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S. HRG. 114–186

HEARING ON PENDING HEALTH CARE AND BENEFITS LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

FIRST SESSION

JUNE 24, 2015

Printed for the use of the Committee on Veterans' Affairs

Available via the World Wide Web: http://www.fdsys.gov

U.S. GOVERNMENT PUBLISHING OFFICE

96–261 PDF WASHINGTON : 2016

For sale by the Superintendent of Documents, U.S. Government Publishing Office
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HEARING ON PENDING HEALTH CARE AND BENEFITS LEGISLATION

WEDNESDAY, JUNE 24, 2015

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

The Committee met, pursuant to notice, at 2:40 p.m., in room 418, Russell Senate Office Building, Hon. Johnny Isakson, Chairman of the Committee, presiding.

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

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

Chairman ISAKSON. I call this meeting of the Veterans' Affairs Committee of the U.S. Senate to order, and I apologize that we are a few minutes late in starting.

Senator Blumenthal and I have been with 50 of the Wounded Warrior star athletes with the Speaker of the House, the Majority and Minority Leaders of the Senate, and a number of supporters of their games that are going on, and General Dempsey was there, so we took a little bit of extra time. We apologize for that—apologize for not being here on time.

Let me make a few opening remarks. We have some very important proposed pieces of legislation to be discussed today. We are looking forward to hearing from our Veterans Service Organizations and we are looking forward to hearing from our two distinguished members from the State of Wisconsin, Senator Baldwin and Senator Johnson. Thank you for being here today.

Let me just say two or three things for the record, which the staff can make note of and tell the Members when they get here that I said this. You know, during the last markup of NDAA, we had an inordinate number of amendments posed that required a waiver by the VA Committee to waive jurisdiction so that it could be handled by the Armed Services Committee. In most cases, I objected and did not clear those amendments because I am never going to cede our responsibility or our jurisdiction as a Member of the Veterans' Committee to another committee of the Senate, and that is the reason I objected.

So, I apologize to any Members that might have felt like I was being a little unfair or unfriendly, but I think it is important that I protect the integrity of our Committee and its jurisdiction and I will continue to do so. So, if you in the future have amendments that you are going to put on a bill that is not of a bill before our

committee, you might talk to the staff ahead of time, so we do not run into a last minute conflict on the floor with the Chairman of Armed Services or whatever other committee it is.

I know we are going to discuss issues in terms of over-prescription of opiates and some of the damages that have been done and the difficulties in Tomah. I appreciate both the Senators from Wisconsin being here today.

Patty Murray is not here yet, but Senator Murray has got two particular bills, one on IVF benefits for veterans of the services that has passed this Committee before. I am working with her to help perfect that legislation so it can come before this Committee and be passed out. I look forward to her comments on that, as well as the VA's testimony.

We also have a proposal by Senator Murray regarding caregivers, extended benefits to those that served prior to 2001, 9/11/2001. We are looking at that, but we have an IG's report in terms of a number of problems with the existing caregivers' program regarding eligibility, so we are going to look at making sure we clean up the problems that we have got first before we extend further benefits and run the risk of having more problems than we intended to have.

I look forward to hearing from the VSOs that provide us with such great information always in terms of legislation and their opinions on it. I look forward to hearing from the Veterans Administration, as well.

With that said, I want to introduce our two Senators from the State of Wisconsin to make their remarks, which I hope they would limit to 5 minutes or less. I will start with Senator Baldwin from Wisconsin, then go to Senator Johnson.

STATEMENT OF HON. TAMMY BALDWIN,
U.S. SENATOR FROM WISCONSIN

Senator BALDWIN. Thank you, Mr. Chairman. I want to appreciate you and Senator Blumenthal for convening this hearing to discuss a number of important bills, including my bipartisan bill, the Jason Simcakoski Memorial Opioid Safety Act. I am tremendously grateful for the opportunity to share my work on this legislation and to share Jason's story, which inspired this critical proposal. I also want to recognize you, Mr. Chairman, for your willingness to hold a hearing earlier this session that illuminated the topic and informed this legislation.

The issue that I will discuss this afternoon does not run along party lines. I believe it is an issue that unites us all; and that is the care of those who have served and sacrificed for our Nation, America's veterans.

I take great pride in the fact that I have worked across the aisle to introduce this bipartisan legislation, the Jason Simcakoski Memorial Opioid Safety Act, with Senator Capito of West Virginia, as well as Ranking Member Blumenthal. It is also supported by a number of other Senators on this Committee, including Senators Brown, Hirono, Manchin, Moran, Murray, Sanders, and Tester.

This bipartisan legislation is aimed at addressing the problem of over-prescribing practices at the VA and providing safer and more effective pain management services to our Nation's veterans.

It is named in honor of Wisconsin veteran, U.S. Marine veteran Jason Simcakoski. Jason's family is here today, and I am so honored to have worked with them in putting together these reforms for your consideration.

On August 30, 2014, Jason tragically died at Wisconsin's Tomah Veterans Affairs Medical Center as a result of what was medically deemed mixed drug toxicity. I believe that this exposed a glaring failure to serve somebody who had faithfully served our country. At the time of his death at the VA, Jason was on 14 different prescription drugs, including opioids.

Incredibly, this soldier's heartbreaking story is just one example of the over-prescribing problem throughout the VA. After two decade-long wars, a large number of our servicemembers are coming home with the damage of combat, and our veterans and their families are facing the very difficult challenge of physical injuries, PTSD, and other mental illness. Unfortunately, I believe the VA's over-reliance on opioids has resulted in getting our veterans hooked rather than getting them help, and that is not acceptable.

We have a duty to guarantee that our veterans and their families receive the highest quality care that they deserve and that they have earned and this bipartisan bill will do just that. The Jason Simcakoski Memorial Opioid Safety Act will help improve pain management services for veterans and give veterans and their families a stronger voice in patient care to prevent tragedies like Jason's from occurring to other veterans and their families. It will also put in place stronger oversight and accountability for the quality of care that we are providing to our veterans.

Specifically, my bill will require stronger opioid prescribing guidelines and education for VA providers, including stricter standards against prescribing dangerous combinations of opioids with other drugs and guidance for prescribing opioids to patients struggling with mental health issues.

It will increase the coordination and communication throughout the VA with medical facilities, providers, patients, and their families surrounding pain management, alternative treatments for chronic pain, and appropriate opioid therapy.

It will hold the VA system accountable for appropriate care and quality standards through consistent internal audits, as well as GAO reviews and reports to Congress.

It will strengthen patient advocacy to guarantee that veterans truly have their voices heard.

We all know that pain and pain care is a complex issue, and each and every patient's situation is different and it is unique. The goal of my bipartisan bill is to move away from a one-size-fits-all approach of relying only on more opioids to treat patients with pain. This legislation will empower doctors with the tools and resources they need to take a comprehensive approach to pain management care for our veterans, and it will arm both doctors and patients with the most up-to-date tools, including education and training, as well as the latest scientific guidelines to help provide the best care decisions.

I am going to submit my full statement for the record, as I note that my time is up and I want to respect that, but let us work together to fix what has been broken and restore the sacred trust

with our veterans and their families by passing the Jason Simcakoski Memorial Opioid Safety Act.

I thank you, Mr. Chairman.

[The prepared statement of Senator Baldwin follows:]

PREPARED STATEMENT OF HON. TAMMY BALDWIN, U.S. SENATOR FROM WISCONSIN

The issue that I will discuss this morning does not run along party lines. It is an issue that I believe unites us all—and that is the care of those who have served and sacrificed for our Nation—America's veterans.

I take great pride in the fact I have worked across the aisle to introduce this bipartisan legislation, the Jason Simcakoski Memorial Opioid Safety Act, with Senator Capito of West Virginia, as well as Ranking Member Blumenthal. It is also supported by a number of other Senators on this Committee including Senators Brown, Hirono, Manchin, Moran, Murray, Sanders, and Tester.

This bipartisan legislation is aimed at addressing the problem of overprescribing practices at the VA and providing safer and more effective pain management services to our Nation's veterans.

It is named in honor of a Wisconsin veteran, U.S. Marine Veteran Jason Simcakoski. Jason's family is here today and I am so honored to have worked with them and others in putting these reforms together.

On August 30, 2014, Jason tragically died in Wisconsin's Tomah Veterans Affairs' Medical Center as a result of what was medically deemed, mixed drug toxicity. I believe that this exposed a glaring failure to serve someone who had faithfully served our country.

At the time of his death at the VA, Jason was on 14 different prescriptions drugs, including opioids. Incredibly, this soldier's heartbreaking story is just one example of the overprescribing problem throughout the VA.

After two, decade long wars, a large number of our servicemembers are coming home with the damage of combat and our veterans and their families are facing the difficult challenge of physical injuries, PTSD and other mental illnesses.

Unfortunately, I believe the VA's overreliance on opioids has resulted in getting our veterans hooked instead of getting them help. This is not acceptable.

We have a duty to guarantee that our veterans and their families receive the highest-quality care that they deserve. And my bipartisan bill will do just that.

The Jason Simcakoski Memorial Opioid Safety Act will help improve pain management services for veterans and give veterans and their families a stronger voice in patient care to prevent tragedies, like Jason's, from occurring to other veterans and their families. It will also put in place stronger oversight and accountability for the quality of care we are providing our veterans.

Specifically, my bill will:

- Require stronger opioid prescribing guidelines and education for VA providers, including stricter standards against prescribing dangerous combinations of opioids with other drugs and guidance for prescribing opioids to patients struggling with mental health issues;
- Increase coordination and communication throughout the VA with medical facilities, providers, patients and their families surrounding pain management, alternative treatments for chronic pain, and appropriate opioid therapy;
- Hold the VA system accountable for appropriate care and quality standards through consistent internal audits as well as GAO reviews and reports to Congress; and
- Strengthen patient advocacy to guarantee that veterans truly have their voices heard.

We all know that pain and pain care is a complex issue. And each and every patient's situation is different and unique. The goal of my bipartisan bill is to move away from the one-size-fits-all approach of relying only on more opioids to treat patients with pain.

My legislation will empower doctors with the tools and resources they need to take a comprehensive approach to pain management care for our veterans. It will arm both doctors and patients with the most up-to-date tools, including education and training as well as the latest scientific guidelines to help them make the best care decisions.

It also works to improve coordination and communication throughout the VA and puts in place stronger oversight and accountability for the quality of care we are providing our veterans.

Jason's story is sad example of the devastation caused by addiction and the problem of over-prescription of opioids at the VA. This is a growing problem with an im-

pact that is being felt beyond the walls of the VA and across America in the communities we work for everyday here in our Nation's capital.

It is our job to make sure that the veterans who have bravely served and sacrificed for our country, and their families, do not feel alone and that they feel secure in knowing that we are doing everything we can to fix this.

I want to thank the Simcakoski family and let them know that I have a tremendous amount of respect for the courage they have shown telling their story and working to make a difference in the lives of other veterans and their families.

It is my hope they will inspire my colleagues to join us in taking action.

Again, I would like thank Senators Blumenthal, Brown, Hirono, Johnson, Kaine, Manchin, Markey, Moran, Murray, Sanders, and Tester for signing on as original cosponsors to this bipartisan effort.

I'd also like to thank the many veteran's service organizations—a number who are here today—and medical professionals for their invaluable support and input as we crafted this legislation.

Today, I ask the rest of my colleagues to join us in working to confront the problem of overprescribing practices at the VA and to provide safer and more effective pain management services to our Nation's veterans.

Let us work together to fix what has been broken and restore that sacred trust with our veterans and their families by passing the Jason Simcakoski Memorial Opioid Safety Act. Thank you.

Chairman ISAKSON. Thank you, Senator Baldwin.

Senator Johnson.

STATEMENT OF HON. RON JOHNSON, U.S. SENATOR FROM WISCONSIN

Senator JOHNSON. Thank you, Chairman Isakson, Ranking Member Blumenthal, and other distinguished Members of the Committee, for the opportunity to present my legislation, the Ensuring Veteran Safety Through Accountability Act of 2015.

To understand the need for this legislation, it is important to know the history of tragedies that have occurred at the Tomah VA medical center in Wisconsin. Since January, the Senate Committee on Homeland Security and Governmental Affairs has been investigating serious allegations of mismanagement, misconduct, whistleblower retaliation, and, tragically, veteran deaths at Tomah. Here is a partial list of what we have learned during our investigation.

In November 2007, a veteran named Kraig Ferrington died from a lethal mixture of seven different drugs shortly after receiving treatment at Tomah.

In April 2009, the Tomah VA Employee Union raised concerns about a doctor nicknamed "Candyman" and referred to the facility as "Candyland" because veterans were prescribed, quote, "large quantities of narcotics."

In June 2009, Dr. Noelle Johnson was fired from Tomah for refusing to fill prescriptions she believed to be unsafe. Dr. Johnson is in the audience here today.

In July 2009, Dr. Chris Kirkpatrick was fired from Tomah after raising concerns about over-medication. Tragically, the same day he was terminated, Dr. Kirkpatrick committed suicide.

In March 2014, the Office of Inspector General closed its nearly 3-year health care inspection of the Tomah VA. The report was not initially shared with Congress, and it was only made public after the media exposed these tragedies.

On August 30, 2014, Jason Simcakoski died in the Tomah Mental Health Wing as a result of, quote, "mixed drug toxicity." His au-

topsy revealed he had over a dozen different medications in his system. Jason's family is also in the audience here today.

On January 12, 2015, Candace Delis brought her father, Thomas Baer, to the Tomah VA Urgent Care Center with stroke-like symptoms. Mr. Baer waited over 2 hours for attention. His family believes he died of neglect. It is hard not to agree.

As soon as I became aware of the problems at Tomah, I directed committee staff to open an investigation into the problems of the facility. Since then, we have received tens of thousands of pages of documents, spoken with dozens of whistleblowers, and convened a bicameral field hearing at Tomah. There was powerful testimony provided there.

We have faced tremendous resistance in uncovering the facts. The VA Inspector General has stonewalled our efforts to obtain complete information in its Tomah review. After 3 months of noncooperation, my committee was finally forced to subpoena the VA Inspector General on April 29. Even after the subpoena, the VA IG has applied inappropriate redactions and outright refused to provide other subpoenaed documents.

The VA Office of Inspector General conduct made it clear that Congress must act. We have already used my authority as Chairman to advance a bill to enhance the transparency and accountability of all Inspectors General that also would prevent the VA Inspector General from writing secret reports in the future.

The events in Tomah make it abundantly clear that there must be more accountability for VA medical professionals. That is why I have introduced the Ensuring Veteran Safety Through Accountability Act. Last year's Phoenix wait time scandal showed us that there is a severe lack of accountability for VA officials. Congress attempted to address this accountability shortfall when it gave the VA Secretary greater authority to remove high-level VA officials. That law was a step in the right direction.

My committee's investigation has found that it does not go far enough. To date, no one at Tomah has been fired. The medical professionals who prescribed the lethal cocktail of drugs that killed Jason Simcakoski are still collecting a paycheck from the American taxpayer.

My bill would give the VA Secretary the authority to expedite termination of health care professionals who fail to deliver the high-quality care our veterans deserve. Currently, the bill has 16 cosponsors who share a common goal of holding bad actors accountable.

I would also like to voice my support for Senator Baldwin's bill as an important step in addressing VA's protocols on prescribing highly-addictive opiate drugs to our veterans.

Our committee's investigation is ongoing. Tomorrow, our committee will release an interim report that presents some preliminary findings. We will continue to investigate until we gather all the facts at Tomah and wrongdoers are held accountable.

As an initial step, the Ensuring Veteran Safety Through Accountability Act of 2015 is a common sense measure to bring some much needed accountability to the VA.

Again, thank you for giving me this opportunity to speak today.

Chairman ISAKSON. Well, I want to thank both of you for your diligence on this particular issue.

I want Mr. and Mrs. Simcakoski and their daughter to stand, if they would. I want to say with everybody in the Committee present what I said to them in my office earlier today, that we share in the tragic loss of your son, but we have the greatest respect and admiration for you to advocate on behalf of change so that this does not happen again to anyone else. Your courage is appreciated and your attendance is appreciated.

I also told them that the Committee is going to work diligently to make sure that the legislation is not redundant in terms of things that have already been done in response to the over-prescription of opiates and that it is codified so that it works well for the system. We will look forward to the VA's testimony on this a little bit later.

Thank you all for being here very much. We appreciate your service.

Senator Johnson, as a committee chairman, I respect your authority and your committee's authority and I look forward to working with you on your Accountability Act. We know that there has to be more ability for there to be accountability in the Veterans Administration and there are many barriers to doing that. Your bill offers an opportunity for us to begin to tear down some of those barriers and see to it that we have a more responsive VA. I commend you on your work. I commend you on your work, Senator Baldwin. I appreciate both of you being here today.

Do any Members of the Committee happen to have a question of either member before they are excused? Anybody? [No response.]

If not, we appreciate your testimony and your time.

Senator JOHNSON. Thank you.

Chairman ISAKSON. Before we hear from our panels, we have three Members of the Committee that have legislation on the list of what is being heard today. Senator Murray has two. Senator Moran and Blumenthal have one. I wonder if they wanted to address their bills at this time.

Senator MURRAY. Mr. Chairman.

Chairman ISAKSON. Senator Murray.

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

Senator MURRAY. Mr. Chairman, I appreciate the opportunity to speak about the legislation I have before the Committee. We have a lot of really important bills on the agenda today.

But, before I get to those, I do want to address some very disturbing news. According to the VA's most recent data, wait times are again increasing dramatically, and I understand the VA has seen an enormous growth in demand, but we are very concerned about this, and as the expiration of the Choice Program approaches, we need VA to be ready with a comprehensive plan. So, I hope our Committee focuses on that.

On the agenda today, I do want to address the Women Veterans and Families Health Services Act. This is a bill that would finally end the VA's decades-old ban on fertility services and give some new hope to our veterans who were injured while fighting for our

country to realize their dream of starting a family. I really believe that offering this service is very important to fulfilling the promise to take care of the men and women who served our country.

It would expand the services that DOD is allowed to offer, taking lessons from the best practices of some of our close allies around the world, and would also offer assistance for adoption and make permanent the Child Care Pilot Program, which has been very successful. So, I really appreciate your having a hearing on that.

I have heard cost should be a consideration. I absolutely believe cost should not be an excuse to deny essential care to our military families and our veterans.

Equally important is my military caregivers legislation which I have introduced with Senator Collins. This is a program that recognizes the sacrifices of the friends and family who take care of our severely injured servicemembers by offering assistance to ease their burden. The bill that we are offering would finally open the caregiver program to veterans of all eras through a responsible phased-in approach that allows VA to manage the additional workload.

I think this is an absolutely essential service. I understand, Mr. Chairman, that you have commented on the GAO report on this and want to work with you, because I really believe that this is a program that we need to make sure is available for so many men and women, their families, and their providers as we move forward.

So, thank you very much for the hearing today.

[The prepared statement of Senator Murray follows:]

PREPARED STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Before I get to the bills, I want to address some very disturbing news. According to VA's most recent data, wait times are again increasing dramatically. I understand VA has seen enormous growth in demand for care from veterans. But to see wait times climbing again, after we provided $15 billion to address this very problem, is concerning. As the expiration of the Choice Program approaches, VA needs to be ready with a comprehensive plan to bring down wait times, and to create a comprehensive program for non-VA care that will work for the future. I will continue to keep a close watch on this situation, and I want to see continued progress to bring down wait times.

Now, turning to the agenda——

First on the list is my bill, the Women Veterans and Families Health Services Act. This bill would finally end VA's decades-old ban on fertility services and give new hope to veterans—who were injured while fighting for our country—to realize their dreams of starting a family. I believe offering this service is critically important to fulfilling the promise to take care of the men and women who served our country.

My bill would also expand the services that DOD is allowed to offer, taking lessons from the best practices of some of our close allies around the world. My bill would also offer assistance for adoption. And it would make permanent the child care pilot program, which has been very successful.

Caring for our veterans shouldn't be a partisan issue. I think we all agree that our country has a duty to do whatever we can to improve the lives of those who have sacrificed so much for our country. Cost cannot be an excuse to deny essential care to seriously injured veterans. Not when they have put everything on the line to protect our country.

But since there are concerns about the cost, let's remember that according to a Pentagon report, the military health system can provide a cycle of IVF for $7,000 which is significantly less than the $12,400 it costs in the private sector. It's not often the right thing to do is also the cost effective option—we should take that opportunity and pass this bill right away.

Equally important is my military caregivers legislation that I was very pleased to introduce with Senator Collins. This program recognizes the sacrifice of the friends and family who take care of our injured servicemembers by offering assistance to ease their burden. Our bill would finally open the caregiver program to veterans of all eras, through a responsible, phased-in approach that will allow VA to manage the additional workload. This is just common sense, and it's the right thing to do for our veterans and their caregivers. It also expands the services available for caregivers, and aligns eligibility for VA and DOD services. Finally, the bill takes a major step toward improving caregiver support for the whole country by coordinating the many services offered across the government.

I am committed to working with my colleagues to make sure VA has the resources it needs to effectively administer this program. In fact, an amendment I authored to the VA appropriations bill will give VA another $10 million to hire more caregiver support coordinators. These additional staff will help address some of the important findings from the GAO, strengthen the program, and prepare VA to finally meet the needs of veterans of all eras.

We also know that treating a veteran through the Caregiver Program is far less expensive than through a private nursing home or through a VA nursing home. But most important, it helps veterans stay out of the hospital, and have shorter stays when they do have to go in. It allows veterans to be in their own homes, surrounded by their loved ones. Giving veterans a better quality of life is not just the cost effective thing to do, it's the right thing to do.

Our veterans shouldn't have to wait any longer for these important improvements to their care.

Finally, thank you to our witnesses. And a special thank you to the VSOs for appearing today and for your support for these two important bills.

Thank you, Mr. Chairman, and I look forward to working with you to get these bills through markup and then through the Senate floor.

Chairman ISAKSON. Well, thank you, Senator Murray. And since I made reference to both your bills in my opening statement when you were not here, you deserve to hear from me what I already told everybody else.

I look forward to working with you on the IVF bill. There are some issues I want to work with you on to see to it that we get it to the Committee and then, ultimately, get it to the floor of the United States Senate.

The same is true with the caregiver bill. However, I made note, as you said, of the GAO report with regard to those who are currently eligible and the way that the program has been handled. I want to make sure that we tidy up the caregiver program as it exists before we expand that to those prior to 9/11/2001.

Senator MURRAY. I have——

Chairman ISAKSON. I look forward to working with you on that.

Senator MURRAY. I appreciate that. I do not mind tidying up; I just do not want to delay.

Chairman ISAKSON. I got the message.

Senator MURRAY. Thank you. [Laughter.]

Chairman ISAKSON. Senator Moran.

Senator MORAN. I defer to the Ranking Member.

Chairman ISAKSON. Senator Blumenthal.

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

Senator BLUMENTHAL. Thanks, Mr. Chairman. Sorry I was delayed at the session that we both attended. I was not here as quickly as you, so——

Chairman ISAKSON. I had a car. [Laughter.]

Senator BLUMENTHAL. I, first of all, want to express my appreciation to the Chairman for including so many of our bills on a bipar-

tisan basis, very much in the spirit of this Committee, and I thank him.

I also want to join Senator Murray in expressing my very strong alarm about the deeply troubling increase—and it is a dramatic increase—in the wait times for VA care. It is exactly what we have been warning might well happen, and I am very hopeful that VA and this Committee will have a plan to address it. It is the kind of phenomenon that just cannot wait for months to be addressed. It has to be addressed right away, and I challenge the VA to come forward with a plan to address it, literally within days, not weeks or months.

I want to thank Senator Murray for both of her bills. I strongly support them, particularly the caregivers bill, which will expand access to caregivers beyond the post-9/11 population and make important changes to this program.

I express my strong support for Senator Baldwin's opioid bill, named after Jason Simcakoski. I thank his family for being here today. Thank you for your courage and strength. You inspire us with your presence today. It makes a big difference, so thank you.

Finally, I want to thank the Veterans Service Organizations represented here today for their strong support of S. 901, the Toxic Exposure Research Act of 2015 that Senator Moran and I have offered.

Here is what we know about the modern battlefield. It is filled with all kinds of toxic substances, unimaginable just 10 years ago, whether it is depleted uranium or pollutants from burn pits or nerve gas in unexploded ordinances. It is a fact of life about the modern battlefield. The perils of combat, even for the veteran who has not been exposed to fire from the enemy, are real and urgent. The battlefield is a dangerous place for every man and woman in uniform; dangerous not only to them, but to their children and their families, and their grandchildren, because those toxic substances can have lasting, enduring effects that are transmitted from one generation to another.

This bill is just one step in the right direction. We need to know more about the effects of these toxic substances on veterans and their families. We need to support a research center that can do the kind of fact finding and fact gathering that other kinds of medical challenges and scientific research will help to solve, and this bill helps us to not only conduct the research, but eventually provide the kind of treatment that these veterans need and deserve.

So, I thank Senator Moran for his partnership in this effort and I yield to him, with your permission, Mr. Chairman.

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

Senator MORAN. Mr. Chairman, thank you very much. Thanks for the opportunity to speak briefly about legislation pending before the Committee, and I thank you for your active engagement and leadership as we try to find solutions to the challenges veterans and their family members face.

I appreciate the opportunity to cosponsor and work with the Ranking Member on the Toxic Exposure Act. Let me highlight it first and indicate that I think it has significant value and merit.

When an individual serves their country in the military, I assume that they recognize the challenges and the sacrifices that they may make. So, when something happens to them, it is a terrible thing, but I cannot imagine the pain or concern that comes to a father or a mother who now sees the consequence of their military service affecting their children and their grandchildren.

So, while I expect that many veterans do, in a sense, assume a risk when they serve, I cannot imagine any circumstance in which that veteran, that military man or woman, believes that they are causing harm to their children and grandchildren, those born and those not yet born.

So, in listening to many veterans, particularly veterans of the Vietnam era, this issue of toxic substances has impacted them and greatly impacted their family. And, as usual, missing is the necessary medical research that demonstrates the connection to allow the Department of Veterans Affairs to make conclusions about how to treat those veterans. But more significantly, there is no ability to tie the next generation to any kind of benefit or care and treatment.

So, the bill that Senator Blumenthal and I have introduced is pretty straightforward. It creates two centers within the VA itself to study and analyze the connection, intergenerational, between exposure to toxic substances and its effect upon the future generations, and then creates the potential connection between that service and a veteran's dependent or that dependent's children.

And, I would urge this Committee to take this issue very seriously, and when our Veterans Service Organizations testify today, I hope that you will listen to them closely.

If any of you have spent time with these individuals and met their family members, you will see exactly what it is that they face, no question in their minds but that the connection of their service has a consequence—a dramatic consequence—to the health and well-being of their children and grandchildren.

In addition to that, I would say that the NPR story yesterday, although only slightly related to this topic—it is related in that it is an exposure to a substance, mustard gas, and the circumstances that World War II veterans are facing in the lack of attention and care, at least described by NPR, is something that is worthy of our attention. It is one more instance of fulfilling your military service and having a tremendous consequence.

And, I just—I wanted to quote from the NPR article, Mr. Chairman, just briefly. The point that Harry Bollinger, age 88, is making, a World War II veteran who was used as an individual to test the effects of mustard gas, and these individuals were tested in various circumstances, according to NPR, including being locked in a gas chamber with mustard gas being induced into the room with no ability for the veterans to leave, and then they were studied consequently to see what the consequence was to them.

While that in and of itself raises issues, what Mr. Bollinger said, he says he still suffers from chronic breathing problems and breaks out in eczema in places where he was burned as a young Navy recruit, "around my privates and under my arms and face and everywhere else." But, here is the point I wanted to make to the Committee. Bollinger gave up appealing VA rejections in 1994, after 4

years of traveling back and forth 30 miles to a VA office in Pittsburgh. Then in 1996, Bollinger received a military commendation in the mail. The document acknowledged his participation in mustard gas experiments. But Bollinger says he would not go back to the agency after the way he was treated there. Quote, "I was disgusted already. What is the use?"

Mr. Chairman, one more example of toxic substance and its consequences to our veterans, but also a reminder that we have to have a Department of Veterans Affairs whose focus is clearly on the veterans and meeting their needs.

So, Mr. Chairman, thank you for the opportunity to speak in support of Senator Blumenthal and I's bill, and I hope that we can continue to work to improve the services that all of our veterans receive.

Chairman ISAKSON. Thank you, Senator Moran.

Would the first panel come forward, please. Dr. Jain, Assistant Deputy Under Secretary for Health and Patient Care Services, Veterans Health Administration, U.S. Department of Veterans Affairs; Cathy Mitrano, Deputy Assistant Secretary for the Office of Resolution Management of the Office of Human Resources Management; and Jennifer Gray, the Staff Attorney of the Office of General Counsel.

Before you start your testimony, Dr. Jain, I want to echo what Senator Murray, Senator Blumenthal, and others have said, by acknowledging two things. One and one-half to 2 years ago, VA's problems were being masked in places like Phoenix because employees were doing the wrong thing. They were canceling appointments; they were fudging records. We have done a good job of purging that and we are now getting the right data from the VA. So, one statement I want to make, for those that have seen wait times protracted or not reduced as fast as we would like, that is bad news. But, it is good news that we are getting all the facts, and I want the VA to continue to do that.

But, the VA needs to understand on this issue of running out of money, no agency of government has gotten more increases in funding than Veterans Affairs over the last 7 or 8 years. The Veterans Choice bill was designed to be a force multiplier for VA, to increase our ability to serve our veterans within a timely basis, whether they live too far away or whether the Veterans Administration was understocked in performance people. And, we expect as a Committee the VA to continue to do everything it can do to make Veterans Choice work to be a force multiplier for the agency and not just a substitute for money that has already been depleted through veterans' non-VA health care and the like.

So, as you go back to talk to Sloan and Secretary McDonald and the others there, we are watching. We want to be a team with VA, to acknowledge the problems that we have and work hard to solve those problems, not by blaming each other but by working together to see to it we reduce the wait times and eventually get to within times we all want.

So, I appreciate Senator Murray and Senator Blumenthal raising that question. I appreciate what Senator Moran said about the VA in terms of attention to veterans' health care problems.

Now, I will recognize Dr. Jain for your testimony. Please try to keep it within 5 minutes, but if you fudge a little bit, I will not hit you.

STATEMENT OF RAJIV JAIN, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CATHERINE MITRANO, DEPUTY ASSISTANT SECRETARY, OFFICE OF RESOLUTION MANAGEMENT, OFFICE OF HUMAN RESOURCES MANAGEMENT; AND JENNIFER GRAY, STAFF ATTORNEY, OFFICE OF GENERAL COUNSEL

Dr. JAIN. Good afternoon, Mr. Chairman, Ranking Member, and distinguished Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect the Department of Veterans Affairs benefits, programs, and services.

Joining me today, to my right is Catherine Mitrano, Deputy Assistant Secretary for Resolution Management; and to my left is Jennifer Gray, Staff Attorney in the Office of General Counsel.

I would like to start by thanking you for confirming the nomination of LaVerne Council as Assistant Secretary for Information and Technology, and Dr. David Shulkin as Under Secretary for Health, and also by stating that many of the bills of the agenda are very complex and we do not have completed views for all of them, but we do know the Committee is anxious to get our views in anticipation of its legislative markup. We are working to get them to you on an expedited schedule.

I would like to acknowledge the Simcakoski family and thank them for being here today. I know they spoke to Dr. Clancy earlier today and we both want to express our sorrow at the loss of their son, Jason. We hope that this bill will work to help close the gaps in prescription drug monitoring.

We also want to thank Senator Baldwin for drafting the Jason Simcakoski Memorial Opiate Safety Act that addresses many details of this important issue. The Department is pleased with the collaborative and productive conversations we have had with Senator Baldwin's staff since April and we look forward to continuing this collaboration.

Our written testimony goes into depth on those efforts. We want to work with the Committee to ensure we are not duplicating the efforts or perhaps being too prescriptive in some areas. But, again, I want to emphasize that many ideas in this bill find much common ground with VA's multi-pronged approach to opioid safety.

VA generally supports the concept of S. 469, the Women Veterans and Families Health Services Act, to improve the reproductive treatment provided to certain severely wounded, ill, or injured veterans. Although some aspects of the bill present complications, VA supports doing all we can to restore to the greatest extent possible a veteran's quality-of-life, including the ability to have a family. We do have concerns about ensuring that we have the appropriate resources to provide the assisted reproductive services.

We also support the concept of expanding the child care in VA facilities as a way to make access to VA care easier for parents

with small children. However, we cannot responsibly support creating these programs in every facility without further conversations about the resources required.

Regarding S. 901, VA understands the importance of research in the areas of toxic exposures during military service and in responding when the signs show a connection of that exposure to specific ailments. As detailed in our testimony, however, VA believes the approaches in the bill may duplicate existing research and relationships with other Federal agencies and organizations that serve the same goal.

S. 1085 would provide expanded support and benefits for caregivers of eligible and covered veterans, most notably an expansion beyond the post-9/11 eligibility restriction. In the report required by the 2010 caregivers law on the feasibility of this expansion, we said that it would provide more equitable access to these programs. However, in this report, VA also noted the difficulties in expanding the program, again, without addressing the cost issues. Unfortunately, these facts have not changed and, therefore, we are unable to offer our support for that reason.

The discussion draft bill requires the Secretary to work with institutions of higher learning to develop partnerships with the establishment or expansion of programs of advanced degrees in prosthetics and orthotics. While VA supports means to improve and enhance the ability to hire and retain prosthetists and orthotists, it cannot support the proposed bill because it would require partnerships with colleges or universities with programs that largely would not benefit the VA or the veterans. We would like to work with the Committee in making technical adjustments so we could directly enhance this bill in benefiting our veterans.

As for the two bills regarding employee removal actions, we do not have views for S. 1117. However, both of these bills are similar in that they remove both senior executives and non-senior executive employees from the civil service or demote the employee to a reduction in grade or annual rate of pay. While VA understands the motivations for this bill, our written statement goes into detail on what we believe would be the negative unintended consequences, including real concerns about degrading our ability to recruit and retain the best and brightest to serve veterans.

Thank you, Mr. Chairman, for the opportunity to testify here today. My colleagues and I would be pleased to respond to questions that you or the other Members may have at this time.

