these acts intend for DOD and VA to work more closely together in joint projects of mutual benefit to beneficiaries of both agencies, and in particular health resources sharing that benefits active duty servicemembers and veterans. Therefore, we support the purposes of this bill.

Given the recent controversy concerning the practice of over-prescribing of opioids both within VA and in private health care, we recommend the definitions of "systemic pain" and the word "psychiatric" be defined in the bill, but that the word "psychotropic" be substituted for "psychiatric" in creating such definitions.

Mr. Chairman, this concludes my testimony. DAV appreciates your request for this statement. I would be pleased to answer any questions from you or Members of the Committee dealing with this testimony.

Chairman ISAKSON. Thank you very much. Mr. Benjamin.

STATEMENT OF FRED BENJAMIN, VICE PRESIDENT AND CHIEF OPERATING OFFICER, MEDICALODGES, INC.

Mr. BENJAMIN. Good afternoon, Chairman Isakson. I better turn this on. Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee. I would like to thank you for holding this hearing to discuss, among other veterans related health care issues, the discussion draft on VA pro-

vider agreements language. I especially appreciate the opportunity to appear before you here today.

I would also like to take a moment of personal privilege and extend a special hello to Senator Moran from my home State of Kansas. My name is Fred Benjamin and I am the Chief Operating Officer of Medicalodges, a company that offers a continuum of health care options, including independent living, skilled nursing home care, rehabilitation, assisted living, in-home services, and services for those with developmental disabilities.

Medicalodges was launched in 1961 when its first nursing home, Golden Age Lodge, was opened in Coffeyville, KS. The company steadily grew and in 1998, the employees acquired the company from its founders becoming the first 100 percent employee owned nursing home company in the U.S.

Today we own and operate over 30 facilities in Kansas, Missouri, and Oklahoma, and employ over 2,500 people. I have served as the company's Chief Operating Officer since 2009. I am honored to have worked in health care for 30 years, including senior management roles in skilled and sub-acute care hospitals and other for-profit and not-for-profit ventures. I currently serve also as the Chairman of the Kansas Health Care Association, the leading provider advocacy group for seniors in Kansas.

Medicalodges is a member of the American Health Care Association, the Nation's largest association of long-term and post-acute care, providing essential services to approximately 1 million individuals and more than 12,000 not-for-profit and proprietary member facilities.

Today I submit a statement on behalf of American Health Care Association (AHCA), in strong support of provider agreements for veterans extended care services. AHCA has been working on the issue of VA provider agreements for over two decades and was supportive of the VA releasing its proposed rule in February 2013.

This important rule, among other things, increases the opportunity for veterans to obtain non-VA extended care services from local providers and is an example of how the Government and the private sector can effectively work together for the benefit of veterans.

Last Congress, through the advocacy efforts of AHCA's members, close to half of the U.S. Senate chamber and 109 U.S. House members signed onto a letter to the VA encouraging the release of the final VA provider agreement rule. Soon after, it was determined that the VA needed the legislative authority to enter into these agreements.

The Senate and House Veterans' Affairs Committees are currently working on this issue through the VA provider agreement discussion draft that we are here to focus on today.

We have worked very closely with the VA and Chairman Isakson, Ranking Member Blumenthal, Senator Manchin, along with House Chair Representative Miller and Representatives Walorski and Gabbard. It is long-standing policy that Medicare and Medicaid providers are not considered to be Federal contractors. However, if a provider currently serves VA-referred patients, they are considered to be a Federal contractor.

The draft legislation being considered today would cover the gamut of care that VA provides, including primary care and other areas outside of extended care. Across that spectrum of health care, VA purchases through both the Federal Acquisition Regulation, so called FAR, and non-FAR-based agreements and that would continue under this proposal.

I speak specifically from my experience leading Medicalodges and also from my fellow extended care providers across the country when I tell you that FAR-based agreements are simply not workable for many extended care providers. A streamlined approach that still protects veterans, taxpayers, and preserves oversight is desperately needed.

What we like about the draft legislation is that it makes sure that the non-FAR-based option is still available so that we can continue in partnership with the VA to provide veterans quality health care close to their homes.

By way of illustration, FAR-based Federal contracts come with extensive reporting requirements to the Department of Labor on the demographics of contractor, employees and applicants which have deterred providers, particularly smaller ones, and I particularly appreciated the comments that were made earlier about the rural aspect of the problems presented therein with VA participation.

The use of provider agreements would promote provision of services from providers who are closer to veterans' homes and community support structures under terms and oversight similar to those used by Medicare. AHCA fully endorses the VA provider agreements draft legislation.

As a provider myself managing VA contracts at nine locations, I can tell you that it is vital that extended care providers have the provider agreement option. My written testimony further outlines some of the day-to-day issues from the experience of our company and many other extended care providers.

In closing, we must ensure that those veterans who have served our country so bravely have access to quality health care, and the legislative draft being worked on by Senators Hoeven and Blumenthal will ensure this to be the case. We are looking forward to continuing to work with both the Senate and House VA committees and members on the VA provider agreement and hoping to get it across the finish line and signed into law.

Thank you for the opportunity to comment and I am happy to answer any questions.

[The prepared statement of Mr. Benjamin follows:]

PREPARED STATEMENT OF FRED BENJAMIN, VICE PRESIDENT AND CHIEF OPERATING OFFICER OF MEDICALODGES, INC.

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and distinguished Members of the Committee. I'd like to thank you for holding this hearing to discuss, among other veterans related health care issues, the discussion draft on VA provider agreements language. I especially appreciate the opportunity to appear before you here today. My name is Fred Benjamin, and I am the Vice President and Chief Operating Officer of Medicalodges, Inc., a company that offers a continuum of health care options which include independent living, skilled nursing home care, rehabilitation, assisted living, specialized care, outpatient therapies, adult day care, in-home services, as well as services and living assistance to those with developmental disabilities.

Medicalodges was launched in 1961 when its first nursing home, Golden Age Lodge, was opened in Coffeyville, Kansas by founding owners Mr. and Mrs. S.A. Hann. The company grew through the 1960's with the addition of eight nursing facilities. In 1969, Golden Age Lodges was renamed Medicalodges, Inc. As new care centers were built or purchased, the company expanded its products and services to include a continuum of health care. In February, 1998 the employees of Medicalodges acquired the company from its previous owners in a 100% Employee Stock Ownership Trust transaction. Today, the company owns and operates over 30 facilities with operations in Kansas, Missouri and Oklahoma and employs over 2500 people in the communities it serves.

I have served as the Company's Chief Operating Officer since May 2009. I am honored to have worked 30-years in this industry that includes senior management roles in skilled and sub-acute care, hospitals and other for-profit and not-for-profit ventures. I am also currently serving as Chairman of the Board of the Kansas Health Care Association, the leading provider advocacy group for seniors in Kansas.

I would like to note that Medicalodges is a member of the American Health Care Association (AHCA), which is Nation's largest association of long term and post-acute care providers. The Association's members provide essential care to approximately one million individuals in more than 12,000 not-for-profit and proprietary member facilities.

AHCA, its affiliates, and member providers advocate for quality care and services for frail, elderly, and disabled Americans—including our Nation's veterans—and for the continuing vitality of the long term care provider community. The Association is committed to developing and advocating for public policies which balance economic and regulatory principles to support quality of care and quality of life. Therefore, I appreciate the opportunity today to submit a statement on behalf of AHCA in strong support of the concept of veteran's provider agreements for extended care services in particular.

AHCA has been working on the issue of VA provider agreements for over two decades, and was supportive of the VA releasing its proposed rule, RIN 2900-A015, on this issue in February 2013. This important rule, among other things, increases the opportunity for veterans to obtain non-VA extended care services from local providers that furnish vital and often life-sustaining medical services. This rule is an example of how government and the private sector can effectively work together for the benefit of veterans who depend on long term and post-acute care.

Last Congress, and through the advocacy efforts of AHCA's members, close to half of the U.S. Senate chamber and 109 U.S. House members signed onto a letter to the VA encouraging the release of the final VA provider agreement rule. Shortly after these letters were sent to the VA, it was determined that the VA needed the legislative authority to enter into these agreements. The U.S. Senate and House Veteran's Affairs Committees are currently working on this issue through the VA provider agreement discussion draft we are here to focus in on today.

As I mentioned earlier, AHCA started work with the VA and Capitol Hill on the provider agreement issue for extended care services several years ago. In this current Congress, AHCA has worked very closely with Congressional members like Senators John Hoeven (R-ND), Chairman Johnny Isakson (R-GA), Committee members Richard Blumenthal (D-CT) and Joe Manchin (D-WV), along with House VA Committee Chairman Jeff Miller (R-FL–1st), Representatives Jackie Walorski (R-IN–2nd) and Tulsi Gabbard (D-HI–2nd) on ensuring that the VA has the legislative authority to enter into provider agreements. It is long-standing policy that Medicare (Parts A and B) or Medicaid providers are not considered to be Federal contractors. However, if a provider currently has VA patients, they are considered to be a Federal contractor. The discussion draft legislation being considered today, and worked on under the leadership of Senators Hoeven and Blumenthal, would cover the gamut of care VA provides, including primary care and other areas outside of extended care. Across that spectrum of health care, VA purchases care through both the Federal Acquisition Regulation (FAR) and non-FAR based agreements, and that would continue under this proposal.

I speak specifically from my experience leading Medicalodges and also for my fellow extended care providers across the country whom the AHCA represents. For 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. What we like about the draft legislation is that it makes sure the non-FAR based option is available so that we can continue in partnership with the VA to provide veterans quality health care as close to home as possible.

To illustrate the details, FAR-based Federal contracts come with extensive reporting requirements to the Department of Labor (DOL) on the demographics of con-

tractor employees and applicants, which have deterred providers, particularly smaller ones, from VA participation. The use of provider agreements for extended care services would facilitate services from providers who are closer to veterans' homes and community support structures, under terms and oversight similar to those used by Medicare. Once providers can enter into provider agreements, the number of providers serving veterans will increase in most markets, expanding the options among veterans for nursing center care and home and community-based services. Services covered as extended care under the proposed rule include: nursing center care, geriatric evaluation, domiciliary services, adult day health care, respite care, and palliative care, hospice care, and home health care.

After years and years of work on this issue by many, we are delighted to be at the point we are now of discussing a comprehensive provider agreement proposal. AHCA fully endorses the VA provider agreements draft legislation being worked on by Senators Hoeven and Blumenthal. As a provider myself and with a total of 9 VA contracts currently, I can tell you why it is so vital that extended care providers have the provider agreement option. I'll outline some of the day to day issues from the experience of our company and other extended care providers:

Issue: Additional administrative workload. Additional administrative responsibilities under the Contractor Performance Assessment Reports System (CPARS) as compared to Medicaid or Medicare. Please note that aside from designated State Veterans Homes, most facilities have less than 5 Veterans in house at a time. Each of our contracts with the VA has 68 pages of terms and responsibilities with rates that are updated quarterly. Beyond this, with the new CPARS program, I receive multiple emails daily from this automated system requesting approval or acknowledgement of payment in full when full payment has not yet been received. This alone has added to our administrative workload to deal with this correspondence.

Issue: Lack of Clarity in Approval processes. Separate reporting structures for those writing and administering contracts results in lack of clarity in approval of needed supplies and services. Contracting personnel are not at the same location as those referring Veterans for care and managing contracts on a day to day basis. These include durable medical equipment such as wheelchairs, specialty equipment such as Clinitron beds, drugs and non-emergent dental services.

Issue: Lack of consistency in contract administration. This includes different procedures at each location for getting approval for items such as durable medical equipment, oral medications whose cost exceed 8.5% of the approved daily rate. Another example is differing administration of daily rates and the requirement for pre-approval of services when personnel are not available to answer questions or provide approval. This sometimes leaves providers in the position of having to provide equipment or services because of State or Federal Centers for Medicare and Medicaid Service (CMS) requirements without guarantee of payment.

Issue: Duplication of Regulatory Supervision. In addition to State and CMS performance reviews, the VA conducts its own annual reviews inspections that are largely duplicative of those in other governmental health programs.

Issue: Additional DOL supervision and review. While we understand the need to be under DOL regulations for wage and hour/overtime rules and the like, there are additional requirements for those providing services under FAR. These include identification of direct care workers and documentation benefit premiums of 40% of base pay and exactly which workers this covers. This proposal strikes a good balance.

To close, we must ensure that those veterans who have served our Nation so bravely have access to quality health care—and the legislative discussion draft being worked on by Senators Hoeven and Blumenthal will ensure this will be the case. We are looking forward to continuing to work with both the Senate and House VA Committees and Members of Congress on getting the VA provider agreement proposal across the finish line, and signed into law. Thank you again for the opportunity to comment on this important matter. I am happy to answer any questions that you may have.

Chairman ISAKSON. Thank you, Mr. Benjamin.

Mr. Snee.

STATEMENT OF THOMAS J. SNEE, NATIONAL EXECUTIVE DIRECTOR, FLEET RESERVE ASSOCIATION

Mr. SNEE. Chairman Isakson, Ranking Member Blumenthal, and Committee Members, good afternoon, and thank you. I am Tom Snee, the National Executive Director for the Fleet Reserve Association, FRA. We are the oldest enlisted sea service association for over 90 years representing members of our families in the U.S. Navy, Marine Corps, and the Coast Guard.

I wish to thank you, Mr. Chairman, and the Ranking Member and the Committee for your support for our veterans of past, present and future. Your acknowledgments of our service are sincerely appreciated, not just in words, but in actions that we have come to know from all of you.

If I may quote from a distinguished Member of this particular Committee, Senator Bernie Sanders, "Taking care of our veterans is a cost of war itself. If you can spend $6 trillion sending people to war, you can spend a few billion dollars taking care of them when they come home."

The FRA strongly supports and urges passage of S. 425 and S. 684. Mr. Chairman, some of my thoughts are reflective from both a personal account and from an already published VA Inspector General's report of May, 2012. Homelessness in the United States is a social concern for both local and State jurisdictions. We may never solve the national problem, but perhaps we can establish a template of aggressive and positive actions for our veterans to be the model for the rest of the country.

Homeless veterans are not new to this country. The first sighting of homeless veterans is mentioned as early as the 1812 War and continued on through the Civil War. World War II veterans returned home only to face economic depression.

World War II veterans returned, however, with the relief that the G.I. Bill upscaled their quality-of-life. 20th century sociologists began to identify certain demographic factors associated with the homeless phenomenon, including benefits, education, medical, and other associated services.