[The prepared statement of Dr. Jain follows:]

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

Good morning Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA benefits programs and services. Joining us today is Catherine Mitrano, Deputy Assistant Secretary for Resolution Management, and Jennifer Gray, Staff Attorney in VA's Office of General Counsel.

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

to work with the Committee on prioritization of those views and cost estimates not included in our statement.

S. 469, WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

VA is providing views on Title II—Reproductive, Adoption, and Child Care Assistance for Veterans except for sections 203, 205, 208, and 209(b).

Section 201 would amend the definition of "medical services" in 38 U.S.C. 1701 to include "Fertility treatment and counseling, including treatment using assisted reproductive technology." This amendment would in effect require VA to provide these services and override VA's regulation prohibiting the provision of in vitro fertilization at 38 CFR 17.38(c)(2). VA supports section 201 conditioned on the availability of the additional resources needed to implement this provision. The provision of fertility treatment and counseling, including assisted reproductive technologies (ART) is consistent with VA's goal to restore to the greatest extent possible the physical and mental capabilities of Veterans and improve the quality of their lives and that of their families. For many, having children is an important and essential aspect of life. Those who desire but are unable to have children of their own commonly experience feelings of depression, grief, inadequacy, poor adjustment, and poor quality of life.

Section 202 would require VA to furnish fertility treatment and counseling, including the use of ART, to a spouse, partner, or gestational surrogate of a severely wounded, ill or injured Veteran who has an infertility condition which was incurred or aggravated while on active duty. This treatment would be furnished regardless of the sex or marital status of the Veteran. In vitro fertilization would be limited to 3 completed cycles or 6 attempted cycles to a spouse, partner or gestational surrogate. Section 202 would not require VA to find a gestational surrogate for a Veteran or furnish additional maternity care. For a spouse, partner, or gestational surrogate of a Veteran who is not severely wounded, ill or injured, VA could only coordinate fertility treatment and counseling.

VA supports section 202 in part, conditioned on the availability of the additional resources needed to implement this provision. VA supports providing fertility services and counseling to an enrolled severely wounded, ill, or injured Veteran and his or her spouse or partner. However, VA does not support coverage of gestational surrogates. The complex legal, medical and policy arrangements of surrogacy vary from state to state due to inconsistent local regulations. If implementing this provision, VA would need to consider potential conflicts with state and local laws governing surrogacy arrangements. VA acknowledges that surrogacy may offer the only opportunity for Veterans and their spouses/partners to have a biological child. There may be other options to consider when exploring how best to compensate these Veterans for their loss and to facilitate procreation.

VA estimates costs associated with enactment of the draft bill to be as follows: $177 million (consisting of approximately $64 million for Veterans and $113 million for eligible spouses). Expenditures are expected to decline to approximately $80 million in FY 2017, gradually increasing to $154 million by FY 2025. Total expenditures from FY 2016 to FY 2025 are expected to be approximately $1,207 million (approximately $437 million for disabled Veterans and $769 million for eligible spouses). Expenditures for pregnancies resulting from fertility services are estimated to be $28.9 million from FY 2016 through FY 2025.

Section 204 would require VA to submit an annual report to Congress on the fertility treatment and counseling furnished by VA. VA has no objection to this provision.

Section 206 would require VA to facilitate research conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services to help VA meet the long-term reproductive health care needs of Veterans with service-connected disabilities affecting Veterans' ability to reproduce.

Generally, VA supports implementing research findings that are scientifically sound and that would benefit Veterans and improve health care delivery to Veterans. VA's goal is to restore the capabilities of Veterans with disabilities to the greatest extent possible, and we utilize new research into various conditions to improve the quality of care we provide. VA expects the costs of this provision would be nominal; however, if facilitation is intended to mean direct funding, proposal reviews, and additional staff, costs would be greater.

Section 207 would require VA to enhance the capabilities of the Women Veterans Call Center (WVCC). VA supports section 207 to improve the WVCC by extending its current capability to host an interactive, secure chat capability. In addition to the efficient handling of both incoming and outgoing calls, the system would provide real-time messaging collaboration ("Live Chat" or "Text") with WVCC Contact Rep-

resentatives (CR) upon user (Veteran) request. This would provide women Veterans who have questions and/or concerns about VA health care and benefits with an online, one-to-one "Live Chat" service, in addition to the already provided WVCC telephone-based service.

Section 209(a) would require VA to carry out a program to provide assistance to qualified Veterans to obtain childcare so that the Veterans can receive health care services. Such assistance may include stipends for payment of child care by licensed centers, direct provision of child care at VA facilities, payment to private child care agencies, and collaboration with other Federal facilities or programs. VA would be required to carry out the program at each VA medical center not later than five years after the date of enactment of this bill.

VA is aware of the challenges faced by Veterans with children in regard to access to medical appointments and other medical care, counseling, and care giving services. With the growing numbers of younger Veterans and the increasing demands placed on grandparents to care for grandchildren, lack of child care can create a barrier to access to health care services at VA facilities. With the projected doubling of the number of women receiving health care through VA in the next several years and the projected number of those women who are of child bearing age, in addition to the reality of single-parent households with men as well as women serving as the parent, facilitating child care as a means of enhancing access to services is an important consideration. VA recognizes that the lack of competent, accessible child care negatively impacts the ability of Veterans who are primary caretakers of a child or children to attend scheduled appointments.

VA cannot responsibly provide a position in support of creating a new child care assistance program for veterans without a realistic consideration of the resources necessary, including an analysis of the future resources that must be available to fund other core direct-to-Veteran health care services. That consideration includes the budget levels included in the fiscal year 2016 budget resolution adopted by Congress, S. Con. Res. 11, as well as the fiscal year 2016 Military Construction/VA appropriations measures passed in the House and awaiting action in the Senate (H.R. 2029).

S. 901, TOXIC EXPOSURE RESEARCH ACT OF 2015

In general, S. 901 would require the Secretary to establish a National Center (Center) charged with researching the diagnosis and treatment of health conditions of descendants of individuals who were exposed to toxic substances while serving in the Armed Forces. It would also establish an Advisory Board (the "Board") that would oversee and assess the work of the National Center, meet with the National Center, review the annual report of the National Center, and advise the Secretary on various matters.

VA is committed to working with other Federal departments and agencies to ensure that Veterans exposed to toxic substances receive the best possible care we can provide and the benefits for which they are eligible. With respect to military exposures, VA is working closely with DOD to ensure that those who have transitioned to Veteran status are identified and provided information about their exposures. VA will also ensure their records document their exposures and they are provided access to the health care and benefits for which they are eligible.

Section 2 would define several terms for purposes of the bill, including the term "toxic substance," which would mean any substance determined by the Administrator of the Environmental Protection Agency to be harmful to the environment or hazardous to the health of an individual if inhaled or ingested by or absorbed through the skin of that individual.

Section 3 would require VA, in consultation with the Board established by section 4 of the bill, to select, not later than one year after the date of enactment, a VA medical center to serve as the Center for research on the diagnosis and treatment of health conditions of descendants of individuals exposed to toxic substances while serving in the Armed Forces that are related to such exposure. It would also establish selection criteria for the site and require the Center to conduct research on the diagnosis and treatment of health conditions of such descendants. In conducting such research, the Center would be required, at the election of the individual, to study individuals whom the Secretary has determined to be descendants of individuals who served as members of the Armed Forces who were exposed to a toxic substance while serving as a member of the Armed Forces; and who are afflicted with a health condition that is related to such exposure.

Section 3 would require the Secretary of Defense or the head of another Federal agency to make available to VA, for review, records held by DOD, an Armed Force, or that Federal agency, as appropriate, that might assist the Secretary in making

the determinations required above. To this end, VA and DOD or the head of the appropriate Federal agency would be compelled to jointly establish a mechanism for the availability and review of records by VA. This measure would also require the Center to reimburse the reasonable cost of travel and lodging of any individual participating in a study at the Center, plus those of any parent, guardian, spouse, or sibling who accompanies the individual. In addition to other reporting requirements, the Center would further be required to submit a report to the Congress, at least annually, that summarizes, for the preceding year, the functions of the Center, its completed research efforts, and the research that is still on-going. Finally, section 3 would require the Center to employ not less than one licensed clinical social worker to coordinate access of individuals to appropriate Federal, State, and local social and health care programs and to handle case management.

Section 4 would, in general, require the Secretary to establish, not later than 180 days after the Act's enactment, the Board, which would, among other things, be charged with advising the Center and overseeing and assessing its work, plus advising the Secretary of Veterans Affairs with respect to the work of the Center. The measure would also establish specific requirements related to composition of the Board, selection of members, terms of service, and duties. The Board would be required to review the annual reports submitted by the Center and advise the Secretary of Veterans Affairs on issues related to the Center's research; health conditions of descendants of individuals who were exposed to toxic substances during service in the Armed Forces that are related to such exposure; health care services that are needed by these descendants; and, any determinations or recommendations that the Board may have with respect to the feasibility and advisability of VA providing health care services to these descendants. This section would also establish separate Congressional reporting requirements for the Board.

Section 5 would require the Secretary of Defense to declassify documents related to any known incident in which no fewer than 100 members of the Armed Forces were exposed to a toxic substance that resulted in a least one case of a disability that a member of the medical profession has determined to be associated with that toxic substance. It would limit such declassification to information necessary for an individual who was potentially exposed to a toxic substance to determine: whether that individual was exposed to that toxic substance; the potential severity of the exposure; and any potential health conditions that may have resulted from the exposure. Declassification would not be required, however, if the Secretary of Defense "determines that declassification of those documents would materially and immediately threaten the security of the United States."

Section 6 would require the Secretary of Veterans Affairs, in consultation with the Secretaries of Health and Human Services and Defense, to conduct a national outreach and education campaign directed toward members of the Armed Forces, Veterans, and their family members. Specific details about the type of information to be included in this program and the manner of its dissemination are also set forth in this section.

Section 7 would prohibit additional funds from being authorized (to be appropriated) to carry out this Act; VA would be required to carry it out using amounts otherwise made available for this purpose.

VA does not support this bill. Unlike VA, other Federal Departments and agencies are chartered and funded to support research on the multi-generational health effects of toxic exposures. VA would be better designated as a collaborator with these organizations. To determine health effects of exposure for what are expected to be relatively rare health outcomes, large populations need to be studied over many years, perhaps decades. A proposed Center focusing solely on military toxic exposures would likely not have the statistical basis to support conclusive findings.

VA's approach to date has been to monitor Veterans' health, conduct surveillance studies, and remain abreast of findings from well-conducted studies in other populations. Based on that evidence, new Veteran-centric studies are then conducted as appropriate, that is, when indicated by findings from clinical care, surveillance, or recommendations from the clinical/scientific community for such studies—and particularly when they are likely to yield new insights.

Examples of current VA activities include collaborations with CDC to improve national surveys and databases to better understand Veterans' health, and communications research investigators from the Agency for Toxic Substances and Disease Registry regarding studies of Veteran populations. If enacted, this Act would effectively force VA to redirect already scarce funds—necessary for Veterans' care—to this Center. Any effort to study health conditions of descendants of individuals exposed to toxic substances should focus on rigorous scientific studies. The legislation's direction for the Center to conduct research on the diagnosis and treatment of de-

scendants of Veterans would not contribute to the scientific understanding we believe are at the center of the bill's purpose.

This new Center, as proposed, would clearly duplicate work already being done by the National Institute of Environmental Health Sciences, the Agency for Toxic Substances and Disease Registry, other non-governmental agencies, as well as work already within VHA programs, such as the War Related Illness and Injury Study Center, the Office of Research and Development, and the Office of Public Health). These existing organizations have for many years conducted research on the impact of environmental exposures on human health. In addition, the Department of Justice advises us that it opposes the inclusion of section 5 in the Toxic Exposure Research Act on the ground that it interferes with the President's exclusive authority to "classify and control access to information bearing on national security." *Dep't of Navy* v. *Egan*, 484 U.S. 518, 527 (1988).

Without authorization for additional appropriations to carry out the program established by the bill, resources would have to be diverted from existing Veterans' health care programs. VA estimates the costs associated with enactment of the draft bill to be $7.2 million for FY 2016; $96 million over a 5-year period; and $222 million over a 10-year period.

S. 1082, DEPARTMENT OF VETERANS AFFAIRS ACCOUNTABILITY ACT OF 2015

Section 2 of S. 1082 would give the Secretary of Veterans Affairs the same authority for VA non-Senior Executive employees granted to him for VA Senior Executives under 38 U.S.C. § 713. Under section 2, the Secretary could remove a VA non-Senior Executive employee from the civil service or demote the employee, either through a reduction in grade or annual rate of pay. If the individual being removed or demoted is seeking corrective action from the Office of Special Counsel (OSC) the Secretary could not take an action under this section without approval from OSC. Individuals removed or demoted under section 2 could appeal that action to a Merit Systems Protection Board administrative judge (AJ), who would be required to issue a decision on the appeal within 45 days. Decisions issued by an AJ would be final and not subject to further appeal.

Section 3 of this bill would require all new VA employees who are competitively appointed or appointed to the Senior Executive Service at VA to serve a probationary period of at least 18 months. The probationary period could be extended past 18 months by the Secretary.

S. 1082 is the latest in a series of legislative proposals targeting VA employees by providing extraordinary authority to sanction them, not available in other Federal agencies. Last summer, section 707 of the Veterans Access, Choice, and Accountability Act of 2014 added 38 U.S.C. § 713, establishing an expedited removal authority that strictly limits VA Senior Executives' post-termination appeal rights. While that provision gave the Secretary additional flexibility in terms of holding VA Senior Executives accountable for misconduct or poor performance, it constrained the Secretary's ability to retain gifted senior leaders by singling out VA Senior Executives for disparate treatment from their peers at other agencies.

It is likely that S. 1082 would result in unintended consequences for VA, such as a loss of qualified and capable staff to other government agencies or the private sector. Section 2 of this bill, which is based on 38 U.S.C. § 713, would apply to all VA employees regardless of their grade or position. VA's workforce consists of a diverse array of employees, including employees with advanced degrees in business, law, and medicine. Many of these employees accept lower pay to serve at VA, and a large number of these employees are Veterans. While VA's employees are motivated first and foremost by a desire to serve Veterans, another motivation to accept lower pay shared by many Federal employees is the job security afforded by protections such as appeal rights that attach at the end of a probationary period. Diminishing those appeal rights or expanding the probationary period will reduce the motivation to pursue public service at VA.

Section 2 of the bill poses due process concerns, due to its failure to provide the employee with a chance to be heard prior to losing the benefits of employment and its failure to guarantee that an employee's case will be fairly judged before the sanction becomes final.

Section 3 of this bill would also adversely impact recruitment at VA by extending the probationary period for employees from what is usually 12 months to 18 months and authorizing the Secretary of Veterans Affairs to extend the probationary period beyond that time at his discretion. In general, the probationary period serves as a way of examining whether an employee is suitable for his or her position. The 12-month cap of probationary periods serves a dual role: it gives management a finite amount of time within which to gauge an employee's performance, and it gives the

employee a reasonable period of time within which he or she would be made a permanent Federal employee. By expanding that time to 18 months and allowing the Secretary to extend the probationary period past 18 months, section 3 of this bill may impact VA's ability to recruit employees. Like the diminishment of due process and appeal rights, the longer probationary period simply makes VA less competitive for the candidates seeking job security. In effect, S. 1082 would create a new class of employees in the government, a "VA class." These "VA class" employees could be removed or demoted at the discretion of the Secretary, would receive fewer due process rights and abbreviated MSPB appeal rights in actions taken under section 2 of the bill and would serve longer probationary periods than their peers at other government agencies. This will hinder VA efforts to make the "VA class" of employee the very finest employees to serve our Veterans and ensure that they timely receive the benefits and care to which they are entitled.

By singling out VA employees, the legislation would dishearten a workforce dedicated to serving Veterans and hurt VA's efforts to recruit and retain high performing employees. VA will continue to work with the Committee and VSO's on how the Secretary can best hold employees accountable while preserving the ability to recruit and retain the highly skilled workforce VA needs to best serve Veterans.

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

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

Section 2 of S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015, would remove "on or after September 11, 2001" from the statutory eligibility criteria for the Program of Comprehensive Assistance for Family Caregivers, and thereby expand eligibility under the program to Veterans of all eras who otherwise meet the applicable eligibility criteria. Family caregivers could not receive assistance under this expanded eligibility until Fiscal Years 2016, 2018, or 2020 depending on the monthly stipend tier for which their eligible Veteran qualifies. Section 2 would also add "or illness" to the statutory eligibility criteria, and thereby expand eligibility to include those Veterans who require a caregiver because of an illness incurred or aggravated in the line of duty. In addition, the bill would expand the bases upon which a Veteran could be deemed to be in need of personal care services, to include "a need for regular or extensive instruction or supervision without which the ability of the Veteran to function in daily life would be seriously impaired."

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

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

Family Caregivers. Finally, the bill would amend the annual reporting requirements for the Program of Comprehensive Assistance for Family Caregivers.

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

In the report, however, VA noted difficulties with making reliable projections of the cost effect of opening the Program of Comprehensive Assistance for Family Caregivers to eligible Veterans of all eras, but estimated a population range of 32,000 to 88,000 additional Veterans in the first year (estimated for FY 2014), at a cost of $1.8 billion to $3.8 billion in the first year (estimated for FY 2014). After VA provided this report to Congress, the RAND Corporation published a report titled, "Hidden Heroes: America's Military Caregivers," which estimates a significantly larger eligible population (1.5 million) that may be eligible if the program were expanded to caregivers of pre-9/11 Veterans. VA's estimates in the 2013 report did not account for expansion to eligible Veterans with an illness incurred or aggravated in the line of duty, other Veterans who would become eligible for the program based on the amendments in section 2 of S. 1085, or the additional assistance that would become available to primary family caregivers under the bill.

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

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

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

H.R. 91, VETERAN'S I.D. CARD ACT

H.R. 91, the "Veteran's I.D. Card Act," would establish a program under which VA would issue a Veteran identification card, produced by VA, upon request by a Veteran who was discharged from the Armed Forces under honorable conditions. The Veteran would have to present to VA a copy of his or her DD–214 form or other official document from his or her official military personnel file describing his or her service, as well as pay a fee set by VA to recoup the cost of implementing the program.

The bill makes clear that issuance of a card would not serve as proof of entitlement to any VA benefits, nor would it establish eligibility for benefits in its own right. The purpose of the card, made clear in section 2(a)(3) and (4) of the bill, would be for Veterans to use the card to secure goods, services, and the benefit of promotional activities offered by public and private institutions to Veterans without having to carry official discharge papers to establish proof of service. Furthermore, the bill would clarify that the new Veteran's I.D. Card would not affect identification cards provided by the Secretary to Veterans enrolled in the health care system established under 38 U.S.C. 1705.

Veterans in 45 States and the District of Columbia may apply for a driver's license or State-issued ID card that designates veteran status. The remaining states (California, Hawaii, Illinois, Minnesota, New Jersey, and Washington) are either pending legislation or have legislation that has been signed into law but is not yet effective. We believe the availability already of this Veteran designation can meet

the intent of the legislation without creating within VA a new program that may not be cost-efficient. It is not known whether enough Veterans would request the card to make necessary initial investments in information technology and training worthwhile.

Also, another VA-issued card could create confusion about eligibility. Although the bill states that a card would not by itself establish eligibility and would not affect other identification cards provided by VA to Veterans enrolled in the VA health care system, there could nonetheless be misunderstandings by Veterans that a Government benefit is conferred by the card. As the Committee knows, entitlement to some VA benefits depends on criteria other than Veteran status, such as service connection or level of income. Confusion may also occur because the Veterans Health Administration issues identification cards for Veterans who are eligible for VA health care, and recently issued every enrolled Veteran a Veterans Choice Card. Having several VA-issued cards creates the potential for confusion on several levels.

Because it is difficult to predict how many Veterans would apply for such a card, VA cannot provide a reliable cost estimate for H.R. 91. Although the bill is intended to allow VA to recoup its costs by charging Veterans for the cards, in reality VA could be assured of recouping its costs only if it knew in advance what those costs would be, and those costs cannot be reliably estimated without knowing how many Veterans would request the card.

DISCUSSION DRAFT

Section 1 of the Discussion Draft would require the Secretary of Veterans Affairs to work with institutions of higher learning to develop partnerships for the establishment or expansion of programs of advanced degrees in prosthetics and orthotics with a goal of improving and enhancing the availability of prosthetic and orthotic care for Veterans.

VA provides rehabilitation services to Veterans with a mix of providers, including physical medicine and rehabilitation physicians, physical therapists, occupational therapists, prosthetists and orthotists all of whom work with the Veteran to enable the best possible rehabilitation given the individual's needs. VA offers in-house orthotic and prosthetic services at 79 locations across VA. In addition, VA contracts with more than 600 vendors for specialized orthotic and prosthetic services. Through both in-house staffing and contractual arrangements, VA is able to provide state-of the art commercially available items ranging from advanced myoelectric prosthetic arms to specific custom fitted orthoses. Nationally, VA has approximately 312 orthotic and prosthetic staff.

With regard to training and development, VA offers one of the largest orthotic and prosthetic residency programs in the Nation. In fiscal year 2015, VA's Office of Academic Affiliations allocated $877,621 to support 20 orthotics and prosthetics residents at 10 Veterans Affairs Medical Centers. The training consists of a yearlong post-masters residency, with an average salary of $44,000 per trainee. In recent years, VA has expanded the number of training sites and the number of trainees, but expansion has been limited due to a lack of certified supervisors for the training programs.

While VA supports means to improve and enhance the ability to hire and retain prosthetists and orthotists, it cannot support the proposed bill. Under the proposed bill, VA would be required to partner with colleges and universities for the establishment or expansion of programs of advanced degrees in prosthetics and orthotics. These programs, however, would not directly benefit VA or Veterans as the legislation does not require that the programs affiliate with VA or send their trainees to VA as part of a service obligation.

Tying the granting of funds to the establishment or expansion of programs of advanced degrees that would directly benefit VA and Veterans is one of the changes that VA recommends for this legislation. VA looks forward to working with the Committee to craft a bill that more directly enhances advanced degrees in prosthetics and orthotics while benefiting VA and Veterans.

DRAFT LEGISLATION: JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

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

VHA currently has a Patient Advocacy program established to ensure that all Veterans and their families served in VHA facilities and clinics have their complaints addressed in a convenient and timely manner. The program operates under a philos-

ophy of Service Recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall services to Veterans.

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

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

The proposed bill reflects the existing Patient Advocacy program but does not account for the strategy to transform the Patient Advocate role to keep pace with private sector advances in patient experience. The model has been successfully demonstrated in VHA pilots and private sector health care systems[1] and is consistent with VA's vision of providing world-class customer service. This vision will engage staff from across the organization as well as Veterans to be actively involved in the transformation process. VA is thus very supportive of the concept in section 201, but has concerns that detailed statutory directives could restrict the evolution and breadth of the Patient Advocacy program.

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

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

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

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

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

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

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

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

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

For example, on the topic of opioids safety, all the education programs listed above, except ATACS which is focused on acupuncture skill training, have presentations on universal precautions and risk management in opioid therapy for pain, including clinical evaluation, written informed consent, screening such as urine drug monitoring, use of state monitoring programs, and safe tapering. Related specifically to safe opioid prescribing, the VHA has implemented the Opioid Safety Initiative, a mandatory academic detailing program that identifies targets of risky practices (e.g., high opioid doses, co-prescribed benzodiazepines, use of urine drug screens) and universally monitors these practices in VHA at the provider and facility/VISN level through appointed VISN and facility OSI and Pain Management Point of Contact, or POCs. A POC is a clinician appointed and supported at the VISN level who is an appropriately trained, experienced and credentialed in pain medicine, pain management, or another credential appropriate to the clinical discipline. These individuals identify targets of risky practices through regular monthly and 'on-demand' progress reports, and provide education and counseling for facilities and prescribers whose patterns of prescribing and pain management practices require remediation.

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

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

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

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

pleted. The findings from these reviews are helping to inform decisions on how to best use CAM within VA and identify areas for further research.

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

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

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

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

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

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

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

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

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

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

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

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

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

DEPARTMENT OF VETERANS AFFAIRS,
Washington, DC, July 15, 2015.

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

DEAR MR. CHAIRMAN: The agenda for the Senate Committee on Veterans' Affairs' June 3, 2015, and June 24, 2015, legislative hearings included a number of bills that the Department of Veterans Affairs (VA) was unable to address in our testimony. We are aware of the Committee's interest in receiving our views and cost estimates for those bills.

By this letter, we are providing the following remaining views and cost estimates for the following bills from the June 3, 2015, legislative hearing: S. 471, the Women Veterans Access to Quality Care Act of 2015; and sections 4(b)-(c) and 5 of the draft Veterans Health Act of 2015.

We are also providing views and costs on the following bills from the June 24, 2015, legislative hearing: the Draft Biological Implant Tracking and Veteran Safety Act of 2015; on S. 1117, the Ensuring Veteran Safety Through Accountability Act of 2015; sections 203, 205, 208, and 209(b) of S. 469, the Women Veterans and Families Health Services Act of 2015; sections 3 through 8 of S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015; section 2 of the draft bill referred to on the agenda as "Discussion Draft;" and sections 101–106, 204, 205, 403 and 501 of the draft Jason Simcakoski Memorial Opioid Safety Act.

In the time requested for transmittal of follow up views, VA was not able to include in this letter the following views: sections 2 and 4 of S. 297, the Frontlines to Lifelines Act of 2015; the draft bill on establishing a joint VA-Department of Defense (DOD) formulary for systemic pain and psychiatric medications; sections 2, 3, and 5 of the draft Veterans Health Act of 2015, sections 203, 208, and 209(b) of S. 469, the Women Veterans and Families Health Services Act of 2015; sections 4(b) and 8 of S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015; and sections 105, 205, 403, and 501 of the Jason Simcakoski Memorial Opioid

Safety Act. The remaining views can be forwarded in a separate and final follow-up views letter.

We appreciate this opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

ROBERT A. MCDONALD,
Secretary.

Enclosure.

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JUNE 24, 2015, AGENDA

DRAFT BILL, BIOLOGICAL IMPLANT TRACKING AND VETERAN SAFETY ACT OF 2015

Section 2 of the draft bill would add a new section 7330B to title 38 to require the Secretary to adopt or implement the unique device identification system developed by the Food and Drug Administration (FDA) for medical devices (or a comparable standard identification system) for use in identifying biological implants intended for utilization in VA medical procedures. VA would be required to permit a vendor to use any accredited agency identified by the FDA as an issuing agency pursuant to 21 CFR 830.100. Section 2 would also require the Secretary to implement a system for tracking biological implants from donor to implantation and implement a system of inventory controls compatible with such system. The inventory controls would need to enable the Secretary to notify, as appropriate (based on an evaluation of the risks and benefits provided by appropriate VA medical personnel), VA patients who are in receipt of biological implants that are subject to recall by the FDA. In addition, section 2 of the bill would provide that in cases of conflict between the proposed revision to title 38 and a provision of 21 U.S.C. 301 et seq. or 42 U.S.C. 262, (including any regulations issued pursuant to such Acts), the provisions of these other laws or regulations would apply.

VA agrees with the general purpose of these requirements, and VA intends to institute new recommendations from the Department of Health and Human Services (HHS) for tissue tracking. On April 7–8, 2015, the HHS Advisory Committee on Blood and Tissue Safety and Availability voted unanimously to recommend that the HHS Secretary adopt a step-wise, risk-based approach to standardizing the identification, tracking, and tracing of medical products of human origin. In particular, the Committee recommended establishing ISBT 128 labeling as "a universal standard for mandatory implementation of unique donation identifiers for all human tissue products." It suggested that the HHS Secretary promote the integration of transplantation records into searchable, electronic patient records. It further recommended taking steps to ensure that patients are informed when they receive a tissue product and provided a means of tracing it. The Committee asked that the HHS Secretary promote education for health care providers regarding the risks of human tissue transplants, the need for meaningful informed consent and the necessity of engaging in activities to ensure tracking and tracing of tissue products. Lastly, it noted the importance of promoting international collaboration and data sharing on outcomes of tissue transplantation.

The draft bill recognizes the need for a higher standard for human biologics as indicated by the requirement for the use of a production identifier at all stages in production; however, as currently written, the bill would force human tissues to be grouped with other biologics in terms of identification.

Additionally, the bill states that VA shall permit vendors to use any of the FDA accredited entities identified as an issuing agency for adopting or implementing a standard identification system for biological implants. This effectively limits VA to the use of the FDA's Unique Device Identifier (UDI) and its minimum standards. VA already tracks blood and cellular products successfully using ISBT 128 identifiers in its facilities, and as a result, we should be able to extend this system to ISBT 128-labeled human tissue products providing both electronic health record documentation and inventory control. VA is working with HHS and other Federal partners to identify the optimal tracking and tracing systems to ensure the highest safety standards for human tissues

The term "biological implant" would be defined as any human cell, tissue, or cellular or tissue-based product: (1) under the meaning given the term "human cells" in 21 C.F.R. 1271.3 (or any successor regulation); or (2) that is regulated as a device under section 21 U.S.C. 321(h). With respect to biological implants of "human cells,"

the standard identification system would have to be implemented not later than 180 days after the Act's enactment. With respect to products that are regulated as a device), the Secretary would be required to adopt or implement such standard identification system in compliance with the compliance dates established by the FDA pursuant to 21 U.S.C. 360i(f).

Should the tracking system for biological implants not be operational by the 180-day deadline described above, the Secretary would be required to submit a written explanation to the Committees on Veterans' Affairs explaining why the system is not operational for each month until the system is operational.

Section 3 would add a new section 8129 to title 38 to govern the procurement of biological implants. VA would be limited to procuring human biological implants from vendors that meet several conditions. First, the vendors would have to use the standard identification system adopted or implemented by VA with safeguards to ensure that a distinct identifier has been in place at each step of distribution from its donor. Additionally, each vendor would have to be registered with the FDA, ensure that donor eligibility determinations and other records accompany each biological implant at all times, and agree to cooperate with all biological implant recalls initiated by the vendor, the manufacturer, or by the FDA. Moreover, the vendors would have to agree to notify VA of any adverse event or reaction it provides to FDA, or any warning letter from FDA. The vendors would have to agree to retain all records associated with procuring a biological implant for at least 10 years, and would have to provide assurances that the biological implants provided are acquired only from tissue processors that maintain accreditation with the American Association of Tissue Banks or a similar national accreditation.

Vendors supplying biological implants of non-human origin would have to use the standard identification system adopted or implemented by VA, be registered with the FDA and agree to cooperate with all biological implant recalls initiated by the vendor, the manufacturer, or by the FDA. For a vendor that is not the original product manufacturer, the vendor would have to provide assurances that the original product manufacturer is registered with FDA or is not required to register. Vendors would also have to agree to notify VA of any adverse event or reaction it provides to FDA, or any warning letter from FDA. Finally, vendors would have to agree to retain all records associated with procuring a biological implant for at least 10 years.

VA would be required to procure biological implants under the Federal Supply Schedules (FSS) of the General Services Administration (GSA) unless such implants are not available under these schedules. VA would be required to accommodate reasonable vendor requests to undertake outreach efforts to educate VA medical professionals about the use and efficacy of biological implants if the implants are listed on the FSSs. If FSSs were unavailable, VA would be required to procure such implants using competitive procedures in accordance with applicable law and the Federal Acquisition Regulations (FAR). The bill would also clarify that 38 U.S.C. 8123, which addresses procurement of prosthetic appliances, does not apply to the procurement of biological implants.

Paragraph (b) of the new section 8129 would establish penalties, in addition to any penalty under another provision of law, for procurement employees who are found responsible for a biological implant procurement transaction with intent to avoid or reckless disregard of the requirements of this section. Such an official would be ineligible to hold a certificate of appointment as a contracting officer or to serve as the representative of an ordering officer, contracting officer, or purchase card holder.

Paragraph (c) of the new section 8129 would define several terms. The new section 8129 would take effect on the date that is 180 days after the date on which the tracking system is required. The bill also contains a special rule for cryopreserved products, allowing VA for 3 years to procure biological implants produced and labeled before the effective date of section 8129 without relabeling the product as would be required under the new section 7330B.

VA has several concerns with section 3 of the bill. First, vendors would be required to retain records for up to 10 years under the draft bill. VA notes that some institutions permanently retain these records. In particular some types of biologic may be stored for extended periods prior to use and it may take several years for an adverse outcome to manifest. Disposal of records, in particular, the actual production identifier and donor documentation, will prevent the ability to track human derived biologics to their donor and ensure the presence of biologics in VHA that cannot be reliably tracked back to the original donor.

VA also has concerns with the requirement that biological implants be procured from FSS sources (unless the products are not available from these sources). This would unduly restrict VA's authority to determine the hierarchy of sources. All bio-

logical implants are not currently available on the FSS, and clinicians are not involved in the decision to place these products on contract. Additionally, VHA has determined that these should be available through national contracts that would take precedence over FSS. VA is developing an appropriate initial contract vehicle to acquire such products.

We are also concerned that the penalties imposed under proposed section 8129(b) could produce unfair results if a procurement employee needed to purchase a product off-contract to meet the immediate needs of a patient and provider. This could be exacerbated by vendors choosing not to contract with VA given the new requirements imposed upon them, thereby eliminating or limiting the availability of products for our patients. Shortages of biologic products could also affect VA's ability to obtain products under contract or through competitive processes. As a result, Veterans' medical care could be delayed.

VA is unable to estimate the costs for the draft bill at this time.

S. 1117, ENSURING VETERAN SAFETY THROUGH ACCOUNTABILITY ACT OF 2015

S. 1117 would amend 38 U.S.C. 713 to allow the Secretary to remove individuals appointed under 38 U.S.C. 7401, which include health care and scientific professionals (e.g., physicians, dentists, nurses), if the Secretary determines the performance or misconduct of the individual warrants removal. Under S. 1117, actions taken under 38 U.S.C. 713 would not be subject to the provisions of 38 U.S.C. 7461(b) and 7462, or 5 U.S.C. 7503, 7513, and 7543(b). The bill would also make conforming amendments to 38 U.S.C. 7461(b) and 7462.

38 U.S.C. 713 was established last summer under section 707 of the Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146). Under 38 U.S.C. 713, the Secretary may remove or, under certain circumstances, transfer an employee to a General Schedule position, if the Secretary determines that the performance or misconduct of the individual warrants such a removal or transfer. Individuals who are removed or transferred under 38 U.S.C. 713 have limited post-termination or transfer appeal rights.