The economics and politics of poverty gained nationwide attention during the 1960s, especially when thousands of returning Vietnam veterans were visibly homeless after military separation due to physical, emotional, and mental health issues. Most of these veterans were young junior enlisted personnel.

Today, some returning veterans are faced with the climate of unemployment, economic uncertainty, and nowhere to turn for the credible assistance due to trends or attitudes toward helping them or receiving the services they are so entitled to. Some, however, do have a very strong network of family and friends to back them on. For others, the lack of help has placed a hardship due to the waiting times, emotional and financial uncertainties leading to alternative choices to be given to the homeless.

Former Secretary of the VA Shinseki established a 5-year plan of six strategies. The cause and effect factor focused on strategies targeting risk factors for homelessness, promoting employment of veterans, better access to preventive mental care, and enlarging transitional and affordable permanent housing options for homeless veterans.

It was discovered that some of these initiatives under HUD and VA eligibilities offered the veteran a way out of being homeless. Between 2009 to 2011, homelessness among veterans declined nearly 12 percent. I will not go into it any further, but we all understand the hierarchy of his concerns, of his needs: basic food, safety, communal feeling of belonging, achievement status, and of course self-actualization.

As noted in our testimony, the female veteran population has grown and deep concerns in both social and medical areas. This year marks the 20th anniversary of the combat exclusionary law allowing female servicemembers to serve in combat roles. We must extend and reauthorize the VA reintegration program through 2020 for job training, counseling, and placement services to expedite entry into the labor force.

All of these will give the veteran a better boost to the quality-of-life, to move forward making a positive and personal decision that will have an influence if not peace of mind. FRA believes that enhancing the basic services and benefits of training, counseling, and medical awareness will ensure those individuals alternatives rather than homelessness.

We have got a lot of members that are going into PTSD, and I can say from a personal example of a former student who recently came to me for assistance, citing the fact that he did not have the faith in VA. But, Mr. Chairman and Members, after 15 years from having him in school, this past Sunday this veteran is on his way and has the trust of the VA. The Committee's oversight will always be needed to ensure these actions are measured and successful.

Mr. Chairman, how many other veterans feel the same despair of the system that should be assisting rather than adding more stress in administrative burdens? FRA applauds Secretary McDonald's new VA efforts of care. Passage of these two bills will endorse timely and needed momentum for the VA's position of serving the veteran.

As for the homelessness, specifically, all veterans, let us give them assurances of relief in concrete and success to have a place they can call home of their own. If we care for the veteran, let us listen to their basic hierarchy of needs, provide for them and their families. Let us support and meet the VA's Secretary's goal of zero homelessness for vets.

Again, I want to thank you and the Committee and especially for your dedication on behalf of veterans and their families and I wait for your questions.

[The prepared statement of Mr. Snee follows:]

PREPARED STATEMENT OF THOMAS J. SNEE, M.ED., NATIONAL EXECUTIVE DIRECTOR, FORCM (SW), USN, (RET), THE FLEET RESERVE ASSOCIATION

INTRODUCTION

Distinguished Committee Chairman Johnny Isakson, Ranking Member Richard Blumenthal and other Members of the Committee; Thank you for the opportunity to present the Association's views on various pending legislative proposals.

HOMELESS LEGISLATION

Recently, Department of Veterans Affairs (VA) Secretary Robert McDonald addressed over 600 organizations at the annual National Coalition for Homeless Veterans (NCHV) conference held in Washington, DC. He urged attendees to keep the

progressive momentum for VA's self-imposed deadline of ending veteran's homelessness for this year. In 2009, then VA Secretary, Eric Shinseki, set the bold goal of ending veteran homelessness by the end of 2015. Secretary McDonald stated that the department's goal of "zero homeless veterans" by January 2016 is less important than ensuring that the number doesn't rise again in the out years to come. He said, "The important thing is not just to get to zero, but to stay at zero." "How do we build a system that is so capable, that as a homeless veteran moves from Chicago to Los Angeles in the winter, (that) we have the ability to touch them immediately?"

According to VA, the number of homeless veterans from 2010–2013, fell by more than one-third to about 50,000 veterans. VA officials expect those numbers will decrease even further when the 2014 estimates are released later this summer. VA funding for homeless assistance and prevention programs have noticeably increased from $2.4 billion in FY 2008 to nearly $7 billion for FY 2016. These funds, according to homeless activists, say were nonexistent over a decade ago. Despite the downward trend, the VA's effort to end veteran's homelessness by the end of 2015 is expected to fall short.

FRA thanks Senators John Boozman (Ark.) and Jon Tester (Mt.) for introducing the "Homeless Veterans Reintegration Programs Reauthorization Act" (S. 425) that reauthorizes current programs for 5 years and clarifies for the veterans who receive housing assistance under the Department of Housing and Urban Development's Veterans Affairs Supportive Housing (HUD-VASH) program. Native American veterans participating in the Native American Housing Assistance program are in fact eligible to receive valuable assistance such as job training under the Homeless Veteran Reintegration Program (HVRP).

Currently, if a veteran qualifies for housing under one of these programs, the VA no longer considers them "homeless," and does not allow them to participate in HVRP.

The Association also thanks Senators Richard Burr (NC) and Joe Manchin (WV) for introducing the "Homeless Veterans Prevention Act" (S. 684) that allows the VA to house the children of homeless veterans in transitional housing programs. This bill will allow the VA to partner with public and private entities to increase the availability of legal services for homeless veterans, and increases the amount of money available for supportive services to low-income veteran families in permanent housing.

Approximately 33 percent of the homeless US population are veterans, and seven percent of homeless veterans are women. According to Veterans Inc., over 529,000 to 840,000 veterans are homeless at one time during the year. On any given night, more than 300,000 veterans are living on the streets or in shelters across America.[1]

According to the National Alliance to End Homelessness, the veteran homeless populations are veterans who served or have served in past wars/conflicts, from World War II to the most recent conflicts. Though research indicates that veterans who served in the Vietnam and post-Vietnam era conflicts are at a greater risk of homelessness, veterans returning from recent conflicts in Afghanistan and Iraq often have severe disabilities, including Traumatic Brain Injuries (TBIs) and Post Traumatic Stress Disorder (PTSD), and have a closer connection with homelessness.

Since then, the Obama Administration, VA Secretary Bob McDonald, and Congress have demonstrated their support of this goal by devoting substantial and approved funding to the homelessness problem, an increase from recent years.

FRA supports the recommendations of the *IB* which was recently released by AMVETS, Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA) and the Veterans of Foreign Wars (VFW). The *IB* provides detailed funding analysis of the proposed VA budget and is intended to be used as a guide for policymakers to make necessary adjustments to meet the challenges of serving America's veterans. According to the *Independent Budget* for FY 2016, "VA's efforts to eliminate veterans' homelessness have been impressive and are showing significant success. However, female veterans still have a higher rate of homelessness than their nonveteran counterparts, and housing support for female veterans needs to be enhanced, particularly for veteran mothers with dependent children."

VETERANS ACCESS TO HEALTH CARE

FRA also thanks Senator Jerry Moran (Kan.) for introducing the "Veterans Access to Community Care Act" (S. 207), legislation cosponsored by a bipartisan group of 18 Senators, that requires the VA to implement the "Veterans Access, Choice and Accountability Act" (the Choice Act) as Congress intended. The bill requires the VA to provide veterans access to non-VA health care when the nearest VA medical facil-

[1] Veteransinc.org

ity within 40 miles drive time from a veteran's home is incapable of offering the care sought by the veteran. The FRA supported legislation that was passed in the wake of a nationwide audit of the VA that indicates that over 57,000 veterans waited more than 90 days for an appointment at a VA medical facility, and over 64,000 who requested medical care were not even put on a waiting list. The audit also found that 13 percent of schedulers were told to falsify appointment requests to make the wait time appear to be smaller than they actually were. The VA forced thousands of veterans to choose between their traveling time to a VA medical facility, to paying out of pocket, or go without any care altogether. Since the introduction of this pending legislation the VA has announced that it will change the geographic calculation used to determine the distance between a veteran's home and the nearest VA medical facility for the Veterans Access, Choice and Accountability Act (VACAA) that was enacted on November 5, 2014. The VA has made a regulatory change from straight line distance (as the crow flies) to an actual driving distance to ensure veterans have more access to needed care. Enacting this legislation made the regulatory change permanent and in the favor of the veteran.

The Association would also like to thank Senator Mark Kirk (IL) for introducing the "Frontlines to Lifelines Act" (S. 297) that makes it easier for veterans with medical training to care for their fellow veterans. The legislation expands a pilot program to hire combat medics, medical technicians and hospital corpsmen straight from active duty service to care for their fellow veterans at VA hospitals. The Intermediate Care Technicians (ICT) pilot program facilitates the employment of these veterans straight from active duty without additional training or certifications. This common-sense measure authorizes the VA to quickly hire former Department of Defense (DOD) medical professionals by seamlessly transferring credentials between agencies. VA Secretary Bob McDonald recently identified the need for more than 26,000 new VA healthcare providers. This bill extends the pilot program for three more years and helps the VA meet its shortfall by increasing ICTs and speeding up the transfer of other healthcare providers into the VA system from DOD.

FRA supports the "Women's Veterans Access to Quality Care Act" (S. 471) sponsored by Senator Dean Heller (NV) that provides the following:

- Requires VA to establish standards in VA health care facilities to meet the specific needs of women veterans and integrate these standards into prioritization for construction projects.
- Analyzes women's health outcomes as a performance measure for VA medical center executives.
- Requires every VA medical center to have a full-time obstetrician and/or gynecologist.
- Improves outreach to veterans by requiring VA to provide state veterans agencies with contact information for veterans.
- Conducts GAO study of VA's ability to meet the needs of women veterans and their privacy and security in VA facilities.

FRA strongly supports this legislation due to the fact that women are now the fastest growing segment of eligible VA health care users. Today, nearly 2.3 million women are veterans of military service, and that number is expected to increase as women comprise 15 percent of the U.S. military's active duty personnel and 18 percent of the National Guard and Reserve forces.

DRAFT LEGISLATION

FRA wants to express its appreciation for having the opportunity to comment on draft legislation that includes provisions from other bills. FRA will support this legislation. The draft bill includes provisions from the "Veterans Affairs Research Transparency Act" (S. 114) sponsored by Senator Dean Heller (NV) that among its other provisions requires the VA/DOD Joint Executive to submit options and recommendations for establishing a program of long-term cooperation and data-sharing between VA and DOD to facilitate research on outcomes of military service, readjustment after combat deployment, and other topics of importance to veterans, members of the Armed Forces (members), their families, and members of communities that have a significant population of veterans or members. FRA has long supported efforts to ensure adequate funding for DOD and VA health care resource sharing in delivering seamless, cost effective, quality services to personnel wounded in combat and other veterans, and their families.

There is currently some acceptable cross sharing accomplishments now in place between DOD, VA and the private sector; however more is needed to meet the expectations for a wider expansion of data sharing and exchange agreements. VA, DOD and the private sector will still need to actively pursue a mutual technological advantage to serve the VA's "Blue Button" initiatives. This would permit veterans

to have online access to medical history, appointments, wellness reminders and military service information, but only after permissible measures and accessible after in-person authentication.

The draft legislation that contains the provisions of the "Access to Appropriate Immunizations for Veterans Act" (S. 172) sponsored by Senator Jon Tester (Mt.) promotes a timelier and appropriate vaccinations for veterans, placing a greater emphasis on preventive care. This legislation is a win-win for veterans and the VA. The bill should in the long-term save money for the VA by preventing veterans from getting diseases and seeking health care and help to avoid certain illnesses.

The draft legislation containing provisions of the "Chiropractic Care Available to All Veterans Act" (S. 398), sponsored by Senator Jerry Moran (Kan.), requires the VA to have at least 75 of their medical centers offer chiropractic care by December 31, 2016 and in all VA medical centers by December 31, 2018.

Finally the draft legislation that includes provisions of the "Rural Veterans Travel Enhancement Act" (S. 398), sponsored by Senator Jon Tester (Mt.) will authorize the Secretary of Veterans Affairs to transport individuals to and from facilities of the Department of Veterans Affairs in connection with rehabilitation, counseling, examination, treatment and care and for other purposes.

JOINT VA/DOD FORMULARY

The need for a joint VA/DOD prescription drug formulary is the part of the eighth recommendation of the Military Compensation and Retirement Modernization Commission (MCRMC). The Commission's recommendation is supported by FRA. The lack of seamless transition for prescription formulary has had an impact on the treatment of PTSI. Treatment for this condition is difficult and no specific drugs have been approved for treating this condition. Finding the right combination and dosage of drugs for an individual is difficult. Often when DOD doctors identify an effective treatment, the VA with a much more limited formulary, has no access to those drugs. A big step forward in treating PTSI with creating a seamless transition would be to allow VA and DOD to use the same prescription drug formulary.

CONCLUSION

In closing, allow me again to express the sincere appreciation of the Association's membership for all that you and the Members of the Senate Veterans' Affairs Committees and your outstanding staff do for our Nation's veterans.

Our leadership and Legislative Team stand ready to work with the Committees and their staffs to improve benefits for all veterans who have served this great Nation.

Chairman ISAKSON. Thank you, Mr. Snee.

Sergeant MEDINA.

STATEMENT OF SERGEANT FIRST CLASS VICTOR MEDINA, U.S. ARMY, RETIRED

Sergeant MEDINA. Chairman Isakson, Ranking Member Blumenthal and Committee Members, thank you for having me today and allowing me to testify. Just a quick note before I start. I did develop, as a result from my combat injuries, a speech impairment, so if you do not understand, I do not have any issues in repeating myself.

Second, my testimony today is not intended to criticize the El Paso VA. The level of care and access to care that I have received from my facility has exceeded any expectation. I proudly served in the U.S. Army from 1994 to 2012. After three combat tours, two in support of Operation Iraqi Freedom and one in support of Operation Enduring Freedom.

On June 29, 2009, I was wounded in action while on patrol in Iraq when an explosive formed projectile struck my vehicle. I received the Purple Heart for injuries sustained during this event. I sustained a moderate Traumatic Brain Injury which affected me both physically and cognitively. According to my health care pro-

viders, the effects of my injuries are expected to worsen over time, and in fact they have.

Since 2009, I received approximately 2 years of rehabilitation. Since the beginning of my injury, I was prescribed different medications to attempt to lessen the effects of the cognitive disorder and pain. After several attempts, doctors were able to find the correct medication to lessen the effects of the newly acquired cognitive disorder and the pain.

To address the cognitive disorders, I was finally prescribed Vyvanse, which was medication that caused no secondary effects and helped me find a new normalcy. After 3 years with a medication that was working very well, I was forced to change medications to a less effective formula. Why? Unfortunately, the original medication that was working tremendously with no secondary effects and included in the DOD formulary is not included in the VA formulary.

This situation forced me to return to a medication that was already discontinued from my care due to experienced adverse side effects.

My health care services are provided by El Paso VA Health Center. Particular to my health care facility in El Paso, TX, is that both the DOD pharmacy and the VA pharmacy are co-located. They are both in the same building. While Vyvanse physically exists inside the building, I cannot receive it because the VA does not carry it in its formulary.

That means that while I could be receiving the medication with no side effects, I have to settle for a medication that has been no good to me only because of a limitation in the VA formulary.

In my case the medication is not intended to help with attention and concentration. This medication was vital in my successful completion of graduate studies and in becoming a certified rehabilitation counselor. So, I am not the case of one veteran with a tantrum because of not being able to receive one random medication. I am the case of one veteran that wants to succeed in my life by having my playing field level. My past medication levels my playing field.

Today I do not come to you as an isolated veteran. I come to as the voice of many. I support the joint formulary bill. It is a bill that is economically sound. This bill may result in the better utilization and allocation of our resources, which in turn may reflect an increased quality of services provided to veterans.

I have come across veterans with situations similar to mine. These veterans asked me to be their voice today. The following veterans have similar stories. They have authorized me to mention their names here today. Fernando Esquivel from Texas, Mike Barbour from Illinois, Zen Cypher from Texas, DeWayne Mayer from Ohio.

This afternoon I am saddened as I ask myself how many veteran suicides have been related to medication change for the lack of uniform formularies? We may never know the answer. I only know one thing. I wish I could go back to the medication that worked well enough to live for 2 years than daily adverse secondary effects of a medication given to me solely because it is only option available.

Thank you very much for having me and for everything you do for the veterans.

[The prepared statement of Sergeant Medina follows:]

PREPARED STATEMENT OF SERGEANT FIRST CLASS VICTOR MEDINA, U.S. ARMY (RET.)

I proudly served in the United States Army from 1994 to 2012. I have three combat tours: two in support of Operation Iraqi Freedom and one in support Operation Enduring Freedom. On June 29th, 2009 I was wounded while on patrol in Iraq when an Explosive Formed Projectile struck my vehicle. I received the Purple Heart for injuries sustained during this event. I sustained a moderate Traumatic Brain Injury, which affected me both, physically and cognitively. According to my healthcare providers, the effects of my injuries are expected to worsen over time, and in fact they have.

Since 2009, I received approximately 2 years of rehabilitation. Since the beginning of my injury, I was prescribed different medications to attempt to lessen the effects of the cognitive disorder and pain. After several attempts, doctors were able to find the correct medication to lessen the effects of the newly acquired cognitive disorder and pain.

To address the cognitive disorders I was finally prescribed Vyvanse, which was a medication that caused no secondary effects, and helped me find a new normalcy. After 3 years with a medication that was working very well, I was forced to changed medications to a less effective formula. Why? Unfortunately, the original medication that was working tremendously with no secondary effects and included in the DOD formulary is not included in the VA limited formulary. This situation forced me to return to a medication that was already discontinued from my care due to the experienced adverse side effects.

My healthcare services are provided by El Paso VA Health Center. Particular to my health care facility in El Paso, Texas is that both, the DOD pharmacy and the VA Pharmacy are co-located, they are in the same building. While Vyvanse physically exists in the building, I cannot receive it because the VA does not carry it in its formulary. That means that while I could be receiving the medication with no side effects, I have to settle for a medication that it has been no good to me, only because of a limitation in the VA formulary.

In my case the medication, Vyvanse, is intended to help with attention and concentration. This medication was vital in my successful completion of graduate studies and in becoming a Certified Rehabilitation Counselor. So, I am not the case of one a Veteran with a tantrum because of not being able to receive one random medication. I am the case of one Veteran that wants to succeed in life, by having the playing field leveled. My past medication leveled my playing field.

Today, I do not come to you as one isolated Veteran. I come to you as the voice of many. I support this bill. It is a bill that is economically sound. This bill may result in the better utilization and allocation of resources, which in turn may reflect in an increased quality of services provided to Veterans.

I have come across Veterans with situations similar to mine. These Veterans ask me to be their voice here today. The following Veterans had similar stories to mine; they authorized me to mention their name here today: Fernando Esquivel from Texas, Mike Barbour from Illinois, Zen Cypher from Texas, and, DeWayne Mayer from Ohio.

This afternoon, I am saddened as I ask myself: how many Veteran suicides have been related to medications changed for the lack of uniformed formularies? We may never know the answer. I only know one thing: I wish I could go back to the medication that worked well and to not live for 2 years with daily adverse secondary effects of a medication given to me, solely because it is the only available option to me.

Thank you.

Chairman ISAKSON. Well, thank you for your service to the country and thank you for your testimony.

Dr. Lynch and the members of the VA, I want to repeat what the sergeant said and make sure I understood it correctly. While on active duty after your TBI injury and the explosion, you were prescribed Vyvanse. Is that right?

Sergeant MEDINA. Vyvanse.

Chairman ISAKSON. You were on it for 3 years and it dealt well with your cognitive disability, is that correct?

Sergeant MEDINA. Mr. Chairman, it was a long process. It was a lot of trial and error, and here when I was in Walter Reed about

3 years after the injury, they finally found the right medication, and then I continued to take it until 6 months ago—I am sorry, 2 years ago when I got to the VA and then I got switched.

Chairman ISAKSON. So, you were switched from active duty to VA about 2 years ago, is that right?

Mr. ATIZADO. Correct, Mr. Chairman.

Chairman ISAKSON. Dr. Lynch, when you testified on the formulary issue, I thought I heard you say that if there was an inconsistency between DOD formulary and VA formulary, you did not change a prescription for a veteran who became under VA health care. Is that right?

Dr. LYNCH. That should not have happened, Senator.

Chairman ISAKSON. OK. What happened to the sergeant was he was on Vyvanse and when he went into VA health care in El Paso, whose pharmacy—the VA pharmacy and the DOD pharmacy are side-by-side, is that correct?

Sergeant MEDINA. They are not physically side-by-side, Mr. Chairman.

Chairman ISAKSON. But they are in the same area?

Sergeant MEDINA. They are in the same building.

Chairman ISAKSON. So, this soldier, when he went in under veterans health care, because that formulary for Vyvanse was not on your list, he was switched to a less effective drug. Is that correct?

Sergeant MEDINA. Correct, Mr. Chairman.

Chairman ISAKSON. Are you still on the less effective drug?

Sergeant MEDINA. Yes, Mr. Chairman.

Chairman ISAKSON. I would think his case merits a revisit in terms of the VA, first of all, in consult with his physician. If going back to Vyvanse is in his best interest, I think it ought to happen, and it is a good testimony as to why the formularies should have a parallel agreement in terms of VA and DOD. This is a perfect example case.

When I read this last night—I was not an expert on the formulary issue, but I am an expert on taking pills at my age. I know when you get the wrong one it is not good and when you get one that was working and you do not get it anymore it is bad. So, I think the VA ought to investigate this case and I would appreciate your advising the Committee of what happens in that investigation.

Dr. LYNCH. Yes, sir. We will do that.

[Responses were not received within the Committee's timeframe for publication.]

Chairman ISAKSON. Thank you for your service and thank you for your testimony and thank you for your courage, not only to represent the country, but to speak out at this hearing today. We appreciate you very much.

Sergeant MEDINA. Thank you, Mr. Chairman.

Chairman ISAKSON. Mr. Benjamin, I think I understood you. You used a lot of acronyms, but I think you were in support of the legislation that allows—that is going to revise the contracting procedures at VA for private care providers, is that correct?

Mr. BENJAMIN. Yes, sir, absolutely.

Chairman ISAKSON. The way it is written, it does not have all the red tape that you used in terms that I was not familiar with, such as FAR, Federal Acquisition Regulations.

Mr. BENJAMIN. In fairness, I was not familiar with them until a couple of days beforehand because I figured you would be asking me a lot of tough questions.

Chairman ISAKSON. Well, I feel better. But you think the way the legislation is drafted is good?

Mr. BENJAMIN. It is and we very much appreciate the openness that the VA has had and Senator Blumenthal and also Senator Hoeven and the staffs of the various people involved. I have been doing this for a long time and sometimes you try to tell people things that they might not agree with. This has been one where there has been a lot of agreement and we have appreciated the support that we have received.

Chairman ISAKSON. Mr. Atizado—is that better?

Mr. ATIZADO. That works just fine.

Chairman ISAKSON. With the Isakson name, I am tough with last names anyway. I want to thank DAV for their outspoken support of women's issues in the military for our women veterans. Your organization is doing an outstanding job of illuminating and elevating the women's issues and this Committee is going to do everything we can to respond to the illumination and elevation to see to it that they are provided equal access to health care that is particular to women just like we provide to men today. I appreciate your organization's testimony and your advocacy for them.

Mr. ATIZADO. We thank you for championing this cause, Chairman and Ranking Member Blumenthal. We really appreciate it, as well as all the work on your Committee staff and the Members of this Committee.

Chairman ISAKSON. As my wife always reminds me, if there were not any women, there would not be any men. So, we want to make sure we take care of them.

Ranking Member Blumenthal.

Senator BLUMENTHAL. I might just say about Senator Isakson and his wife Dianne, since he referred to her, that he and I share the good luck of having married above ourselves. So, I join in approving of her sentiment in that regard.

I want to thank again Sergeant First Class Medina, for being here today, for your courage in serving our Nation and also speaking for so many veterans who have unfortunately been—I am going to use the word victims because I think that is the correct word of the failure of the two formularies, Department of Defense and Veterans Administration, to coordinate.

I am appreciative particularly to you for responding to the invitation that we issued, that my staff issued to you, and we thought about other witnesses, so-called experts, but you were really the expert and the best expert on this problem, and I referred to your testimony earlier by saying how compelling and important it was, and I truly believe it has been very powerful and will have an effect today.

My thanks to you and the other veterans whose names you mentioned and the others who are nameless on this occasion, but who also can attest to this problem. Thank you for being here.

Mr. Benjamin, let me just say that in my view, talking about FAR, FAR actually is an acronym for about five or six different things in military, VA, HUD, world. In my view, acronyms are the great enemy in Washington. So, I try to avoid using them, but thanks for explaining what FAR means in this context.

Mr. BENJAMIN. I brought a whole bunch of other paperwork if you would like it.

Senator BLUMENTHAL. I thank you, but no thank you.

Mr. BENJAMIN. I thought you might say that.

Senator BLUMENTHAL. We see plenty of paperwork in our line of work. I just want to thank you for supporting this initiative because I think it is very important in broadening the opportunities that are available for health care for our veterans. I think all of our witnesses today have spoken very powerfully to the need for more opportunities and I thank all of you for being here.

I want to join in thanking the DAV for its support for women's health care, one of the great challenges of our time, increasingly important as more women become veterans. That is a good thing. So, we need to be prepared for more women becoming veterans since they are contributing more and more to our armed services. I do not have any other questions, so thank you, Mr. Chairman, for having this hearing.

Chairman ISAKSON. Thank you, Ranking Member Blumenthal. The Committee will stand adjourned and thank you for your testimony today. We appreciate it.

[Whereupon, the hearing was adjourned at 3:50 p.m.]

A P P E N D I X

PREPARED STATEMENT OF DIANE M. ZUMATTO,
NATIONAL LEGISLATIVE DIRECTOR, AMVETS

- S. 207, Veterans Access to Community Care Act of 2015
- S. 297, Frontlines to Lifelines Act of 2015
- S. 425, Homeless Veterans Reintegration Programs Reauthorization Act of 2015
- S. 471, Women Veterans Access to Quality Care Act of 2015
- S. 684, Homeless Veterans Prevention Act of 2015
- S. ——, Discussion draft to include provisions from S. 114; S. 172; S. 398 & S. 603
- S. ——, Discussion draft on provider agreement language
- S. ——, Joint VA/DOD formulary for pain and psychiatric medications

I would like to begin today's statement with the following introductory remarks prior to turning to each specific piece of legislation: As the United States absorbs the aftereffects of more than a decade of continuous war and in the face of the planned draw-down of military personnel, the physical and mental health of our military and veterans will continue to be priority issues for AMVETS, the veteran's community and hopefully Congress. Thanks to improvements in battlefield medicine, swift triage, aeromedical evacuations and trauma surgery, more combat-wounded than ever before are surviving horrific wounds and will be needing long-term rehabilitation, life-long specialized medical care, sophisticated prosthetics, etc. Your committee has a responsibility to ensure that the VA and our Nation live up to the obligations imposed by the sacrifices of our veterans.

It is encouraging to acknowledge at this time that, despite the extraordinary sacrifices being asked of our men and women in uniform, the best and the brightest continue to step forward to answer the call of our Nation in its time of need. I know that each of you is aware of, and appreciates the numerous issues of importance facing our military members, veterans and retirees; therefore this testimony will be, following these introductory remarks limited to the specific legislation listed above.

I would also like to first delineate several general issues that AMVETS would like the Committee to monitor and enforce as it goes about its work, followed by specific recommendations related to the VA.

General Recommendations:

- ensure that the VA provides a continuity of health care for all individuals who were wounded or injured in the line of duty including those who were exposed to toxic chemicals;
- ensure that all eligible veterans not only have adequate access, but timely and appropriate treatment, for all of their physical and mental healthcare needs;
- continue to press the VA to work collaboratively with the DOD in creating and implementing a completely operational and fully integrated electronic medical records system;
- continue the strictest oversight to ensure the safety, physical and mental health and confidentiality of victims of military sexual trauma;
- ensure that the VA continues to provide competent, compassionate, high quality health care to all eligible veterans; and
- ensure that the VA continues to receive sufficient, timely and predictable funding for VA health care.