At present, 38 U.S.C. 713 only applies to VA Senior Executives: career appointees in the Senior Executive Service or individuals appointed under 38 U.S.C. 7306(a) or 7401(1) to an administrative or executive position. S. 1117 would expand the application of 38 U.S.C. 713 to allow the Secretary to remove other Title 38 employees, including practicing physicians, dentists, nurses, and other individuals, regardless of their grade or rank, while limiting the post-termination appeal rights for these employees.

While 38 U.S.C. 713 gave the Secretary additional flexibility in terms of holding VA Senior Executives accountable for misconduct or poor performance, it constrained the Secretary's ability to retain gifted senior leaders by singling out VA Senior Executives for disparate treatment from their peers at other agencies. It is likely that S. 1117 would result in unintended consequences for VA, such as a loss of qualified and capable health care and scientific professionals to other government agencies or the private sector. Many of these employees accept lower pay to serve at VA, and a large number of these employees are Veterans. While VA's employees are motivated first and foremost by a desire to serve Veterans, another motivation to accept lower pay shared by many Federal employees is the job security afforded by protections such as appeal rights that attach at the end of a probationary period. Diminishing those appeal rights will reduce the motivation to pursue public service at VA.

The bill also poses due process concerns, due to its failure to provide the employee with a chance to be heard prior to losing the benefits of employment and its failure to guarantee that an employee's case will be fairly judged before the sanction becomes final.

By singling out VA employees, the legislation would dishearten a workforce dedicated to serving Veterans and hurt VA's efforts to recruit and retain high performing employees. VA will continue to work with the Committee and VSO's on how the Secretary can best hold employees accountable while preserving the ability to recruit and retain the highly skilled workforce VA needs to best serve Veterans.

S. 469, WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

Section 203 would add a new section 1789 to title 38 authorizing the Secretary to pay to assist a covered veteran in the adoption of one or more children. Covered veterans would include any severely wounded, ill, or injured veteran who has an infertility condition incurred or aggravated in the line of duty and who is enrolled in VA's health care system. VA would be limited to paying an amount equal to the cost

to the Department of paying the expenses of three adoptions by covered Veterans, as determined by the Secretary.

VA's goal is to restore to the greatest extent possible the physical and mental capabilities of Veterans and improve the quality of their lives and that of their families, and adoption would be a means to that end. However, we note that payment for adoption services raises a host of issues regarding differing State laws, as well as complications from administering what would be a non-medical benefit. We would also note that additional funds would be necessary to support adoption services. VA is still analyzing this section and would be glad to provide further views at a later time.

Section 205 would require VA to promulgate regulations within 540 days of the enactment of the Act on the furnishing of fertility treatment to veterans using reproductive technology; fertility treatment and counseling for spouses, partners, and gestational surrogates of Veterans under the new section 1788; and adoption assistance for covered Veterans under the new section 1789. Prior to publishing these regulations, VA would be prohibited from furnishing any fertility treatment that uses an assisted reproductive technology that the Secretary has not used before the enactment of this Act, to furnish any fertility treatment or counseling under the new section 1788, or to offer any adoption assistance under the new section 1789.

While VA has no objection to section 205, we note that our previous testimony cited only partial support for some of the programs in question

Section 208 would modify the pilot program on counseling in retreat settings for women Veterans newly separated from service in the Armed Forces by increasing the number of locations from 3 to 14 and by extending the duration of the program another 3 years through calendar year 2018. It would also authorize such sums as may be necessary to be appropriated to support the program for fiscal years 2016, 2017, and 2018.

VA is still analyzing this section and would be glad to provide views at a later time. We note that additional funds would be necessary to support the extension of this program.

Section 209(b) would require VA to carry out a program to provide child care assistance for certain Veterans receiving readjustment counseling and related mental health services at Vet Centers. VA would be required to carry out this program in not fewer than three Readjustment Counseling Service Regions selected by the Secretary.

The child care program requirements would generally be the same as the requirements for the current child care pilot program, with several notable exceptions. First, VA would be limited to assisting qualified Veterans with child care only during the period that the qualified Veteran is receiving readjustment counseling and related health care services at a Vet Center, but not the time to travel to and from the Vet Center. VA is unsure if this is an accidental omission, but believes this limitation could significantly limit the effect of this authority. Second, under this provision, VA would not be authorized to directly provide child care services as an acceptable form of child care assistance. This omission is potentially troublesome in light of the first concern we raised, because if VA cannot directly provide child care assistance but also cannot provide child care during the travel time to and from the appointment, there would be at least some amount of time when either the Veteran would be liable for the cost of child care services or the Veteran's child could not receive such services. We would also note that additional funds would be necessary to support program. VA is still analyzing this section and would be glad to provide views at a later time.

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

Section 3 of this bill proposes to add a new section 3319A to title 38 to authorize individuals who are eligible for and participating in a program of comprehensive assistance for family caregivers under 38 U.S.C. 1720G(a) the opportunity to transfer their unused Post-9/11 GI Bill education benefits to their dependents. Veterans may complete the transfer of entitlement any time during the 15-year period beginning on the date of their last discharge or release from active duty. Transferees would be subject to the same rules in place for individuals who receive transferred benefits under 38 U.S.C. 3319. However, there is no length of service requirement, and the monthly rate of educational assistance would be the same rate payable to the individual making the transfer. The Secretary would be authorized to prescribe regulations to carry out this section.

Currently, DOD determines eligibility for transfer of entitlement. If enacted, the proposed legislation would require VA to develop procedures to receive requests to transfer entitlement for certain individuals, determine eligibility, and award bene-

fits for the transfer of entitlement program. Because the transfer of entitlement provisions of the Post-9/11 GI Bill were established as a recruitment and retention tool for the uniformed services, VA defers to DOD on this section of the bill. However, VA notes that Congress would need to identify appropriate offsets for the cost of this legislation, which we are unable to estimate at this time.

Section 4(a) would amend 37 U.S.C. 439, providing for special compensation for members of the uniformed services with catastrophic injuries or illnesses requiring assistance in everyday living, by amending the definition of covered members to include those Servicemembers who have a serious injury or illness that was incurred or aggravated in the line of duty, are in need of personal care services as a result of the injury, and who would require hospitalization, nursing home care, or other residential care in the absence of such personal care services. Section 4(b) would further amend section 439 by requiring VA to provide family caregivers of a Servicemember in receipt of monthly special compensation assistance available to family caregivers of eligible veterans under 38 U.S.C. 1720G(a)(3)(A), other than the monthly caregiver stipend. VA would provide assistance under this subsection in accordance with a memorandum of understanding (MOU) between VA and DOD, and an MOU between VA and the Secretary of Homeland Security. Section 4(c) would define the term "serious injury or illness," which would replace the term "catastrophic injury or illness," to mean an injury, disorder, or illness that (1) renders the afflicted person unable to carry out one or more activities of daily living; (2) renders the afflicted person in need of supervision or protection due to the manifestation by such person of symptoms or residuals of neurological or other impairment or injury; (3) renders the afflicted person in need of regular or extensive instruction or supervision in completing two or more instrumental activities of daily living; or (4) otherwise impairs the afflicted person in such manner as the Secretary of Defense or Homeland Security prescribes.

VA defers to DOD and the Department of Homeland Security regarding amendments sections 4(a) and 4(c).

VA is still analyzing section 4(b) and would be glad to provide views at a later time.

Section 5 would authorize the Office of Personnel Management (OPM) to promulgate regulations under which a covered employee, which would include a caregiver defined in 38 U.S.C. 1720G or a caregiver of an individual receiving compensation under 37 U.S.C. 439, to use a flexible schedule or compressed schedule or to telework.

VA defers to OPM on this section.

Section 6 would amend the Public Health Service Act (42 U.S.C. 300ii), which governs lifespan respite care, to amend the definition of "adult with special need" to include a veteran participating in the family caregiver program under 38 U.S.C. 1720G. It would also amend the definition of "family caregiver" to include family caregivers under 38 U.S.C. 1720G. Furthermore, in awarding grants or cooperative agreements to eligible State agencies to furnish lifespan respite care, the HHS would be required to work in cooperation with the interagency working group on policies relating to caregivers of Veterans established under section 7 of this bill. Section 6 would also authorize appropriations of $15 million for fiscal years 2016 through 2020 for these grants.

VA defers to HHS on this section.

Section 7 would establish an interagency working group on policies relating to caregivers of Veterans and Servicemembers. The working group would be composed of a chair selected by the President, and representatives from VA, DOD, HHS (including the Centers for Medicare & Medicaid Service), and the Department of Labor. The working group would be authorized to consult with other advisors as well. The working group's duties would include regularly reviewing policies relating to caregivers of Veterans and Servicemembers, coordinating and overseeing the implementation of policies relating to these caregivers, evaluating the effectiveness of such policies, developing standards of care for caregiver and respite services, and others. Not later than December 31, 2015, and annually thereafter, the working group would be required to submit to Congress a report on policies and services relating to caregivers of Veterans and Servicemembers.

VA generally supports a working group that would provide a forum for analyzing and evaluating different issues that family caregivers of Veterans and Servicemembers face. Such a working group would be ideally suited to considering in depth the types of issues other provisions of this bill are intended to address, and would also be able to evaluate emerging issues.

The Department of Justice advises, however, that it believes the method for selecting members of the working group raises Appointment Clause concerns, which DOJ will convey in greater detail under separate cover.

Section 8(a) would require VA to conduct a longitudinal study on Servicemembers who began their service after September 11, 2001. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. Within 1 year of the date of the enactment of the Act, VA would be required to submit to the Committees on Veterans' Affairs a plan for the conduct of the study. Not later than October 1, 2019, and not less frequently than once every 4 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of the study. Section 8(b) would require VA to provide for the conduct of a comprehensive study on Veterans who have incurred a serious injury or illness and individuals who are acting as caregivers for Veterans. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. The study would be required to include the health of the Veteran and the impact of the caregiver on the health of the Veteran, the employment status of the Veteran and the impact of the caregiver on that status, the financial status and needs of the Veteran, the use by the Veteran of VA benefits, and any other information VA considers appropriate. Not later than 2 years after the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of this study.

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

DRAFT BILL, DISCUSSION DRAFT

Section 2 of the discussion draft would require, within 2 years of enactment, the Secretary, in consultation with the Secretary of Defense and such agencies and individuals the Secretary considers appropriate, to submit a report to Congress. The report would include the extent to which Laotian military forces provided combat support to the Armed Forces of the United States between February 28, 1961, and May 15, 1975; whether the current classification of the service by individual of the Hmong ethnicity by the Civilian/Military Service Review Board of the Department of Defense is appropriate; and any recommendations for legislative action.

VA does not support this section because DOD is in better position than VA to research this issue. In determining whether a claimant is eligible for a VA benefit, VA is legally bound by service department determinations as to what service a claimant performed.

DRAFT BILL, THE JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

Section 101 would require, within 1 year of the date of the enactment of the Act, VA and DOD to jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. The guidelines would have to include guidelines for safely prescribing opioids for the treatment of chronic, non-cancer pain in outpatient settings; enhanced guidance with respect to absolute contraindications for opioid therapy; enhanced guidance with respect to the treatment of patients with behaviors or comorbidities, or a history of substance abuse or addiction, that require consultation or co-management of opioid therapy with one or more specialists; enhanced guidance with respect to the conduct by health care providers of an effectiveness assessment for patients receiving opioid therapy; requirements that each VA and DOD provider, before initiating opioid therapy, use VA's Opioid Therapy Risk Report tool to assess the risk for adverse outcomes; guidelines to govern the methodologies used by VA and DOD providers to taper opioid therapy when adjusting or discontinuing opioid therapy; guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient settings; enhanced recommendations on the use of routine and random urine drug tests for all patients before and during opioid therapy; and guidance that health care providers discuss with patients before initiating opioid therapy other options for pain management therapies. Before updating these guidelines, VA and DOD would be required to jointly consult with the working group on pain management and opioid therapy established under section 3 of this bill. Within 1 year of the date of enactment of this Act, GAO would be required to submit to the Committees on Veterans' Affairs a report on the implementation of the updated guidelines by each VA medical facility and the compliance of each medical facility with these guidelines.

VA appreciates the intent of this thoughtful and comprehensive bill, and agrees that more needs to be done to support clinicians with clearer guidance and training on prescribing medications for pain management. VA, because of its central role in training physicians across the country, can provide leadership by training clinicians in pain management and supporting a team approach to care. There are cases

where the use of opioids is clinically indicated, albeit closely controlled and monitored, to control pain when nothing else does. We have a number of recommendations to improve the bill, and would be glad to meet with the Committee to discuss these further. For example, the requirement in section 101(b) that VA and DOD jointly consult the working group on pain management and opioid therapy established in section 103 of the bill would be redundant, as the VA/DOD Health Executive Council (HEC) already has a Pain Management Work Group whose focus is on improving pain management practices in the two Departments.

Section 102(a) would require VA, within 180 days of enactment, to expand the Opioid Safety Initiative to include all VA medical facilities.

Section 102(b) would require VA to ensure all providers responsible for prescribing opioids to receive education and training on pain management and safe opioid prescribing practices. The education and training would have to cover a number of identified areas, and in providing the training, VA would be required to use the Interdisciplinary Chronic Pain Management Training Team Program.

Section 102(c) would require each VA medical facility to identify and designate a pain management team of health care professionals responsible for coordinating and overseeing therapy at the facility for patients experiencing acute and chronic pain that is not related to cancer. Each VISN Director would be responsible for establishing protocols for the designation of a pain management team at each VA medical facility in the VISN, and the protocols would need to ensure that any health care provider without expertise in prescribing analgesics or who has not completed required training not prescribe opioids, with limited exceptions. Within 1 year of enactment of this Act, each VA medical facility would be required to submit to the VISN Director a report identifying the health care professionals that have been designated as members of the pain management team at the facility.

Section 102(d) would require, within 18 months of the date of the enactment of the Act, that VA provide for real time tracking and access to data on the use of opioids and prescribing practices. VA also would be required to ensure access by VA health care providers to information on controlled substances prescribed by community providers through State prescription drug monitoring programs. Within 180 days of the enactment of this Act, VA would be required to submit to Congress a report on the implementation of these improvements.

Section 102(e) would require VA to increase the availability of opioid receptor antagonists, such as naloxone, to veterans and for use by VA health care providers treating Veterans. Within 90 days of enactment of this Act, VA would be required to equip each VA medical facility with opioid receptor antagonists approved by FDA. VA notes that other opioid receptor antagonists approved by FDA exist, but only one type (naloxone) is approved for overdose reversal. This section also directs VA to enhance training of providers on distributing such antagonists, and to expand the Overdose Education and Naloxone Distribution program to ensure all Veterans in receipt of health care who are at risk of opioid overdose (as defined by the bill) have access to opioid receptor antagonists and training on their proper administration. Within 120 days of the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on compliance with this requirement.

Section 102(f) would require that VA include in the Opioid Therapy Risk Report tool information on the most recent time the tool was accessed by a VA health care provider with respect to each Veteran and information on the results of the most recent urine drug test for each Veteran. VA would also be required to determine if a provider prescribed opioids without checking the information in this tool first.

Section 102(g) would require VA to modify VA's Computerized Patient Record System (CPRS) to ensure that any health care provider that accesses the record of a Veteran will be immediately notified whether the Veteran is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose, has a history of opioid abuse, or is at risk of becoming an opioid abuser.

VA agrees that additional training for providers is necessary. Clinicians want to help Veterans and Servicemembers, but often do not have the skills and resources to do so. A well-trained physician and clinical team will know how to evaluate comprehensively a patient with pain, including making clinical diagnoses and how to develop a goal oriented management plan for pain, as well as how to engage the particular resource needs of each patient. Regarding other parts of section 102, VA is currently taking steps to fulfill the intent of many of these provisions. For example, section 102(e) would require VA to increase the availability of opioid receptor antagonists approved by the FDA, and VA is currently exploring ways to increase the availability of these life-saving medications. Similarly, section 102(g) would require VA to modify the Computerized Patient Record System to ensure providers will be immediately notified about opioid risks for each patient. VA's electronic

health record already has real-time mechanisms in place to alert VA health care providers of existing opioid prescriptions to prevent prescribing of additional opioids to Veterans who receive all their healthcare and prescriptions through the VA system. These mechanisms include real-time order checks that alert providers of prescriptions with potential problems with duplication, drug interactions, and doses in excess of the maximum recommended amount. In some facilities, VA health care providers also can check the State Prescription Drug Monitoring program databases to determine if a Veteran has an opioid prescription outside of VA.

Section 103 would establish within the VA-DOD Joint Executive Committee (JEC) a working group on pain management and opioid therapy for individuals receiving health care from either VA or DOD. The working group would cover the prescribing practices of health care providers in both Departments, the ability of each Department to manage acute and chronic pain, the use of complementary and integrative health in treating such individuals, the concurrent use of opioids and prescription drugs to treat mental health disorders, the practice of prescribing opioids, the coordination in coverage and consistent access to medications for patients receiving care from VA and DOD, and the ability of each Department to identify and treat substance use disorders. The working group would be required to coordinate with other working groups established under 38 U.S.C. 320, consult with other Federal agencies, and review and comment on the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain. The Secretaries of VA and DOD would be required to jointly ensure that the working group is able to consult meaningfully with respect to the updated guideline required by section 101 of this bill within 1 year of the date of the enactment of this Act.

As noted previously, the VA-DOD HEC already has a pain management work group, so to that extent, we think VA and DOD are already meeting the intent of section 103.

Section 104 would add a new section 7309A to title 38, which would require VA to establish in each VISN a Pain Management Board. These Boards would have a series of defined duties, including consulting with health care professionals and other VA employees in the VISN about resources and best practices for pain management, overseeing compliance and providing oversight of professionals using pain management practices, and carrying out educational forums and public hearings on best practices on pain management. The Boards would be able to provide treatment recommendations for patients in some situations. Each Board would be required to submit an annual report to the Under Secretary for Health on pain management practices within the VISN and recommended best practices. VA would be required to submit an annual report to Congress that contains comprehensive information from the reports submitted by the Boards.

VA appreciates the intent of this provision, but is concerned that the time it would take to participate in this admittedly very important activity would be time these professionals are not able to furnish direct clinical care and treat patients. In particular, the clinicians who would be best qualified to serve on such boards are also those likely to be treating the most complex patients. If additional resources were available to ensure that patient care would not suffer as a result of implementing these Boards, this concern would be alleviated. We note that the bill is unclear in terms of the appointment of non-Federal employees to the Pain Management Boards and the implications of such appointments under other laws.

Section 105 would require VA to conduct a study on the feasibility and advisability of carrying out a pharmacy lock-in program under which veterans at risk for abuse of prescription drugs would be permitted to receive prescription drugs only from certain specified VA pharmacies. VA would be required to report to the Committees on Veterans' Affairs within 1 year on this study.

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

Section 106 would require the Comptroller General, within 2 years of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs, a report on the Opioid Safety Initiative and the opioid prescribing practices of VA health care professionals. The report would include recommendations for improvement, and VA would be required to report to the Committees on Veterans' Affairs on a quarterly basis on the actions taken by VA to address any outstanding findings and recommendations from the Comptroller General.

We defer to GAO on this provision.

Section 106 would also require VA to conduct an annual report and investigation on opioid therapy, and to submit this report to the Committees on Veterans' Affairs. This report would include information on patient populations and prescribing patterns for opioids. Facilities that are among the top 10 percent in prescription rates would be subject to a full investigation by the Office of the Medical Inspector, and

VA would be required to notify the Committees on Veterans' Affairs and the senators and representatives from the area in which the facility is located.

Section 204 would require the Comptroller General to submit to the Committees on Veterans' Affairs a report on VA's Patient Advocacy Program, including recommendations and proposals for modifying the program and other information the Comptroller General considers appropriate.

We defer to GAO on this provision.

Section 205 would require VA, within 180 days of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs a report on the transitions undergone by Veterans in receiving health care in different health care settings. The report would have to include an evaluation of VA's standards for facilitating and managing the transitions undergone by veterans in receiving health care in different settings, an assessment of the case management services that are available, an assessments of the coordination in coverage of and consistent access to medications, and such recommendations to improve transitions, including coordination of drug formularies between VA and DOD.

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

Section 403 would require, within 2 years of the date of the enactment of this Act, VA to submit a report on its compliance with VA's policy to conduct a review of each health care provider who transfers to another VA medical facility or leaves VA to determine whether there are any concerns, complaints, or allegations of violations relating to the medical practice of the health care provider, and to take appropriate action with respect to any such concern, complaint, or allegation.

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

Section 501 would add a new section 527A to title 38 requiring VA to carry out a program of internal audits and self-analysis to improve the furnishing of benefits and health care to veterans and their families. The Secretary would be required to establish an office within the Office of the Secretary to carry out these audits. The office would conduct periodic risk assessments, develop plans in response to these assessments, and conduct internal audits. At least five covered administrations, staff organizations, or staff offices would have to be audited each year. Within 90 days of completing an audit, the Secretary would be required to submit to Committees on Veterans' Affairs, the House Committee on Oversight and Government Reform, and the Senate Committee on Homeland Security and Government Affairs a report on the audit. The first audit would have to be completed within 180 days of the date of the enactment of this Act.

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

Overall, VA understands the bill is a well-intentioned effort to combat a national public health problem, as outlined in a 2011 study by the Institute of Medicine (IOM).

DEPARTMENT OF VETERANS AFFAIRS,
Washington, DC, September 4, 2015.

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

DEAR MR. CHAIRMAN: The agenda for the Senate Committee on Veterans' Affairs' June 3, 2015, and June 24, 2015, legislative hearings included a number of bills that the Department of Veterans Affairs (VA) was unable to address in our testimony or in our prior correspondence with you on July 15, 2015. By this letter, we are providing the final remaining views and cost estimates on the following bills from the June 3, 2015, legislative hearing: sections 2 and 4 of S. 297, the Frontlines to Lifelines Act of 2015; the draft bill on establishing a joint VA-Department of Defense (DOD) formulary for systemic pain and psychiatric medications; and sections 2, 3, and 5 of the draft bill, Veterans Health Act of 2015.

We are also providing the final remaining views and cost estimates on the following bills from the June 24, 2015, legislative hearing: sections 203, 208, and 209(b) of S. 469, Women Veterans and Families Health Services Act of 2015; sections 4(b) and 8 of S. 1085, Military and Veteran Caregiver Services Improvement Act of 2015; and sections 105, 205, 403, and 501 of the Jason Simcakoski Memorial Opioid Safety Act.

We appreciate this opportunity to comment on this legislation and look forward to working with you and the other Committee Members on these important legislative issues.

Sincerely,

ROBERT A. MCDONALD,
Secretary.

Enclosure.

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JUNE 24, 2015, AGENDA

S. 469, WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

Section 203 would add a new section 1789 to title 38 authorizing the Secretary to pay to assist a covered Veteran in the adoption of one or more children. Covered Veterans would include any severely wounded, ill, or injured Veteran who has an infertility condition incurred or aggravated in the line of duty and who is enrolled in VA's health care system. VA would be limited to paying an amount equal to the cost to the Department of paying the expenses of three adoptions by covered Veterans, as determined by the Secretary.

VA understands the intent of this provision, and VA's goal is to restore to the greatest extent possible the physical and mental capabilities of Veterans and improve the quality of their lives and that of their families, and adoption would be a means to that end. However, we note that payment for adoption services raises a host of issues regarding differing state laws, as well as complications from administering what would be a non-medical benefit. As a result, VA cannot offer support for this provision. We would also note that additional funds would be necessary to support adoption services.

Section 208 of S. 469 would modify the pilot program on counseling in retreat settings for women Veterans newly separated from service in the Armed Forces by increasing the number of locations from 3 to 14 and by extending the duration of the program another 3 years through calendar year 2018. It would also authorize such sums as may be necessary to be appropriated to support the program for fiscal years 2016–2018.

VA supports the intent of section 208, conditioned on the availability of additional resources to implement this provision. VA is currently in the final year of a pilot program consisting of three retreats per year to determine the feasibility and advisability of such retreats. Since June 2011, a total of eight retreats were conducted for women Veterans. One more is planned for November 2015. These retreats focus on building trust and developing peer support for the participants in a therapeutic environment. Data have shown that those who participated in these retreats were able to increase their coping abilities and decrease their symptoms associated with Post Traumatic Stress Disorder (PTSD). VA is expecting similar results for those who participated in the retreats in 2015.

While VA agrees that providing these retreats is beneficial to women Veterans, other Veteran and Servicemember cohorts could also benefit from this treatment modality, conditioned on the availability of the additional resources needed to implement these additional services. VA recommends that legislative language be amended to provide permanent authority and allow VA the ability to conduct these retreats for all Veteran or Servicemember cohorts eligible for Vet Center services. Examples include those who have experienced military sexual trauma, Veterans and their families, and families who experience the death of a loved one while on active duty. VA estimates the total cost of the bill for fiscal years 2016–2018 would be $1.1 million. We note that additional funds would be necessary to support the extension of this program.

Section 209(b) would require VA to carry out a program to provide child care assistance for certain Veterans receiving readjustment counseling and related mental health services at Vet Centers. VA would be required to carry out this program in not fewer than three Readjustment Counseling Service Regions selected by the Secretary.

VA appreciates the goal of section 209(b) and notes that additional resources would be required to carry out this program. Some Veterans who use Vet Center services, especially those who have served in Iraq or Afghanistan, have voiced concern that a lack of child care has affected their ability to use Vet Center services consistently. Although Vet Center staff continue to search for new initiatives to increase Veteran access to services, VA has concerns about implementing child care assistance under section 209(b) without the opportunity to pilot this type of benefit.

A pilot program is needed because VA is currently unable to predict utilization of this type of assistance within the Vet Center program. Comparisons to medical center pilots are not useful because Vet Centers provide services during non-traditional hours, including before and after normal business hours and on weekends. This inability to predict utilization affects VA's ability to budget for the program appropriately. VA recommends that if Congress desires to provide this authority, it consider authorizing a pilot program in five Readjustment Counseling Service Regions to determine the feasibility, advisability, and costs of providing child care assistance to Veterans who utilize Vet Center services.

The child care program requirements would generally be the same as the requirements for the current child care pilot program, with several notable exceptions. First, VA would be limited to assisting qualified Veterans with child care only during the period that the qualified Veteran is receiving readjustment counseling and related health care services at a Vet Center but not the time to travel to and from the Vet Center. VA is unsure if this is an accidental omission but believes this limitation could significantly limit the effect of this authority. Second, under this provision, VA would not be authorized to directly provide child care services as an acceptable form of child care assistance. This omission is potentially troublesome in light of the first concern we raised, because if VA cannot directly provide child care assistance but also cannot provide child care during the travel time to and from the appointment, there would be at least some amount of time when either the Veteran would be liable for the cost of child care services or the Veteran's child could not receive such services. We would also note that additional funds would be necessary to support program.

VA is unable to determine the cost of this provision at this time because it is unknown which locations would be selected or how many Veterans would participate in the program.

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

Section 4(b) of S. 1085 would amend 37 U.S.C. 439 by requiring VA to provide family caregivers of a Servicemember in receipt of monthly special compensation assistance under 37 U.S.C. 439(a) the assistance that is currently provided to family caregivers of eligible Veterans under 38 U.S.C. 1720G(a)(3)(A), other than the monthly caregiver stipend. VA would provide assistance under this subsection in accordance with a memorandum of understanding (MOU) between VA and DOD and an MOU between VA and the Secretary of Homeland Security.

VA does not support section 4(b). DOD already provides many of the services and supports available under VA's Program of Comprehensive Assistance for Family Caregivers including health care coverage, mental health services, and respite care. Requiring VA to furnish these services as well would result in a duplication of benefits.

Section 8(a) would require VA to conduct a longitudinal study on Servicemembers who began their service after September 11, 2001. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. Within 1 year of the date of the enactment of the Act, VA would be required to submit to the Committees on Veterans' Affairs a plan for the conduct of the study. Not later than October 1, 2019, and not less frequently than once every 4 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of the study. Section 8(b) would require VA to provide for the conduct of a comprehensive study on Veterans who have incurred a serious injury or illness and individuals who are acting as caregivers for Veterans. VA would be required to award a grant to or enter into a contract with an appropriate entity unaffiliated with VA to conduct the study. The study would be required to include the health of the Veteran and the impact of the caregiver on the health of the Veteran; the employment status of the Veteran and the impact of the caregiver on that status; the financial status and needs of the Veteran; the use by the Veteran of VA benefits; and any other information VA considers appropriate. Not later than 2 years after the date of the enactment of this Act, VA would be required to submit to the Committees on Veterans' Affairs a report on the results of this study.

We do not believe this section is necessary. Currently, VA researchers are seeking new ways to address the mental health issues of Iraq and Afghanistan Veterans, including PTSD. They are also researching Traumatic Brain Injury (TBI) and its treatment and are developing and testing prostheses that will allow Veterans with amputations or other issues to live as independently as possible. One major effort is the Marine Resiliency Study (MRS), involving some 2,600 Marines who deployed to Iraq and Afghanistan. Beginning in 2008, the research team conducted clinical

interviews on Marine bases and collected psychological, social, and biological data before deployment and then multiple times after deployment. Researchers are analyzing the data to identify risk and resilience factors for combat-related PTSD. The team recently published two articles in *JAMA Psychiatry*. One shows deployment-related brain injury to be a significant risk factor for PTSD. Another implicates high levels of inflammation in the body as a PTSD risk factor. VA is also conducting a longitudinal study of the neuropsychological and mental outcomes of Veterans of the Iraq war (CSP #566). VA will soon have large datasets to characterize health status and changes over time for Vietnam, Iraq, and Afghanistan Veterans, which will be a rich resource for researchers.

In addition, VA researchers are already studying the impact of caregivers on the health of Veterans. For example, one recently initiated randomized study is examining the effectiveness of an innovative caregiver skills training program and whether it can help Veterans to have increased days at home, reduced total health care costs, and higher satisfaction with VHA health care compared to Veterans in usual care; it will also examine if caregivers in the program have lower depressive symptoms than caregivers who do not receive the training. Another ongoing project is studying an intervention aimed at dementia patients with pain, assessing whether it decreases incidence of aggression, pain, caregiver burden, injuries, use of antipsychotic medication, and nursing home use. Another study is seeking to understand better how war-related psychiatric symptoms of Operation Enduring Freedom/Operation Iraqi Freedom Veterans may interfere with family reintegration and negatively affect family functioning; this study is testing whether difficulties with family reintegration account for the impact of psychiatric symptoms on overall family functioning over time. Another current study is examining whether a brief, inexpensive intervention to foster end-of-life preparation and completion improves quality of life and health utilization for Veterans with serious illness and improves outcomes for caregivers of these Veterans at the end of life.

Additionally, VA works closely with other Federal research agencies to ensure effective use of scarce taxpayer resources in executing its research mission. We carry out joint programmatic reviews with DOD and NIH to ensure that our research efforts are complementary and not duplicative. Under the auspices of the President's National Research Action Plan, VA has worked with DOD to create two research consortia for TBI and PTSD, at a combined investment of $107 million over 5 years. This tight coordination has become routine for all three agencies, with benefits that accrue to Veterans and the American public at large.

DRAFT BILL, THE JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

Section 105 would require VA to conduct a study on the feasibility and advisability of carrying out a pharmacy lock-in program under which Veterans at risk for abuse of prescription drugs would be permitted to receive prescription drugs only from certain specified VA pharmacies. VA would be required to report to the Committees on Veterans' Affairs within 1 year on this study.

VA has numerous concerns with section 105. We believe a pharmacy lock-in program, under which Veterans at risk for abuse of prescription drugs are permitted to receive prescription drugs only from certain specified VA pharmacies, will lead to negative patient outcomes. For example, Veterans who are traveling or require emergent/urgent medical care from a VA facility may need to receive a prescription from another VA facility's pharmacy to treat the Veteran's emergent/urgent condition. The pharmacy lock-in program would prevent medically-necessary drugs from being dispensed to Veterans. VA health care providers receive duplicate order checks from other VA facilities at the point of prescribing. These duplicate order checks would notify the provider and pharmacist in real-time that the Veteran is receiving similar medications at another VA facility. Therefore we do not believe a study on a pharmacy lock-in program would yield useful information.

Section 205 would require VA, within 180 days of the date of the enactment of this Act, to submit to the Committees on Veterans' Affairs a report on the transitions undergone by Veterans in receiving health care in different health care settings. The report would have to include an evaluation of VA's standards for facilitating and managing the transitions undergone by Veterans in receiving health care in different settings, an assessment of the case management services that are available, an assessments of the coordination in coverage of and consistent access to medications, and such recommendations to improve transitions, including coordination of drug formularies between VA and DOD.

VA does not support Section 205 because its requirements would duplicate multiple GAO investigations regarding the health care transition of Servicemembers and Veterans, most notably a November 2012 report, *Recovering Servicemembers*

and Veterans: Sustained Leadership Attention and Systematic Oversight Needed to Resolve Persistent Problems Affecting Care and Benefits. In response, DOD and VA are enhancing care coordination and case management to improve transitions across health care settings, including the development of an Interagency Comprehensive Plan for Servicemembers and Veterans requiring complex care coordination as well as a Lead Coordinator to align and standardize care coordination processes, roles, and responsibilities and to reduce confusion, duplication, and frustration.

In addition, GAO is currently conducting a study, *Engagement on Care Transitions and Medication Management for Post-Traumatic Stress Disorder and Traumatic Brain Injury* (GAO code 291282). GAO is interviewing DOD and VA officials, as well as staff in the field. Thus far, GAO has conducted interviews at the Washington, DC VA Medical Center, at Fort Hood, Texas, and at Fort Carson, Colorado. VA looks forward to their objective, third-party assessment.

Section 403 would require VA, within 2 years of the date of the enactment of this Act, to submit a report on its compliance with VA's policy to conduct a review of each health care provider who transfers to another VA medical facility or leaves VA to determine whether there are any concerns, complaints, or allegations of violations relating to the medical practice of the health care provider and to take appropriate action with respect to any such concern, complaint, or allegation.