Specific Recommendations:

- Ensure that both advanced appropriations and discretionary funding for VA keeps pace with medical care inflation and healthcare demand as recommended in the *IB* so that all veterans healthcare needs can be adequately met;

- Maximize the use of non-physician medical personnel as a way to mitigate physician shortages and reduce patient wait times especially while utilization of the VA system continues to rise;
- Ensure that VA makes more realistic third-party medical care collection estimates so that Congress doesn't end up under-appropriating funds based on false expectations which in turn negatively impact veteran care. Additionally, VA needs to redouble its efforts to increase its medical care collections efforts, because taken together, the cumulative effects of overestimating and under-collecting only degrade the care available to our veterans. Furthermore, VA needs to establish both first- and third-party copayment accuracy performance measures which would help minimize wasted collection efforts and veteran dissatisfaction;
- VA needs to incorporate civilian healthcare management best practices and include a pathway to VA hospital/clinic management for civilians as part of their succession plan requirements, so that VA will be able to attract the best and the brightest healthcare managers in the industry;
- VA could immediately increase its doctor/patient (d/p) ratio to a more realistic and productive levels in order to cut wait times for veterans needing treatment and/or referrals. While the current VA (d/p) ratio is only 1:1200, the (d/p) ratio for non-VA physicians is close to 1:4200. Instituting this one change would drastically improve our veterans access to needed healthcare;
- VA needs to improve its patient management system so that veterans have more appointment setting options available to them, which could reduce staffing errors and requirements. VA should also consider utilizing a hybrid system whereby half the day might consist of scheduled appointment and the other half would be for walk in or same-day appointment. The elimination of the need for non-specialty appointments would allow veterans quicker access to their primary care providers;
- The current VA healthcare system appears to be top-heavy with administrative staff and short-handed when it comes to patient-focused clinical staff. This imbalance can only lead to noticeable veteran wait times;
- The VA needs to thoroughly review its entire organizational structure in order to take advantage of system efficiencies and to maximize both human and financial resources, while also minimizing waste and redundancies;
- VA needs to collaborate with HHS (Health & Human Services) so that it can utilize/share the benefits of the UDS (Uniform Data System). The UDS is a core set of information appropriate for reviewing and evaluating the operation and performance of individual health centers. The ability to track, through the UDS system, a wide variety of information, including patient demographics, services provided, staffing, clinical indicators, utilization rates, costs, and revenues would be invaluable in improving the overall VA healthcare system;
- Rather than have veterans go unseen or untreated due to limited appointment or physician availability, veterans should be allowed to utilized the currently existing system of FQHCs (federally Qualified Health Centers). FQHCs include all organizations receiving grants under section 330 of the Public Health Service Act, certain tribal organizations, and they qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs are required to: serve an underserved area or population; offer a sliding fee scale; provide comprehensive services; have an ongoing quality assurance program; and to have a governing board of directors. Allowing veterans to seek care, even on a temporary basis, until the VA appointment backlog is eliminated, would provide our veterans with immediate care and would relieve some of the pressure on the VA system;
- VA must immediately improve its recruitment, hiring and retention policies to ensure the timely delivery of high quality healthcare to our veterans. VA currently utilizes a cumbersome and overly-lengthy hiring process which reduces its ability to deliver critical services. VA need to consider adopting a more expedient hiring/approval process which could include some form of provisional employment;
- VA needs to have, and utilize, the option to terminate non-performing employees at all levels of the organization so that only dedicated, accurate, motivated employees will remain in service to our veterans; and
- Finally, VA needs to reform their incentive programs so that only high-performing employees receive appropriate bonuses for their excellence in serving our veterans.

PENDING LEGISLATION

S. 207, Veterans Access to Community Care Act of 2015—AMVETS supports this legislation which directs the VA Secretary to use existing authority to provide health care to veterans at non-VA facilities to veterans living more than 40 miles driving distance from the closest VA facility that furnishes the care needed by the veteran.

There is an additional problem that should be considered when making improvements to the Choice legislation which I have not heard any discussion about that I would like to bring to your attention—this problem involves the inability of veterans to cross VISN lines for medical treatment when they live closer to a facility in another VISN than one in their own VISN.

The issue of "Timely Access to High-Quality Health Care," which is directly related to underlying foundation of S. 207, is the number one "Critical Issue" outlined in the *Independent Budget* and is among the highest priorities of AMVETS. Hopefully this legislation gets veterans one step closer to 'real' choice and easier health care access.

S. 297, Frontlines to Lifelines Act of 2015—AMVETS supports this legislation which seeks to address the physician shortage within the VA by:

- reintroducing, for a three-year period, VA's Intermediate Care Technician Pilot Program;
- streamlining the transfer of medical credential data regarding DOD health care providers that move from DOD to VA;
- allows advanced practice nurses to practice independently under a set of VA-approved privileges, regardless of the state in which VA employs the covered nurse.

S. 297 goes a long way toward meeting our recommendation to maximize the use of non-physician medical personnel as a way to mitigate physician shortages and reduce patient wait times.

S. 425, Homeless Veterans Reintegration Programs Reauthorization Act of 2015—AMVETS supports this legislation which seeks to reauthorize, for five-years, the Homeless Veterans/Homeless Women Veterans/Homeless Veterans with Children Reintegration Programs and to provide clarification regarding eligibility for said services.

AMVETS believes that S. 425 will help continue the trend of reducing the number of homeless veterans.

S. 471, Women Veterans Access to Quality Care Act of 2015—AMVETS fully supports this legislation, which is one of the *Independent Budget*'s "Critical Issues" for the 114th Congress. Women are a rapidly growing component of the Armed Forces, comprising approximately: 20% of new recruits; 14.5% of active duty members; and 18% of the reserve component. Additionally, while the number of male veterans is expected to decline by 2020, the opposite is true for the number of women veterans.

S. 684, Homeless Veterans Prevention Act of 2015—AMVETS supports this legislation which seeks to address the issue of homeless veterans by expanding a number of important services, including:

- increasing per diem payments for transitional housing assistance to veterans placed in housing that will become permanent;
- allows qualified veterans to receive diem payments for dependents;
- encourages public/private partnerships to provide legal services to homeless veterans and/or veterans at risk of homelessness;
- providing dental care to homeless veterans;
- repeals the sunset authority of the VA and DOL to carry out a referral and counseling program for veterans at risk of homelessness and/or those transitioning from certain institutions; and
- expands supportive services to very low-income veteran families in permanent housing.

There has been marked progress over the last few years in reducing the number of homeless veterans and these services need to continue until there are no longer any veterans in need.

Discussion Draft, Veterans Health Act of 2015, to Include Provisions from S. 114; S. 172; S. 398; and S. 603—this legislation, which AMVETS supports, combines a variety of provisions aimed at improving veteran health, access to care and transparency, including:

- improved access to adult immunizations;
- expansion of chiropractic care including—rehabilitative & preventative services;

- extension of sunset date regarding transportation of individuals to/from VA facilities and the requirement of a report;
- access to VA research data and data sharing between VA and DOD

Discussion Draft, Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act—this somewhat technical legislation, which AMVETS supports, expands veteran access to non-VA health care and sets conditions for: eligibility to participate in the program; establishment of a certification process for eligible non-VA providers; establishment of specific requirements under Terms of Agreement; the termination of Veterans Care Agreements; the periodic review of Veterans Care Agreements; the exclusion of certain Federal contracting provisions; the establishment of a monitoring system to measure the quality of care and services received by veterans; the establishment of equitable dispute resolution procedures; and modifies the authority to enter into agreements to provide nursing home care.

Discussion Draft, Joint VA/DOD Formulary for Pain and Psychiatric Medications—This legislation, which AMVETS fully supports, calls for the establishment of a joint uniform formulary with respect to certain medications. Not only should this benefit servicemembers transitioning out of the DOD health care system into the VA system, it should also be more economical for both the DOD and VA, in that greater quantities generally equate to price reductions.

This completes my statement at this time and I thank you again for the opportunity to offer our comments on pending legislation. I will be happy to answer any questions the Committee may have.

PREPARED STATEMENT OF CONCERNED VETERANS FOR AMERICA

S. 207: THE VETERANS ACCESS TO COMMUNITY CARE ACT OF 2015

To require the Secretary of Veterans Affairs to use existing authorities to furnish health care at non-Department of Veterans Affairs facilities to veterans who live more than 40 miles driving distance from the closest medical facility of the Department that furnishes the care sought by the veteran, and for other purposes.

In August of last year, President Obama signed the Veterans Access, Choice and Accountability Act that established a temporary "choice card" program, which was intended to address an access problem at VA, by extending the possibility of private care to veterans who wait more than 30 days for an appointment and/or reside more than 40 miles from a VA facility—including a Community Based Outpatient Clinic (CBOC). However, rather than access and appointments getting easier, we have seen a process that is confusing, frustrating, and still unacceptably long. However, the primary implementation impediment has been VA's interpretation of the law; specifically their decision to restrict the use of the Choice program to those within 40 miles of a VA facility, even if that facility does not offer the care needed. The law states that veterans are eligible if they reside "more than 40 miles from the medical facility of the Department, including a community-based outpatient clinic [CBOC], that is closest to their residence." VA has taken this quite literally—drawing 40 mile, "as-the-crow-flies" circles around every single VA facility, regardless of whether that facility provides the services needed by the veteran seeking care.

This legislation would clarify that language, requiring that determination of eligibility take into account whether the facility actually offers the needed care. This is a common-sense clarification, and one that is essential to choice card functioning as intended to improve the choices and access to care that veterans have earned by their service.

Concerned Veterans for America SUPPORTS this legislation

S. 297: THE FRONTLINES TO LIFELINES ACT OF 2015

To revive and expand the Intermediate Care Technician Pilot Program of the Department of Veterans Affairs, and for other purposes.

Concerned Veterans for American has no position on this legislation.

S. 425: THE HOMELESS VETERANS REINTEGRATION PROGRAMS REAUTHORIZATION ACT OF 2015

To amend title 38, United States Code, to provide for a five-year extension to the homeless veterans reintegration programs and to provide clarification regarding eligibility for services under such programs.

Concerned Veterans for American has no position on this legislation.

S. 471: THE WOMEN VETERANS ACCESS TO QUALITY CARE ACT OF 2015

To improve the provision of health care for women veterans by the Department of Veterans Affairs, and for other purposes.

Concerned Veterans for American has no position on this legislation.

S. 684: THE HOMELESS VETERANS PREVENTION ACT OF 2015

To amend title 38, United States Code, to improve the provision of services for homeless veterans, and for other purposes.

Concerned Veterans for American has no position on this legislation.

DISCUSSION DRAFT TO INCLUDE PROVISION FROM S. 114 (HELLER); S. 172 (TESTER); S. 398 (MORAN); AND S. 603 (TESTER)

To amend title 38, United States Code, to improve the access of veterans to health care and related services from the Department of Veterans Affairs, and for other purposes.

Concerned Veterans for American has no position on this legislation.

DISCUSSION DRAFT ON PROVIDER AGREEMENTS LANGUAGE

To amend title 38, United States Code, to allow the Secretary of Veterans Affairs to enter into certain agreements with non-Department of Veterans Affairs health care providers if the Secretary is not feasibly able to provide health care in facilities of the Department or through contracts or sharing agreements, and for other purposes.

Concerned Veterans for American has no position on this legislation.

JOINT VA/DOD FORMULARY FOR PAIN AND PSYCHIATRIC MEDICATIONS

To require the Secretary of Defense and the Secretary of Veterans Affairs to establish a joint uniform formulary with respect to systemic pain and psychiatric drugs that are critical for the transition of an individual from receiving health care services furnished by the Secretary of Defense to health care services furnished by the Secretary of Veterans Affairs, and for other purposes.

Concerned Veterans for American has no position on this legislation.

PREPARED STATEMENT OF JAMIE TOMEK, CHAIR, GOVERNMENT RELATIONS COMMITTEE, GOLD STAR WIVES OF AMERICA, INC.

Thank you for the opportunity to submit Testimony for the Record for the Senate Veterans Affairs' Committee hearing on Wednesday, June 3, 2015.

Gold Star Wives of America, Inc. (GSW) was founded in 1945 and is a Congressionally Chartered Veterans Service Organization which serves the surviving spouses of military servicemembers and veterans who died in service or died of a service-connected cause.

HEY15526—DEPARTMENT OF VETERANS AFFAIRS PURCHASED HEALTH CARE STREAMLINING AND MODERNIZATION ACT

This bill would provide civilian medical care to veterans who cannot readily access VA medical care. This would substantially reduce the long wait for appointments at VA health care facilities.

GSW recommends passage of this initiative.

HEY15530—VETERANS HEALTH ACT OF 2015

This bill would provide adult immunizations against infectious diseases to veterans on the recommended adult schedule; expand chiropractic care and services to veterans; extend transportation to and from VA facilities for veterans; and provide a Web site to share VA research with the public.

GSW concurs with these objectives and requests that surviving spouses entitled to CHAMPVA be included in the immunization initiative either directly from VA immunization clinics and/or through CHAMPVA without co-pay. GSW also requests that surviving spouses entitled to CHAMPVA be included in the extended chiropractic care and services initiative.

HEY 15532—
VA AND DOD DRUG FORMULARIES FOR SYSTEMIC PAIN AND PSYCHIATRIC DRUGS

This bill would ensure that military personnel who are being successfully treated for pain and/or psychiatric conditions would be able to continue receiving the same

pain and psychiatric medications when they transition from DOD medical care to VA medical care.

Care should be taken to ensure that patients entitled to or receiving both military medical care and VA medical care are not overmedicated, i.e., receiving medication from both the DOD medical facility and the VA medical facility.

GSW recommends passage of this initiative.

PREPARED STATEMENT OF MILITARY OFFICERS ASSOCIATION OF AMERICA

CHAIRMAN ISAKSON, RANKING MEMBER BLUMENTHAL, the Military Officers Association of America (MOAA) is pleased to present its views on veterans' benefits legislation under consideration by the Committee today, June 3, 2015.

MOAA does not receive any grants or contracts from the federal government.

On behalf of our more than 390,000 members, MOAA thanks the Committee for its steadfast commitment to the health and well-being of our servicemembers, veterans and their families and for considering the very important health care provisions before you today.

The following provides MOAA's position and recommendations on the following provisions:

- S. 207, Veterans Access to Community Care Act of 2015
- S. 297, Frontlines to Lifelines Act of 2015
- S. 425, Homeless Veterans Reintegration Programs Reauthorization Act of 2015
- S. 471, Women Veterans Access to Quality Care Act of 2015
- S. 684, Homeless Veterans Prevention Act of 2015
- HEY 15530 Draft Legislation on the Veterans Health Act of 2015
- HEY 15526 Draft Legislation on the Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act
- HEY 15532 Draft Legislation on Joint VA-DoD Formulary for Pain and Psychiatric Medications

S. 207, Veterans Access to Community Care Act of 2015

This provision expands the current law, the Veterans Access, Choice and Accountability Act of 2014 (Public Law 113-146) ("Choice Act"), signed by the President on August 7, 2014, and implemented by the Secretary of the Department of Veterans Affairs (VA) last November. The law was a result of last year's shocking report of lengthy wait times for veterans at the VA medical facility in Phoenix, AZ. In April 2015, the Secretary published a change to the 40-mile eligibility criteria for determining distance between a veterans residence to the closest VA medical facility from a 'straight-line' distance to that of calculating 'driving' distance as the new formula because of the mounting pressure for the change.

MOAA is grateful to Senator Jerry Moran (R-KS) for sponsoring S. 207. We support further refinement to the Choice Act, and this bill allows VA to furnish hospital and medical services at non-VA facilities to veterans who reside more than 40 miles driving distance from the closest VA medical facility near the veteran's residence that provides the required care or medical services, including a community-based outpatient clinic.

Such a technical change is important as it takes into consideration the care needed for the veteran and the capabilities of VA medical facilities. MOAA believes requiring a veteran residing within the 40 mile drive time to use a VA medical facility that does not provide the necessary medical care or services is impractical and not in the best interest of the veteran. This provision allows veterans to access care at a medical facility that is able to provide the needed care.

MOAA supports S. 207.

S. 297, Frontlines to Lifelines Act of 2015

MOAA recognizes the challenges faced by the VA in hiring qualified medical professionals to effectively address quality and access to care issues, as well as the particular employment and State credentialing challenges experienced by enlisted medical technicians, combat medics or corpsman before leaving active duty service.

Senator Mark Kirk's (R-IL) bill addresses both of these challenges. The bill seeks to revive and expand the Intermediate Care Technician Pilot Program of the VA. The program would cover a three-year period and include not less than 250 intermediate care technicians. The VA Secretary would be required to assign these technicians to priority medical facilities where veterans have the longest wait times for hospital care or medical service appointments.

Additionally, the provision authorizes the VA to allow covered nurses in certain specialties to practice independently, without supervision or direction of others, under a set of privileges approved by the Secretary, regardless of the State in which the covered nurse is employed by the VA. While MOAA generally supports this section of the provision, we are concerned that the Act excludes Certified Registered Nurse Anesthetists (CRNAs) from the list of covered nurse specialties given full practice authority. Including this specialization further enhances VA's capabilities and goes a long way in addressing the critical advances needed to improve veterans' access to care.

According to the American Association of Nurse Anesthetists, veterans, nurse organizations and the AARP all support full practice authority for CRNAs. Further, such change would also be consistent with current Department of Defense (DoD) practices.

MOAA supports S. 297 with one addition. We recommend that the "Certified Registered Nurse Anesthetist" be added to the list of covered specializations on SEC. 4 (b).

S. 425, Homeless Veterans Reintegration Programs Reauthorization Act of 2015 and S. 684, Homeless Veterans Prevention Act of 2015

Senators John Boozman's (R-AR) and Jon Tester's (D-MT) bill, S. 425, would reauthorize Department of Veterans Affairs (VA) homeless veterans reintegration programs through FY 2020. The legislation is directed at expediting the reintegration of veterans into the labor force, clarifying that veterans who receive housing assistance under the Department of Housing and Urban Development's Veterans Affairs Supportive Housing (HUD-VASH) Program and Native American veterans participating in the Native American Housing Assistance program, are eligible to receive job training under the Homeless Veteran Reintegration Program (HVRP).

Currently, if a veteran qualifies for housing under one of these programs, the VA no longer considers the veteran "homeless," and does not allow their participation in HVRP. From 2010 to 2013, the number of homeless veterans fell more than one-third to about 50,000 veterans, and VA officials expect that number to shrink further when the 2014 estimates are released later this year. VA funding for homeless assistance and prevention programs has increased dramatically from $2.4 billion in FY 2008 to nearly $7 billion for FY 2016. Despite commendable progress, the VA effort to end veterans' homelessness by the end of 2015 is expected to fall short. S. 425 is needed to sustain Federal and community efforts to eliminate veteran homelessness as quickly as possible.

S. 684, the Homeless Veterans Prevention Act (Senators Richard Burr (R-NC) and Joe Manchin (D-WV) would keep veteran families together by allowing VA to house the children of homeless veterans in transitional housing programs; allow VA to partner with public and private entities to increase the availability of legal services for homeless veterans; extend and increase the amount of money available for supportive services to very low-income veteran families in permanent housing; and, for other purposes.

MOAA supports S. 425 and S. 684.

S. 471, Women Veterans Access to Quality Care Act of 2015

MOAA is especially grateful to Senators Dean Heller (R-NV) and Patty Murray (D-WA) for introducing S. 471, and endorsed this measure, which will significantly improve the health care of those accessing services through the Department of Veterans Affairs (VA) medical system.

Specifically, S. 471 will:

- establish structural medical facility standards, using health outcomes to evaluate the performance of medical staff;
- require full-time obstetricians and/or gynecologists in every medical center;
- improve data sharing between VA and state veteran agencies, and;
- direct GAO to evaluate VA's ability to meet the needs of female veterans.

The Women Veterans Access to Quality Care Act of 2015 is an extremely important piece of legislation to the nearly 2.3 million women veterans of military service. Women are the fastest growing cohort accessing VA medical care—a segment that is expected to grow by nearly 18 percent by 2040. The legislation will help VA to not only address current needs and workload requirements but prepare for the significant demand for services and care this population will need in the coming years.

MOAA supports S. 471.

HEY 15530 Draft Legislation on the Veterans Health Act of 2015

The Veterans Health Act of 2015 combines important provisions included in Senator Heller's S. 114, "Veterans Affairs Research Transparency Act of 2015," Senator Tester's, S. 172 and 603, "Access to Appropriate Immunizations for Veterans Act of 2015 and Rural Veterans Travel Enhancement Act of 2015," Senator Moran's, S. 398, "Chiropractic Care Available to All Veterans Act of 2015," bills. MOAA provides the following comments and recommendations on selected sections of the proposal for consideration:

Immunizations for Veterans

MOAA supports SEC 2 and endorsed Senator Tester's provision in a February 25, 2015 letter. This legislation will ensure veteran access to appropriate vaccinations for immunization against infectious diseases, supporting the recommended adult immunization schedule established by the Secretary of Health and Human Services. Establishing quality measures and metrics to ensure veterans receive immunizations at appropriate times is an important issue. This measure offers not only peace of mind to veterans by eliminating one additional medical procedure a veteran or family member must track, but also goes a long way in improving the quality of care within the VA health system and the quality of life of our veterans and their families.

MOAA supports SEC 2 of the draft bill.

Chiropractic Care

SEC 3 of the draft bill would expand the provision of chiropractic care and services to veterans. DoD provides for such services in its health system and establishing the requirement in law in VA's health system will allow for consistency and continuity of care between the two systems, particularly for servicemembers requiring such services upon separation from the military.

MOAA supports SEC 3 of the draft provision.

Veterans Affairs Research

MOAA has long supported improved data sharing between the VA and DoD. SEC. 5 of draft bill requires VA to establish a website to allow public access to VA research and improved data sharing between the Departments. This provision is in line with MOAA's 2015 major legislative priorities for veterans health care as well as, what we believe is the intent of the Military Compensation and Retirement Modernization Commission (MCRMC) under the Recommendation 8 section of the report—to improve collaboration between the VA and DoD (Page 127). Synchronizing and making public research conducted in the VA is essential to the long-term sustainability of the veterans and military health systems. MOAA believes a change to SEC 5 (c) (2), (4) and (5) should be made in the list of research topics—by changing the term "Armed Forces" to "Uniformed Services" to enable the U.S. Public Health Service and NOAA Corps to be included in research outcomes.

MOAA supports SEC 5 of HEY 15530 with the following change. Delete the term Armed Forces and substitute "Uniformed Services" in subsections(c), (2), (4) and (5).

HEY 15526 Draft Legislation on the Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act

MOAA generally supports this draft provision and recognizes this is a top legislative priority for the VA this year. The bill authorizes the VA to purchase care under specific circumstances through agreements that are not subject to certain provisions of law governing federal contracts so that providers are treated similarly to providers in the Medicare program.

According to VA, such authority will be used to expedite purchased care in the community through veteran care agreements when the necessary care cannot be purchased through existing contracts or sharing agreement mechanisms.

VA has outsourced care for years but the process remains cumbersome for veterans, providers and the VA. Implementing the Choice Act Program and the earlier Patient Centered Community Care (PC-3) contracts further challenge Department's ability to seamlessly integrate purchased care into an overall plan for delivering care to all veterans.

Regardless of the increased authority in purchasing non-VA care through this provision, or through the Choice Act or PC-3 programs, MOAA believes this is a critical time and excellent opportunity for the agency to develop strategic and tactical plans for fee-based care system-wide. This draft provision provides the impetus for establishing, implementing, and integrating this strategy.

MOAA generally supports HEY 15526.

HEY15532 Draft Legislation on Joint VA-DoD Formulary for Pain and Psychiatric Medications

Senator Richard Blumenthal's (D-CT) draft bill, HEY15532 would require DoD and the VA to establish a joint formulary for "systemic pain and psychiatric" conditions.

The bill addresses the insufficient coordination between the departments of the VA and Defense as the drug formularies for transitioning servicemembers differ in significant ways.

Currently, there are several key drugs which appear on DoD's formulary that do not appear on the VA's. For example, the VA formulary does not contain two pain medications (celecoxib and acetaminophen with codeine) and two psychiatric medications (escitalopram oxalate and duloxetine HCL) that are among DoD's top-10 prescribed drugs in these classes. The GAO also conducted a study of all psychiatric and pain medications on the two agencies' formularies and found that 43% of the medications on DoD's formulary were not on VA's formulary. They also found inconsistencies in VA's non-formulary request process.

The unavailability of these drugs for transitioning servicemembers causes unnecessary hardship because finding the ideal medication and dose takes time, and abrupt changes for these medications are not medically advisable. Because of the potential adverse health effects that could arise if medication is not taken as intended, medication management is crucial to effective continuity of care for members transitioning out of the military. There have been numerous GAO reports documenting the adverse effects of this un-coordination between the two departments.

This bill mandates inter-departmental coordination and collaboration on the establishment of a joint transitional formulary which will be reviewed and updated frequently with periodic reports to Congress. It puts into policy what should already be happening at the Military Treat Facility-VA hospital level.

MOAA supports HEY15532.

MOAA thanks the Committee and the members who sponsored or co-sponsored the measures before us today. We look forward to the opportunity to work with the members to make these important provisions a matter of law.

PREPARED STATEMENT OF GENERAL PETER W. CHIARELLI, USA (RET.), CHIEF EXECUTIVE OFFICER, ONE MIND

Upon retirement from Military Service, last as the 32nd Vice Chief of Staff of the U.S. Army, I became the Chief Executive Officer of the non-profit, One Mind, which is dedicated to the treatment of brain diseases and injuries.

DRAFT BILL—ESTABLISHING A JOINT UNIFORM FORMULARY FOR SYSTEMIC PAIN AND PSYCHIATRIC DRUGS

I fully support the proposed Legislation that will require the Secretary of Defense and Secretary of Veterans Affairs to establish a joint uniform drug formulary. Unfortunately today, systemic pain and psychiatric drugs that are critical for the health care of our military members suffering from what is commonly called "the invisible wounds of war," specifically Traumatic Brain Injury, post-traumatic stress and other related mental injuries (e.g., depression), differ greatly from what is initially provided by the DOD health care system to what they receive when they transition to the VA system.

Let me state that hindsight is the best teacher. Little did I know that such serious formulary differences existed, particularly for these injuries. The process of prescribing the right drug and dosage for an individual takes time to find the right combination for treatment of the invisible wounds described above. Due to genetic and other differences among individuals, patients react differently to varying drugs and dosages. Finding the right mix can be a frustrating saga of trial and error. The wrong drug or dose can, if not caught in time, become a factor to an individual's well being.

It only makes sense that once DOD doctors identify an effective treatment for a servicemember, that same treatment should be available when the servicemember leaves active duty and moves to the VA for care. As stated before, more often than not, this is not the case.

Why should a joint formulary be adopted? Rather than repeating the laborious process of finding another drug that works, many veterans have told me they sought out private providers to fill their prescriptions, usually paying for their medications out of pocket. Imagine how they feel about VA when their first experience with the system is a doctor telling them they cannot fill a prescription that has relieved their pain or psychiatric symptoms for months or even years? In some cases, the veteran is not even given enough of the recommended drug to safely discontinue its use.

It is also important that medications be made available immediately upon a servicemember transitioning to VA care, not two to three weeks after. This is absolutely critical. The drugs need to be made available in the pharmacy and ready to distribute when the servicemember has their first appointment at the VA.

The Legislation states that the Secretary of Defense and Secretary of Veterans Affairs have 180 days to submit a joint drug formularies report to Congress. I do not understand why it should take this long. The joint formulary needs to be initiated in the next 90 days. In the interim, DOD doctors should coordinate with VA doctors to support the facilitated transition of servicemembers. Every day that the joint uniform formulary is delayed is another day where servicemembers, veterans and their families are struggling and losing confidence in the ability of the VA to provide medical care.

I believe The Legislation takes a huge step forward in ensuring a future where servicemembers experience a more seamless transition through the harmonization of the DOD and VA drug formularies. This bill focuses on formularies, but I urge the Committee to look into other areas or policies that will make the transition from DOD to VA seamless for servicemembers and their families.

PREPARED STATEMENT OF PARALYZED VETERANS OF AMERICA

S. 297, THE "FRONTLINES TO LIFELINES ACT OF 2015"

PVA generally supports S. 297, the "Frontlines to Lifelines Act of 2015." This bill would revive and expand a pilot program that lapsed in February 2014. This bill would authorize VA to hire 250 intermediate care technicians at facilities with the longest wait times. It would transfer credentialing data of a health care provider who relocates from the Department of Defense to employment with the Department of Veterans Affairs. By rapidly absorbing qualified, experienced health care providers, this bill could ease some of the strains on VA's hiring process.

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

PVA supports S. 425, the "Homeless Veterans Reintegration Programs Reauthorization Act of 2015." This bill would extend authority for the VA Homeless Veterans Reintegration Programs (HVRP) and the Homeless Women Veterans and Homeless Veterans with Children Reintegration Grant Program through Fiscal Year 2020. The HVRP program is one of the most cost-effective and cost-efficient programs in the Federal Government. Despite being authorized $50 million per year, it generally is appropriated less than half of that authorized level every year. And yet, it continues to serve a large number of veterans who are taking the necessary steps to overcome homelessness.