VA does not support section 403 because reporting systems are already in place. VA has broad authority to report employed or separated health care professionals to state licensing boards when their behavior or clinical practice so substantially failed to meet generally accepted standards of clinical practice as to raise reasonable concern for the safety of patients. VA medical facility Directors are required to ensure that a review is conducted of the clinical practice of a licensed health care professional who leaves VA employment or when information is received suggesting that a current employee's clinical practice has met the reporting standard. VA has established a comprehensive quality assurance program for reporting any licensed health care professional to state licensing boards who was fired or resigned following the completion of a disciplinary action relating to such professional's clinical competence, resigned after having had such professional's clinical privileges restricted or revoked, or resigned after serious concerns about such professional's clinical competence had been raised but not resolved. When a report is made to a state licensing board, a copy of that letter is also forwarded to VA Central Office. VA would be happy to provide this information upon request, but we do not believe a statutory requirement to submit this information is warranted.

Section 501 would add a new section 527A to title 38 requiring VA to carry out a program of internal audits and self-analysis to improve the furnishing of benefits and health care to Veterans and their families. The Secretary would be required to establish an office within the Office of the Secretary to carry out these audits. The office would conduct periodic risk assessments, develop plans in response to these assessments, and conduct internal audits. At least five covered administrations, staff organizations, or staff offices would have to be audited each year. Within 90 days of completing an audit, the Secretary would be required to submit to the Committees on Veterans' Affairs, the House Committee on Oversight and Government Reform, and the Senate Committee on Homeland Security and Governmental Affairs a report on the audit. The first audit would have to be completed within 180 days of the date of the enactment of this Act.

VA understands the intent of this section, but is concerned about creating an entirely new structure that would in essence duplicate efforts of other organizations, such as the Inspector General or the Office of the Medical Inspector. We are also concerned that legislation directing VA to create certain offices or functions could produce conflict with the Department-wide restructuring effort underway through the MyVA initiative. VA recommends against further consideration of this section until VA's MyVA restructuring plans are more advanced so we can ensure that any new offices and functions are properly aligned and do not overlap with the missions of other organizations.

Chairman ISAKSON. Thank you, Dr. Jain.

I will start the questioning. Would you please explain to me—I scanned the testimony quickly, so if I missed it, I apologize—but would you please explain to me—and Senator Johnson, you might wait 1 second, if you do not mind—would you explain to me what your reluctance is in terms of the unintended consequence of S. 1117?

Dr. JAIN. Sir, let me start, and then I will turn to Cathy in a second here. I think the big concern we have—we certainly understand that we need to do a better job in accountability, so no question about that. But, part of our concern is that the bills as they are structured would make it harder for us to recruit the type of quality people that we need as senior managers in the VA. And, I can tell you from being in the VA for a number of years, it is already having a—I hate to say this—a chilling effect on many of our senior administrative-type people who would want to become an SES, a director, an associate director, or a chief of staff tomorrow. They see all of what is going on. It really gives them cause for concern so they really do not want to step up to those roles.

So, I think we want to find a way where we could retain the best, hold people accountable, no question about that, but find a way to go forward.

Chairman ISAKSON. Well, let me pose this question as succinctly as I can. Your legal counsel may want to be the person to respond to this. But, I cannot for the life of me comprehend a recruiting problem if the reasons for dismissal or removal are for a cause that is clearly defined. I can recognize if it is a vague term, where somebody might say, well, I do not want to take the risk of losing my job because somebody on a whim is going to fire me.

But, I ran a company, and I know Senator Johnson ran a company, and others have, as well, and accountability is the essence of making an organization work in a timely fashion, whether it is a rifle platoon in the U.S. Army, a cup manufacturer in Wisconsin, or whether it is a real estate brokerage in Georgia.

And, I cannot understand—what I want to ask Senator Johnson to maybe comment on this after the answer from Dr. Jain—if we define what "cause" is in terms of the discipline, and it was clearly things like insubordination, over-prescription of opioids, not following through on mental health appointments for somebody who commits—things that are definitively, obviously breaches of the duty and responsibility, would you still have a fear of having accountability provisions in the VA code?

Dr. JAIN. No, sir, I will not, but let me turn to Cathy.

Ms. MITRANO. Thank you, sir. I think what you have pointed out there is exactly one of our concerns, is that the bill as currently structured does not require any type of written notice at all for employees as to the cause for their removal. They can be removed, basically, without any type of notice or an opportunity to respond. Sometimes that is very critical to all of our employees, that opportunity to respond. Many times, that is when we identify for the first time that maybe there are mitigating factors in the misconduct or maybe even the facts surrounding the misconduct or lack of performance were not fully developed.

So, I do think what you are proposing right now, if worked into the requirements of the legislation, would be a very positive factor that would, as you put it, make us less reluctant to endorse such a procedure. But right now, as currently written, we do not see that in there.

Chairman ISAKSON. Well, and I am not trying to meddle in Senator Johnson's legislation in the least, and I am going to get you to respond in just a second, but it would seem to me like, given the

problems that we have had at Tomah and a lot of other places, and the fact that we have moved 700 people laterally with pay and only fired one who was upheld in court, which was a lady who had broken the illegal gratuity law. It was not the reason we fired them.

And, it is time we had a situation of accountability in the VA that worked, and I would hope the VA—you can talk to Secretary McDonald and Sloan Gibson—but there ought to be a list of things that are clear cause, that could be delineated clearly in an accountability act, that would not be a deterrent to any morally sound person wanting to come to work for the VA, but would be a deterrent to somebody who did not want to be held accountable.

Senator Johnson.

Senator JOHNSON. Well, thanks, Senator Isakson.

Let us first acknowledge, I think the vast majority of people working in the VA are incredibly dedicated, professional, doing everything they can to honor the promises to the finest among them. I think that is just true.

What my bill is addressing is we have made it a little bit easier to terminate bad apples at the SES-level category, but we are seeing in terms of the caregivers themselves, the doctors and nurses, we have to hold them accountable also.

Now, I have been involved in business management for 31 years. I do not think there is anything more corrosive to the morale of an organization than if bad actors just continue to be able to conduct themselves in an inappropriate manner. So, what I have found in business is the good employees wanted the bad employees terminated. They wanted people held accountable, so long-term, there is nothing more corrosive to an organization than allowing bad actors to continue to be employed. That destroys an organization.

So, all my bill is trying to do is provide accountability, give the VA the tools to remove truly those people that are not honoring the promises, that are the bad actors that need to be held accountable.

Thank you, Mr. Chairman.

Chairman ISAKSON. To that end, my message to the VA is this. If I were the VA—so you clearly understand the attitude of this Committee—I would be working with the authors of accountability bills to try and come up with language that does not cause concern. The better the specificity in terms of the discipline, the better the concern can be enforced. I think Senator Johnson is on the right track there.

I understand that too vague, undisciplined, amd broad brush approaches could cause a problem. But, we have had too many instances of situations that really should not be tolerated, where if there was an ability to have an accountability system with the VA, I think it would help the VA, it would help the veterans, and it would help all of you.

Senator JOHNSON. Mr. Chairman, let me say, I am happy to work with the VA to structure the bill that maintains high morale and high quality health care for our veterans.

Chairman ISAKSON. Thank you.

Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman.

Dr. Jain, I take it from your non-response that you would be willing to work with the Committee in devising some language that might meet the concerns that you have expressed.

Dr. JAIN. Yes, Senator.

Senator BLUMENTHAL. And you are in favor of that goal of accountability?

Dr. JAIN. I think I am in favor of the goal of accountability. I think that——

Senator BLUMENTHAL. Well, you think you are in favor of it?

Dr. JAIN. No, no, I am. There is no question about that. I guess my only hesitation is we need to just work together to work out the language——

Senator BLUMENTHAL. Well, we are all in favor of working together——

Dr. JAIN. Right.

Senator BLUMENTHAL [continuing]. But I strongly support heightening and intensifying accountability within the VA. This need was plainly apparent as a need in the wake of crises just a year ago, the revelations about wait times and cooking the books and culpability, which in my view still have not been adequately addressed in terms of discipline. So, I would recommend that you do work with the Committee.

Doctor, I am actually surprised by your testimony opposing the bill that Senator Moran and I have offered relating to toxic exposures. I am surprised, because you say that this work is already being done by other agencies, and your written testimony talks about duplicate work already being done by the National Institute of Environmental Health Sciences, the Agency for Toxic Substances and Disease Registry, and other non-government agencies.

Is that sufficient reason, in your view, to oppose establishing a center that would focus on the effects of toxic exposures on veterans and their families and the children and grandchildren who come after them?

Dr. JAIN. Thank you, Senator, for that question. Let me state that we are committed to working with the other departments and agencies to ensure that the veterans exposed to toxic substances receive the best possible care and benefits. So, to the extent that the bill supports the research and those aspects, I think that those are certainly consistent with what we are——

Senator BLUMENTHAL. I understand your willingness to work with other agencies, but why are you abrogating and refusing responsibility to protect veterans? That is your job.

Dr. JAIN. We are not, Senator. I think what we are saying——

Senator BLUMENTHAL. Well, the legislation gives you that responsibility and obligation to take ownership, in effect, for addressing this problem. It is veterans who are affected. There is no agency, none, whose exclusive or even primary responsibility is to address this problem, would you not agree?

Dr. JAIN. I would agree with that, Senator. I think the difference is that the legislation asks that there be a center created. We are already—we already have a center. We have the War-Related Injury and Illness Centers that do a lot of research in this area. So, part of our position is that creating another center would not necessarily add anything to that. That is, I think, part of the concern.

The other part of the concern is that in the legislation, as proposed, there is discussion about clinical care to be provided, and we do not have the evidence at the present time. If you look at the literature, the evidence——

Senator BLUMENTHAL. Well, it is really a catch–22. If you do not do the research——

Dr. JAIN. I understand.

Senator BLUMENTHAL [continuing]. You will not have the evidence. If you do not have an agency responsible for doing the research, it will not be done, because the National Institute of Environmental Health Science and the Agency for Toxic Substance and Disease Registry, with all due respect to them—they may be doing great work—have a lot of other issues they want to address. This one has been ignored and neglected and disregarded which is the reason that we do not have the evidence to support the clinical treatment. Do you disagree?

Dr. JAIN. No, I do not disagree with that, sir. I think the only issue is, you know, do we let—I think if there is a way to get there where we can collaborate with these agencies, we have a process either through legislation or through other processes that we can be more focused on doing that kind of work, I think is the key. Now, whether creating a center and a board gets us there, or perhaps there is another mechanism, I think that may make some difference.

Senator BLUMENTHAL. My time has expired, but the word "collaboration" bothers me when it comes to a problem this urgent that has been neglected and I think there ought to be a center that can be held accountable.

Thank you, Mr. Chairman.

Chairman ISAKSON. Senator Rounds.

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

Senator ROUNDS. Thank you, Mr. Chairman.

Dr. Jain, I am just curious. You mentioned your multi-pronged approach to opiate safety. We have not really gone into that, so I would like to have you explain a little bit about where that is. It would appear that we have got folks that have come here in support of changing what is going on because, clearly, there is a need. I would love to have you just take a few minutes to explain to us just what you mean by your existing multi-pronged approach.

Dr. JAIN. Thank you, Senator, for that question. So, for example, we in the VA now have published VA/DOD guidelines for management of pain. We also have a system where there is a facility pain management team, and there is also a network or a VISN lead for pain management.

A lot of Senator Baldwin's bill about the board, about having a joint work group with the Department of Defense, those are activities that are presently going on. What we like about Senator Baldwin's bill is that it further enhances what is currently ongoing in the VA and makes it more focused, more concentrated. So, I think there are lots of parts of the bill that we already have in place.

Senator ROUNDS. What went wrong with the existing program that requires and has clearly caused the loss of life and clearly has

become an item which this Committee finds itself very concerned about? What went wrong with your existing program?

Dr. JAIN. So, as we look at the existing programs, we do believe there needs to be a stronger monitoring of the prescriptions by our providers. We also feel that the participation with the State Prescription Monitoring Program can be strengthened. We have some of that now. But, I think in the bill, there is a stronger provision for doing that, including getting the information back to the VA on an ongoing basis, which is a positive part of the bill.

So, I think we see pieces of what we have, but clearly, the unfortunate incident in Tomah and other experiences are really showing us that we need to do a lot more. We are willing to do more and we need to do more. We recognize that and we are going to move forward. Certainly, the legislation could help us in that direction, but we are certainly taking the steps to go forward with that.

Senator ROUNDS. Even if you discover using the new tools available within the bill, even if you discover the individuals responsible for the over-prescribing, systems in which they are failing now to catch it, what do you do about it? What is your tool? How do you fix it once you have found it? And, you will find it. What do you do then?

Dr. JAIN. Well, we normally have at least two different processes. One would be our standard process of peer review in which we would then have the peer review done, and if the provider is discovered to be over-prescribing the narcotics, then you have the tools available.

When I was chief of staff in Pittsburgh or when I was in Salem, I would work with the clinicians then—I mean, there are a lot of options. You can start with education. You can take disciplinary actions. You can do other types of—if you have evidence that is, indeed, based on the peer review, that the practice is not consistent with the community standard, then we do have tools available to work with them.

Senator ROUNDS. Let me ask, about how many peer reviews for this type of activity do you believe have been accomplished over the last, whatever number you want to use, 1 year, 2 years, 3 years? How many peer reviews have actually been done?

Dr. JAIN. I do not have access to that, Senator——

Senator ROUNDS. Could you get that for me? Is it available?

Dr. JAIN. We can certainly try to see if we can get that data.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MIKE ROUNDS TO DR. RAJIV JAIN, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. Twenty-five peer reviews for quality management were conducted in April 2015 for a single VHA facility related to opioid prescribing. The peer review for the quality management process is a quality assurance activity. As such, there would not have been any disciplinary actions issued in conjunction with the peer review.

Senator ROUNDS. I would like to see that, because what we are hearing here is that if you are doing peer reviews, the next question is if you find the problems, what do you do to fix them, and you have suggested that you have the disciplinary capabilities today. Could you also get me or get the Committee the actual dis-

ciplinary actions that have occurred so far, whether it be in a 1-year period, 2-year period, or 3-year period of time?

Dr. JAIN. Senator, yes, sir, we will.

Senator ROUNDS. OK. You do not have that available today, by any chance?

Dr. JAIN. No, sir, I do not.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. MIKE ROUNDS TO DR. RAJIV JAIN, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. No disciplinary actions were initiated as a result of these reviews. Peer Review for Quality Management is a 5705 protected (quality assurance) process, and as such, administrative actions are not applicable. For additional information please see VHA Directive 2010–025—*Peer Review for Quality Management*. Administrative actions, such as, summary suspension of privileges, could be initiated based on clinical findings from the Ongoing Professional Practice Evaluation and Focused Professional Practice Evaluation process, or if there were executive concerns that warranted initiation of management reviews. The findings from a management review would determine if formal disciplinary action was warranted.

Senator ROUNDS. OK. It would appear to me that what Senator Johnson has proposed here has been designed to be able to make it more—it would provide the Department with more capabilities to actually take care of the problems that clearly exist. And I would most certainly second what the Chairman has suggested, which is that you find a way to come forward with a plan that clearly will take care of those individuals who have not been following the existing guidelines already in place with regard to opiate distributions that are clearly occurring right now.

Dr. JAIN. Yes, sir.

Senator ROUNDS. Thank you. Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Rounds.

We will go in the following order: Senators Manchin, Cassidy, Sullivan, and Boozman.

Senator Manchin.

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

Senator MANCHIN. Thank you, Mr. Chairman. I was just talking to the sponsor here and seeing if she had anything that she wanted me to follow up on.

Chairman ISAKSON. You will be a good surrogate, I am sure. [Laughter.]

Senator MANCHIN. First of all, Doctor, I have been very much concerned about this. While I think in every part of the country we are concerned, West Virginia has been hit very hard by opiates, as you know——

Dr. JAIN. Yes, sir.

Senator MANCHIN [continuing]. Number 1 killer in my State, prescription drugs. So, I started getting very interested in finding out why we have such a high unemployment rate with our veterans. Once I looked into it further, I discovered they could not pass drug tests. That was the biggest problem that we had. So, where are they getting it, why were they getting it, and how come so much has been prescribed? Why were alternatives not being used?

I talked to Secretary McDonald and I believe that if VA, Medicaid, and Medicare, the three providers where we have some input

as Congress and we pay for as taxpayers, basically did not go to prescribing opiates first, but as a last resort versus prescribing opiates on the front end, it would make such a difference. And, the Secretary has told me that he is committed to trying, basically, the alternatives.

In my State, I do not have alternatives. They do not even offer an alternative to opiates. Are you trying it, where you have said, absolutely—or could you, or do you need us to have legislation to move you in that direction? So, I am understanding it could be anywhere from acupuncture to equine to all these different things. Secretary McDonald seemed to be very receptive, but no one is practicing them. They are still going to the easiest front line defense, which is prescribing opiates.

Dr. JAIN. Thank you, Senator, for that question. So, let me try to respond to that. I think your point is very well taken. There are some alternatives to opiates in management of chronic pain, and you mentioned some of them—acupuncture, chiropractors, massage therapy, and other types of relaxation therapies.

I think part of the challenge as a large system that we are trying to balance is that you have to balance the regulatory meaning, licensing, and other types of authorities to hire the chiropractors—chiropractors are not an issue. You can hire them now. The issue with acupuncturists, for example, we just recently passed some regulation to be able to look at the qualification standards, so we will very soon be able to hire acupuncturists.

So, I think we are just going one step at a time to offer these options——

Senator MANCHIN. Well, I am not saying that the VA has to.

Dr. JAIN. Right.

Senator MANCHIN. If the person, basically, is prescribed this type of service——

Dr. JAIN. Right.

Senator MANCHIN [continuing]. Which is what the VA is going to pay for, you are paying for the pills. Why not pay for the service that would be needed that would not get them addicted?

Dr. JAIN. I think as a general rule, Senator, I mean, that is a good question and I can ask our legal folks to comment on that. You have to look at the standard of care, and if there is evidence for it and it is within the standard of care, then the VA, as a general rule, can pay for it, but do you want to comment on that, Jennifer?

Ms. GRAY. I think the——

Senator MANCHIN. Let me ask you, from a legal standpoint, do you all have guidelines for alternative services right now? Is there anything that you have developed within the VA?

Ms. GRAY. We have—do we not have the new committee that is working on——

Senator MANCHIN. But you have no—I do not think there is any——

Dr. JAIN. I do not think there is anything specific, Senator.

Senator MANCHIN. You do not have alternative guideline treatments?

Ms. GRAY. Not——

Dr. JAIN. No, sir.

Ms. GRAY. No, not specific——

Dr. JAIN. Not at the present time.

Senator MANCHIN. Are you developing them?

Dr. JAIN. Yes, sir, we are.

Senator MANCHIN. So, you are looking at different options.

Dr. JAIN. We are looking at the evidence maps for these alternate services. I think, as you indicated, the Secretary is very concerned about this issue. I know that a lot of the leadership is very concerned about this issue. So, I think we are now in the process of developing the evidence maps. That is just the first step, and then once the evidence map is together——

Senator MANCHIN. Let me ask one follow-up question, if I may, because my time is so—sorry, time is precious here. If this was 1960 or 1970, what would you have—the opioids were not there. What would you be doing then?

Dr. JAIN. I think you—well, the—you had—I do not know. I was not practicing back then——

Senator MANCHIN. I know, but I am just saying, we did not have all these concoctions.

Dr. JAIN. Right.

Senator MANCHIN. So, I am saying, all of a sudden now, because the pharmaceuticals are making——

Dr. JAIN. Yes.

Senator MANCHIN [continuing]. So many products on the market, and FDA seems to be approving everything they bring to the market. We have got to look at how did we become the most addicted nation on earth.

Dr. JAIN. I could not agree with you more, Senator. It is a very important issue to us and we are working on it.

Senator MANCHIN. But, from what we are saying as Senators here, elected officials——

Dr. JAIN. Yes.

Senator MANCHIN [continuing]. We have the ability through the VA, Medicaid, and Medicare to do something, and if we can set the culture going in a different direction——

Dr. JAIN. Yes, sir.

Senator MANCHIN [continuing]. Maybe we can set the country going in a different direction.

Dr. JAIN. Yes, sir.

Senator MANCHIN. But, if—you are not pushing back on that. If we continue to push you on alternative treatments and do different things that allow you to offer alternatives and help us develop some plans and regulations——

Dr. JAIN. Yes, sir. I think we can work together on that. We can also work with DOD on it, and we do. We already have a lot of joint work with them.

Senator MANCHIN. I am so sorry, my time is up, but thank you.

Chairman ISAKSON. Thank you, Senator Manchin.

Well, next, in order, will be Senators Cassidy, Murray, and Sullivan.

HON. BILL CASSIDY, U.S. SENATOR FROM LOUISIANNA

Senator CASSIDY. I will just make a point, Senator Manchin. I read an article, if I can find it, that oral opioids are not indicated

for chronic nonmalignant pain. So, if we are speaking of a standard of care, the standard of care is not to give oral opioids for non-cancer chronic pain. I say that as a physician.

Let me also weigh in on the Johnson bill. As a doctor, I agree totally. If I have a bad actor as a colleague physician, I would like that bad actor to be relieved of responsibility because it reflects poorly upon the care that is delivered at the institution. So, I would agree with Senator Isakson's point that we could have an accountability, a fair, due process——

Dr. JAIN. Yes.

Senator CASSIDY [continuing]. But people who are abusing their medical license should be released from the practice of which I am entertaining.

OK. Now to my real point. Dr. Jain, I assume that VA uses medical devices.

Dr. JAIN. Yes, sir.

Senator CASSIDY. And, I assume they use things like porcine or pig heart valves, correct?

Dr. JAIN. Yes, sir.

Senator CASSIDY. Non-human-based tissue, correct? The tracking system, and I assume that you will be compliant with the FDA's directive to have the tracking systems in place, the unique device identification rule, correct? You will be in compliance?

Dr. JAIN. Uh——

Senator CASSIDY. You plan to be in compliance with that.

Dr. JAIN. There is some new guidance that has just come out, Senator, that talking with our SMEs, we are now trying to put some systems in place to make sure that we are in compliance. So, this is an evolving field, the standards are evolving and changing and we are certainly trying to stay on top of that.

Senator CASSIDY. Now, according to the piece of literature I have from the American Association of Tissue Banks, after September 24, 2015, all labels and packages of devices produced (i.e. biological devices), must bear a unique device identifier.

Dr. JAIN. That is correct.

Senator CASSIDY. Now, I am told, and I have a letter confirming this, that of the three systems approved by the FDA, the VA plans to use the one—all these initials, but let me just suffice it to say, use the one that is only appropriate to use on human tissue products. And, I have a letter here from Dr. Clancy confirming it. But, you have already said that you use pig valves. Specifically, pig valves are not humans. It seems kind of self-evident, but I will make that point. [Laughter.]

So, if you are going to use a system which only tracks human tissue, how do you plan to comply with the FDA rule to have a unique device identification if you are using non-human tissue? That is my question, I suppose.

Dr. JAIN. Senator, I do not have that answer, but I will certainly look into that and will provide that answer for you.

Senator CASSIDY. Now, there is no answer. You are either going to get a waiver——

Dr. JAIN. Yes.

Senator CASSIDY [continuing]. Or you are going to be out of compliance. I mean——

Dr. JAIN. Right. Right.

Senator CASSIDY [continuing]. We do not need you to research——

Dr. JAIN. Right.

Senator CASSIDY [continuing]. With a porcine valve, and you cannot track a porcine valve. Do you see what I am saying?

Dr. JAIN. Right.

Senator CASSIDY. I am not saying this to fuss at you.

Dr. JAIN. Right.

Senator CASSIDY. I am just saying this is logical.

Now, our legislation—I see that you do not have a cleared response on it—our legislation would allow the VA to use a tracking system that could track non-human tissue. And since you have used, I have learned, non-human tissue devices, why would the VA not want to track that and be in compliance with the FDA rule? And, this does not have to be cleared testimony. It is just kind of an obvious—it begs to be asked. Why would you not want to be in compliance, and, therefore, why would you not use another system that allowed you to track such tissue?

Dr. JAIN. I think the way you are asking the question, we would want to be in compliance, but I cannot answer that today, but I will certainly look into that and get the answer for you.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. BILL CASSIDY TO DR. RAJIV JAIN, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. VA's tracking system will use all forms of approved Unique Device Identifications (UDI) as appropriate to track both human and non-human derived biologics. The International Society of Blood Transfusion (ISBT–128) is preferred for human derived tissues as they require a higher standard for tracking as discussed in IUSH response to the Senator's letter from April 9th 2015 requesting the VA rationale for "* * * why VA is contemplating the use of ISBT–128 for some biological implants and not allowing the use of all the three issuing agencies for the labeling of biological products."

Non-human products will be required to use the other forms of UDI from the approved issuing agencies, GS1 (global barcoding and numbering organization) and Health Industry Business Communications Council (HIBBC) as ISBT–128 is only for human tissues.

This approach is entirely consistent with current FDA regulations and publically agreed at the recent 46th Meeting of the Advisory Committee on Blood & Tissue Safety & Availability (April 7 & 8, 2015). Moreover, this Committee, a workgroup of clinical, industry, public health professionals and patient advocates (including FDA, CDC, DHHS) unanimously voted to recommend that the DHHS Secretary take action in a stepwise risk-based approach to: "Establish use of ISBT 128 code in electronically readable format as a universal standard for mandatory implementation of unique donation identifiers for all human tissue products."

While it is was expressed that the intent of H.R. 1016 is to allow the VA to use a system to track both human and non-human biologics, Section 2 requires VA to permit a vendor to use any of accredited entities identified by FDA in adopting or implementing a standard identification. As written, this would require VA to use identifiers which while adequate for tracking animal tissues, are inadequate for tracking human tissues at our facility level. Section 2 would compel VA to be out of compliance with FDA and international guidelines and treat human tissue in the same fashion as animal tissue. This is the very system of vendor controlled tracking and reporting databases, which, has been shown to be both slow and inadequate for tracking human biologics. Section two should permit VA to require the use of any of the accredited entities identified by FDA to promote the optimal care and business practices for US veterans, not compel the VA to accommodate products which hinder it efforts.

Senator CASSIDY. OK. Well, my point, Mr. Chairman, is that we have a letter from Dr. Clancy, and as I gather, they are not going to use the system which will allow—to be in compliance with an FDA rule to track non-human tissue. Anyone in this room with an artificial heart valve, there is a good chance it is from a pig. So, we are not going to be tracking that which is commonly used. So, our legislation would allow the VA—in fact, direct the VA—to use that system which would allow them to track these devices that currently (under the system they indicate they are going to use), they will be unable to track.

With that said, I yield back.

Chairman ISAKSON. That is why we have hearings, to get input and differences and then try and find a way to work them out. And, I appreciate your attention and respect the fact that you are the only physician on the Veterans' Committee, so you know from whence you come. Thank you.

For the benefit of everyone here, we are going to have five votes at four o'clock. Senator Murray is next, followed by Senator Sullivan for questions. I am going to recognize both of them and hope they will be succinct. Then we will take the VSOs' testimony as far as we can take it, until about 10 minutes after 4 o'clock, when I am going to go vote. That may change if votes get put off, but I just want to give you all that fair warning.

So, Senator Murray.

Senator MURRAY. Mr. Chairman, thank you very much. I will try to be succinct.

Dr. Jain, I want to thank the VA for its support of my bill to improve fertility services at the VA. In your testimony to us, you described some of the serious consequences for veterans when, as a result of their injuries from their service, they cannot have children. And, I have certainly heard from veterans how difficult it can be to deal with this new reality. It can destroy relationships. It can be very stressful. And, it can create an incredible financial burden for our veterans.

Can you describe some of the other health effects veterans face when they cannot realize their dream of starting a family?

Dr. JAIN. Well, Senator, thank you for that question. In talking with our program lead in women's health, they have talked about depression clearly is one of those that they see. It is also about the overall quality-of-life, and I think it goes to, you know, how one feels as a human being, and having a biological family is clearly a part of the equation that makes a person feel whole. So, I do think that there are lots of other types of softer mental health type of issues, but there is clearly an issue in the overall sense of well-being.

Senator MURRAY. Well, thank you for that answer; and Mr. Chairman, again, thank you for your commitment to working with me to get that done.

I also want to ask about my caregivers bill. In an earlier study by VA, the Department found that for veterans in the caregiver program, their inpatient hospital admissions decreased by 30 percent, and VA found that when a veteran was hospitalized, their length of stay decreased by 2½ days. How important is it to vet-

erans' health and quality-of-life to spend less time in the hospital and more time at home?

Dr. JAIN. I think it is hugely important, Senator. Thank you for that question. We are encouraged by that preliminary report. So, based on that, what we have done a few months ago, 4 or 5 months ago, we began a more formal evaluation of the caregivers program, which would be ready by about this time next year. It looks at multiple aspects, not only the aspect on the veterans themselves, some of the issues relating to length of stay, but also looks at the caregivers. What impact is it having on their health and well-being as they are serving as the caregivers for our veterans. So, it will be a very comprehensive evaluation, and when it is ready, I will be very happy to share that with the Committee.

Senator MURRAY. OK, very good. GAO has raised some important concerns about the caregivers program. I really believe that the VA can address those concerns and strengthen the program while also finally opening up the program to veterans of all eras.

Mr. Chairman, to help the VA meet that goal, I did include in the veterans appropriations bill an additional $10 million for VA to hire more caregiver support coordinators. So, I do look forward to working with you on that.

Dr. Jain, I did want to ask you, as you may be aware, DAV, citing a VA report, found the caregivers program to be one of the most cost-effective ways to provide care for this group of veterans. For example, the average cost per veteran to participate in the caregiver program was $36,800, significantly less than the average $332,800 per veteran in a VA nursing home. Overall, can you tell us how much VA estimates it saves when it can provide care through a caregivers program rather than through other types of care?

Dr. JAIN. Thank you, Senator, for that question. I do not have those numbers for you today, but we could certainly try to find that and respond back. I think it is a very important issue you are raising and we certainly agree with DAV's evaluation. I think when you talk to our clinicians, they are very impressed by the results of the caregivers program, which is why in our report a few months ago we talked about, conceptually, being all for expanding the program. The challenge always has been how do you find the resources to match that.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO DR. RAJIV JAIN, U.S. DEPARTMENT OF VETERANS AFFAIRS

Response. VA does believe over the long term, health care savings can result from participation in the caregiver program. Those savings would only be realized over the long term and cannot be projected with any specificity. There can be in some instances sooner and more quantifiable savings from individuals who otherwise would likely be placed in nursing home care. However, only a small fraction of Veterans in the caregiver program are in that circumstance, given the variety of types and severity of injuries and conditions for Veterans in that program.

Senator MURRAY. From my position, whether it is IVF care or whether it is caregivers program, when someone serves us in this country overseas and is injured as a result, our country should step up. So, I hope we can move forward with both of these bills.

Thank you, Mr. Chairman.

Chairman ISAKSON. Thank you, Senator Murray.
Senator Sullivan.

HON. DAN SULLIVAN, U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman, and thank you, Ranking Member Blumenthal.

I know we are looking at several bills here, but I have a developing crisis in my State, Dr. Jain, that I would like to talk about. I think all the Members of this Committee care deeply about our veterans. I certainly do, as a veteran myself, coming from a State with the largest per capita number of veterans in the country, and I have certainly viewed my role on this Committee as wanting to work with the VA, wanting to work with you, the leadership, the Secretary. That has been the constructive approach to trying to solve our numerous problems. But, I must admit, after what has been going on in my State the last few months, I am starting to lose patience.

As you know, Dr. Jain, the Choice Act in many ways removed some of the positive aspects of what we were actually doing in Alaska with regard to VA health care. Many of the challenges that we have, many are unique, given our distances, given the number of veterans we have, the partnerships that we have developed. We had a system that was not perfect by any means, but in many ways it was working. Now, we have, I think, without exaggeration, a five-alarm fire going on in my State with our veterans because of the way the Choice Act is being implemented.

Mr. Chairman, for the record, I have a couple of things. An AP story, "Federal VA Health Care Program Jeopardizes Alaska's System." I would like to submit all of these for the record, with your permission.

Chairman ISAKSON. Without objection.

Senator SULLIVAN. A local TV report in Alaska last week, "Veterans' Federal Health Program Under Fire Due to Health Care Delays." Senator Murkowski, the senior Senator from Alaska, several pages to Secretary McDonald, Congressman Young, Governor Bill Walker, the Governor of Alaska, all within the last 2 weeks: urgent, urgent problems in Alaska.

[The submissions by Senator Sullivan follow:]

LETTER FROM HON. LISA MURKOWSKI, U.S. SENATOR FROM ALASKA, TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

LISA MURKOWSKI
ALASKA

United States Senate

May 29, 2015

Honorable Bob McDonald
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Mr. Secretary:

I write with great urgency concerning changes that appear to be occurring in the Alaska VA Healthcare System as a result of Central Office mandates related to the implementation of the Veteran's Access Choice and Accountability Act of 2014 ("Choice Act") and the Veterans Health Administration's recently adopted hierarchy of care policy.

Yesterday I had the opportunity to visit the DOD/VA joint venture hospital in Anchorage. At that time I learned that while the hierarchy of care policy does provide the authority for the VA to continue to refer Alaska veterans to the DOD/VA joint venture and to the tribal healthcare organizations, current budget shortfalls in the non-VA care funds limits such care to urgent and emergent services.

This news could not come at a worse time given that the VA was recently forced to close the two procedure rooms at its "new" Anchorage outpatient facility due to defects in the ventilation system. The joint venture hospital is the backup.[1] The situation also threatens to undermine proactive steps taken by Alaska VA to address staffing shortages in Anchorage and in its Community Based Outpatient Clinics through sharing arrangements with tribal health partners such as the Southcentral Foundation in Wasilla.

Moreover, under the "Hierarchy for Purchased Care" directive, I am led to believe that Alaska VA may not enter into new sharing agreements to address extreme staff turnover in Fairbanks or address continuing problems in Wasilla.[2] Cumulatively these developments could result in the return of waitlists at Alaska VA healthcare facilities.

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[1] http://www.adn.com/article/20150527/operating-rooms-closed-anchorage-va-clinic-until-ventilation-problem-resolved

[2] On May 21, 2015, the Senate Appropriations Committee report to accompany the FY16 Military Construction, Veterans Affairs and Related Agencies Appropriations Act was adopted. The report speaks directly to this issue: *Staffing of Alaska VA Healthcare System. –In its report to accompany the Fiscal Year 2015 bill, the Committee made note of the difficulties VA has encountered in finding a full time physician to staff the Wasilla Community Based Outpatient Clinic - a facility that should be assigned two full time providers given its patient load. The Committee also understands VA has faced challenges in maintaining consistent staffing at its Fairbanks Community Based Outpatient Clinic. To address gaps in primary care staffing in Anchorage and the Matanuska-Susitna Borough, the Alaska VA Healthcare System has entered into agreements with the Alaska Neighborhood Health Center and Southcentral Foundation, an Alaska Native health provider, to take over a significant portion of its primary care caseload. These are a few examples of the chronic difficulties the Alaska VA Healthcare System faces*

COMP PAGE ACTIVE ARCHIVE

For the past decade I have been personally involved in efforts to reform the Alaska VA so that our veterans can obtain timely care in close proximity to their home communities. When I began this struggle, the Alaska VA was bound by a Lower 48 "one size fits all" mentality in which Alaska veterans were directed to the Puget Sound VA Medical Center for services that could be purchased from community providers within miles of their home, even if the veteran was medically determined to be too old or too frail to travel. Veterans in Interior Alaska who required chemotherapy were forced to endure regular trips to Seattle even though the service was available at Fairbanks Memorial Hospital.

Alaska Native veterans and non-Native veterans residing in bush Alaska had all but given up on registering to use their earned health benefits because the closest VA facility was hundreds of miles and thousands of dollars in airfare away from their home communities. When Secretary Nicholson visited Alaska in 2006 he learned that Anchorage VA was willing to reimburse travel eligible veterans for the cost of flying into Anchorage for care but not for the cost of hotel rooms or meals while in town for that care. Central Office unwillingness to enter into partnerships with the Alaska Native Healthcare System until 2011 effectively disenfranchised Operation Iraqi Freedom era veterans living in rural Alaska from accessing health benefits which were guaranteed by Congress. This unwillingness placed an unfair burden on the tribally operated Native health system which had to make up for the VA's absence in rural Alaska using the meager funds available through the Indian Health Service.

In 2007 I conducted hearings under the auspices of the Senate Committee on Indian Affairs to try to better understand why the VA allowed Alaska Native veterans to suffer this discrimination. I continued to pursue changes through the Military Construction and Veterans Affairs Appropriations Subcommittee which I joined in 2009. But change was very slow in coming.

In response to a VA Inspector General report that I requested, the Alaska VA began to purchase care it was previously unwilling to from community providers.[3] Even then, the VA continued to resist change, as documented in my May 28, 2011 Anchorage Daily News Op-Ed entitled "VA Struggling to Serve Alaska Veterans"[4] on the eve of Secretary Shinseki's first visit to the state.

Following Secretary Shinseki's visit we saw a sea change in the way Alaska VA delivered care. The "Care Closer to Home" program was vastly expanded and the VA entered into landmark agreements with every willing component of the Alaska Native healthcare system. Susan Yeager was hired to manage the Native partnership in 2011. She was elevated to Director

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in maintaining consistent staffing. Recognizing these difficulties, the Alaska VA Healthcare System is investigating partnerships with medical schools to increase the number of physicians who pursue postgraduate training in Alaska. The reasoning behind this effort is physicians often decide to permanently practice in the communities in which they are trained. The Committee encourages VA to pursue this effort as well as other proactive steps to ensure Alaska veterans receive timely and appropriate healthcare. Toward this end, VA may also wish to investigate whether to contract the operation of particular Community Based Outpatient Clinics in Alaska to components of the Alaska Native Healthcare System and Community Health Centers which have the capacity to provide care to Alaska veterans without compromising the service provided to existing patients.

[3]http://www.va.gov/oig/54/reports/VAOIG-10-01509-241.pdf

[4] http://www.adn.com/article/20110528/va-struggling-serve-alaskas-veterans

of the Alaska VA Healthcare System in 2013.[5] Things have been getting better for Alaska's veterans under her leadership.

We have come too far to turn back now. Last spring, while VA facilities in the Lower 48 were struggling under the burden of an old culture that was hostile to service delivery partnerships, Alaska VA was successfully implementing the new paradigm. As a consequence the Alaska VA, even while suffering from staffing and capacity shortages, was able to proactively address a primary care backlog that would have quickly turned scandalous if ignored.[6]

I appreciate the VA's decision to issue a Choice Act card to all of Alaska's veterans enrolled for VA healthcare. Whether the Choice Act will prove to be a superior means of service delivery than existing VA partnerships remains uncertain. Anecdotally, I have heard that the Choice Act program is a godsend in southern Southeast Alaska but in urban centers has attracted few, if any, primary care providers. In rural Alaska, where private practice providers do not exist the Choice Card may prove less financially attractive to Native health providers than existing partnerships. That may result in the denial of access to non-Native veterans. It is essential that the VA uphold its promises to the Native health providers with which it has entered into agreements. The Choice Act does not preclude the continuation of these agreements using non-Choice Act appropriations and I understand that such appropriations are available for this purpose.

When considering how best to serve our veterans one must bear in mind that there is more demand for providers in Alaska than there are providers. Managed care has never been successful in the Alaska market due to this demand/supply imbalance. Tricare recognized this years ago when it chose to retain rate setting responsibilities in Alaska rather than allow its regional contractors to negotiate rates with providers. This remains the case today. While I appreciate the VA's interest in controlling the cost of outside healthcare, ensuring consistent care to the veteran, wherever he or she chooses to live must be the VA's first priority.

Nathan Bergerbest, my Senior Counsel in Washington, contacted VA Congressional and Legislative Affairs about this issue late last evening. Interim Assistant Secretary Chris O'Connor's team responded shortly before midnight Eastern Time and are to be commended for their attentiveness. I understand that there may be a misunderstanding between Central Office and the Alaska VA Healthcare System about how the new guidance is to be interpreted and that this may be resolved early next week. I expect a briefing at your earliest possible convenience on the outcome of these discussions.

I cannot understate the value of working collaboratively with the Alaska congressional delegation regarding policy changes that can affect the access to care our veterans receive. Alaska is proud to host the largest veteran population per capita of any state in the union. Our veterans know that their congressional delegation has their back and will go to bat for them no matter how late the hour.

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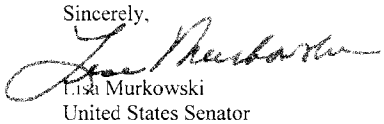
[5] http://www.akbizmag.com/Alaska-Business-Monthly/March-2013/Murkowski-New-Alaska-VA-Director-Has-the-Tools-for-Outside-In-Progress-in-Alaska/

[6] http://www.adn.com/article/20140330/va-partners-anchorage-health-clinic-veterans-care

Thank you, once again, for considering my views.

Sincerely,



Lisa Murkowski
United States Senator

cc: Hon. Mark Kirk, Chairman,
Military Construction, VA and Related Agencies Subcommittee.
Senate Committee on Appropriations

LETTER FROM GOV. BILL WALKER, STATE OF ALASKA, TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

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Governor Bill Walker
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June 11, 2015

The Honorable Robert McDonald
Secretary
United State Department of Veterans Affairs
810 Vermont Avenue, NW
Washington DC 20420

Dear Secretary McDonald:

Please help me prevent the devastating loss of an innovative and award-winning program that has improved access to medical care for all of Alaska's veterans. I was notified recently the Veterans Administration (VA) intends to withdraw funding at the end of the current federal fiscal year for the historic partnerships between the VA and twenty-six different Alaska Native healthcare organizations. I strongly urge you and your agency to reconsider this action and work with the State of Alaska and all the Alaska Native healthcare partners to keep these agreements in place.

Ironically, it is my understanding that Alaska's new and efficient agreements with Alaska Native healthcare providers are being jeopardized by a dramatic rise in "purchased care" in the lower 48 states under the Veterans Choice and Accountability Act of 2014, which seeks, in part, to emulate Alaska's groundbreaking model of having other federal healthcare providers care for veterans. Due to budget constraints, all non-VA clinic care is now being restricted to the Veterans Choice program enacted under the Veterans Choice and Accountability Act of 2014.

Because the reimbursement rates under the program are uncompetitive in Alaska's higher cost environment and due to the success of these newly-forged partnerships with Alaska Native healthcare providers, only a handful of Alaska providers participate in the Veterans Choice program. Therefore, this change will set us back to the same kind of healthcare our veterans experienced before 2011, resulting in expensive multi-day trips from rural, non-roaded communities, if the veteran resolves to seek care at all.

Please allow me the opportunity to refresh you on the dramatic healthcare challenges faced by Alaska Veterans and the remarkable improvements in that care resulting from the partnership forged by the State of Alaska Division of Veterans Services, Alaska Native healthcare providers, and the VA. Prior to these agreements, Alaska Veterans could only receive care at five VA clinics in urban hubs or on the limited Alaska road system. These clinics served the approximately 56 percent of Alaska veterans who could drive to them.

Alaska has approximately 220 rural communities accessible only by air or water. Through the Alaska Native healthcare partnerships created over three years of painstaking collaboration, Alaska veterans now have access to care in 127 medical facilities across the state, resulting in access for approximately 96 percent of Alaska veterans in the communities where they reside.

This is no small feat. Alaska proudly has the highest number of veterans per capita of any state – approximately 73,000. This is ten percent of the total population of the state, and our state is the roughly one-fifth the size of the combined lower 48 states. Through these partnerships, the VA reduced its travel costs by $3.5 million annually, and trips for out-of-state specialty care went from 591 veterans per year to just 71. We reduced veteran travel time for healthcare from an average of four days to almost all visits being satisfied in the local community.

For its role in these accomplishments, the Alaska Division of Veterans Affairs was awarded the 2014 Abraham Lincoln Pillars of Excellence Award by your agency. Now, one year later, we are being told this award-winning program and the resulting partnerships with Alaska Native healthcare providers are to be discarded.

These actions will negatively impact the level of care our veterans currently receive and will damage the working relationship between the VA and the State of Alaska. Our State spent over two years working with 26 Alaska Native healthcare providers to put into place a comprehensive agreement to serve our veterans where they live – only to now tell them the VA no longer has the funds to pay for this service and cannot honor the agreements it recently put in place. This will be yet another federal promise to Alaska and Alaskans broken.

The same lower 48 budget challenges are negatively affecting other parts of the Alaska VA provider network. Along the lines of the Alaska Native Health Agreements, Alaska has in place the nation's first joint venture agreements between the VA and Department of Defense (DoD) hospitals. It is my understanding the funding for this program will be stopped as well. This will reduce the availability of care at the Joint Base Elmendorf Richardson and Fort Wainwright facilities. At the two DoD hospitals, the VA employs 90 healthcare providers who work hand-in-glove with DoD employees to provide in-patient and specialty care to veterans that is not available through the five VA clinics in Alaska. Without these providers, veterans and active duty personnel will have longer wait times for service and reduced access to care.

Additionally, in response to the challenges, I am told the VA is reducing funding for training and hiring VA mental healthcare providers in Veterans Centers in Alaska, an area where Alaska is also dramatically underserved. Alaska veterans needing mental health counseling have fewer private care options. Closing off access to these vital services at time when 22 veterans a day commit suicide in our country would be truly tragic and unwise.

Given the high proportion of Alaska veterans to the overall population, VA health care benefits are one of the major access points to healthcare for all Alaskans, and these sudden changes will have dire effects on Alaska veterans, and it is painfully easy to forecast consequences for the entire Alaska healthcare provider system.

In summary, over the past five years Alaskans have worked hard and created strong partnerships with the VA to ensure Alaska's veterans are well cared for. We have come a long way in our ability to provide equal service to veterans on and off the road system. Decreased funding and cessation of innovative and effective programs will destroy the efforts over the past five years, and will set us back decades in the area of trust.

I know the VA has funding challenges; Alaska has its own. However, when the time comes to prioritize spending, we cannot do so at the risk of failing to keep our promises to our veterans. As a nation, we wrote the check when we sent them to war, and now it is incumbent on us to honor that agreement and their service. I urge you and the Veterans Administration to reverse these plans and to ensure Alaska veterans receive the timely and appropriate care they earned.

Sincerely,

Bill Walker
Governor

cc: The Honorable Lisa Murkowski, United States Senate
The Honorable Dan Sullivan, United States Senate
The Honorable Don Young, United States House of Representatives
The Honorable John Coghill, Joint Armed Services Committee, Alaska State Senate
The Honorable Gabrielle LeDoux, Joint Armed Services Committee, Alaska State House of Representatives
The Honorable Bob Herron, Special Committee on Military and Veterans Affairs, Alaska State House of Representatives
The Honorable Charlie Huggins, Veterans Caucus, Alaska State Senate
Brigadier General (AK) Laurel Hummel, Commissioner, Alaska Department of Military and Veterans Affairs
Susan Yeager, Alaska Region Director, Veterans Administration
Andy Teuber, Chair, Alaska Native Tribal Health Consortium
Kip Knudson, Director of State and Federal Relations, Office of the Governor

LETTER FROM REP. DON YOUNG, CONGRESSMAN FOR ALL ALASKA, TO HON. ROBERT MCDONALD, SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS

DON YOUNG
CONGRESSMAN FOR ALL ALASKA
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Congress of the United States
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COMMITTEE ON
NATURAL RESOURCES

CHAIRMAN, SUBCOMMITTEE ON
INDIAN AND ALASKA NATIVE AFFAIRS

COMMITTEE ON
TRANSPORTATION & INFRASTRUCTURE

REPUBLICAN
POLICY COMMITTEE

June 16, 2015

The Honorable Bob McDonald
Secretary of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Mr. Secretary,

I would like to thank you for accepting the President's nomination to serve as the Secretary of Veterans Affairs. An Army veteran myself, I know the great efforts you and your team are doing to care for our nation's veterans. I appreciate your willingness to serve and the actions you have already done to reform the broken VA System.

As you are aware, the Alaska VA Healthcare System is facing serious issues as a result of the poor implementation of the Veteran's Access Choice and Accountability Act of 2014 and a shortage of funds in the VA's Purchased Care accounts. Both Governor Bill Walker and Senator Lisa Murkowski have described in great length the issues Alaskan veterans currently face, and I too share their concerns. My staff and I are committed to working with members of the VA, the Congressional Veterans Affairs Committees, and my colleagues in the Alaska Delegation to find solutions to these problems.

To help us find a solution to this crisis, can you please reply with answers to the following questions:

General

What is the VA doing to ensure all Alaskan veterans are able to receive the medical care and other services they need?

What is the VA's plan to ensure this kind of situation does not arise in future fiscal years?

What is required for the VA to fix this problem?

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VA Choice Act

What steps are being taken by the VA to ensure a sufficient number of Alaskan health care providers register to provide health care via the VA Choice Program? What obstacles does the VA face in recruiting Alaskan health care providers to register for the VA Choice Program?

What efforts are the VA undertaking to ensure VA Choice Program-eligible veterans in Alaska understand exactly how to use the program?

What is required to ensure the VA Choice Program is successful in Alaska?

VA Purchased Care

Why is the VA Purchased Care account empty in June of 2015, with four months remaining in Fiscal Year 2015?

Why did the President's FY16 budget request not include additional funds for the VA's Purchased Care accounts?

Based on the amount of purchased care funds used in FY15, how much will the VA need for the entirety FY16?

Would the VA support using VA Choice Act funds to fund other purchased care accounts?

Thank you very much for taking the time to answer my questions. I look forward to working with you to ensure all Alaskan veterans are able to receive the quality health care they earned through service to our great nation.

Sincerely,

DON YOUNG
Congressman for All Alaska

Federal VA health care program jeopardizes Alaska system

By Becky Bohrer, The Associated Press 9:46 a.m. EDT June 20, 2015

[The URL to the article follows, in respect of the AP Copyright request.]

http://www.armytimes.com/story/military/benefits/veterans/2015/06/20/federal-va-health-care-program-jeopardizes-alaska-system/29029189/

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Veterans' Federal health program under fire due to health care delays

ADAM PINSKER, Reporter, apinsker@ktuu.com / POSTED: 08:18 PM AKDT Jun 22, 2015

ANCHORAGE, Alaska—A new program designed to streamline access to health care for military veterans is coming under fire as veterans say they've been stymied by Federal health care program.

Senator Dan Sullivan, of Alaska says Congress will hold hearings on the "Choice" program Wednesday, after complaints about delays in delivering health care to Alaska veterans.

"It's making sure that veterans have access to care when they need it and where they need it,"said the freshman senator. "The Choice Act, which is supposed to do that in Alaska is actually undermining it."

Congress passed the Choice Act in 2014, in the wake of a scandal that rocked the Veterans Administration when 40 veterans died at a Phoenix hospital mainly because of delay in care.

The Choice Act was intended to make wait times shorter by allowing veterans to seek care outside the VA system but since its implementation, some veterans say it has done just the opposite.

"I had the appointment on a Tuesday and I got a call on the Monday before and said we're not canceling your appointment, we're canceling your authorization for payment," said Jeff Foener of Anchorage.

A 9-year army veteran, Foener had been waiting 6 weeks to have his hand checked after complications from surgery.

"I think the choice program should live up to its name."

The rest of Alaska's congressional delegations has also called for reforms to the Choice Care Act.

Senator Sullivan says hearings over the Choice act will also be held in Alaska this summer, with VA officials present.

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Senator SULLIVAN. It is a very big crisis, and part of the problem that we have seen with this crisis is this issue of the lack of accountability that has been an ongoing matter we have discussed today, and we have been talking about for months. We worked—my staff, Senator Murkowski's staff—worked with the local VA in Alaska. They helped us identify these problems with regard to the implementation of the Choice Act. They knew it was a problem.

And then when we raised it to senior staff in Washington, you know what they said? This is not our fault, it is Congress' fault because they implemented the Choice Act. As recently as last week, we were hearing from officials here that there is no problem in Alaska. Well, let me guarantee you, there is a problem in Alaska, a big problem.

I talked to Dr. Shulkin last night. I was going to put a hold on his nomination because of this. He was confirmed, as you know, last night. He is going to be your new boss. So, I got a commitment from him to come to Alaska as part of field hearings, because this is an issue that is way bigger than this hearing.

So, Mr. Chairman, Senator Blumenthal, I appreciate the opportunity to have field hearings in the State from the Committee. I certainly would want to invite any Members of the Committee to come to Alaska to learn about our unique challenges and this problem.

But, Dr. Jain, I know that in many ways, you are not responsible for this, but here is what I need from you: a commitment. Dr. Shulkin committed to me he would come to Alaska as part of these hearings to help address these issues. These hearings will be in August. I want a commitment from you, as someone who understands the bureaucracy—he is brand new—to help make sure when you get to Alaska, it is not just to hear what the issues are. We know what the issues are. To have solutions ready, solutions to what is clearly a crisis in a State that in many ways was the model for the Choice Act. Now, implementing the Choice Act, we are undermining the whole system in Alaska.

It is Phoenix all over again. People are having their appointments canceled at the last minute, showing up for surgery. The VA in Washington has to take responsibility. You cannot blame this on the Congress.

So, can I get your commitment to help Dr. Shulkin come to my State with answers, with solutions when he comes up in August?

Dr. JAIN. Yes, sir, Senator. Thank you for that question, and I completely agree with you. I know that Dr. Tuchschmidt and Dr. Lynch recently visited your State and saw firsthand how the health care is structured, working with Department of Defense, joint ventures, and also with the Alaska Native Health Care model, and——

Senator SULLIVAN. And these models are very innovative.

Dr. JAIN. They are very innovative——

Senator SULLIVAN. And now they are not working.

Dr. JAIN. Well, no, I understand, and I think that is what they have come back with—what I understand from them is that they are now committed to supporting those models, because they are what is working. We cannot have veterans going 500 miles or 400 miles. So, what I heard from them is that they are committed to supporting that, and I would certainly take the word back in terms of Dr. Shulkin's support at the field hearing that you bring up.

Senator SULLIVAN. Great. Thank you; and Mr. Chairman, I am sorry I took so long on this, but it is a huge issue for my State and we need to fix it.

Chairman ISAKSON. Let the record reflect that the Senator from Alaska came to me over a month ago about having a field hearing in Alaska, which I have approved; and I think it is an important field hearing to have.

I want to also acknowledge the fact that he could have last night, had he exercised his authority as a Senator, held up Dr. Shulkin's final approval, but he did not in the spirit of cooperation. I hope that VA will, in the same spirit of cooperation, ensure that Dr. Shulkin and the appropriate people are in Alaska with solutions and not questions when you have the field hearing.

Dr. JAIN. Yes, sir.

Chairman ISAKSON. Thank you all for your testimony.

[Responses to posthearing questions to VA follow:]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DEAN HELLER TO DR. RAJIV JAIN, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION (VHA), U.S. DEPARTMENT OF VETERANS AFFAIRS (VA)

Question 1. During the last hearing on June 3rd, my Women Veterans Access to Quality Care Act, which I introduced with Senator Murray, was on the agenda. I was disappointed that the VA failed to provide views on this important bill. The VA not providing these views delays this bill from moving forward through the regular process in Committee. Why was the VA unable to provide the views on the Women Veterans Access to Quality Care Act in time?

Response. The Department of Veterans Affairs (VA) understands the importance of providing its views on legislation to the Committee. In some cases the number, complexity, and subject matters of the combined agenda make it necessary for VA to provide its official views for some bills or parts of bills in a follow-up letter. This was the case with the Women Veterans Access to Quality Care Act. VA will do everything possible to work with the Committee to ensure views on bills are timely to the fullest extent possible.

Question 2. On what date will the views for S. 471 be provided to the Committee and to my office?

Response. VA provided those views to the Committee by letter dated July 15, 2015, a copy of which is appended to these responses.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO DR. RAJIV JAIN, ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION (VHA), U.S. DEPARTMENT OF VETERANS AFFAIRS (VA)

RE: S. 469, WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

Question 3. Dr. Jain, you mentioned the VA's support for Section 207 of the proposed Women Veterans and Families Health Services Act which would require VA to enhance the capabilities of the Women Veterans Call Center. In July 2012, I wrote to the VA about the women's hot line number, which was then a 202 area code number and not toll free. In May 2013, the VA launched the 1–855-VA-WOMEN toll free line, which I applaud.

Do you know if the capabilities of the Women Veterans Call Center were enhanced as proposed with real time text messaging, would that service be provided at the expense of the veteran or the VA?

Response. VA supports section 207 to improve the Women Veterans Call Center (WVCC). This legislation does not require real time messaging capabilities. While VA believes such capabilities would be beneficial, they would require additional IT capabilities and resources. Decisions on whether to move forward will depend on available resources and other IT priorities.

Section 207 can be fulfilled through additional training and other improvements that would not require additional real time text messaging or other IT investment.

We also note that as part of the MyVA initiative the Department is planning to consolidate its numerous toll-free numbers to improve customer service to Veterans.

Chairman ISAKSON. We will change panels real quick. Our VSOs, if they will come forward. [Pause.]

So that you are all prepared, what I am going to ask you to do—we have votes starting at four o'clock. I think that is still the case. We do not have time to hear everybody's testimony if everybody took 5 minutes. So, I want you to make your best shot at 3 minutes or less so you can say what you need to say as quickly as possible. If you cannot do it within 3 minutes, there might not be any of us here to listen, so I want to encourage you to do that.

We have Ian de Planque from The American Legion; Peter Hegseth from the Concerned Veterans of America and Fox News, which I see him on Fox News all the time; Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans;

Carl Blake, Associate Executive Director, Paralyzed Veterans of America; Max Stier, President and CEO of the Partnership for Public Service; and John Rowan, the National President, Vietnam Veterans of America.

We will start with Ian. Ian.

STATEMENT OF IAN DE PLANQUE, LEGISLATIVE DIRECTOR, THE AMERICAN LEGION

Mr. DE PLANQUE. Thank you, Mr. Chairman, Ranking Member Blumenthal——

Chairman ISAKSON. Three minutes, Ian. [Laughter.]

Mr. DE PLANQUE. I will go through as quickly as I can.

First of all, I want to thank Senator Baldwin for her press conference this afternoon and for pushing forth this legislation. I was happy to be there, and I am happy to see the family is here, as well, and can see that this is moving forward. I think that is a strong bill and The American Legion is behind it. We would really, really like to see some improvement in that area.

I am going to cut short to one other thing that we wanted to address and that is proper accountability within the VA. Let us be clear here; this is also about protecting VA employees. VA employs well over 300,000 employees, and more than one-third of those are veterans. The vast majority of them are good people who go to work every day to help America's veterans. They do not need to see the good name of VA employees dragged through the mud every time there is a bad employee who gives the system a bad name. This would not happen if VA could and would swiftly take action when employees cross the line and hurt veterans with their actions.

Senator Rubio's bill, like the Veterans Access to Care and Accountability Act of last year, seeks to extend the same level of accountability we sought for executives at all levels. We need a system of accountability that is enforceable and is the same for employees at all levels. VA employees can and should take charge of VA and make it the veteran-centric agency that it needs to be.

To do so, VA needs to be able to clear out employees who would manipulate the system and put veterans at disadvantage or for their own gain. We should be championing the brave whistleblowers who come forward because they believe VA should serve veterans, and they observe practices and operations that are contrary to that mission. It is those brave men and women that we should direct our focus to when it comes to VA employees, not the men and women who lie, and cheat, and then sit on paid leave for months and even years because a toothless system cannot remove them from VA payrolls. Those bad employees only stay in the public focus because VA cannot or will not deal with them swiftly.

When we can turn the tide to quickly remove these few problem employees, we can turn our attention more easily to the hundreds of thousands of VA employees who work very hard every single day in the service of veterans.

I know we are keeping it short. As always, I thank you for the opportunity to present the views of The American Legion and I am happy to answer any questions you might have.

[The prepared statement of Mr. de Planque follows:]

PREPARED STATEMENT OF IAN DE PLANQUE, DIRECTOR, NATIONAL LEGISLATIVE DIVISION, 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. 469: WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

As a result of more than a decade of war, thousands of male and female servicemembers are returning home with physical and/or psychological wounds of the war resulting in a variety of fertility and reproductive health issues. Many young servicemembers have been documented with low testosterone levels that can be attributed to the medications that they are taking for their physical injuries, and conditions such as Traumatic Brain Injury (TBI) or Post Traumatic Stress Disorder (PTSD), as well as the poisonous effects of environmental exposures they have faced while serving on active duty.

Currently, the Department of Defense (DOD) and Department of Veterans Affairs (VA) offer servicemembers and veterans some form of fertility and reproductive treatment and counseling. However, the servicemembers and veterans who choose to start a family but struggle with fertility issues as a result of their injuries will, in many cases, face paying tens of thousands of dollars out of pocket for treatments and services that are not paid for by the DOD or VA. Some fertility treatments can be extremely costly. In addition, veterans currently cannot receive many of these services from VA.

The DOD and VA need to create solutions for those who have lost anatomical parts required to participate in the physical act, but there seems to be little support either through counseling or medical intervention to offer young veterans who have lost their ability to procreate due to lack of testosterone. Unfortunately, many veterans with TBI are also on hypertension medications, and adding sexual performance medications may represent a serious health risk. This can also create a loss of intimacy in relationships, exacerbating psychological disorders such as PTSD and depression. Ultimately, it affects the self-esteem of both veteran and spouse.

Through Resolution, The American Legion urges Congress to support and fund quality of life features including, but not limited to, adequate medical, mental health, and morale services.[1] Congress should also extend and improve additional quality of life benefits to those servicemembers and dependents that have been injured while serving on active duty.

The American Legion supports this legislation.

S. 901: TOXIC EXPOSURE RESEARCH ACT OF 2015

The effects of the often dangerous environments in which servicemembers operate is a top concern of The American Legion, as thousands of servicemembers and veterans who are and/or have been exposed to various toxins are often "left behind" when it comes to vital medical treatments and benefits. The American Legion remains committed to ensuring that all veterans who served in areas of toxic exposure receive recognition and treatment for conditions linked to environmental exposures.

This legislation requires VA to establish a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans that were exposed to toxic substances during their military service, as well as an advisory board on exposure to toxic substances.

The American Legion has long been at the forefront of advocacy for veterans who have been exposed to environmental hazards such as Agent Orange, Gulf War-related hazards, ionizing radiation, the various chemicals and agents used during Project Shipboard Hazard and Defense (SHAD), and contaminated groundwater at Camp Lejeune, North Carolina. Through Resolution, The American Legion continues to urge the study of all environmental hazards and the long-term effects they have on our servicemembers, veterans, and their families.

The American Legion has also called on the DOD to immediately cease burning dangerous chemicals in open burn pits, exposing servicemembers to deadly and debilitating toxins.

The American Legion believes in treating the veteran first, funding the necessary research, and ensuring servicemembers are not exposed to chemical hazards again.[2]

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[1] Resolution No. 182: *Support Military Quality of Life Standards*—AUG 2014

[2] Resolution No. 125: *Environmental Exposures*—AUG 2014.

This legislation addresses the need to better understand the toxins that many veterans have been exposed to, and enhance the understanding of the effect toxic exposures may have on veterans' descendants.

The American Legion supports this legislation.

S. 1082: DEPARTMENT OF VETERANS AFFAIRS ACCOUNTABILITY ACT OF 2015

This bill would provide for the removal or demotion of Department of VA employees based on performance or misconduct. Last year Congress passed and President Obama signed into law H.R. 3230; Public Law (PL) 113–146, The Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014, which provided the Secretary of Veterans Affairs the authority to remove any individual from the Senior Executive Service (SES) if the Secretary determines the performance of the individual warrants such removal, or transfer the offending individual to a General Schedule position without any increased monetary benefit.

The American Legion supported H.R. 3230, The Veterans' Access to Care through the Choice, Accountability, and Transparency Act of 2014 due in part to the systematic failures in the VA which included: preventable deaths, delays in providing timely and quality health care, and VA's failure to adjudicate claims in a timely manner.[3] While H.R. 3230 provided the Secretary of Veterans Affairs with authority to hold SES officials accountable, The American Legion remains concerned about the lack of accountability within VA for non SES employees. S. 1082 would provide the Secretary of Veterans Affairs the legal authority to better manage all VA employees, and hold them accountable when they fail to perform their duties in a manner that is befitting of a Federal employee who veterans have entrust their care to, and it establishes consistent standards across all grades of employees within VA.

The American Legion supports this legislation.

S. 1085: MILITARY AND VETERANS CAREGIVER SERVICES IMPROVEMENT ACT OF 2015

The struggle to care for veterans who have been wounded in the defense of this Nation takes a terrible toll on their families. In recognition of this, Congress passed, and President Obama signed into law, the Caregivers and Veterans Omnibus Health Services Act of 2010 in May of that year. However, the toll of war does not discriminate between periods of service. Veterans of all wars and conflicts suffer no less than veterans of the Post-9/11 era.

The American Legion does not distinguish between periods of service. Simply put, a veteran is a veteran is a veteran, and all veterans are entitled to receive the same level of benefits.[4] This legislation would remove a restriction limiting the benefits to veterans and their caregiver "on or after September 11, 2001" as well as adding additional enhancements to the Caregiver program. The American Legion urges Congress to restore consistency and equitability to veterans' programs and treat the caregivers of all critically wounded veterans the same regardless of when the veteran served.

The American Legion supports.

S. 1117: ENSURING VETERAN SAFETY THROUGH ACCOUNTABILITY ACT OF 2015

This bill seeks to improve the ability of the VA to discipline and dismiss physicians for poor performance or bad behaviors. This bill will also expand the expedited disciplinary authority that was given to the Secretary of Veterans Affairs under the Veterans Choice, Access and Accountability Act of 2014.

The American Legion supports the intentions of this bill, but rather than an individual, piecemeal approach targeting each class of VA employees, instead favors a more complete and streamlined authority affecting ALL employees of the Department of Veterans Affairs such as is proposed in Senator Rubio's bill S. 1082.[5] Accountability is one of the most vital components needed in reforming and improving VA's relationship with the veterans' community and must be consistently enforced across all levels.

The American Legion does not support this legislation.

H.R. 91: VETERANS I.D. CARD ACT

This bill would require VA to issue veterans an identification card (ID) for purposes other than obtaining VA benefits, and would require veterans to pay a minimal fee for the ID card. The American Legion does not see how this program would

[3] Resolution No. 30: *Department of Veterans Affairs Accountability*—MAY 2015
[4] Resolution No. 160: *Veterans Receive the Same Level of Benefits*—AUG 2014
[5] Resolution No. 30: *Department of Veterans Affairs Accountability*—MAY 2015

support VA's core missions which includes providing VA benefits to eligible veterans and their eligible dependents, medical; education, research, national emergency preparedness, and DOD contingency support.

The American Legion does support ensuring veteran status is listed on state identification cards and driver's licenses[6] however adding this as an additional mission to VA at this time rather than integrating it into the existing mission of state departments of motor vehicles raises additional challenges to an already heavily burdened VA.

The American Legion does not have a position on this legislation.

DISCUSSION DRAFT: S. 1021: WOUNDED WARRIOR WORKFORCE ENHANCEMENT ACT

This bill would require the Secretary of the Department of Veterans Affairs to award grants to establish, or expand upon, master's degree programs in orthotics and prosthetics, and for other purposes.

The American Legion believes due to the shortage of physicians in certain specialized areas, such as orthotics and prosthetics, Congress must ensure resources and funding are available to support continuing education and training of such physicians.[7] Through this continuing education program, VA would benefit from providers of these professions being available to treat VA patients through their continuing education program, and upon completion of the program becoming gainfully employed by the VA.

The American Legion supports this legislation.

S. 1358: HMONG VETERANS' SERVICE RECOGNITION ACT

The American Legion is deeply committed to the indigenous people of Vietnam, and by resolution has called upon Congress and the administration to work to affect real change to assist those peoples in their native homeland. The American Legion believes in basic human rights for the Hmong, the Montagnards and all others within that country.

The issue of burial in national cemeteries is complex, and must balance consideration of American servicemembers, veterans and their families with the needs of those who have served maintaining primacy. The American Legion recognizes the heroic sacrifices and service of the indigenous people of Vietnam. Through resolution, The American Legion urges Congress to investigate, evaluate, and prescribe legislation to provide these special groups who have lawfully obtained United States citizenship, burial rites in national cemeteries.[8]

The American Legion supports this legislation.