This bill would also clarify eligibility to include homeless veterans participating in the Department of Housing and Urban Development—VA Supported Housing program (HUD-VASH), Native veterans receiving assistance under the Native American Housing Assistance and Self Determination Act of 1996, and those transitioning from incarceration.

S. 471, THE "WOMEN VETERANS ACCESS TO QUALITY CARE ACT OF 2015"

PVA supports S. 471, the "Women Veterans Access to Quality Care Act of 2015." This bill would establish structural standards in VA health care facilities that are necessary to meet the health care needs of women veterans. Implementation of this bill would generate a report to the House and Senate Veterans' Affairs Committees listing the facilities that fail to meet these standards and the projected cost to do so. VA would be required to publish the health outcomes of women in each facility, juxtaposed with the men that facility serves. VA would be required to hire a full-time obstetrician or gynecologist at every VA Medical Center, and pilot an OB-GYN graduate medical education program to increase the quality of and access to care for women veterans.

The women veteran population who use VA health care doubled between 2003 and 2012, from 200,631 to 362,014. By 2040, it will have doubled again. Given this projection, VA must increase their capacity to meet the needs of women veterans. This legislation is a crucial step in assessing the quality of care women veterans receive and the steps needed to improve it.

S. 684, THE "HOMELESS VETERANS PREVENTION ACT OF 2015

PVA supports S. 684, the "Homeless Veterans Prevention Act of 2015" to improve services for homeless veterans.

Section 2 would increase per diem payments for transitional housing assistance that becomes permanent for veterans. Section 3 would authorize per diem payments to provide care for a dependent of a homeless veteran while the veteran receives services from a VA grant and per diem recipient.

Section 4 would instruct VA to partner with public and private entities to provide legal services to homeless veterans and veterans at risk of homelessness. These services, subject to available funding, would be made available in an equitable geographic pattern to include rural populations and tribal land. The legal services would include those related to housing, including eviction defense and landlord-tenant cases; family law, including assistance with court proceedings for child support, divorce and estate planning; income support, including assistance in obtaining public benefits; criminal defense, including outstanding warrants, fines and driver's license revocation, and to reduce the recidivism rate while overcoming reentry obstacles in employment or housing.

Section 5 would expand the authority of VA to provide dental care to eligible homeless veterans who are enrolled for care, and who are receiving housing assistance under "section 8" for a period of 60 consecutive days. Those eligible also include veterans receiving care in a therapeutic residence; community residential care coordinated by the Secretary; or a setting for which the Secretary provides funds for a grant and per diem provider.

Section 6 would repeal the sunset on authority to carry out the program of referral and counseling services for veterans at risk for homelessness who are transitioning from certain institutions. Section 7 would extend the authority for financial assistance for supportive services for very low-income veteran families in permanent housing. Section 8 of this bill would require VA to assess and measure:

- Whether existing capacity meets the needs of the subpopulations of homeless veterans located in each geographic area.
- The amount of capacity that recipients of grants under sections 2011 and 2061 and per diem payments under section 2012 of such title have to provide services for

which the recipients are eligible to receive per diem under section 2012(a)(2)(B)(ii) of title 38, United States Code, as added by section 3(5)(B) of this bill.

Assessment and recommendations for improvements of the programs would be submitted to Congress by the Secretary.

Section 9 would require the GAO to complete a study of VA programs that provide assistance to homeless veterans and a review of the privacy, safety, and security of women veterans receiving assistance from such programs. Section 10 would repeal the requirement for annual reports on assistance to homeless veterans.

DRAFT BILL, THE "VETERANS HEALTH ACT OF 2015"

PVA supports the "Veterans Health Act of 2015." This bill would include immunizations in the statutory definition of "medical services," thereby improving access to immunizations. It would expand the availability of chiropractic care in VA facilities; extend the sunset date of VA transportation programs for veterans to access VA health care; and make publicly available the results of VA research.

While VA already conducts an immunization program, this bill would broaden and regulate immunizations in accordance with the adult immunization schedule established by the Secretary of Health and Human Services.

This bill would expand the provision of chiropractic care and services to veterans. It would require chiropractic services be made available in two VA medical centers in each VISN in two years from enactment, and in 50% of VA medical centers in each VISN in three years. It would also see that "chiropractic services" be included in title 38, United States Code, as a medical service, a rehabilitative service, and a preventative health service.

The proposal would extend to December 31, 2016, VA's ability to directly transport certain veterans for the purpose accessing health care. The bill would also authorize $4 million to carry out the program, and would require a VA report on the program within one year of enactment. The extension of this program would allow veterans to maintain their ability to access VA health care.

Further, it requires VA to create a Web site containing VA research data as well as a digital archive of published manuscripts of all VA-funded research.

Last, it would also require the VA/DOD Joint Executive Committee to submit a report to the respective Secretaries recommending methods to facilitate greater sharing of research between the departments addressing the outcomes of military service on veterans, family members and their communities.

DRAFT BILL, "TO REQUIRE THE SECRETARY OF DEFENSE AND THE SECRETARY OF VETERANS AFFAIRS TO ESTABLISH A JOINT UNIFORM FORMULARY WITH RESPECT TO SYSTEMIC PAIN AND PSYCHIATRIC DRUGS THAT ARE CRITICAL FOR THE TRANSITION OF AN INDIVIDUAL FROM RECEIVING HEALTH CARE SERVICES FURNISHED BY THE SECRETARY OF DEFENSE TO HEALTH CARE SERVICES FURNISHED BY THE SECRETARY OF VETERANS AFFAIRS, AND FOR OTHER PURPOSES."

The bill would exempt the established joint uniform formulary for transitioning servicemembers from the existing requirements of DOD's pharmacy benefits program. This bill would not interfere with each agency's maintenance of its own formulary for other purposes. The bill would require a joint report by DOD and VA to Congress on the establishment of the new process. This bill allows for DOD and VA to work more closely together in order to provide consistent, quality care to servicemembers transitioning.

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

PVA supports the "Department of Veterans Affairs Purchased Health Care Streamlining and Modernization Act." This bill is a necessary tool to allow the VA to meet the wide-ranging and unique health care needs of veterans, particularly veterans with spinal cord injury and dysfunction.

Through various authorities VA purchases private sector health care services for veterans, their families and survivors. Among veterans and community providers, the multiple avenues for procuring care often creates more confusion than resources. Under this proposed rule, VA would be able to obtain extended care services for veterans from providers who are closer to veterans' homes and communities.

The proposed legislation would protect VA's ability to continue to purchase private medical care when not otherwise available through VA, contracts, or sharing agreements. This allows VA to purchase care through agreements that are not subject to provisions of law governing Federal contracts, ensuring providers are treated

similar to Medicare providers. This would enable VA to meet the needs of veterans in an effective manner.

This measure preserves the protections against waste, fraud and abuse, based on the Federal and VA Acquisition Regulations. However, this legislation will also accelerate the purchasing process of a veteran's care by avoiding some of the complicated contracting rules governed by Federal Acquisition Regulations. This authority should prove extremely appealing to solo practitioners and small practices.

This concludes PVA's statement for the record. We would be happy to answer any questions for the record that the Committee may have.

PREPARED STATEMENT OF THE AMERICAN LEGION

Chairman Isakson, Ranking Member Blumenthal and distinguished Members of the Committee, on behalf of National Commander Michael D. Helm and the over 2 million members of The American Legion, we thank you and your colleagues for the work you do in support of servicemembers, veterans and their families.

S. 297: FRONTLINES TO LIFELINESS ACT OF 2015

To revive and expand the Intermediate Care Technician (ICT) Pilot Program of the Department of Veterans Affairs, and for other purposes.

S. 297 would provide VA a good opportunity to expand patient care by employing veterans. This bill is beneficial for all parties involved, especially for the veteran. However, The American Legion has the following recommendations to improve the legislation:

Section 3, subsection (b), (3)

This section states "was credentialed by the Secretary of Defense." The American Legion understands from the previous pilot program that Coast Guard corpsmen could also participate in the program. It is the recommendation of The American Legion that the Coast Guard not be excluded from this pilot program.

Section 3, subsection (d), (3)

This section states "Credentialing Defined." In defining credentialing, the legislation lists "health status" as a part of the credentialing process. However, "health status" is not part of a credential unless the member does not have the ability to perform a task. Health status should not be construed as a requirement that the DOD supply VA the servicemembers medical records.

The American Legion supports efforts to eliminate employment barriers that impede the timely and successful transfer of military job skills to the civilian labor market.[1]

The American Legion could support this legislation with the above recommendations.

S. 425: HOMELESS VETERANS REINTEGRATION PROGRAMS REAUTHORIZATION ACT OF 2015

To amend title 38, United States Code, to provide for a five-year extension to the homeless veterans reintegration programs and to provide clarification regarding eligibility for services under such programs.

This legislation extends through FY 2020 the Department of Veterans Affairs (VA) homeless veterans reintegration programs. In addition, it makes eligible for participation in those programs:

(1) Homeless veterans;

(2) Veterans who are participating in the VA supported housing program for which rental assistance is provided under the United States Housing Act of 1937; and

(3) Veterans who are transitioning from being incarcerated.

Current estimates put the number of homeless veterans at approximately 50,000 on any given night, a decline of 33 percent (or 24,837 people) since 2010.[2] This includes a nearly 40 percent drop in the number of veterans sleeping on the street. The issues facing homeless veterans fall into three primary categories: health, financial, and access to affordable housing. A critical program in the fight to eliminate veteran homelessness is the Homeless Veterans Reintegration Program (HVRP)

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[1] Resolution No. 313: Support Licensure and Certification of Servicemembers, Veterans, and Spouses—AUG 2014

[2] U.S. Department of Housing and Urban Development (HUD) press release HUD no. 14–103 AUG 2014

within the Department of Labor's Veterans' Employment and Training Services (DOL-VETS). HVRP is the only nationwide program focused on assisting homeless veterans to reintegrate into the workforce. This program is a highly successful grant program that needs to be fully funded at $50 million. Currently, HVRP is funded at $38 million.

Furthermore, there is long-term follow-up in HVRP—grantees must check in with and offer support to veteran participants for 270 days after completion—and a commitment to serve veterans transitioning out of incarceration, women veterans, and veterans with families. HVRP gives an opportunity for those who served in the Armed Forces and fallen into homelessness to build the skills necessary to become gainfully employed.

The American Legion has taken a leadership role within local communities by volunteering, fundraising, and advocating for programs and funding for homeless veterans. Additionally, The American Legion provides housing for homeless veterans and their families (i.e., Departments of Connecticut and Pennsylvania). One of the goals of The American Legion is to help bring Federal agencies, non-profit and faith-based organizations, and other stakeholders to the table to discuss best practices, along with funding opportunities, so homeless veterans and their families can obtain the necessary care and help in order for them to properly transition from the streets and/or shelters into gainful employment and/or independent living.[3]

The American Legion supports S. 425.

S. 471: WOMEN VETERANS ACCESS TO QUALITY CARE ACT OF 2015

To improve the provision of health care for women veterans by the Department of Veterans Affairs, and for other purposes.

S. 471 addresses the need for VA to provide the overall health care and services women veterans need in facilities that provide women veteran's the privacy, safety, and dignity they need and deserve. It is has been reported often that women veterans are the fastest growing demographic that is serving in the military[4] and there needs to be a robust and comprehensive VA healthcare system to care for veterans when they transition from active duty to civilian life. Over the years, the Department of Veterans (VA) has made great strides in making health care services available for women veteran's to include providing women veterans with providers to meet their gender-specific health care needs. However, there is still much work to be done to meet the overall health care needs of women veterans. Even though the military has seen a significant increase in the number of women veterans joining the military, the number of women veterans enrolling in the VA health care system still remains relatively low when compared to their male counterparts.

Despite the numerous improvements that VA has taken to improve their healthcare programs and services for women veterans, there are still numerous challenges and barriers women veterans face with enrolling in the VA including:

- Women veterans often do not identify themselves as veterans,
- Women veterans are often not recognized by VA staff as being a veteran,
- Among women veterans, there can be a lack of awareness, knowledge, and understanding of their VA benefits,
- There is a stigma associated with the VA healthcare system as a being an "all male" healthcare system, and
- The VA does not provide all of the gender specific health care needs for their enrolled women veterans.

As a result, The American Legion, through its Veterans Affairs and Rehabilitation Division, advocates ensuring women veterans are receiving the highest quality of VA health care, and the care is tailored to meet their gender specific health care needs.[5]

The American Legion supports S. 471.

S. 684: HOMELESS VETERANS PREVENTION ACT OF 2015

To amend title 38, United States Code, to improve the provision of services for homeless veterans, and for other purposes.

This bill authorizes the Supportive Services for Veterans Families (SSVF) program at $500 million for Fiscal Year (FY) 2016. In addition, the bill allows the payment of per diem to support the dependents of homeless veterans in Grant and Per

[3] Resolution No. 306: Support Funding for Homeless Veterans—AUG 2014

[4] "The number of women Veterans using VHA nearly doubled in the past decade, from 200,631 in FY 2003 to 362,014 in FY 2012 (an 80% increase)"—VHA Sourcebook Vol. 3 Women Veterans in the Veterans Health Administration, FEB 2014

[5] Resolution No. 45: Women Veterans—OCT 2012

Diem (GPD) beds; allows up to 150% of the per diem rate be paid to support Transition-in-Place beds; expands dental care to homeless veterans living in Housing Urban Development-Veterans Affairs Supportive Housing (HUD/VASH) units, Domiciliary, or GPD programs; and creates an expansive corps of lawyers, through public-private partnerships, to attend to the legal services needs of homeless and at-risk veterans.

Tremendous progress has been made in the fight to eliminate veteran homelessness; however, a great deal of work remains. S. 684 would continue to move the needle toward VA's goal of eliminating veteran homelessness by the end of 2015. The provisions in the bill would help VA's homeless veteran programs become more productive and efficient, while continuing to effectively partner with the community, national and local service providers, and other state and Federal agencies to provide comprehensive care to homeless veterans and veterans at-risk for homelessness. Due to our work with homeless veterans and their families, The American Legion understands that homeless veterans need a sustained coordinated effort that provides secure housing and nutritious meals; essential physical healthcare, substance abuse aftercare and mental health counseling; as well as personal development and empowerment. Veterans also need job assessment, training and placement assistance. The American Legion believes all programs to assist homeless veterans must focus on helping veterans reach their highest level of self-management.[6]

The American Legion strongly believes that Congress, VA and other stakeholders must continue to invest in the progress that has been made and remove any remaining barriers to housing for veterans. The VA's Five-Year Plan to eliminate veteran homelessness by 2015 is roughly 200 plus days away. By helping to provide the necessary resources and changes to reach this obtainable, and worthy, goal, this Nation can finally end the scourge of veteran homelessness.