DISCUSSION DRAFT: JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

In the wake of serious concerns about over prescription of medications at the Tomah Veterans Affairs Medical Center, the Nation has become more focused on ensuring veterans and servicemembers are treated properly with opioid medications and do not unduly suffer due to mixed drug toxicity. The American Legion has been concerned about increasing reports of overmedication with pain management even before the stories began to circulate out of Tomah.

This legislation would work to improve pain management policies between the Departments of Defense and Veterans Affairs through establishing better clinical guidelines, countering overdoses, encouraging more collaboration between VA and DOD, and establishing pain management boards across VA to ensure better compliance. The legislation would also strengthen communication between VA and the veterans' community, enhance patient advocacy, and improve research and education on complementary and alternative care.

The American Legion firmly believes in increasing Federal funding throughout the Department of Defense, Department of Veterans Affairs and the National Institutes of Health for pain management research, treatment and therapies. Furthermore, The American Legion urges these institutions to increase investment in pain management clinical research by accelerating clinical trials at military and VA treatment facilities, as well as at affiliated university medical centers and research programs.[9] The increased use of complementary and alternative medicine is directly

[6] Resolution No. 43: *Veteran Coding on Driver's Licenses*—OCT 2012

[7] Resolution No. 311: *The American Legion Policy on VA Physicians and Medical Specialists Staffing Guidelines*—SEP 1998

[8] Resolution No. 72: *Benefits and Burial Rights for Select Surrogate Forces*—AUG 2014

[9] Resolution No. 190: *Support for Pain Management Research, Treatments and Therapies at DOD, VA and NIH*—AUG 2015

in line with policies of The American Legion regarding treatment for veterans with mental health and brain injuries, and represents a welcome expansion of care in these areas.[10]

The American Legion supports this legislation.

DISCUSSION DRAFT: BIOLOGICAL IMPLANT TRACKING AND VETERAN SAFETY ACT

At a March 25, 2014, House Committee on Veterans' Affairs Legislative hearing, The American Legion raised concerns about the lack of a robust tracking system in the Veterans Health Administration (VHA). The VA Office of the Inspector General (OIG) conducted an audit in 2012 and made recommendations regarding VA's management of their prosthetics supply inventory. In VHA's response, they indicated that they would work to develop a plan to replace the Prosthetic Inventory Package (PIP) and the Generic Inventory Package (GIP) with a more comprehensive system. The target completion date was March 30, 2015. In the interim, VHA indicated they were working on a VA Office of Information and Technology (OI&T) patch (VistA Prosthetics patch 101), which was 95 percent completed.

While reaching this goal by 2015 is indeed laudable, 2015 is rapidly becoming a critical year for VA to meet strategic goals including the elimination of veteran homelessness and the disability claims backlog. The American Legion would like to see a more detailed timeline implementing these changes and improvements for veterans. Reports through System Worth Saving Task Force visits and contact with VHA employees indicate responsibility for entering serial numbers of implant devices is manual, not automated, and are inconsistently implemented.

Although VHA claims to work to a standard of "removing recalled products from inventory within 24 hours of a recall," there is still no clear policy on how veterans who have already received implants are being tracked. It is not enough to cutoff the problem at the source, attention must be paid to veterans who are already downstream in the process. Without consistent tracking of implants, including positive identification by serial number and other identifying factors, uncertainty remains as to how veterans are served in the case of recalls. The American Legion noted that we would like to see a more comprehensive procedure and policy clearly delineated by VA Central Office to ensure consistency in all Veterans Integrated Service Networks (VISNs).

The analysis of the current inadequacy of the tracking system for bio-implants derives directly from The American Legion's System Worth Saving Task Force reports.[11] The System Worth Saving Task Force was established to examine the state of VA Medical Facilities by resolution in 2004. This annual report that is provided to the Administration, Congress, VA leadership, and the veterans' community is a vital resource as the primary third party analysis of the quality of VA healthcare throughout the country. The work of the System Worth Saving Task Force has now combined with the Regional Office Action Review visits to create Veterans Benefits Centers to continue this work, and in more detail that addresses concerns not solely with the healthcare system, but also with the disability claims system and indeed any manner in which veterans interact with VA.

The American Legion supports this legislation.

CONCLUSION

As always, The American Legion thanks this Committee for the opportunity to explain our position on these bills. Questions concerning this testimony may be directed to Warren Goldstein in The American Legion Legislative Division (202) 861–2700, or wgoldstein@legion.org.

Chairman ISAKSON. Thank you, Ian.

Peter.

STATEMENT OF PETER B. HEGSETH, CHIEF EXECUTIVE OFFICER, CONCERNED VETERANS FOR AMERICA

Mr. HEGSETH. Mr. Chairman, Ranking Member Blumenthal, thank you very much for the time. I will do my best micro-machine impression here.

[10] Resolution No. 292: *Traumatic Brain Injury and Post Traumatic Stress Disorder Programs*—AUG 2014

[11] Resolution No. 26: *Veterans Benefits Centers*—MAY 2015

I will focus the balance of my time on one bill, the VA Accountability Act, S. 1082, Sen. Marco Rubio's bill, that would simply empower the VA Secretary to efficiently and fairly remove underperforming VA employees. I would also note that there is a bipartisan companion bill in the House.

We believe S. 1082 is critical to overhauling a dysfunctional and bureaucratic culture that has infected VA at all levels. We certainly recognize that VA has a lot of great employees, many of which are veterans themselves. But, the fact of the matter is, for a long time, mediocrity and failure has been rewarded at VA, and it, in many ways goes back to Congress, as well.

What happens when VA fails to properly manage its massive and growing budget? It just gets rewarded with more money, another $3 billion here, another $3 billion there into the same bureaucracy and nothing changes, which is despite the best of intentions. I think more money gets thrown at VA in the hopes that it would fix itself. The VA's budget has doubled in the last 7 years, as you noted, Mr. Chairman, yet according to the *New York Times*, wait times have increased in the last year, significantly. More money should not equal longer wait times, and this is a clear image of what rewarding failure looks like. Ultimately, veterans pay the price for a lack of accountability.

There was a field hearing in Philadelphia with whistleblowers where it was acknowledged that morale is worse than it has ever been, and this should be a surprise to nobody. Who would want to work at a place where mediocrity is continually rewarded, a place where if you speak up about dysfunction and waste, instead of getting rewarded, you get a target on your back? That is a real morale crusher. And, because there is no accountability, there is lowering morale which results in losing good employees; and you are never going to attract the best employees, the quality employees that veterans deserve.

Now, we realize that some, almost exclusively public employee unions, have voiced concern about protections for rank and file employees. We strongly believe their concerns to be unfounded. Not only would existing whistleblower protections remain in place, but S. 1082 actually increases protections for whistleblowers. As far as willy-nilly firings, all VA workers retain the same Federal protections afforded other government workers. They simply would not be on paid administrative leave for as long. This bill is not about unions. This bill is about veterans.

Now, I know there is another bill that has been largely discussed today, Senator Johnson's bill, S. 1117. It makes a laudable move toward expanding removal authority. However, we do not think it goes far enough, because the problem is, unfortunately, not just health care workers. The Phoenix problem was largely an administrative problem, not a health care problem, which Senator Johnson's bill would not address. We think S. 1082 is full and fair in its accountability, medical and administrative, and is necessary to achieve the kind of cultural change that VA badly needs. That is what S. 1082 would deliver.

Ultimately, CVA believes that the VA will never provide efficient service and real choice until it is reformed, which is why CVA continues to fight for a complete overhaul of VA care. If you want to

address wait times, you need to introduce Choice, and VA is never going to do it on their own. That is why we believe veterans deserve the VA Accountability Act.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Hegseth follows:]

PREPARED STATEMENT OF PETER B. HEGSETH, CEO, CONCERNED VETERANS FOR AMERICA

Chairman Isakson, Ranking Member Blumenthal and Members of the Committee, thank you for affording me the opportunity to testify on pending legislation today on behalf of Concerned Veterans for America.

While several of these bills do worthwhile things, I want to focus the balance of my time on one bill that we believe represents a crucial step toward fixing ongoing culture problems at the Department of Veterans Affairs. The bill is S. 1082, the Department of Veterans Affairs Accountability Act of 2015, introduced by Senator Marco Rubio. The legislation builds on the work already begun by last year's Veterans Access, Choice and Accountability Act of 2014, which made it easier to remove incompetent and negligent VA Senior Executive Service officials. This common sense bill—S. 1082—simply expands the Secretary's authority to swiftly remove poor employees, regardless of their rank in the organization.

We believe this bill is badly needed—and critical to VA's recovery—because so much of what ills VA stems from a dysfunctional and bureaucratic culture that has infected the organization at all levels. Of course we recognize that the vast majority of VA employees care deeply for veterans and have a strong desire to serve them. As is often noted, many of these employees are veterans themselves. However, in a system that punishes whistleblowers and all too often rewards complacency and incompetence, even the best employee can become jaded, and just "go along to get along." When this becomes the case throughout an organization, mediocrity—and even failure—can become the norm.

As a matter of fact, VA has a history of rewarding mediocrity and failure. Employees that failed at their job—and ought be fired swiftly—are instead put on paid administrative leave, or even paid a bonus. Remember, it was not long ago that we were discussing improper bonus practices at the VA. This reward-for-failure practice goes all the way back to Congress itself. What happens when VA fails to properly manage its massive and growing budget resources and finds itself in a budget shortfall? It always gets rewarded with more resources. If we keep rewarding failure—if we keep just spending another $3 billion here and $3 billion there—we can only expect more failure.

For years, that has been Congress and the veterans community's default response: throw money at a failing VA bureaucracy and it will fix itself. That is the reason why the VA's budget has more than doubled in the last seven years, while the number of veteran patients (as reported by VA) grew by less than one million. In fact just this week the *New York Times* reported yet again that wait times have actually increased since the VA scandal broke last year. This is a clear image of what rewarding mediocrity and failure looks like at the Departmental level—failure that cascades down from the leadership to the frontline employee, and ultimately, to the underserved veteran. Remember, it is veterans who pay the price for no accountability at VA.

A whistleblower even noted at a field hearing this month at the VA regional office in Philadelphia that conditions there are now "worse than ever,"[1] and employee morale is at an all-time low. This should surprise nobody. Who would want to work at a place where mediocrity and failure gets rewarded? A place where, if you speak up about dysfunction and waste, instead of getting rewarded you get a target on your back? Because there is no accountability at VA, VA is losing good employees—and will continue to be unable to attract the best employees.

This common-sense bill—S. 1082—would simply increase the accountability for VA employees, but more importantly it would make the removal of bad employees more efficient, thereby enhancing the morale and dedication of the good employees which constitute the majority.

We realize that some—especially public employee unions—have voiced concerns about protections for rank-and-file employees, fearing that the VA Accountability Act would result in an increase in retaliations of whistleblowers and/or politicized personnel decisions. We strongly believe these concerns are unfounded. Not only

[1] http://www.stripes.com/news/veterans/it-s-worse-than-ever-employees-of-beleaguered-philadelphia-va-office-vent-to-visiting-lawmakers–1.352536

would existing whistleblower protections remain in place, but S. 1082 actually increases protections for whistleblowers. As far as willy-nilly firings, all VA workers will retain the same Federal protections afforded other government workers. S. 1082 simply condenses the appeal and adjudication period for fired workers—placing them on unpaid administrative leave in the process. VA workers retain full protections and full appeal rights; they just won't be sitting on paid administrative leave for months and years. Again, common sense stuff.

Another bill being considered today—Senator Ron Johnson's S. 1117, Ensuring Veteran Safety Through Accountability Act of 2015—makes a laudable move toward expanded removal authority. However, this bill simply does not go far enough. By applying the increased firing authority only to VA health care workers (Title 38 employees), many potentially problematic VA employees will continue to fly beneath the radar with little accountability. The bill also strikes us as unfair—with some employees held accountable, others not. Full and fair accountability for all VA employees is necessary to achieve the kind of culture change that VA badly needs. That is what S. 1082 delivers.

As we all know, the stories associated with the actions of bad VA employees are numerous and infuriating. For example, it took over year to fire a VA employee in Alabama who took a drug-addicted veteran to a crack house and left him overnight. Worse, a year after the scandal broke, still not a single VA employee have been fired specifically for manipulating patient wait times. In fact, overall firings have actually decreased at the VA since the wait list scandal broke despite the fact that the manipulation of waitlists was found to be a wide and systemic problem. The status quo is unacceptable.

It's blindingly obvious that more accountability is needed to help fix what ills the VA bureaucracy. In fact, Deputy Secretary Sloan Gibson recently testified before the House Veterans' Affairs Committee, saying "it's hard to hire and it's hard to fire" employees across the Federal Government, including at VA. He added that, "We will not change the culture of the VA unless we hold people accountable."[2]

We adamantly agree with Secretary Gibson—as do all the VSOs who also support S. 1082.

It is to give VA the tools they need to live up to their own words.

Chairman ISAKSON. Thank you very much.

Adrian Atizado.

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

Mr. ATIZADO. Chairman Isakson, Ranking Member Blumenthal, Senator Baldwin, Senator Rounds, I would like to thank all of you for inviting DAV to testify at this legislative hearing.

As you know, DAV is a nonprofit Veterans Service Organization. Through our 1.3 million members, who are wartime service-disabled veterans, our nearly 4,000 service officers, and nearly 13,000 volunteers, we are dedicated to one purpose, one goal: to empower veterans to lead high-quality lives with dignity and respect.

Three minutes is an awful short time. I will get to it.

S. 469, the Women Veterans and Families Health Services Act of 2015, is a comprehensive bill, as Senator Murray has said. We support this bill. We support it with a resolution that our delegates passed last year in our National Convention.

S. 1085, the Military and Veteran Caregiver Services Improvement Act, this would expand eligibility to VA's comprehensive Caregivers Support Program from veterans severely injured before September 11, 2001. This will be done by phasing in veterans based on need to allow VA to manage the workload while keeping quality services high. DAV supports parts of this bill in accordance with our resolution, again, passed by our delegates from our last convention.

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[2] http://www.govexec.com/management/2015/05/va-officials-say-theyre-trying-fire-people-its-still-really-hard/112717/

Now, for all the effort over the past 3 years, the greatest obstacle to expanding this program to the greatest generation and after them is cost. I heard Chairman Isakson talk about a GAO report which primarily hinges on IT. The IT solution that VA has been going for is in their budget request, $6 million, I think, $6.8. I think that in and of itself will address GAO's concerns about this program, its ability to meet the new workload if the program is expanded. We have worked with VA to address its current IT solution, to stabilize it, to make sure people in the program are being served properly as well as into the future.

Perhaps it is because caregivers lie outside a market economy that it is socially and politically invisible and its economic value is not generally acknowledged. What we do acknowledge is the cost of deploying servicemembers to war. Caregivers of veterans severely disabled before September 11, 2001, bear the cost every day with little recognition of services and sacrifices. A recent Met Life study put that cost at over $320,000 in terms of lost wages and benefits. This is not including the quality-of-life that they suffer.

The business case for expanding this program has been made by RAND, by AARP, a number of other formidable institutions. We ask this Congress to pass this in 2015.

Thank you.

[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. 469, THE WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

This is a comprehensive bill that would expand child care and women veteran retreat pilot programs in the Department of Veterans Affairs (VA), and would direct the Department of Defense (DOD) and VA to furnish voluntary fertility treatment and counseling programs.

Section 101 would direct the Secretary of Defense to furnish fertility treatment and counseling, including through the use of assisted reproductive technology, to a spouse, partner, or gestational surrogate of a severely injured, ill or wounded member of the Armed Forces who has an infertility condition incurred or aggravated while serving on active duty. This service would be provided regardless of the servicemember's sex or marital status. This section would further require that if the servicemember were unable to provide gametes for fertility treatment purposes, DOD would pay or reimburse the reasonable cost of the member's procuring donor gametes. In addition, a maximum of three completed cycles or six attempted cycles of in vitro fertilization (IVF) could be provided to a spouse, partner, or gestational surrogate of the member.

Section 102 would direct DOD to establish procedures for gamete retrieval from a severely injured, ill or wounded servicemember when the fertility of the member is potentially jeopardized as a result of military service.

Section 103 would mandate DOD to give active duty members the opportunity to cryopreserve and store gametes prior to deployment to a combat zone, at no cost. The gametes would be stored until one year after the retirement, separation, or release of the member from the Armed Forces, and the member would retain the option of extending the preservation of gametes by paying out-of-pocket to continue such storage or transfer the material to a private cryopreservation and storage facility, or to a VA facility if cryopreservation and storage were available.

Section 104 would require DOD and VA to share best practices and facilitate fertility treatment and counseling referrals for eligible individuals.

Section 201 would amend section 1701(6) of title 38 to include fertility counseling and treatment under the definition of authorized VA medical services.

Section 202 would direct the VA Secretary to furnish fertility treatment and counseling, including through the use of assisted reproductive technology, to a spouse, partner, or gestational surrogate of a severely injured, ill or wounded veteran who is enrolled in VA and has an infertility condition incurred or aggravated while serving on active duty. In the case of IVF treatment furnished, a maximum of three completed cycles or six attempted cycles of IVF would be authorized, whichever occurs first, to a spouse, partner, or gestational surrogate of the veteran.

Section 203 would authorize VA to pay adoption expenses for up to three adoptions for a severely wounded, ill, or injured veteran with an infertility condition incurred or aggravated in the line of duty, and who is enrolled in the VA health care system.

Sections 204 and 205 would direct VA to report annually to Congress on the counseling and treatment provided under this act; and would require prescribed regulations on the furnishing of such counseling, treatment, and adoption assistance.

Section 206 would direct VA to facilitate research conducted collaboratively by DOD and the Department of Health and Human Services in order to improve VA's ability to meet the long-term reproductive health care needs of veterans with service-connected genitourinary disabilities or conditions incurred or aggravated in the line of duty that affect reproductive ability.

Section 207 would require VA to enhance the capabilities of the women veterans contact center to respond to requests for assistance with accessing VA health care and benefits, and would require referral of such veterans to Federal or community resources to obtain assistance not furnished by VA.

Section 208 would modify the Caregivers and Veterans Omnibus Health Services Act of 2010 that authorized a pilot program of group retreat reintegration and readjustment counseling for women veterans recently separated from service. Section 208 would increase the number of counseling locations from three to 14, and extend the program through December 31, 2018.

Section 209 would establish VA programs to provide child care assistance to qualified veterans so that such veterans could receive regular mental health care services; intensive mental health care services; other intensive health care services; and, readjustment counseling and related mental health services.

DAV is pleased to support this bill, parts of which are in accord with DAV's Resolution No. 040, which supports enhanced medical services and benefits for women veterans. DAV also supports this bill on the strength of Resolution 220, calling for VA to provide comprehensive services to enrolled veterans. While DAV has no specific resolution from our membership related to reproductive and infertility treatments per se, this bill is focused on improving VA's authority to meet the long-term reproductive health care needs of veterans with service-connected conditions that negatively affect their reproductive health. For these reasons, DAV looks forward to favorable consideration and enactment of this bill.

S. 901, THE TOXIC EXPOSURE RESEARCH ACT OF 2015

The 2008, 2010 and 2012 Institute of Medicine (IOM) Committees to Review the Health Effects in Vietnam Veterans of Exposure to Herbicides concluded there is a plausible basis that male veterans exposed to the herbicides the US military deployed in Vietnam could result in adverse effects being manifested in the adult children and grandchildren as a result of epigenetic changes, and such potential would most likely be attributable to the 2,3,7,8-tetrachlorodibenzo-p-dioxin (TCDD) contaminant, the most toxic form of dioxin in Agent Orange.

The 2012 Agent Orange Study Committee reported it favors renewed efforts to conduct epidemiologic studies on all the developmental effects in offspring that may be associated with paternal exposure. In addition, new studies should evaluate offspring for defined clinical health conditions that develop later in life, focusing on organ systems that have shown the greatest effects after maternal exposure, including neurologic, immune, and endocrine eaeffects. Finally, although the IOM committee recognized that there is evidence that environmental exposures can affect later generations, epidemiologic investigations designed to associate toxic exposures with health effects manifested in later generations will be even more challenging to conduct than research on adverse effects on the first generation.

While TCDD mostly associated with herbicide-exposed Vietnam veterans, it is also one of 56 pollutants, including several types of dioxins, of interest to the 2011 IOM Committee on the Long-Term Health Consequences of Exposure to Burn Pits in Iraq and Afghanistan. Moreover, the Agency for Toxic Substances and Disease Registry has been working on possible adverse health outcomes from exposure to volatile or-

ganic compounds (VOCs) perchloroethylene (PCE), trichloroethylene (TCE), and benzene, in the water supply at the Camp Lejeune Marine Corps Base, North Carolina.

This bill would establish a national VA center to conduct research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to any toxic substance, as defined by the Environmental Protection Agency, during military service provided those health conditions are related to the veterans' exposures. The bill would also establish an advisory board to oversee and assess the national center, to advise the VA Secretary on issues related to the national center, and to assess the health care needs of the descendants of exposed veterans. Finally, the bill would authorize no additional funds for the purposes of this program.

DAV does not have a resolution from our membership to enable DAV to support this legislation. We encourage the Committee and VA to work together to ensure the legislation is in consonance with the IOM committees' recommendations.

S. 1117, THE ENSURING VETERAN SAFETY THROUGH ACCOUNTABILITY ACT OF 2015,
AND
S. 1082, THE DEPARTMENT OF VETERANS AFFAIRS ACCOUNTABILITY ACT OF 2015

S. 1117 would amend section 713, title 38, United States Code, which authorizes the VA Secretary to remove senior VA executives for performance or misconduct. This bill would expand the Secretary's authority, to enable the Secretary to remove anyone employed on a full-time basis under a permanent appointment in a position listed in section 7401, title 38, United States Code. Positions identified in section 7401 are all of VA's direct health care providers.

S. 1082 would provide the VA Secretary the authority to remove from the civil service or demote a VA employee through a reduction in grade or annual pay rate based on performance or misconduct.

Under S. 1082 employees affected by removal or demotion would be given seven days to appeal to the Merit Systems Protection Board. An administrative law judge would be required to make a final decision within 45 days of such appeal, or the original decision would become final.

The bill would prohibit removal or demotion of an employee without the approval of the Special Counsel if the individual sought corrective action from the Office of Special Counsel based on an alleged prohibited personnel practice.

The bill also would prescribe a minimum 540-day probationary period for appointment of an individual to a permanent position within the competitive service or as a career appointee within the Senior Executive Service, and would give the Secretary discretion to extend this probationary time. Final appointment to a permanent position would be the exclusive decision of the employee's supervisor, but based on regulations established for this purpose by the Secretary.

Last, under S. 1082, the Government Accountability Office would be required to study and report to Congress the amount of time spent by VA employees carrying out labor organization activities, the amount of VA space used for such activities, and provide a cost-benefit analysis of the use of such time and space for the conduct of these activities.

In order to ensure that veterans receive the benefits and services they have earned, every VA employee, manager and leader must faithfully fulfill their duties and responsibilities. When they fail to do so, whether due to poor performance or misconduct, systems must be put in place to support decisive and timely actions to hold them accountable, including appropriate training, demotion, suspension, and termination when appropriate.

Mr. Chairman, we, too, become frustrated and angry when veterans are harmed due to poor performance or misconduct by a VA employee, manager or leader, and more so when no action is taken to hold them accountable.

However, it is also vitally important to VA's long-term future to create an environment in which the best and brightest professionals choose VA over other Federal or private employers. While poor performance and misconduct cannot be tolerated, VA employees must be confident that fairness and due process govern how they are selected, promoted, demoted, sanctioned or terminated.

Without such assurances of fairness and due process in the workplace, talented doctors, nurses and other professionals may not even entertain working in the VA, especially since they must already be willing to accept below-market salaries, pay and hiring freezes, government shutdowns, and other challenges of working in the Federal Government.

We must not forget that civil service protections enacted decades ago came about as a result of politicization and ill treatment of government employees, including terminations for almost any reason, or no reason.

Ensuring that the civil service remains free of political influence is a principle that we must protect to guarantee that employees are neither appointed, demoted nor terminated for political reasons, and that benefits and services are delivered to veterans without any partisan bias.

While DAV has no resolution from our membership on this topic or these specific proposals to enable us to take a position on these bills, we do want to stress to the Committee and these bills' sponsors that any legislation changing the existing employment protections in VA must strike an appropriate balance between holding civil servants accountable for their work, while maintaining VA as an employer of choice for the best and brightest individuals.

S. 1085, THE MILITARY AND VETERAN CAREGIVER SERVICES IMPROVEMENT ACT

This measure would expand eligibility for VA's Comprehensive Caregiver Support Program to veterans of all eras, by phasing in veterans based on need, allowing VA to manage the new workload, while keeping service quality high. It would also include a wider range of injuries and illnesses that require caregiving, place a greater emphasis on mental health injuries and Traumatic Brain Injury (TBI), and remove certain restrictions in current law on those eligible to become caregivers.

The bill would also make improvements to the VA caregiver program by making caregivers eligible for VA child care programs, or by providing a stipend to offset the cost of child care. Also, the bill would authorize VA to provide caregivers financial advice and legal counseling.

This bill would affect the Department of Defense caregiver program as well. Improvements in DOD's Special Compensation for Assistance with Activities of Daily Living (SCAADL) would include expanding eligibility for the program by making the criteria similar to those for the VA caregivers program and make caregivers of servicemembers receiving SCAADL eligible for a range of critical supportive services provided by VA.

DAV supports this bill based on Resolution No. 042, which calls for legislation that would expand eligibility for comprehensive caregiver support services, including but not limited to financial support, health and homemaker services, respite, education and training, and other necessary relief to caregivers of veterans from all eras of military service.

VA's comprehensive caregiver program had been operating for over three years when Congress held a hearing late last year on how best to expand eligibility for the services and benefits of this program to severely ill and injured veterans of all eras. During the hearing, concerns were expressed about the program, and arguments were made that improvements should be made to the existing program prior to its further expansion.

We believe that program improvements can be achieved while expanding eligibility without further delay. DAV continues to address concerns about the program with VA, and we are engaging Congress to ensure caregivers of all severely disabled veterans receive comprehensive support.

Members of Congress pointed out that additional VA caregiver support coordinators (CSC) were needed in order to be responsive and meet the needs of caregivers currently participating in the program. DAV worked with VA to ensure funding was allocated for an additional 42 CSCs at the beginning of the current fiscal year (FY), and we are working with Congress to ensure a minimum of $10 million is directed to hire additional CSCs for FY 2016. Also, as was noted in the hearing, the information technology (IT) system that supports caregivers needs improvement. We have worked with VA to ensure that funds were released in FY 2015 to make necessary IT corrections and we have urged the Department to request additional funding for FY 2016 to deliver a comprehensive IT solution for the program that would serve caregivers of severely ill and injured veterans of all eras.

The greatest obstacle to expanding this program is the cost for enacting legislation that would provide comprehensive caregiver support to all severely disabled veterans; nevertheless, we must also acknowledge the cost of deploying servicemembers to war. Caregivers of veterans severely ill and injured before September 11, 2001, bear that cost already, with little recognition or services for their sacrifices.

The business case to expand the comprehensive caregiver program has already been made in the report Hidden Heroes: America's Military Caregivers, by the RAND Corporation. The loving assistance provided by family caregivers saves taxpayers billions of dollars each year in health care costs, and enables severely wounded, injured and ill veterans to live at home rather than in institutions. DAV believes it is time for Congress to act to expand these benefits to veterans of all eras.

DRAFT BILL—THE JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

This draft bill, the "Jason Simcakoski Memorial Opioid Safety Act," named in honor of a Wisconsin veteran who died from prescribed opioid drugs while in the care of the Department of Veterans Affairs (VA), would strengthen and better regulate VA's policies on the use of opioids and drugs containing benzodiazepine, particularly patients with mental health challenges and those suffering from chronic pain.

We strongly support the sponsor's intention to control and reduce the use of addictive substances in VA health care. The VA has previously acknowledged it is challenged by the prescribing practices of some of its providers.

Title I of the bill would establish a far-reaching and ambitious new program to deal with, protect against, control, and report any over-prescribing of benzodiazepines and opioid substances in the care of veterans enrolled in health programs of VA. While VA has made recent efforts to address overprescribing, its existing pain management program is not well organized, and is insufficiently staffed in our view, so enactment of this bill would call attention to the need for VA to better manage and staff this function at both the national and local levels.

DAV strongly supports Title II of the bill, which would establish a formalized national patient advocacy program in VA. As a co-author of the *Independent Budget*, DAV has called for improvements in patient advocacy and ombudsman programs in VA for several years. We believe the bill would give this program the weight and importance it deserves to help veterans to better navigate the VA health care system.

Title III of this bill would enhance complementary and alternative health care programs in VA. We support the advent of complementary and alternative care, both in substitute to VA's use of pharmacological agents, and to better respond to the needs and demands of a younger generation of veterans, who often do not want traditional medical management—especially if it involves the prescribing of pain and psychotropic medications.

Title IV of the bill would require VA to strengthen its scrutiny in hiring practices for physicians and other providers by validating that such candidates for employment in VA carry no blemishes on their state licenses. If a VA provider were to violate a requirement of medical licensure, VA would be required by the bill to report any such violation to the state medical board(s) of the state(s) that had granted licensure. Also, if the VA provider were to resign from VA, or transfer from one VA facility to another, this bill would require VA to determine whether there were any "concerns, complaints, or allegations related to the medical practice" of the individual during VA employment, and to take appropriate action in response. In respect to these requirements, the Committee may wish to consider amending the bill to clearly define the term "provider," and whether the intention is to include all or only some of the individuals identified as direct care providers in section 7401 of title 38, United States Code.

Title V of the bill would require the establishment and reporting to Congress of a series of internal audits of VA administrations and key offices.

In summary, based on several resolutions adopted by our membership in our most recent National Convention (Resolution Nos. 039, 201 , 218 , and 220, DAV supports this bill, we appreciate the sponsor's leadership in developing this proposal, and we urge Congress to proceed with its enactment this year.

DRAFT BILL—THE BIOLOGICAL IMPLANT TRACKING AND VETERAN SAFETY ACT OF 2015

This draft bill would require VA to establish a biological implant inventory identification and management system with the same features and requirements of an existing system in use by the Food and Drug Administration to regulate origin, movement, surgical implantation, and recall (if necessary) of any such biological material.

The bill would define the term biological implant as any "animal or human cell, tissue, or cellular or tissue-based product," and would tie that definition to the existing regulatory definition under the Federal Food, Drug, and Cosmetic Act.

The bill would set a number of milestone and deadline dates for implementation, and would require VA to submit a series of reports to document its progress in implementation of this system.

The bill would restrict the procurement of biological implants to vendors who meet certain conditions laid out in the bill, and would sanction any VA procurement employee involved in the procurement of biological implants who acted with intent to avoid, or with reckless disregard of the requirements of the bill.

DAV has received no resolution from our membership that deals with the specific topic of biological implants. However, DAV's Resolution No. 220 calls for VA to provide a comprehensive health care service for all enrolled veterans. Better control of

the origins, movement, surgical implantation and recall, if necessary, of implantable biological material would be in keeping with the intent of our resolution. Therefore, DAV supports the purposes of this bill and endorses its enactment.

DISCUSSION DRAFT

Section one would require a report to the House and Senate Veterans' Affairs Committees from VA about its plan to establish or expand advance degree programs in orthotics and prosthetics for the purposes of improving such care to veterans. Under the ill, a plan would be developed in consultation with veterans service organizations, institutions of higher education with accredited degree programs in prosthetics and orthotics, and with representatives of the prosthetics and orthotics field.

As part of the *Independent Budget* (*IB*), DAV supports the intent of this section of the bill that would develop future VA prosthetists and orthotists. The VA Prosthetic and Sensory Aids Service (PSAS) is a special-emphasis program that serves approximately half of the veterans that receive health care services in VA, and continues to have major positive impact on meeting the specialized needs of severely disabled veterans.

This measure is consistent with the *IB*'s recommendation for VA to revise qualification standards for prosthetics representatives and orthotics/prosthetics personnel to most efficiently meet the complexities of programs throughout the VA health care system and to attract and retain qualified individuals. Additionally, VA must ensure that PSAS departments are staffed by certified professional personnel or contracted staff that are capable of maintaining and repairing the latest and most advanced prosthetic devices.

To this end, we urge the Committee to include a provision in this bill that would specify that the plan to be reported to Congress would directly improve and enhance orthotic and prosthetic care for veterans. For example, VA contracts with academic affiliates encompass the Department's education and training program for health professional trainees to enhance the quality of care provided to veteran patients through coordinated programs and activities in partnership with academic affiliates.

Additionally, we ask the Committee to consider defining the term "veterans service organizations" the same as this term is defined in section 5902, title 38, United States Code.

Section two of this measure would require VA to consult with the Department of Defense (DOD) and other agencies as appropriate, and afterward to submit a report to Congress on the extent to which Laotian military forces provided combat support to the Armed Forces of the United States in Southeast Asia between February 28, 1961, and May 15, 1975; whether the current classification by the DOD Civilian/Military Service Review Board is appropriate; and to make any recommendations for legislative action.

DAV has no resolution on this specific issue, and takes no position on this section of the bill.

H.R. 91, THE VETERAN'S I.D. CARD ACT

This legislation would authorize the Secretary of Veterans Affairs to issue cards to certain former military servicemembers that identify them as veterans. While DAV has no resolution or position on this matter we recommend this be a collaborative effort between the two principal agencies; DOD, in issuing this type of identification card to those eligible at time of discharge, and VA, in issuing this type of identification card to those already separated from military service.

Mr. Chairman, this concludes my testimony. DAV appreciates your request for our views on this legislation. I would be pleased to answer any questions from you or members of the Subcommittee dealing with this testimony.

Senator BLUMENTHAL [presiding]. Thank you very much.

Mr. Blake.

STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Mr. BLAKE. Thank you, Senator Blumenthal. On behalf of Paralyzed Veterans of America, I would like to thank you for the opportunity to testify today.

PVA strongly supports S. 1085, the Military and Veteran Caregiver Services Improvement Act. This bill is the number 1 legislative priority of PVA, as our members will benefit more from this than any other cohort in the veterans' population.

The needs of catastrophically disabled veterans are not different simply because they were injured prior to September 11, 2001. No reasonable justification can be provided for why veterans with catastrophic service-connected injuries or illnesses should be excluded from the Family Caregiver Program. Unfortunately, some have decided that cost is a reasonable justification. Cost is not a justification. Cost is an excuse. It is time to end this unacceptable inequity once and for all.