The American Legion supports S. 684.

DISCUSSION DRAFT: VETERANS HEALTH ACT OF 2015

To amend title 38, United States Code, to improve the access of veterans to health care and related services from the Department of Veterans Affairs, and for other purposes.

This bill with multiple provisions would expand the immunizations available to veterans within the VA, establish a comprehensive policy to provide a full scope of chiropractic services to veterans, , and enhance public access to information on VA's research data files and publications based upon research funded by VA.

The provisions of this bill fall outside the scope of established resolutions of The American Legion. As a large, grassroots organization, The American Legion takes positions on legislation based on resolutions passed by the membership in meetings of the National Executive Committee. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working within our membership to determine the course of action which best serves veterans.

The American Legion has no current position on this legislation.

DISCUSSION DRAFT: DEPARTMENT OF VETERANS AFFAIRS PURCHASED HEALTH CARE STREAMLINING AND MODERNIZATION ACT

To amend title 38, United States Code, to allow the Secretary of Veterans Affairs to enter into certain agreements with non-Department of Veterans Affairs health care providers if the secretary is not feasibly able to provide health care in facilities of the Department or through contracts or sharing agreements, and for other purposes.

Under title 38 U.S.C. 1703, when Department facilities are not capable of furnishing economical hospital care or medical services because of geographical inaccessibility or are not capable of furnishing the care or services required, the Secretary, as authorized in section 1710 of this title, VA may contract with non-Department facilities. Contracts between VA and non-VA facilities are currently negotiated under Federal contract statutes and regulations (including the Federal Acquisition Regulation, which is set forth at 48 Code Federal Regulations (CFR) Chapter 1; and the Department of Veterans Affairs Acquisition Regulations, which are set forth at 48 CFR Chapter 8).

Federal contract laws and regulations are not always the best method for procuring individual services, which is why for many years VA issued individual authorizations to providers, without following contracting laws and regulations. VA General Counsel has informed VA that they must comply with contracting laws and regulations, which will make it more difficult for VA to procure individual services

[6] Resolution No. 306: Support Funding for Homeless Veterans—AUG 2014

from non-VA providers. Provider agreements would allow the Veterans Health Administration (VHA) to procure non-VA health care services on an individual basis in accordance with the terms and agreements set forth in the law.

The American Legion supports this discussion draft.

DISCUSSION DRAFT: JOINT VA/DOD FORMULARY FOR PAIN AND PSYCHIATRIC CONDITIONS

To require the Secretary of Defense and the Secretary of Veterans Affairs to establish a joint uniform formulary with respect to systemic pain and psychiatric drugs that are critical for the transition of an individual from receiving health care services furnished by the Secretary of Defense to health care services furnished by the Secretary of Veterans Affairs, and for other purposes.

This bill would require the Secretary of Defense and the Secretary of Veterans Affairs to establish a joint uniform formulary with respect to systemic pain and psychiatric drugs that are critical for the transition of an individual from receiving health care services furnished by the Department of Defense to health care services furnished by the department Secretary of Veterans Affairs. One area of concerned is with the Veterans Administration's (VA) flawed formulary and policy which requires a servicemember to switch medications when they transfer from the Department of Defense (DOD) healthcare system to the VA healthcare system. The switch occurs when a new veteran's medication is not on the VA prescription drug formulary. When this occurs, the VA will for no clinical purpose, switch that veteran off of their successful medication treatment regiment to a drug that is on the VA formulary. Only when the veteran fails on the drug's course provided by the VA will that veteran be allowed to return the medication regimen that was successful for them in the DOD healthcare system.

In order to eliminate this potential deadly bureaucratic hurdle, Congress introduced the Enhancing Veterans' Access to Treatment Act (EVAT Act). The EVAT Act mandates that the VA mental health drug formulary match the DOD's and requires that any veteran transferring from the DOD to the VA be kept on the same mental health medication for as long as medically necessary.

In May 2015, The American Legion met with Michael Valentino, Chief Consultant, and Pharmacy Benefits Management Services at Department of Veterans Affairs. According to Mr. Valentino, on January 20, 2015, VHA issued VHA Directive 2014–02, *Continuation of Mental Health Medications initiated by Department of Defense Authorized Providers*.[7] According to VHA's policy directive it is VHA policy that recently discharged DOD Servicemembers who transfer their care to a VA medical facility will be transitioned as follows:

A VA provider must not discontinue mental health medications, initiated by a DOD authorized provider, solely because of differences between the VA and DOD drug formularies, VA Criteria-for-Use, or the cost of the drug. VA providers are not required to continue mental health medications started by a DOD provider if they determine such therapy is no longer safe, clinically appropriate, or effective based on a servicemembers current medical condition(s). In cases where a mental health medication initiated by a DOD provider is not continued by a VA provider, the rationale for the decision must be clearly documented in the progress note section of the medical record and the clinical rationale for this decision clearly explained to the patient.

In the interest of Veteran-centered care principles, VA medical facilities must streamline local processes to ensure prompt access to DOD-prescribed VANF non-formulary or restricted mental health medications for recently discharged Servicemembers. When continuation of a DOD-initiated non-formulary or restricted mental health medication is determined to be safe, appropriate and effective by a VA provider, the only requirement to process the agent is a designation of "Transitioning Veteran."

Standard non-formulary justifications (e.g., documentation of formulary medications that have already been tried, contraindication to a formulary medication, etc.) are not to be required; further ensuring that VA medical facilities will automatically process a "Transitioning Veteran's" prescription of the mental health medication for dispensing.

In accordance with VHA policy, the policy states that VA providers should not discontinue mental health medications, initiated by a DOD authorized provider, solely because of differences between the VA and DOD drug formularies. Therefore, it appears VHA has already addressed these concerns and legislation at this point is not necessary. The American Legion is closely monitoring VA to ensure compliance with

[7] Veterans Health Administration Directive 2014–02 January 20, 2015: *Continuation of Mental Health Medications initiated by the Department of Defense Authorized Providers*

this directive at all levels, but if the directives are followed, this legislation may be superfluous and add an additional layer of confusion to the transition process as VA locations implementing the current directive are forced to determine how they would comply under a new change to the United States Code.

The American Legion does not currently see the need for this legislation.

CONCLUSION

As always, The American Legion thanks this Committee for the opportunity to explain the position of the over 2 million veteran members of this organization. Questions concerning this testimony can be directed to Warren Goldstein in The American Legion Legislative Division (202) 861–2700, or wgoldstein@legion.org

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PREPARED STATEMENT OF CARLOS FUENTES, SENIOR LEGISLATIVE ASSOCIATE, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and our Auxiliaries, thank you for the opportunity to offer the VFW's views on legislation being considered by the Committee.

S. 207, VETERANS ACCESS TO COMMUNITY CARE ACT OF 2015

The VFW supports the intent of this legislation, which would require the Department of Veterans Affairs (VA) to provide veterans the option to receive non-VA health care when the health care they need is not available at a VA medical facility within 40 miles driving distance of their residence.

The purpose of establishing standards for access to non-VA health care is to ensure veterans have timely access to high-quality care in their communities when VA health care is not readily available. The VFW believes that such standards should not require veterans to travel unreasonable distances to receive VA health care and that any travel-based standard should be based on travel to VA facilities that provide the care veterans need, not facilities that are unable to serve their specific needs.

However, feedback the VFW has received regarding the Veterans Choice Program indicates that the 40-mile standard does not appropriately measure the travel burden veterans face when accessing VA health care. Before making any part of the Veterans Choice Program permanent, Congress and VA must properly evaluate the program and determine the most appropriate system-wide eligibility standards for health care furnished through non-VA health care providers. The Institute of Medicine is currently evaluating VA's wait-time standard to determine its efficacy. Yet, no one has been asked to evaluate whether the 40-mile standard is appropriate. The VFW urges Congress to commission a study of the 40-mile standard before making it permanent.

Moreover, such a study must evaluate the impact a travel-based standard for non-VA health care eligibility would have on VA's ability to expand capacity to provide direct care to enrolled veterans. The VFW has conducted a number of surveys to gauge veterans' experiences with the Veterans Choice Program. These surveys have shown that about 50 percent of veterans who are offered the choice to receive non-VA health care choose to continue receiving their care from VA, despite facing access challenges. While ensuring veterans have access to care in their communities is important, VA must have the ability to provide a full continuum of care for veterans who choose to receive their care from VA.

S. 297, FRONTLINES TO LIFELINES ACT OF 2015

This legislation would revive a successful VA program for transitioning servicemembers, improve the transition of health care providers between the Department of Defense (DOD) and VA, and expand the practice authority for certain health care providers. The VFW supports sections 2 and 3 and takes no position on section 4.

Section 2 would revive the Intermediate Care Technician Pilot Program for three years. In December 2012, VA launched this program to recruit transitioning veterans who served as medics or corpsmen in the military to work in VA emergency departments as intermediate care technicians. The goal of this program was to employ transitioning medics and corpsmen who have extensive combat medicine experience and training to provide clinical support for VA health care providers, without requiring them to undergo additional academic preparation. The pilot program ended in December 2014, and resulted in 45 veterans being hired through the pilot

program at 15 VA medical facilities. Veterans who participated in the pilot program and VA medical facilities that hired them were overwhelming satisfied with the program and would like it to continue. Other VA medical facilities have also noted the importance of employing experienced veterans as intermediate care technicians. Nearly 40 VA medical clinics have requested more than 250 additional intermediate care technicians to fill staffing shortages throughout the country. With the end of the wars in Iraq and Afghanistan and the expected drawdown of military personnel, more medics and corpsmen will be leaving military service and transitioning into the civilian workforce. The VFW supports reviving this important program and supports making the intermediate care technician position a permanent health care specialty with the Department.

Section 3 would streamline the hiring process for health care providers who transition from practicing medicine in the Military Health System to VA. This section would also require DOD to transfer the credentialing data of such individuals to VA. However, it does not require VA to accept the credentialing data it receives from DOD. The VFW urges the Committee to amend this legislation to require VA to exempt applicants who are transitioning from the Military Health System to VA from the VA credentialing process, when appropriate. Doing so would expedite the hiring process and ensure VA is able to more quickly address staffing shortages.

Section 4 would grant independent practice authority for certain advanced practice registered nurses employed by the Department. Currently, VA advanced practice nurses are not authorized to practice at the full extent of their license in certain states. This legislation would ensure uniform and system-wide application of practice authority for VA nurses. The VFW does not take a position on scope of practice issues. The VFW defers to VA in determining what scope of practice authority enables its health care professional to provide timely access to high-quality health care to the veterans it serves.

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

The VFW supports this legislation, which would expand and reauthorize a number of programs aimed at addressing the unacceptable problem of homelessness among veterans. The VFW firmly believes that no veteran who has honorably served this Nation should have to suffer the indignity of living on the streets. We praise the great progress that has been made in reducing veterans' homelessness in recent years as a direct result of coordinated efforts across multiple government agencies to provide transitional housing, rapid rehousing, and employment programs for veterans in need. The extensions and adequate funding provided by this legislation for these and other programs are vital to achieving the Secretary's goal of eradicating homelessness among veterans by 2015.

S. 471, WOMEN VETERANS ACCESS TO QUALITY CARE ACT OF 2015

This legislation would improve the health care VA provides women veterans by establishing women health care standards, expanding access to gender-specific services and evaluating VA's ability to meet the health care needs of women veterans. The VFW supports this legislation and would like to offer suggestions to strengthen it.

Recent years have seen unprecedented levels of women serving in the U.S. military. Today, over 1.3 million women wear our Nation's uniform, comprising over 15 percent of the total force. Likewise, the demand for VA services by women veterans has increased dramatically. According to VA data, the number of women using VA services grew from just over 200,000 in 2003 to over 362,000 in 2012, an increase of more than 80 percent. By 2014, that number had grown to over 400,000. In addition, recent VA data shows that approximately 19 percent of women using VA health care served in either Iraq or Afghanistan, compared to only 9 percent of men. Accordingly, women veterans receiving VA care are younger than their male counterparts, with 42 percent of women under the age of 45, compared to only 13 percent of men. As a result, the number of women using VA services as a percentage of the total population will only continue to grow in the coming years, along with their need for health care.

Although VA has made a concerted effort to increase capacity and quality of women's health care, gaps in services remain for women enrolled in VA, particularly in gender-specific specialty care. Today, only 52 VA facilities provide on-site mammography. According to VA testimony given on this April 21, 2015, to this Committee, 35 VAMCs still have no onsite gynecological services. Of those that do, many of the doctors work part-time. The VFW supports requiring all VA medical centers to have a full time obstetrician or gynecologist on staff.

Regardless of what services are available, women veterans will not be afforded the opportunity to utilize them if they are unaware such services exist. This legislation seeks to improve outreach to women veterans by requiring VA to share veterans' information with state and county veterans agencies. The VFW supports sharing data between government agencies to ensure veterans are aware of the benefits and services they have earned and deserve. This legislation would afford veterans the opportunity to opt out of the data sharing mechanism VA is required to establish. The VFW urges Congress and VA to ensure veterans are fully informed that their personal information will be shared and are given clear notification of such action and granted an easily accessible and user friendly mechanism to opt out.

In drafting testimony for women specific hearings, the VFW sought the input of women VFW members from across the country. A consistent issue identified by women VFW members was lack of child care at VA medical facilities. Without access to child care services veterans are often reluctant to take their small children to medical appointments with them. Veterans may even choose to forgo the care they need and deserve. The VFW strongly believes that veterans should not be forced to choose between their own wellbeing and that of their children. For this reason, we urge the Committee to amend this legislation to fully expand the VA child care pilot program to all facilities across the Department.

S. 684, HOMELESS VETERANS PREVENTION ACT OF 2015

This legislation would improve benefits afforded to homeless veterans. As stated above, the VFW strongly supports efforts to end homelessness among veterans who have honorably served this Nation. The VFW supports this legislation and would like to offer a suggestion to strengthen section 4.