PVA also strongly supports S. 469, the Women Veterans and Families Health Services Act. This bill is also a high priority for our members. It would allow the VA to finally provide reproductive assistance to severely injured veterans. As a result of the recent conflicts in Afghanistan and Iraq, many young men and women have incurred injuries from explosive devices that have made them unable to conceive a child naturally. While the Department of Defense does provide assistive reproductive technologies, such as in vitro fertilization, to servicemembers, the VA does not. But, let us be clear. It is not because the VA chooses not to. It is because Congress decided it would not a long time ago.

For too long, moral arguments have stood in the way of eliminating the prohibition of the VA to provide reproductive services, particularly in vitro fertilization. If we accept that this country has a moral obligation to make whole those men and women who have been sent into harm's way and returned broken, then it is time for this legislation to be enacted. If a Member of Congress wants to debate the moral issues that they believe supercede the need to do the right thing by these men and women, we invite that discussion. I would suggest that Member of Congress meet face to face with the men and women who are impacted by this policy every day. The bottom line is the fact that this prohibition even exists is shameful.

Finally, PVA supports S. 1082, the Department of Veterans Affairs Accountability Act of 2015. We believe that Secretary McDonald and Deputy Secretary Gibson want to hold bad employees at the VA accountable in the most appropriate fashion. Unfortunately, at this point, accountability seems to be only defined by transfers, admonishment, reprimands, and retraining, but not termination. We realize that termination of Federal employees is a complicated proposition, but it should not be impossible.

The notion that the fear of termination as a part of accountability is bad for morale is nonsense. I believe the VA uses the term "disheartened" in their testimony today for how VA employees would respond to this legislation. In my experience as an infantry platoon leader, unit morale did not suffer from soldiers being fired or chaptered out of the military entirely. Morale suffered when soldiers knew there was a substandard soldier dragging down the unit and jeopardizing the mission. In fact, morale significantly improved when poor performing soldiers were taken out of the unit or taken out of the Army. We believe the VA employees who are doing an outstanding job understand this concept and will appreciate re-

moval of those individuals around them who are not performing up to the standard.

However, we must emphasize that we are not wholly convinced that this legislation is the solution. In fact, it remains to be seen if this legislation will enable the VA to actually hold individuals accountable, and we only have to look at what has happened as a result of the provisions of VACA to know what might actually happen.

Thank you again, Mr. Chairman.

[The prepared statement of Mr. Blake follows:]

PREPARED STATEMENT OF CARL BLAKE, ASSOCIATE EXECUTIVE DIRECTOR OF GOVERNMENT RELATIONS, PARALYZED VETERANS OF AMERICA

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to testify today on the pending health care legislation. Several of these proposed bills address very high priorities for PVA and our members, veterans with spinal cord injury or disease (SCI/D). We encourage the Committee to give swift consideration to these measures and move them to the floor of the Senate for passage as soon as possible.

S. 469, THE "WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015"

PVA strongly supports S. 469, the "Women Veterans and Families Health Services Act of 2015." This bill will allow the Department of Veterans Affairs (VA) to provide reproductive assistance to severely wounded veterans. For many disabled veterans, one of the most devastating results of spinal cord injury or disease is the loss of, or compromised ability, to have a child. As a result of the recent conflicts in Afghanistan and Iraq, many servicemembers have incurred injuries from explosive devices that have made them unable to conceive a child naturally. While the Department of Defense does provide assisted reproductive technologies (ART), such as in vitro fertilization (IVF), to servicemembers and retired servicemembers, VA does not. When a veteran has a loss of reproductive ability due to a service-connected injury, they must bear the total cost for any medical services should they attempt to have children. It is often the case that veterans cannot afford these services and are unable to receive the medical treatment necessary for them to conceive. For many paralyzed veterans procreative services have been secured in the private sector at great financial and personal cost to the veteran and family.

Procreative services, provided through VA, would ensure that certain catastrophically disabled veterans are able to have a full quality of life that would otherwise be denied to them as a result of their service. For decades, improvements in medical treatments have made it possible to overcome infertility and reproductive disabilities. Veterans who have a loss of reproductive ability as a result of a service-connected injury should have access to these advancements.

Additionally, this bill addresses specific procreative options for women veterans. Some women veterans with a catastrophic injury may be able to conceive through IVF but be unable to carry a pregnancy to term due to their disability. In such an instance the implantation of a surrogate may be their only option. This legislation would allow VA to provide services to a veteran, their partner, or gestational surrogate.

Further, this legislation would allow for genetic material donation. For veterans whose injuries result in the loss or damage of genitalia, a third-party donation may be their only option. If the role of VA is to restore to veterans and their families what has been sacrificed in service to this country, then passage of this legislation is essential.

As of 2013, the Congressional Budget Office estimated that more than 3,000 veterans injured since September 11, 2001, would benefit from these services. Overturning the existing policy would save catastrophically disabled veterans and their families between $25,000 and $36,000 and allow the Federal Government to fulfill the moral obligation it has to these men and women.

Additionally, the bill would also cover expenses involved in the adoption of children, further providing veterans with an option they couldn't otherwise afford. Other elements in the legislation include infertility research, expansion of counseling retreats for women and expansion of the highly successful child care program.

These are invaluable services that will improve the well-being of our servicemembers and veterans.

S. 901, THE "TOXIC EXPOSURE RESEARCH ACT OF 2015"

PVA understands the intent of and generally supports this legislation. This bill would require the VA Secretary to select one VA medical center to serve as the national center for research on the diagnosis and treatment of health conditions of descendents of individuals exposed to toxic substances while serving in the Armed Forces. It would also require the establishment of an advisory board for the national center to determine links between exposure and health conditions. However, the bill does not discuss the processes should the advisory board conflict with the findings of the IOM. We encourage the Subcommittee and VA to work together to ensure the legislation fulfills the IOM Committee recommendations.

S. 1082, THE "DEPARTMENT OF VETERANS AFFAIRS ACCOUNTABILITY ACT OF 2015"

PVA supports S. 1082, the "Department of Veterans Affairs Accountability Act of 2015." The events over the past year have clearly demonstrated the need for greater flexibility for VA leadership to effectively discipline and manage the failures of their staff.

The incompetence, negligence and seemingly willful misconduct at the Phoenix VA medical center and other VA facilities around the country have provided a clear signal that VA has to change its personnel processes. We continue to see growing problems with claims processing, even while VA lauds their successes in reducing the backlog, and despite the ever-growing wave of appeals. Recent hearings conducted by the House Committee on Veterans' Affairs highlighted the failed operations and personnel policies of the Philadelphia and Oakland VA Regional Offices, and these are likely not anomalies. Even more troubling is the billion dollar cost overrun for the Denver VA medical center, a facility critical to PVA members in that region who will rely on the new spinal cord injury center that is included in that project.

Yet in all these events, we have been left wanting when it comes to holding these bad actors accountable in a manner that goes beyond the preemptive resignations of several senior VA executives whose professional negligence or misconduct was rewarded with "golden parachute" retirement packages and benefits. Moreover, accountability for many of these failures should go well beyond just the senior executives of VA.

PVA believes that Secretary McDonald and Deputy Secretary Gibson want to hold any bad employees at the VA accountable in the most appropriate fashion. Unfortunately, at this point accountability seems to only be defined by transfers, admonishment and retraining, not termination. We realize that termination of Federal employees is a complicated proposition, but it should not be impossible. If this legislation eases the ability of VA to truly hold bad employees accountable, then we encourage the Committee to move this bill quickly. However, we must emphasize that we do not believe this legislation really represents the solution. In fact, it remains to be seen if this legislation can move VA to actually hold individuals accountable.

S. 1085, the "Military and Veteran Caregiver Services Improvement Act of 2015"

PVA strongly supports S. 1085, the "Military and Veteran Caregiver Services Improvement Act of 2015." PVA's members would benefit from the passage of this bill more than any cohort of the veterans population. And yet, because of an arbitrary date, most of them are denied a critically needed service. The needs of catastrophically disabled veterans are not different because they became injured or ill prior to September 11, 2001. No reasonable justification can be provided for why veterans with a catastrophic service-connected injury or illness should be excluded from the Comprehensive Family Caregiver Program.

Moreover, the need for a caregiver is not lessened simply because a veteran's service left him or her with a catastrophic illness, rather than an injury. PVA is pleased to see that S. 1085 includes catastrophic illness as a program qualifier. For PVA's members, a spinal cord disease is no less devastating than a spinal cord injury. Veterans that have been diagnosed with Amyotrophic Lateral Sclerosis (ALS) and Multiple Sclerosis (MS) will eventually experience significant decline in their ability to perform activities of daily living and unquestionably become dependent on a caregiver.

Caregivers are the most critical component of rehabilitation and eventual recovery for veterans with a spinal cord injury or disease. Their well-being directly impacts the quality of care provided to veterans. For this reason, PVA includes caregivers in our advocacy for veterans. In fact, PVA has partnered with the Elizabeth Dole

Foundation to work to raise awareness of the role of caregivers in this country and to address alarming gaps in caregiver support services.

Pre–9/11 caregivers have provided decades of uncompensated work to our disabled veterans, often with no support services of any kind and at the expense of their own health and livelihood. A study by the Rand Corp. in 2014 estimated that veterans' caregivers save taxpayers $3 billion a year.

The cost of the services the VA Caregiver Program currently denies to veterans who became catastrophically injured or severely ill prior to September 11, 2001 will ultimately be paid for by society as a whole. The well-being of a family inevitably declines without essential supports. Ensuring that a veteran is able to reside in their home in their community has been shown time and again to reduce medical complications, hospital stays, and costs. At the same time, the veteran and their family maintain a psychosocial wellness that is impossible to achieve in an institution.

No group of veterans understands the importance of caregivers more than PVA members and their families. As many as 70,000 veterans (with estimates as high as 88,000) would be eligible for the Comprehensive Family Caregiver Program if the September 11, 2001 date was eliminated as a barrier. Similarly, nearly half of all PVA members (approximately 10,000) and nearly 20,000 veterans with spinal cord injury would benefit from this change.

PVA understands the costs concerns with expanding the program. The Congressional Budget Office estimated that full expansion would be $9.5 billion over the next five years. While cost is offered as a barrier to expanding access to this program, these concerns ignore the possible net cost savings that the VA could reap by providing services to thousands of veterans through the Comprehensive Family Caregiver program rather than through institutional care. Unfortunately, Congress generally ignores these principles of "dynamic scoring" except when it is politically expedient. When considering the cost of providing caregiver services versus the cost of institutional services, expansion could save the Federal Government between approximately $2.5 billion and $7.0 billion in a given year. Moreover, the health outcomes for veterans served at home by caregivers would likely improve.

Chairman Isakson, we appreciate the positive comments you made concerning the need to expand the Comprehensive Family Caregiver Program during the joint hearing of the House and Senate Committees on Veterans' Affairs when our National President testified in May. We hope that the interest you expressed will translate to real action on this measure.

S. 1117, THE "ENSURING VETERAN SAFETY THROUGH ACCOUNTABILITY ACT OF 2015"

Much like our position with regards to S. 1082, PVA supports S. 1117, the "Ensuring Veteran Safety Through Accountability Act of 2015." Accountability for misconduct of VA employees should go beyond the senior executives of VA. S. 1117 would apply the provisions outlined in Public Law 113–146, the "Veterans Access, Choice and Accountability Act," for holding Senior Executive Service employees accountable to health care providers who exhibited poor performance or misconduct. This legislation would expand on the expedited disciplinary authority given to the VA secretary.

H.R. 91, THE "VETERAN'S I.D. CARD ACT"

PVA has not official position on H.R. 91, the "Veteran's I.D. Card Act." This bill directs the Secretary of Veterans Affairs to issue, upon request, veteran identification cards to certain veterans. We do question why veterans should have to pay a fee for a card that identifies them as a veteran.

THE "JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT"

PVA supports the "Jason Simcakoski Memorial Opioid Safety Act." This bill targets problems recently identified in the VA's use of opioids in treating veterans. Additionally, it seeks to improve patient advocacy by the Department and expand availability of complementary and integrative health Services.

This bill would require the Department of Defense (DOD) and the VA to jointly update the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain that has not been updated since 2010. VA would also be required to adopt safe opioid prescribing guidelines for chronic, non-cancer pain in outpatient settings. It would require each health care provider of VA and DOD to use VA's Opioid Therapy Risk Report tool before starting opioid therapy, emphasizing discussions with patients about alternative pain management therapies. The education and training of health care professionals would be improved for identifying patients

at-risk for addiction and effective tapering programs for patients on an opioid regimen.

Additionally, the VA would be given the authority to increase the availability of naloxone, or "Narcan," a highly effective opioid antagonist. This drug is on the World Health Organization's list of essential medicines in a basic health system. Naloxone reverses the effects of an opioid overdose (typically depression of the central nervous system). When one is prescribed opioids there is always a possibility of an overdose. The ability to respond to a worst case scenario of overdose, accidental or otherwise, must be available at every medical facility. According to a 2011 VA study based on 2005 data, veterans ages 30–64 who received care at VA died of accidental overdoses at two times the rate of their civilian peers. Naloxone has no risk of dependency and can be administered by a layman in the nasal spray form. It is a critical tool that can save lives while the department works to address the widespread use of opioids.

VA would also be required to develop mechanisms for real-time patient information on existing opioid prescriptions from VHA as well as patient prescription information from the state drug monitoring program. This mechanism would alert pharmacists of potential "double-prescribing." A pain management board would be established in each Veterans Integrated Service Network (VISN). It would serve as a resource of best practices recommendations for veterans, families, and providers alike.

Finally, this bill would require VA to incorporate alternative pain management therapies like yoga and acupuncture. PVA fully supports the use of complementary and alternative medicine and believes such care options will give veterans with catastrophic injuries and disabilities additional options for pain management and rehabilitative therapies.

THE "BIOLOGICAL IMPLANT TRACKING AND VETERAN SAFETY ACT"

This proposed bill intends to have the VA adopt and implement a standard identification protocol for use in the tracking and procurement of biological implants by the Department of Veterans Affairs. While we understand and generally support some of the provisions of this legislation, PVA objects to the provisions of the draft legislation that would exclude the purchase of biological implants from the authority of title 38 U.S.C., Section 8123. The use of this authority has been under fire in recent hearings, but the concerns raised ignore the critical importance of this authority.

Section 8123 states, "the Secretary may procure prosthetic appliances (which includes surgical biological implants) and necessary services required in the fitting, supplying, and training and use of prosthetic appliances by purchase, manufacture, contract, or in such other manner as the Secretary may determine to be proper, without regard to any other provision of law."

The Federal Acquisition Regulations (FAR) were issued pursuant to the Office of Federal Procurement Policy Act of 1974. Statutory authority to issue and maintain the FAR resides with the Secretary of Defense, the Administrator of General Services, and the Administrator, National Aeronautics and Space Administration—agencies that do not bear the responsibility of providing lifelong care for disabled veterans. However, the VA does bear the heavy weight of that responsibility.

With this in mind, it is important to note the distinction between VA's responsibility to meet specialized needs versus a Federal agency's responsibility to respond to emergency needs. The FAR provides for procuring prosthetics in cases where, for example, a natural disaster damaged a veteran's equipment. However, the writers who formulated the FAR in 1974 recognized there was a need for special provisions under which VA could purchase prosthetics for disabled veterans with specialized needs in a timelier manner than the FAR allowed, irrespective of whether a bona fide emergency existed. The authors of the FAR recognized this fact and the need for Section 8123 as evidenced by the fact that it is referenced in the FAR. This was reconfirmed in subsequent updates and amendments to the FAR.

Unfortunately, this draft legislation seems to imply that the Federal Supply Schedule and the FAR is all that is needed to procure Prosthetic appliances (biological implants) and services based on a misunderstanding of the difference between "specialized needs" and "emergency needs." Rather than erode a clinician's ability to acquire these prosthetics in a timely manner or manipulate how these prosthetics are defined in order to exclude them from the authority of Section 8123, we believe that the legislation should focus on accountability and oversight. It should not be making efforts to overturn a system that has served veterans well for over half a century. We encourage the removal of the provision of the draft legislation that eliminates the authority of Section 8213.

DRAFT BILL, INCLUDING PROVISIONS DERIVED FROM S. 1021 AND S. 1358

PVA generally supports the draft bill that includes provisions from S. 1021 and S. 1358. We have particularly interest in the provisions that would authorize $10 million to help to establish or expand advanced degree programs in prosthetics and orthotics to improve the availability of such resources to veterans. PVA supports the intent of this provision and fully understands the need that this legislation seeks to address. No group of veterans understands the importance of prosthetics and orthotics more than veterans with spinal cord injury or disease. However, in order to ensure that VA receives a proper return on its investment for these advance degree programs, we recommend that students whose education is provided through these VA-financed programs be required to provide a term of service back to VA immediately following their completion of the program. This would allow the VA to cultivate future prosthetics and orthotics specialists who may be called to serve veterans.

PVA would like to thank you once again for considering these important bills. Our members understand the importance of the provisions of these key measures. We encourage you to consider their point-of-view as you give these bills final consideration.

This concludes my statement. I would be happy to answer any questions you may have.

Chairman ISAKSON [presiding]. Thank you, Mr. Blake.

Mr. Stier, we have—the votes have been called, so if the last two will be as quick as you can with the testimony, I would appreciate it.

STATEMENT OF MAX STIER, PRESIDENT AND CHIEF EXECUTIVE OFFICER, PARTNERSHIP FOR PUBLIC SERVICE

Mr. STIER. Thank you very much, Mr. Chairman and other Members of this Committee. I appreciate it. My name is Max Stier. I am the President of the Partnership for Public Service. We are a nonpartisan, nonprofit organization working to make our government more effective.

Jumping into the accountability issues, the legislation you have before you is not the answer. If anything, it is going to make things much worse. The cure will be much worse than the problem you are trying to solve. In effect, as written—and I think there are things you can definitely do to change it—it will return us to the spoils system, the system we have not had for 100 years.

It is a wonderful idea. We want to make sure that the VA is accountable; but firing federal employees faster is not the right focus. The focus should be how to we serve veterans better.

So, very quickly, here are some things that you could do that would make a difference, and then, very quickly, some things you could do to change the bills to make them better.

The number one thing you could do to make a difference would be to start at the top. Choose political leaders for VA that have the right management experience to run complicated and huge organizations. Typically, the government leaders at the top are selected for political reasons and policy expertise and are not held accountable for poor management. The Senate's confirmation and oversight authority can change this. If you want to change things, that is where it all begins.

Number 2, require those very same political leaders to have clear performance plans and a transparent assessment of whether they are meeting their goals. The career workforce has to do this. Those rules do not apply to political leaders, and as a result, you do not actually have good accountability.

Number 3, invest in training and development of the managers at VA. Only 60 percent of VA employees think their supervisors are doing a good job. Only one-third think senior leaders highly motivate them. We need to select better managers and train them more. This is not happening. It happens for the military, but not for the civilian side of government. that is why you have many of your problems.

Number 4, you need new tools to hire Federal employees. You are not getting the best in, and, therefore, you are going to have a big problem. The better choice is to work on getting better talent in, so there are fewer people you have to remove down the line.

Number 5, make the probationary period real. It is not about making it longer. Today, by default, Federal employees automatically pass through their probationary period. Supervisors are not making an affirmative decision to keep them. The presumption should be reversed. A choice should be made that they are actually doing the jobs well. This should be true for new employees and new supervisors. That would change things. You would have to fire fewer people.

Number 6, use your oversight to make sure the administrative remedies are fully utilized. Many agencies are creating their own problems. They have the right rules and tools, they are just not using them effectively. The DEA example was a perfect one. The DEA administrator testified before Congress and said, "Help me fire my employees faster." In fact, there were self-imposed administrative barriers that stood in the way. It is important to look at what can be done administratively to change things.

And, number seven, consolidate the appeals process.

Mr. Chairman, you mentioned that there is not a clear standard for removing employees in the legislation before you.Right now you have an open-ended blank check that allows whistleblowers to be fired and allows the Secretary to fire people for partisan reasons. You are going to create a real problem unless you tighten this language substantially.

In addition to the whistleblower protections, you need to make sure the due process concerns are better addressed. We also recommend that GAO do research to understand what resources MSPB and the Special Counsel's Office will need to actually do this work right.

I am happy to talk about other things you can do to change the bills. The bottom line is you need to change them if you want to achieve the outcomes that you want. Thank you.

[The prepared statement of Mr. Stier follows:]

PREPARED STATEMENT OF MAX STIER, PRESIDENT AND CEO, PARTNERSHIP FOR PUBLIC SERVICE

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, Thank you for the opportunity to appear before you today. I am Max Stier, President and CEO of the Partnership for Public Service, a nonpartisan, nonprofit organization dedicated to revitalizing the Federal civil service and transforming the way government works. I appreciate your invitation to testify on legislation pending before this Committee, specifically, the *Department of Veterans Affairs Accountability Act of 2015* (S. 1082) and the *Ensuring Veteran Safety through Accountability Act of 2015* (S. 1117).

The Partnership is one of the most vocal and passionate proponents of reforming our civil service system, and we issued a report[1] last year outlining a framework to improve the management and performance of the Federal workforce across government. However, the reforms being promoted in some of the bills before the Senate Veterans' Affairs Committee will do more harm than good. Rather than simply finding ways to fire Federal employees faster, the focus of legislative reform must be on how we can serve our veterans better. There are a number of ways to reform our system and improve service to the veteran community, but moving to an "at-will" employment system for the Department of Veterans Affairs is not one of them.

There are important differences between the Federal Government and the private sector. To start, the top leaders in government are selected for political reasons and typically valued for policy expertise, rather than management capability. Those leaders are not usually held accountable for poor management, and they should be.

But neither should they be permitted to fire employees at will. Our nation experienced a long and unfortunate period of "at-will" employment at the Federal level which amounted to a corrupt spoils system. It took the assassination of a president and an angry public to move us to a merit-based system.[2] Changes to current law must be made carefully, thoughtfully and with high regard for merit and competence. That is why today's hearing is so important, and so needed.

The Partnership strongly agrees that poor performance is a real problem, and we agree that Federal employees should be held accountable for their performance and conduct. Employees themselves cite poor performers as a serious issue: Partnership analysis of the 2014 Federal Employee Viewpoint Survey found that just 26.3 percent of employees at VA believe that steps are taken to deal with poor performers who cannot or will not improve. But ultimately, we believe that perhaps the biggest contributor to the performance problems at the VA is the quality of the management, rather than the quality of the system. While the government's management systems can and must be improved, changing the system alone will not produce the desired results.

You asked me to provide feedback today on pending legislation; however, first I would like to share the Partnership's suggestions for actions that this Committee, and the Congress as a whole, can take to address the underlying problems with our civil service system and the barriers to attracting, hiring, developing, managing and retaining the very best talent. We believe these recommendations for reform will ultimately enable the Department of Veterans Affairs and the Federal Government to provide better service and to operate more efficiently and effectively.

RECOMMENDATIONS

Treat Government as an Enterprise

Government agencies operate as separate, largely independent organizations; only in times of crisis are resources from multiple agencies leveraged to address a single problem. But today's challenges—such as providing timely and high-quality care for veterans—are complex, and can rarely be resolved effectively by one agency acting alone. The Partnership and Booz Allen Hamilton issued a report in 2013 titled, *Building the Enterprise: Nine Strategies for a More Integrated, Effective Government.*[3] In the report, we advocate for a collaborative, multi-agency approach that integrates and leverages the enterprise—that is, the whole of government—to solve today's complex challenges. Encouraging an enterprise approach is one way that Congress can respond to the fragmentation and overlap that continue to exist across agencies and programs. Common-sense solutions like leveraging Federal buying power or sharing mission-support services are possible when we build government's capacity to plan, manage and measure cross-agency goals and missions. There are real opportunities, for example, to better integrate health systems at the Departments of Defense and Veterans Affairs, and ultimately achieve better outcomes.

Civil Service Reform

In no area is this need for a unified, whole-of-government approach more critical than in the way government manages talent. Our civil service system was established over 120 years ago. It governs more than two million workers and is a relic

[1] Partnership for Public Service and Booz Allen Hamilton, *Building the Enterprise: A New Civil Service Framework*, April 2014, http://ourpublicservice.org/publications/viewcontentdetails.php?id=18.

[2] Title 5 U.S. Code § 2301 "Merit System Principles," https://www.law.cornell.edu/uscode/text/5/2301.

[3] Partnership for Public Service and Booz Allen Hamilton, *Building the Enterprise: Nine Strategies for a More Integrated, Effective Government*, August 2013, http://ourpublicservice.org/publications/viewcontentdetails.php?id=28.

of a bygone era, reflecting a time when most Federal jobs were clerical and required few specialized skills, and when the Federal Government's role in society was smaller and far less complicated. The world has changed dramatically, but the civil service system has remained stuck in the past, serving as a barrier rather than an aid to attracting, hiring and retaining highly skilled and educated employees needed to respond to today's domestic and global challenges. As previously mentioned, the Partnership and Booz Allen Hamilton released a report last year which creates an overarching strategy for reforming our civil service system, and includes recommendations for Congress and the administration on reforming pay and classification, hiring, performance management and strengthening senior leadership in government.

We know that civil service reform is ambitious and it will require significant time and sustained attention, but we believe it is critical and deserves such deliberation. In the absence of comprehensive reform, we believe there are a number of actions that can be taken in the near term that will ultimately improve performance and management at VA and across government. Some of these actions fall into the category of good human resources or workforce management policies and practices.

1) Select Agency Leaders with Management Experience, Create Term Appointments and Improve the Presidential Transition Process

Agency leaders must be more than policy or technical experts. They must be equipped to manage and lead their agency. The administration should nominate leaders with management experience, and this Committee, as it participates in the confirmation process, is in a position to ensure that future leaders at VA demonstrate these capabilities. We also urge the Committee to exercise its oversight role and ensure continued focus on departmental management.

In addition, Congress could consider making the Secretary of VA a five-year term appointment, similar to the position of IRS Commissioner, with a performance contract to ensure continuity between administrations and a continued focus on solving long-term management problems. Similarly, Congress could convert certain management-oriented political appointments to career positions, for example C-Suite positions such as chief financial officers, chief human capital officers, chief information officers and the chief acquisition officers, with fixed terms and performance contracts. In addition to promoting greater continuity and attention to management challenges, such a change would also help retain institutional knowledge and relieve some of the burden on the complex and time-consuming political appointments process. The Committee should also examine the compensation provided to individuals in these key positions; while pay is not the primary motivator for the vast majority of individuals considering public service positions, given the level and scope of responsibilities, current pay levels seem significantly inadequate compared to those offered in the private sector.

Finally, Congress should pass S. 1172, *The Edward "Ted" Kaufman and Michael Leavitt Presidential Transitions Improvements Act of 2015*, which is intended to improve knowledge sharing between the outgoing administration and the incoming president's team, ensure agencies are adequately prepared for leadership vacancies, and provide accountability for transition activities across the Federal Government—all critically important for an agency like the Department of Veterans Affairs. This legislation was introduced by Senators Tom Carper and Ron Johnson, and ordered reported by voice vote in the Senate Homeland Security and Governmental Affairs Committee last month.

2) Hold Leaders Accountable in Performance Plans for Managing their Agency

Accountability for management in government starts at the very top. Senior agency leaders, as well as career and political executives, should be held accountable for recruiting and selecting the right talent for their agency, engaging and motivating those employees, training and developing their people and preparing them for future leadership roles, and holding managers accountable for making tough decisions, especially with respect to performance. We recommend Congress require all political appointees at VA, and across government, to have annual performance plans, similar to those required for career employees, and have a transparent assessment of whether they are meeting their goals.

3) Create new Tools to Hire the Right People

If agencies are able to select and hire the right people with the right skills this will hopefully minimize performance issues down the line. In our civil service reform report we outline a series of hiring reforms that we believe would make it easier for agencies to attract the very best talent. For example, we recommend expanding to all agencies the use of flexibilities now available only to

certain "excepted" agencies, which can be achieved without compromising core principals such as veterans' preference, merit-based selection, diversity and equal opportunity.

In addition, agencies should be allowed to share their lists of best-qualified talent with one another. For example, if VA needs to hire a medical professional in a particular area and is having difficulty finding the best talent, the agency could get access to the best-qualified list for a similar position at another department. Senators Jon Tester, Rob Portman, Ben Cardin, Jerry Moran and Heidi Heitkamp recently introduced the *Competitive Service Act*, which would give agencies this authority. We urge Congress to pass this legislation.

We also urge Congress to consider legislation that would permit former high-performing Federal employees to be non-competitively reinstated into government service at levels that match their skills and experience. Currently, a former Federal employee would only be able to return to government non-competitively at the grade level last held in government, not the higher level for which he/she would likely qualify given the additional years of professional experience. This small change would make it easier for VA and other agencies to bring experienced talent back into government.

Creating these new hiring tools would be incredibly valuable, but even more importantly, H.R. staff and hiring managers must be knowledgeable about the hiring tools available and must be trained in how to use them.

4) Invest in Training Managers and Hold them Accountable for Addressing Performance; Create a Promotion Track for Technical Experts

VA must focus on providing better training for new managers and supervisors so they are prepared to succeed, and must hold their managers accountable for managing employee performance. The process for removing or disciplining a Federal employee is daunting in terms of the time and effort required, and this discourages some managers from taking appropriate action. Often managers are not trained in handling these situations and lack the will or the administrative and/or top-level support to act. They may have a legitimate concern about the personal toll and disruptive impact a removal may have on the work unit. Managers should be required to receive necessary training in how to effectively motivate, manage and reward employees, and how to deal effectively with poor performers; they also need access to effective assistance from their H.R. or General Counsel offices. They should also be held accountable in their performance plans for taking action to address poor performance or misconduct.

In addition, VA should create a separate promotion track so that technical experts can advance in their careers without having to go into management positions for which they may be ill-suited. Too often we hear that supervisors promote their employees to management positions because they want to be able to pay them more, even when the employees are technical experts and often uninterested or unskilled in managing people. There should be opportunities for advancement without having to become a manager.

5) Better Utilize the Probationary Period

In addition to providing more and better training, VA should better utilize the probationary period for employees new to government and employees who are new supervisors in the agency. The probationary period serves as a continuation of the assessment process and gives the manager a chance to determine further an individual's fitness for the position; individuals who have not demonstrated the competencies needed to perform well can be removed more easily during this period. As an employee's probationary period is coming to a close, we believe managers should be required to make an affirmative decision as to whether the individual has demonstrated successful performance and should continue on past the probationary period.

For new supervisors, who also serve in a probationary status, successful performance should include demonstrating management competencies in addition to technical skills. If an employee's supervisor decides not to pass them through probation, the employee would return to a nonsupervisory position, as is currently the case according to statute. Employees who are new to government should be required to demonstrate fitness for the position in order to continue in Federal service. In the case that a manager decides the person is not fit for the position, he or she would be removed from Federal service. Managers should be held accountable in their performance plans for providing regular feedback to employees before making a decision on their probationary status.

6) Review and Expedite Internal Processes for Dealing with Performance Issues

In talking with Federal leaders across government, we hear that many of the delays in dealing with performance and accountability happen at the agency level before an action is even taken. We believe much can be done administratively to streamline the process within the existing statutes. We recommend creating an interagency "swat team" that could review agency policies across government to determine how to speed up the internal process for addressing performance and misconduct issues. For example, the team could examine how managers are able to demonstrate that they have provided opportunities for their employee(s) to improve without putting them on a formal Performance Improvement Plan (PIP), which lengthens the time it takes to fire someone who may have already demonstrated they are not the right fit for the job. Once the team has determined best practices they could share those practices among all agencies.

7) Consolidate and Expedite the Appeals Process

The current Federal process for dealing with employee complaints and appeals is fundamentally flawed and does not adequately serve the needs of either managers or employees. Federal employees have access to multiple and sometimes overlapping dispute resolution forums on a wide range of issues and it can routinely take over a year or more to receive a final answer, confusing both managers and employees and delaying resolution.

Greater accountability and workplace justice can be achieved by creating a one-stop shop that would simplify the employee complaint and appeal processes and expedite a final resolution of these cases to the benefit of both agency managers and employees. We recommend creating a single adjudicated body, a reconstituted MSPB that would handle all administrative appeals of agency decisions to remove or discipline employees that are currently filed with the MSPB and/or the EEOC. Such a body, if properly resourced, should be able to issue a decision within 90 days, on average.

COMMENTS ON PENDING LEGISLATION

It is our belief that the legislation pending before the Senate Veterans' Affairs Committee will not fundamentally improve performance and accountability at the Department of Veterans Affairs. Indeed, we believe that the legislation has the potential for harmful effects, including diminished protection for whistleblowers and little incentive for talented and experienced people to seek employment in the Department. We know through first-hand information that legislation passed by Congress last year[4] is having just such effect—i.e., the Department is finding it harder to attract the top-notch talent it needs to Senior Executive Service positions.

If the Committee chooses to move forward on the legislation discussed below, we believe several amendments are necessary to minimize potentially damaging effects. Our recommendations are described below.

Department of Veterans Affairs Accountability Act of 2015 (S. 1082)

Removal or Demotion of Employee Based on Performance or Misconduct

Section 2 of this bill would give the Secretary of Veterans Affairs total discretion to fire or demote employees. While we understand the intent is to expedite the process for demoting or removing someone from Federal service who is failing to serve veterans effectively, we believe this will have several damaging, unintended consequences, including silencing whistleblowers and hindering VA from attracting and retaining talent.

We recommend providing some language to clarify the standard by which the Secretary can take an action to remove someone. A blanket removal for "performance," left undefined, is too vague and could lead to removal for the wrong reasons.

Our understanding of the language in Section 2(f) "Limitation on Removal or Demotion" is that it was drafted with the intention of protecting employees who have already gone to the Office of Special Counsel (OSC) alleging the action was a prohibited personnel practice. While this is important, we are concerned that there is no recourse in this bill for individuals who have not already gone to OSC but who believe the action taken against them is a prohibited personnel practice. In other words, as written, there are no protections for whistleblowers or employees who believe they have been fired for partisan or other discriminatory reasons.

[4] Public Law 113–146.