The VFW generally supports section 4 of the bill which would allow the Secretary to enter into partnerships with public or private entities to fund a portion of certain legal services for homeless veterans. While the VFW recognizes that legal issues are often a significant barrier to homeless reintegration and must be addressed, we are concerned that some for-profit legal entities would view this program as an opportunity to exploit the availability of government resources in exchange for poor or inadequate services. For this reason, we suggest that the language in this section be changed to allow VA to enter into partnerships with only public or non-profit private legal entities that provide services to homeless veterans.

DRAFT LEGISLATION, DEPARTMENT OF VETERANS AFFAIRS PURCHASED HEALTH CARE STREAMLINING AND MODERNIZATION ACT

The VFW strongly supports this legislation, which would streamline VA's ability to purchase health care from private sector health care providers when VA health care is not readily available.

VA must have the ability to quickly provide non-VA health care when it is unable to provide direct care to the veterans it serves. The VFW is glad to see this legislation includes best practices, such as requiring non-VA medical providers to return medical documentation, and quality and safety mechanisms to ensure veterans receive high quality care from non-VA providers. This legislation also required VA to exhaust all other avenues for furnishing non-VA health care before using veteran care agreements. The VFW believes it is important that VA medical facilities use other non-VA care programs such as the Patient-Centered Community Care Program (PC3), the Veterans Choice Program, or any future system wide non-VA health care program before using veteran care agreements. Doing so will ensure local medical facilities do not preclude administrators of system wide programs from expanding their networks to better serve veterans.

DRAFT LEGISLATION TO REQUIRE DOD AND VA TO ESTABLISH A JOINT FORMULARY WITH RESPECT TO SYSTEMIC PAIN AND PSYCHIATRIC DRUGS

This legislation would require DOD and VA to establish uniform systemic pain and psychiatric drugs and treatments for veterans transitioning from the Military Health System to the VA health care system. The VFW supports this legislation and would like to offer suggestions to strengthen it.

The VFW has heard from veterans who were unable to continue their DOD prescribed pain treatment or mental health care therapies once transitioning to the VA health care system because their VA medical facilities refused to recognize their DOD prescriptions, or the drugs they needed were not on VA's formulary. This legislation would ensure veterans are not denied access to treatments that have worked for them due to the inconsistent formularies between DOD and VA. It does not, however, require VA to continue prescribing veterans medications that have proven to successfully address their pain or mental health conditions.

Mental health medications require providers to work with patients to adjust medication treatments and dosages to obtain the optimal outcome. When transitioning from the Military Health System to the VA health care system, veterans must be allowed to continue the medication regiment that works best for them while they work with their VA providers to identify if continuing the same medication regiment is recommended or if they should begin a new regiment. The VFW suggests adding such a requirement to this legislation to ensure the treatments veterans receive from DOD are not disrupted when they transition to the VA health care system.

DRAFT LEGISLATION, VETERANS HEALTH ACT OF 2015

The VFW support this legislation, which would improve VA health care by expanding access to immunizations and chiropractic care, extending VA's ability to provide transportation assistance, and making VA research available to the public.

Section 2 would ensure that veterans receive the full complement of immunizations on the recommended adult immunization schedule established by the Centers for Disease Control (CDC) and Prevention Advisory Committee on Immunization Practices (ACIP). It would also mandate that VA develop and implement quality measures and metrics to ensure that veterans receiving VA medical services receive each immunization at the proper time according to the ACIP.

The evidence is clear that vaccination is one of the safest, most cost effective ways to prevent disease and death from infectious diseases. Efforts to quantify and track vaccine utilizations in the past have clearly shown that prioritizing increased utilization and effectiveness of vaccination inoculations, in tandem with rigorous performance measures, generate monumental savings while improving patient health. When VA adopted performance measures for influenza and pneumococcal, significant improvement in vaccine utilization rates resulted—from 27 percent to 77 percent and 26 percent to 80 percent, respectively. Expanding performance measures to the entire list of VA and CDC recommended adult vaccinations would undoubtedly promote timely and appropriate vaccinations, while placing a greater emphasis on preventable care for veterans.

Section 3 would require VA to provide chiropractic care in at least 50 percent of VA medical centers within three years of enactment. This section would also include chiropractic services in the general health care package VA is required to provide enrolled veterans. It is well known that servicemembers who deploy to combat and participate in military training are subject to extraordinary physical demands, often resulting in the premature onset of painful spine and joint conditions. In its latest analysis of health care utilization among Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF) and Operation New Dawn (OND) veterans, VA listed musculoskeletal ailments as the number one condition for which Iraq and Afghanistan veterans sought VA care. Chiropractic care can often be a successful alternative to drugs or invasive procedures for treating musculoskeletal disorders, while also offering suggestions for lifestyle modifications which promote overall wellness. The VFW believes that chiropractic care is a valuable option and should be made available to veterans at all VA medical centers.

Section 4 would extend VA's authority to administer the Veterans Transportation Service (VTS). This program was commissioned by the Veterans Health Administration's Office of Rural Health in 2010, and greatly improved access to care for rural and seriously disabled veterans by allowing VA facilities to establish and coordinate networks of local transportation providers, including community and commercial transportation providers, and government transportation services. VTS augments veterans service organizations' volunteer-based transportation services, which are limited to transporting ambulatory veterans; the existing beneficiary travel programs of mileage reimbursement, which does not provide assistance with the coordination of transportation for those who need it; and special mode travel, for which few veterans medically qualify.

VTS suffered a major setback in 2012 when it was temporarily suspended following a determination by the VA Office of General Counsel that VA lacked the statutory authority to hire paid drivers to transport veterans. Congress has passed one-year authorizations of the VTS program since January 2013, but a long term fix is still needed. The VFW believes that unnecessary hardships associated with accessing VA health care should be eliminated. The VFW urges the Committee to amend this section to make VTS permanent and expand it system wide to minimize the challenges veterans face in traveling to their VA appointments.

Section 5 would make VA-funded medical research available to the public. The VFW believes that research furnished by VA benefits veterans who seek VA care and the health care community as a whole. VA health research has led to many medical breakthroughs and continues to lead the health care industry in many re-

spects. Veterans service organizations and Congress depend on VA research to develop policy recommendations and advance legislative goals. Although VA's research is available to the public through peer reviewed journals, veteran advocates are at times precluded from obtaining VA research due to lack of access to such peer reviewed journals. The VFW supports making the benefits of VA research available to the public.

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee, this concludes my testimony.

PREPARED STATEMENT OF THOMAS J. BERGER, PH.D., EXECUTIVE DIRECTOR, VETERANS HEALTH COUNCIL, VIETNAM VETERANS OF AMERICA

Good day, Chairman Isackson, Ranking Member Blumenthal and Members of the Senate Veterans' Affairs Committee. On behalf of Vietnam Veterans of America (VVA) National President John Rowan and all of our officers and members, we thank you for the opportunity for VVA to share our statement for the record regarding pending Veterans legislation before this Committee.

S. 207, Veterans Access to Community Care Act of 2015 introduced by Senator Jerry Moran (KS). This legislation would direct the Secretary of Veterans Affairs (VA) to use the Secretary's existing authority to furnish health care to veterans at non-VA facilities for veterans who reside more than 40 miles driving distance from the closest VA medical facility providing the care they seek.

VVA supports this legislation as it will provide veterans access to health care at non-VA facilities where a Choice Card-eligible veteran cannot receive health care at a VA facility within the 40-mile limit because the health care, particularly specialty care, is not available at the VA facility.

S. 297, Frontlines to Lifelines Act of 2015, introduced by Senator Mark Steven (IL), this legislation directs the Secretary of Veterans Affairs (VA) to revive, for a three-year period, VA's Intermediate Care Technician Pilot Program that was carried out between January 2013 and February 2014. Requires VA to: (1) expand the pilot program to include at least 250 intermediate care technicians, and (2) give priority in assigning those technicians to VA facilities at which veterans have the longest wait times. Requires the Secretary of Defense (DOD) to transfer credentialing data regarding DOD health care providers that are hired by VA to VA.

In general, VVA supports this legislation. However, VVA would like to see the pilot program expanded to include medics and Navy corpsmen.

S. 425, Homeless Veterans' Reintegration Programs Reauthorization Act of 2015 introduced by Senator John Boozman (AR), Job readiness training and reeducation are a congressionally mandated function and responsibility of the US Department of Labor (DOL). The Homeless Veterans Reintegration Program (HVRP) has long suffered the consequences of limited funding. VVA is seeking to ensure that DOL request full authorized funding in its budget. This is not only a significant investment in the lives of veterans who are trying to make their way back * * *. It is an investment in our national economy. This training and employment program has proved over time to be extremely successful in retraining and reeducating our homeless veteran, providing a new start at life. It is a labor and training issue, and as such, it should be held accountable for program investment and performance in the same vein as all other agencies to include the U.S. Department of Veterans Affairs.

VVA supports the expansion of the program as identified in this legislation and would also request that language be added to S. 425 amending the eligibility criteria for veterans enrolled in the Department of Labor Homeless Veterans Reintegration Program (HVRP) so those veterans entering into "housing first" would be able to access this training for a period of up to 12 months after placement into housing.

S. 471, Women Veterans Access to Quality Care Act of 2015 introduced by Senator Dean Heller (NV), The Department of Veterans Affairs has become increasingly more sensitive and responsive to the needs of women veterans and many improvements have been made. Unfortunately, these changes and improvements have not been completely implemented throughout the entire system. In some locations, women veterans experience barriers to adequate health care and oversight with accountability is lacking. Primary care is fragmented for women veterans. What would be routine primary care in the community is referred out to specialty clinics in the VA. Over the last five years the per cent of women veterans using the VA has grown from 11% to 17%, with 56% of OEF/OIF women Veterans having enrolled in the VA. Their average age of women Veterans using the VA is 48.

Further, we seek that the Secretary ensures:

• The competency of staff who work with women in providing gender-specific health care.
• That VA provides reproductive health care.
• That appropriate training regarding issues pertinent to women veterans is provided.
• That there is the creation of an environment in which staff are sensitive to the needs of women veterans; that this environment meets the women's needs for privacy, safety, and emotional and physical comfort in all venues.
• Those privacy policy standards are met for all patients at all VHA locations and the security of all Veterans is ensured.
• That the anticipated growth of the number of women Veterans should be considered in all strategic plans, facility construction/utilization and human capital needs.
• That patient satisfaction assessments and all clinical performance measures and monitors that are not gender-specific, be examined and reported by gender to detect any differences in the quality of care.
• That the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value report any significant differences and forward the findings to the Under Secretary for Health, Under Secretary for Operations and Management, the Regional Directors, facility directors and chiefs of staff, and the Women's Health Services Office.
• That every woman veteran has access to a VA primary care provider who meets all her primary care needs, including gender-specific and mental health care in the context of an ongoing patient-clinician relationship.
• That general mental health care providers are located within the women's and primary care clinics in order to facilitate the delivery of mental health services.
• That sexual trauma care is readily available to all veterans who need it and that VA ensure those providing this care and treatment have appropriate qualifications obtained through course work, training and/or clinical experience specific to MST or sexual trauma.
• That an evaluation of all gender specific sexual trauma intensive treatment residential programs be made to determine if this level is adequate as related to level of need for each gender, admission wait times, and geographically responsive to the need.
• That Vet Centers are able to adequately provide services to women veterans.
• That a plan is developed for the identification, development and dissemination of evidence-based treatments for PTSD and other co-occurring conditions attributed to combat exposure or sexual trauma.
• That women veterans, upon their request, have access to female mental health professionals, and if necessary, use VA outsource to meet the women veteran's needs.
• That all Community Based Outpatient Clinics (CBOC) which do not provide gender-specific care arrange for such care through VA outsource or contract in compliance with established access standards.
• Evidence-based holistic programs for women's health, mental health, and rehabilitation are available to ensure the full continuum of care.
• That the Women's Health Service aggressively seek to determine root causes for any differences in quality measures and report these to the Under Secretary for Health, Under Secretary for Operations and Management, the Regional Directors, facility directors and COS, and providers.

Vietnam Veterans of America will continue its advocacy to secure appropriate facilities and resources for the diagnosis, care and treatment of women veterans at all DVA hospitals, clinics, and Vet Centers and we ask the Secretary of Veterans Affairs ensure senior leadership at all facilities and VISN Directors be held accountable for ensuring women veterans receive appropriate care in an appropriate environment and based on our recommendations above and language included in the bill. VVA supports S. 471 as written.

S. 684, Homeless Veterans Prevention Act of 2015 introduced by Senator Richard Burr (NC), Homelessness continues to be a significant problem for veterans. The VA estimates about one-third of the adult homeless population have served their country in the Armed Services. Current population estimates suggest that about 49,000 veterans (male and female) are homeless on any given night and perhaps twice as many experience homelessness at some point during the course of a year. Federal efforts regarding homeless veterans must be particularly vigorous for women veterans with minor children in their care. And those Federal agencies that have responsibilities in addressing this situation, particularly the Departments of Veterans Affairs, Labor, and Housing and Urban Development, must work in concert and

should be held accountable for achieving clearly defined results. VVA also believes the housing first model may work for some veterans; however, to take a homeless veteran off the streets and into permanent housing without first assessing their treatment needs is a mixture for disaster. Failure is not an option; please fix this now or we will see an increase in veteran homelessness, rather than ending veteran homelessness, by 2015. VVA supports S. 684 as written.

A. DISCUSSION DRAFT THAT INCLUDES:

(a) S. 172—Improved access to appropriate immunizations for veterans—VVA supports

(b) S. 398 (and companion H.R. 1170)—Expansion of provision of chiropractic care and services to veterans—VVA supports, but believes that a needs assessment must be conducted in each VISN to determine the extent of expansion needed.

(c) S. 603—Extension of sunset date regarding transportation of individuals to and from facilities of DVA and requirements of report—VVA supports

(d) S. 114—Public access to DVA research and data sharing between departments—VVA supports

B. DISCUSSION DRAFT ON PROVIDER AGREEMENTS LANGUAGE

VVA generally supports this draft, but believes stronger accountability measures must be added for both VA and non-VA providers.

C. PROPOSED JOINT VA/DOD FORMULARY FOR PAIN AND PSYCHIATRIC MEDICATIONS

VVA strongly supports the sharing of information with respect to systemic pain and psychiatric drugs that are critical for the transition of an individual from DOD healthcare to VA healthcare. However, at the present time, VVA also recommends the VA formulary system be overhauled to reflect transparency in the addition and removal of all pharmacological medications. VVA is willing to assist in this matter.

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