The lack of whistleblower protections is particularly important. According to Partnership analysis of the 2014 Federal Employee Viewpoint Survey, 46.2 percent of employees at VA do not currently believe they can disclose a suspected violation of any law, rule or regulation without fear of reprisal. Should this legislation pass without a provision protecting whistleblowers, we anticipate this number will increase significantly. The very people VA needs to help disclose mismanagement, fraud and abuse could refrain from speaking out. One could argue that access to an expedited MSPB appeal protects whistleblowers or individuals who believe the action taken against them was a prohibited personnel practice; however, the prospect of being fired before having any chance to respond to the charges would inhibit many employees from disclosing wrongdoing in the first place because once the action is taken, the person is removed from Federal service and is no longer on the payroll. In the case that a whistleblower alleges retaliation as a result of an action taken by the Secretary, they would not have a venue to bring a claim if they do not do it within seven days from when the action is taken.

We would support retaining the provision to protect employees who have already gone to the Office of Special Counsel (OSC) on an alleged personnel practice, with some modifications. We urge the Committee to add a new provision providing 15 calendar days for all employees to respond to the Secretary, should they believe an action taken against them as a result of this legislation is a prohibited personnel action. Current statute requires "at least 30 days' advance written notice, unless there is reasonable cause to believe the employee has committed a crime for which a sentence of imprisonment may be imposed" (5 U.S. Code § 7513). We propose cutting this time in half to expedite the process but to still allow a short period of time for an employee to respond to the action. If the agency believes the person is a threat to other employees or there are other reasons to order removal from the workplace, the Secretary can place the individual on paid administrative leave during this time—with strict limits on how many days of paid leave are possible. During those 15 days, the employee should also be allowed to take their complaint to OSC.

Since a proposed removal or demotion of an employee in Section 2(f) would need to be approved by the Office of Special Counsel before it could be taken, we also suggest that the language be amended to place a time limit on how long OSC has to approve or disapprove a proposed removal or demotion. The bill should also provide a standard to use to determine whether or not to approve the proposed action. Such a standard, for example, might include a finding by OSC that there are reasonable grounds to believe that the proposed action is a prohibited personnel action (including reprisal for whistleblowing). Of course, it will also be important to ensure that OSC has the resources it needs to handle any new responsibilities. This Committee could ask GAO to do a quick study of the resources OSC would need to meet specific timeframes.

Expedited MSPB Review

Section 2 also includes an expedited appeals process to MSPB. While we are pleased to see some due process protections in the bill from the outset, we do have concerns about the ability of MSPB to review cases within 45 days without additional resources, particularly since they could see an increase in appeals under the proposed changes. In the Partnership's *Building the Enterprise: A New Civil Service Framework*,[5] we call on Congress to expedite the appeals process and argue that MSPB should issue decisions in 90 days. While there should be a mechanism in place to ensure a timely appeal process, as noted in a recent MSPB report, *What is Due Process in Federal Civil Service Employment*,[6] Federal employees no longer receive pay and benefits once a removal action is taken and an appeal is pending. We believe some of the pressure to shorten the time MSPB has to issue a decision is based on an erroneous belief that a terminated employee continues to receive their Federal salary while the appeal is pending. The fact that a Federal employee is not receiving compensation during the appeals process, therefore, should be taken into account. We are also concerned that the bill strips further appeal rights to the courts. We believe this provision is unduly punitive since the employee will have been removed and the government would be at risk only if the courts determine that it acted wrongly. While we agree the process should be streamlined, it is important to choose a timeframe that also allows for a thorough review before a decision is

[5] Partnership for Public Service and Booz Allen Hamilton, *Building the Enterprise: A New Civil Service Framework*, April 2014, http://ourpublicservice.org/publications/viewcontentdetails.php?id=18.

[6] Merit Systems Protection Board, *What is Due Process in Federal Civil Service Employment*, May 2015.

issued. In the case of alleged whistleblower retaliation, for example, we believe it would be difficult for MSPB to resolve issues that typically arise in this type of allegation in 45 days. Congress could ask GAO to assess the resources necessary for MSPB to do such an expedited review.

Probationary Period

Section 3 makes some changes to the probationary period for employees at VA. The language requires employees to serve a probationary period of at least 18 months, which may be extended at the discretion of the Secretary. The Partnership recognizes that there may be value in some cases to having a longer probationary period (e.g., in the case of lengthy training) but we think the emphasis should be on making good use of the probationary period not just on the length.

The probationary period provides an opportunity for managers to help develop high-potential employees. It also gives them a chance to remove poor performers more easily. During this period, all employees should have access to training and should receive regular feedback from their supervisor to give them the best opportunity to succeed. However, employees who have not demonstrated the management and technical competencies needed to perform well in his or her role in the organization should be removed.

We were very pleased that S. 1082 and the House companion legislation, H.R. 1994, include language which would require an employee's supervisor to make a clear decision at the end of the probationary period as to whether or not the employee would continue past the probationary period or be removed from Federal service. While this is a great first step, this provision applies only to employees who are new to government. We urge the Committee to expand this language to make sure it applies to new supervisors in government who also serve a probationary period. We also recommend clarifying what happens if a supervisor does not take an action at the end of the probationary period. One option is to have the employee continue in a probationary status for a finite amount of time while a higher level of review is triggered.

Ensuring Veteran Safety through Accountability Act of 2015 (S. 1117)

This bill would expand recently enacted legislation making it easier to fire senior executives at the Department to include individuals appointed to the Veterans Health Administration. In addition, it would strike procedures under Sections 7461(b) (adverse actions) and 7462 (major adverse actions involving professional conduct or competence) of Title 38 and Sections 7503 (cause and procedure) and 7543(b) (cause and procedure) of Title 5 in addition to the current law which says that procedures under Section 7543(b) (cause and procedure) of Title 5 do not apply.

Similar to the legislation previously discussed, we are concerned that this language does not provide employees with sufficient due process protections other than expedited appeal rights to MSPB after a removal has taken place. In short, it does not protect the public interest in a civil service free of prohibited personnel practices, including reprisals against whistleblowers. We recommend the Committee include language that gives employees an expedited opportunity to respond to the action. At the same time, the individual should have the ability to get a quick decision from the Office of Special Counsel as to whether there is reasonable cause to believe that the termination or demotion proposed constitutes a prohibited personnel practice and, therefore, the action should be stayed until a further review is made.

While MSPB to date appears to have been able to handle its new responsibilities within its current resources, we remain concerned that a truncated appeals process—a 21-day expedited review in this case—could easily exceed MSPB's capabilities if these provisions are expanded to all VHA employees, and especially if it is adopted on a governmentwide basis. Between FY 2009 and FY 2014, a total of 62,965 employees were terminated (fired) for conduct or performance across government. The Department of Veterans Affairs accounted for 13,969 of those 62,965 terminations.[7] If this is expanded governmentwide, it would have significant implications for MSPB.

CONCLUSION

Mr. Chairman and Members of the Committee, thank you for the opportunity to appear before you today. This is a very important issue that deserves the time, attention and understanding that you are devoting to it. The Partnership stands ready to help.

[7] FedScope (fedscope.opm.gov), from the Office of Personnel Management, for Federal civilian employees at most executive branch agencies who were terminated or removed due to discipline or performance during fiscal 2009–2014.

Chairman ISAKSON. Thank you.

Mr. Rowan, 3 minutes. Quickly.

STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. ROWAN. Thank you, Mr. Chairman. We basically support all the bills with certain caveats that are in our written testimony, and I think you can get the details on that.

I really just want to focus on S. 901, which is the main piece of legislation that we have been supporting. We thank Mr. Blumenthal and Mr. Moran and all the other cosponsors of that piece of legislation.

We are celebrating 50 years—we are going to come here in a couple of weeks to celebrate 50 years since the Vietnam War, and the Congress, the Speaker is going to pat me on the back, I guess. But, the truth is, in 50 years, the VA has done no studies on the Vietnam War and its effect on us, and certainly not much on anybody that came after us.

And, with all due respect to all of these other agencies that may study the effects of toxic exposures or particular items or particular issues or particular things, they are not going—covering the comprehensive effects of exposure on the battlefield in Vietnam, the Persian Gulf, or the present day, that needs to be done by the VA, who is mandated to take care of veterans and not anybody else.

This particular piece of legislation goes to the effects on our children. It has taken us years, literally years, to come up with a lists of all of the illnesses related to Agent Orange and now we are going to have to start over again with our children (many of whom are in their 40s), our grandchildren (who are now in their 20s), some of them? That is not fair.

And, forget about the folks after Vietnam. Are they going to wait 40 years? Meaning, my colleagues who came out of Iraq sitting at this table are going to wait 40 years to find out what happened to them? I hope not.

So, that is as simply and as succinctly as I can get. Thank you.

[The prepared statement of Mr. Rowan follows:]

PREPARED STATEMENT OF JOHN ROWAN, NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Good afternoon, Chairman Isakson, Ranking Member Blumenthal, and other Members of this distinguished and important Committee. Vietnam Veterans of America very much appreciates the opportunity to offer our comments concerning several bills affecting veterans that are up for your consideration. Please know that VVA appreciates the efforts of this Committee for the fine work you are doing on behalf of our Nation's veterans and our families.

I ask that you enter our full statement in the record, and I will briefly summarize the most important points of our statement.

S. 469, WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

Introduced by Senator Patty Murray (WA), would direct the Secretary of Defense (DOD) to furnish fertility treatment and counseling, including through the use of assisted reproductive technology, to a spouse, partner, or gestational surrogate of a severely wounded, ill, or injured member of the Armed Forces who has an infertility condition incurred or aggravated while serving on active duty.

Vietnam Veterans of America supports this bill as written. VVA has supported medically assisted procreation procedures for service-disabled veterans for more than three decades, and we will continue to do so.

S. 901, TOXIC EXPOSURE RESEARCH ACT OF 2015

Introduced by Senator Jerry Moran (KS), would establish in the Department of Veterans Affairs a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces that are related to that exposure, to establish an advisory board on such health conditions, and for other purposes.

Among the invisible wounds of war are those brought home by troops, some of which may not manifest for a decade or more. Most tragically, they may also pass on genetically the effects of these wounds to their progeny. No one can argue that our children and grandchildren should have these burdens visited on them. This is a multi-generational bill. It provides a common vehicle for evaluating potential transgenerational effects of toxic exposures, from Camp Lejeune and Fort McClellan, to Agent Orange in multiple locations, to the toxic plume that sickened thousands of Gulf War veterans.

Toxins, such as TCDD dioxin, are believed to cause birth defects in children of military personnel who came into contact with them—in-country troops during the Vietnam War, as well as the several thousand Reservists who rode in and maintained aircraft that had been used to transport the toxins. By means of the desalination units having the perverse effect of concentrating the dioxin up to 30 times, Navy personnel who served off of the coast of Vietnam also were exposed. For Gulf War veterans, the exposure was to chemical weapons in Iraqi ammo dumps containing chemical and biological agents that were blown up by U.S. Forces during the Gulf War; and burn pit smoke and possibly tainted vaccines and medicines ingested by troops in Afghanistan and Iraq.

This is a simple and straightforward proposal that will begin to address the needs of the progeny of every generation of veterans, because the health conditions seen in some are so heartbreaking to so many families who wonder, "Did my service cause my children to suffer? "

(Please see "Faces of Agent Orange" at: https://www.facebook.com/pages/Faces-of-Agent-Orange/187669911280144)

VVA unequivocally supports S. 901.

Vietnam Veterans of America applauds the leadership of Senator Moran (KS), working with his colleague Senator Dick Blumenthal (CT), to construct and introduce this bipartisan bill to begin to properly address the situations outlined above.

Let me address a few important issues within this legislation:

First, the National Center envisioned in this bill belongs in the Department of Veterans Affairs. Doctrine, law, and precedent all dictate that, since the time of Abraham Lincoln, the concerns of veterans and their progeny are vested in this department. This Center for Excellence is a small entity that will functionally manage the activities to assist the Advisory Board in overseeing research.

Second, we agree with VA testimony that the VA lacks the internal capability, capacity, and experience in the intergenerational research that will be required. The Advisory Board provides the VA Secretary with knowledge and scientific expertise to obtain research required by the legislation.

Third, we believe that the VA does have the capability, capacity, and experience to contract with any number of governmental, quasi-governmental, academic, scientific, or non-profit research organizations skilled in the research and administration outlined in the legislation; and further, such organizations would be able to achieve the intent of the legislation in a much more timely and cost-efficient means than the VA could ever achieve.

Fourth, the legislation gives the VA Secretary a strong, independent Advisory Board—of unpaid professionals—to provide diverse perspectives and technical expertise, assuring that the VA is provided with research-based outcomes that are respected and acknowledged by the military, our veterans and their descendants, and the scientific communities.

Finally, we agree with VA testimony before the House Veterans' Affairs Subcommittee on Health on April 23, 2015, that this bill will be funded from existing R&D appropriated funding, that it will be deficit neutral, and that VA cost estimates are correct, if maybe even high.

S. 1082, DEPARTMENT OF VETERANS AFFAIRS ACCOUNTABILITY ACT OF 2015

Introduced by Senator Marco Rubio (FL), would authorize the VA to remove or demote a VA employee based on performance or misconduct.

And,

S. 1117, ENSURING VETERAN SAFETY THROUGH ACCOUNTABILITY ACT OF 2015

Introduced by Senator Ron Johnson (WI), would expand the authority of the VA Secretary to remove senior VA executives for performance or misconduct, to include removal of VA health care professionals.

VVA Supports S. 1082 and S. 1117 with significant reservations, given that there is no excuse for the dissembling and lack of accountability in regard to much of what happens at the VA.

Accountability is certainly better at the VA today than it was a year ago, but there is a long way to go in regard to cleaning up that corporate culture to make it the kind of system it should become. The VA must change so that it can be trusted to get the "biggest bang for the taxpayer's buck" and, most importantly, get the individual veteran the best care or service in a timely way. It can be cleaned up if there is the political will to hold people accountable for doing their job properly.

VVA strongly believes that more due process and other safeguards should be built in for workers as opposed to managers. The split would be roughly at Grade 14 and above and include anyone who has supervisory or management duties. That does not mean that a non-supervisory VA employee or a lower pay grade worker can escape accountability for quality and/or quantity of their work, but it does recognize that the problems primarily rest with management.

Furthermore, it is clear to VVA that those VA employees who voice unwelcome truths and who have the courage to stand up for what is right on behalf of our Nation's veterans are still being harassed, punished, and their livelihoods threatened. The President and the Secretary simply must take immediate and effective action to address this ongoing problem.

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

Introduced by Senator Patty Murray (WA), would expand eligibility for the family caregiver program of the Department of Veterans Affairs to include members of the Armed Forces or veterans who are seriously injured or who became ill on active duty prior to September 11, 2001 (currently limited to service after September 11, 2001).

VVA strongly supports S. 1085, which will primarily assist family caregivers of catastrophically wounded or injured warriors who served prior to September 2001.

Thanks to the bravery and the tenacity of our medevac crews and military medical personnel at evacuation hospitals, catastrophically wounded warriors who would surely have perished in Vietnam are now being saved. Heart-rending testimony before congressional committees by surviving veterans, by their wives, and by their mothers, moved Congress to pass the Caregivers and Veterans Omnibus Health Services Act of 2010 to assist family caregivers of catastrophically wounded or injured warriors after 9/11.

There was a caveat in this legislation: The VA Secretary was to report to Congress on how the caregiver program has been working, and what, in his judgment, might be the efficacy of extending the program to family caregivers of veterans of Vietnam, Africa, and the Persian Gulf War. That report was two years late. Needless to say, these caregivers did not receive some of the benefits of this legislation. Why not? It was not pursued by the Administration because it was deemed to be "too expensive." How many caregivers of Vietnam veterans will potentially be eligible for the VA's caregivers program? We don't know. What we do know is that we will work with Senator Murray to achieve enactment of this bill that will encompass qualified caregivers of veterans who served before 9/11, and we will work with leadership to make enactment of this legislation a priority, despite any budgetary misgivings they may have.

H.R. 91, VETERAN'S I.D. CARD ACT

Introduced by Congressman Buchanan (FL–16), would direct the VA Secretary to issue a veteran's identification card to any veteran who requests such card and is neither entitled to military retired pay nor enrolled in the VA system.

For lack of quick or easy access to their DD–214, many veterans who have received an other-than-dishonorable discharge for their military service lose out on opportunities ranging from obtaining a job, to getting through security to take a flight, to a variety of private as well as public services. H.R. 91, when enacted into law, will provide these men and women with a simple card that they can carry in a wallet. It is our hope that your colleagues from both sides of the aisle will understand its benefits, and we support H.R. 91 as written.

DISCUSSION DRAFT, INCLUDING PROVISIONS DERIVED FROM S. 1021 (DURBIN), S. 1358 (MURKOWSKI/SULLIVAN).

S. XXX JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

To be introduced by Senator Tammy Baldwin (WI).

VVA strongly supports this draft bill with two suggested additions:

1) The Food and Drug Administration should decline to approve or revoke approval for easily abused opioid drugs if an abuse-deterrent version exists. For example, in November 2014, the FDA approved an extended-release formulation of hydrocodone bitartrate with abuse-deterrent properties (Hysingla ER) for the treatment of pain severe enough to require daily, around-the-clock, long-term opioid treatment, and for which alternative treatment options are inadequate. The tablet is designed to be hard to crush, break, dissolve, or prepare for injection. It is available in strengths of 20, 30, 40, 60, 80, 100, and 120 mg and is taken every 24 hours.

2) VA facilities where such opiate pain medications are authorized should be mandated to become signees to a state's prescription drug-monitoring program (PDMP) where available. According to the National Alliance for Model State Drug Laws (NAMSDL), a PDMP is a statewide electronic database which collects designated data on substances dispensed in the state. The PDMP is housed by a specified statewide regulatory, administrative or law enforcement agency, which distributes data from the database to individuals who are authorized under state law to receive the information for purposes of their profession.

VVA thanks you for the opportunity to share our views on the vitally needed legislation that you are considering today. I will be pleased to answer any questions you might have.

Chairman ISAKSON. I want the record to reflect that Vietnam Veterans gets the award for the most succinct and concise testimony. [Laughter.]

Senator BLUMENTHAL. I want to thank all of our witnesses and apologize that we have these votes. Obviously, it was not the Chairman and I scheduling them. Thanks to the Chairman, also, for making sure that we conclude. Your testimony will be in the record. We hope to pursue these issues. Thank you.

Chairman ISAKSON. We stand adjourned. Thank you.

[Whereupon, at 4:13 p.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. MARCO RUBIO, U.S. SENATOR FROM FLORIDA

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee, thank you for holding this hearing today. I would like to submit for the record my views on pending legislation before the Committee, namely S. 1082, the *Department of Veterans Affairs Accountability Act of 2015*.

In the wake of reports detailing how very few people have been held accountable for last year's scandal at the Department of Veterans Affairs, on April 23, 2015, I introduced the "Department of Veterans Affairs Accountability Act of 2015," which would give the VA secretary new, expanded authorities to remove or demote any VA employee based on poor performance or misconduct.

This legislation would expand on last year's VA reform law by giving the VA secretary the authority to terminate any employees for performance-related issues, not just managers. It mirrors legislation (H.R. 1994) filed in the U.S. House of Representatives by House Veterans' Affairs Committee Chairman Jeff Miller.

Last year, I was proud to lead the effort to give the VA secretary the authority to fire senior executives based on performance. A year later, it's clear additional authorities are needed to deal with the full scope of the problems at the VA. Once enacted into law, this new legislation will leave the VA secretary with no excuse but to hold people accountable for the dysfunction and incompetence plaguing our VA system, while protecting whistleblowers from retaliation. We must show our veterans the respect they have earned by removing any employees with terrible performance from the system our veterans rely on.

I also want to recognize that later this week the Subcommittee of the House Committee on Oversight and Government Reform will hold its own hearing on reforming the VA. It will hear testimony from Florida constituent and St. Johns County Assistant Administrator Jerry Cameron about problems stemming from the VA's selection and leasing process for new facilities. It represents part of a larger national problem regarding our VA facilities, which are experiencing significant delays and cost overruns that ultimately hurt both veterans and taxpayers.

I strongly support S. 1082 and recommend the Committee favorably report the bill out as soon as possible so that it receives a vote by the full U.S. Senate. I also hope today's hearing will help shed light on VA accountability reform and provide the Committee with a better understanding of how we can best serve our veterans.

PREPARED STATEMENT OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO AND ITS NATIONAL VETERANS AFFAIRS COUNCIL (AFGE)

Chairman Isakson, Ranking Member Blumenthal, Members of the Committee, thank you for the opportunity to present the views of the American Federation of Government Employees, AFL–CIO and its National Veterans Affairs Council (AFGE) regarding pending legislation. AFGE represents over 670,000 Federal employees, including more than 220,000 employees of the Department of Veterans Affairs. AFGE's representation of non-management, front line employees working in virtually every non-management position in the Veterans Health Administration (VHA), Veterans Benefits Administration (VBA), National Cemetery Administration and other VA functions allows us to share a unique perspective with the Committee. AFGE also greatly appreciates the efforts by Members of this Committee to solicit the views of our AFGE locals in settings where they feel free to share their concerns and recommendations without reprisal.

Overview of S. 1082

AFGE and the National VA Council strongly oppose S. 1082. We urge lawmakers to reject this counterproductive and dangerous anti-accountability bill in favor of legislation that will truly improve accountability by reducing mismanagement from the outset, expanding protections against prohibited personnel practices for every VA employee and strengthening the VA investigative process.

S. 1082 is dangerous because it destroys the civil service protections of the very non-management employees who can hold management accountable to uphold the interests of veterans. This bill is dangerous because longer probationary periods will subject more veterans in the VA workforce to unfounded or discriminatory terminations. This bill is also dangerous because it diverts the resources of the Office of Special Counsel (OSC) and Merit Systems Protection Board (MSPB) away from appropriate claims of retaliation and discrimination. Finally, this bill is dangerous because it will cause significant numbers of physicians and other employees skilled in critical shortage occupations to leave the VA or reject a future VA career, undermining veterans' access to the high quality services they rely on from the VA.

S. 1082 is poised to set the clock of workers' rights back more than 100 years. It makes the employment of VA employees subject to the whims of the VA Secretary, a political appointee. We learned in the Progressive Era that it is a great public good to have a civil service insulated from politics. Anyone who doubts that this bill creates a full-fledged patronage system should take a look at the history of government employment prior to the passage of the Pendleton Act of 1883.

By tearing down the due process protections granted to the covered employees, this bill would have the overall effect of chilling disclosures, destroying employee morale, and undermining the retention of many of VA's most experienced and valuable employees.

Analysis of Section 2: Removal or Demotion of Employees Based on Performance or Misconduct

Section 2 of S. 1082 takes away fundamental due process rights from front line, non-management VA employees in the VHA, VBA, NCA and other VA units, including thousands of service-connected disabled veterans. This section extends the SES due process cuts enacted in the Choice Act to non-SES managers as well as to every non-management front line employee. Despite the fact that the bill is presented as a tool to enhance accountability for SES and upper management, its greatest target is the 350,000 plus non-management employees who work on the front lines, including service-connected disabled veterans who clean operating rooms, police emergency rooms, maintain VA cemeteries and rate disability claims, and their coworkers who are primary care providers, PTSD therapists, surgeons, bedside nurses, electronic health record technicians, among so many other essential positions. Stripping job protections from non-management employees will result in more mismanagement in the form of retaliation, discrimination, patronage and anti-veteran animus. And veterans care will suffer, along with the employees who have pledged their careers to care for veterans.

This bill proceeds from the false premise that it is "too hard" to remove Federal employees under the current system. It is not. The VA already has—and uses—existing tools to fire poor performers and front line employees engaged in misconduct. If more terminations need to go forward, lawmakers should focus on poorly trained supervisors and inadequate use of the existing probationary period. Employees should only be removed for legitimate causes. Yes, this is harder than "at will" employment, but maintaining an apolitical, merit-based civil service requires that termination be for demonstrable causes. This is not "too hard" for a competent and responsible manager.

According to the Merit Systems Protection Board's 2015 Report, *What is Due Process in Federal Civil Service Employment?*, over 77,000 full-time, permanent, Federal employees were discharged as a result of performance and/or conduct issues from FY 2000 to FY 2014. In FY 2014, 2,572 VA employees were terminated or removed for disciplinary or performance reasons, according to the Office of Personnel Management. Also, contrary to some of the rhetoric behind calls to eliminate Federal employee job rights, Federal employees do not continue to receive their salaries after they are terminated.

S. 1082 entirely eliminates the procedural protections of 5 U.S.C. § 7513(b) and 5 U.S.C. § 4303. Section 7513(b) is the adverse action section of the Civil Service Reform Act (CSRA). If S. 1082 were enacted, every non-management VA employee would lose the following rights:

- Right to 30 days' advance notice before an adverse action may be imposed;

- Right to 7 days for the employee to respond;
- Right to a representative; and
- Right to a written decision.

Section 4303 serves much the same function for unacceptable performance actions, although the specifics are different.

By eliminating these two sections, S. 1082 eliminates the "notice and opportunity to be heard" that have been a hallmark of Federal sector due process since before the CSRA was adopted in 1978. These provisions form the very foundation for due process in the civil service system. To be clear, nothing in section 7513 or in section 4303 currently prevents agencies from removing employees or requires the MSPB or any other reviewing body to reach a particular result.

S. 1082 eliminates 7513(b), the core notice and opportunity to be heard section of the CSRA's adverse action protections. This sets up a fundamental denial of due process, which might never be heard because the bill also provides that notwithstanding any other provision of law, including 5 U.S.C. § 7703 (the CSRA's judicial review section for adverse actions), the decision of the MSPB's administrative judge shall be final and shall not be subject to any further appeal.

Put another way, while the bill provides a nominal right to appeal a removal or demotion action by the Secretary to the MSPB, if it is appealed before a harsh 7-day deadline that itself has no textual support, the bill substantively precludes both full MSPB review and judicial review.

This creates a situation that is arguably worse than traditional notions of at-will employment. In the private sector, for example, at-will employees may have access to the courts under a contract or tort theory even if they do not have due process rights. Because of the comprehensive nature of the CSRA, and numerous cases interpreting the CSRA, Federal employees are prohibited from bringing these same types of contract and tort claims to court. VA employees covered by this bill would thus become "at-will plus" or, perhaps more accurately, "at-will minus."

Blocking access to the objective review provided by the courts, or even blocking full review by the MSPB, would invite VA managers (who have already shown themselves willing to abuse the rights of whistleblowers) to engage in arbitrary or capricious conduct vis-à-vis the front line VA workers. This is compounded by the fact that bill contains a provision mandating that if the MSPB's Administrative Judge cannot issue a decision within 45 days, then "the removal or demotion is final." Given that the MSPB already has an active and heavy caseload, this provision is an additional and intentional elimination of fundamental employee rights.

With respect to whistleblower provisions in Section 2, the bill ignores the practical reality that not all individuals will file for corrective action and that OSC is not well-suited to essentially pre-approving the removal of every putative whistleblower. The bill would nonetheless force employees facing discrimination and other forms of prohibited personnel practices into OSC complaints in order to shield themselves from their new at-will employment status. This helps neither veterans nor whistleblowers. It only precipitates a flood of OSC complaints that are likely to paralyze OSC and obscure the most valid cases of whistleblower retaliation at the same time.

AFGE has worked with more than 40 rank-and-file whistleblowers in the VA who have been threatened or retaliated against by VA managers precisely because they blew the whistle on waste, fraud and abuse that was, like the wait list scandal, caused by VA managers. If S. 1082 is enacted, there will be no recourse for these employees, and the derelictions of VA managers will likely be swept under the rug. VA employees will be left with the choice of keeping quiet about mistreatment of veterans or losing their jobs.

Analysis of Section 3: Required Probationary Period for New VA Employees

Section 3 of the bill would extend the current one-year probationary period to 18 months, and the employee's ability to secure permanent status after that would be subject to the complete discretion of the Secretary to extend that probation to two years, three years or even longer. Contrary to the assertions of bill proponents, Section 3 would also extend the probationary periods of over 70,000 health care employees under the Hybrid Title 38 personnel system, including every psychologist, pharmacist, blind rehabilitation specialist, social worker, licensed practical nurse, orthotist-prosthetist, respiratory therapist, physical therapist and other positions under 38 U.S.C. 7401(3). (Under current law, health care personnel appointed under 38 U.S.C. 7401(1), including physicians and registered nurses have two year probationary periods.)

The large numbers of veterans recently hired into the VA workforce know firsthand how powerless they are when a manager who has failed to train them properly or resents having to hire a veteran decides to fire them. Congress has heard testimony about claims processors and health care professionals, among others, who

were summarily fired during probation without recourse, even though their terminations were motivated by retaliation, or what would otherwise be prohibited personnel practices.

It is already extremely difficult for agencies such as the OSC and MSPB to protect probationary employees from unjustified adverse actions, because the burden of proof on employers is extremely low. Subjecting more employees to longer probations and the whim of managers who wish to harass then with even longer periods of at-will employment will further devastate the VA's efforts to hire veterans and Hybrid Title 38 mental health professionals in VA "mission critical" occupations in short supply such as psychologists, pharmacists and physical therapists. (See the Veterans Health Administration's 2014 report, Interim Workforce and Succession Strategic Plan, Table 3.)

Analysis of Section 4: Comptroller General Study of Department Time and Space Used for Labor Organization Activity

Section 4 of S. 1082 mandates a study of Department time and space for labor organization activity. We are concerned that this provision may be used to weaken the rights of non-management employees and limit the ability of taxpayers to hold VA management accountable.

Under current law, union official time allows Federal employees who are volunteer union representatives to represent all their coworkers (those who pay dues and those who don't) while in an official duty status. Union representatives are prohibited from using official time to conduct union-specific business, solicit members, hold internal union meetings, elect union officers, or engage in partisan political activities.

The use of official time in the VA benefits taxpayers, veterans, and Federal employees because it reduces costly employee turnover, improves service, creates a safer workplace, and leads to quicker implementation of agency initiatives. Official time gives workers a voice to resolve disputes efficiently so they can get back to work, protect whistleblowers from retaliation, and implement new technology and other innovations to solve workplace problems in collaboration with management.

In its 2014 report, *Labor Relations Activities: Actions Needed to Improve Tracking and Reporting of the Use and Cost of Official Time* (GAO–15–9), GAO studied union official time and recommended that the Office of Personnel Management consider alternative approaches to developing cost estimate and new opportunities to increase efficiency of data collection and reporting.

A study that assesses the use of official time in VA according to objective criteria, such as those identified and used in the GAO study, is never problematic. But we are concerned that the study of official time mandated in S. 1082 may be used as a means to legitimize the elimination of this important function, given the overall animus toward front line VA employees that infuses the remainder of the bill. We urge the Committee to amend the language in the bill to require that the study use a template resembling the GAO study referenced above, or OPM's annual studies of official time. The study must not be yet another highly politicized means of eliminating frontline workers' ability to hold VA management accountable.

Finally, AFGE urges Committee members to consider the unintended consequences of S. 1082's extreme assault on civil service protections, as articulated by the MSPB in its 2015 report:

> Due process is available for the whistleblower, the employee who belongs to the "wrong" political party, the reservist whose periods of military service are inconvenient to the boss, the scapegoat, and the person who has been misjudged based on faulty information. Due process is a constitutional requirement and a small price to pay to ensure the American people receive a merit based civil service rather than a corrupt spoils system.

S. 1117

Overview of S. 1117

AFGE and the National VA Council strongly oppose S. 1117. We urge lawmakers to reject this equally counterproductive and dangerous anti-accountability bill in favor of legislation that will truly improve accountability. Although S. 1117 is described as an SES bill (a bill "to expand the authority of the Secretary of Veterans Affairs to remove senior executives"), in fact, this bill strips fundamental due process rights from every non-management VA employee. Whereas S. 1082 also targets VA employees in Title 5 positions (including VBA, NCA, and information technology), S. 1117 focuses its due process cuts on the vast majority of VHA employees, i.e. the Full Title 38 and Hybrid Title 38 employees.

Who are the health care employees who will lose all their civil service protections and become at-will employees under S. 1117?

- Every front-line non-management Full Title 38 employee, i.e. every physician, dentist, registered nurse, physician assistant, podiatrist, optometrist, chiropractor and expanded-function dental auxiliary (38 U.S.C. 7401(a); and
- Every front-line non-management Hybrid Title 38 employee including every psychologist, audiologist, biomedical engineer, respiratory therapists, physical therapist, licensed practical nurse, nursing assistant, orthotist-prosthetist, pharmacist, social worker, family therapist, blind rehabilitation specialist and every other position covered by 38 U.S.C. 7401(3).

All these employees will lose the following fundamental due process rights to challenge unfair terminations, demotions, and other adverse actions:

- Right to 30 days' advance notice before an adverse action may be imposed;
- Right to 7 days for the employee to respond;
- Right to a representative; and
- Right to a written decision.

Like S. 1082, S. 1117 is dangerous because it destroys the civil service protections of the very non-management employees who can hold management accountable to uphold the interests of veterans. This bill is also very harmful to the VA health care system because it will cause significant numbers of physicians and other healthcare professionals skilled in critical shortage occupations to leave the VA or reject a future VA career, undermining veterans' access to the high quality of medical services they rely on from the VA.

Like S. 1082, S. 1117 makes the employment of every VA Title 38 employee subject to the whims of the VA Secretary. By tearing down the due process protections granted to the covered employees, this bill would have the overall effect of chilling disclosures, destroying employee morale, and undermining the retention of many of VA's most experienced and valuable employees. Every brave Title 38 employee from Phoenix, Tomah, Pittsburgh, Hines, Wilmington, Delaware and other medical centers who made lifesaving disclosures to Congress, investigators and their own managers in order to protect veterans will become at-will employees with no civil service protections if S. 1117 is enacted.

Analysis of Section 2: Expansion of Authority of Secretary of Veterans Affairs to Removed Senior Executives of Department of Veterans Affairs for Performance or Misconduct to Include Certain Other Employees of the Department

Contrary to the title, Section 2 of S. 1117 does not make any further changes to SES rights. Instead, Section 2 applies all the SES due process cuts from the Choice Act to every non-management Title 38 employee.

The only difference in due process rights between S. 1117 and S. 1082 relates to the length of time the MSPB has to complete its one-level review before the termination is finalized. Under S. 1117, MSPB has 21 days, whereas under S. 1082, MSPB has 45 days. Under both bills, if MSPB is unable to review this case within the fixed timeframe, the Secretary's unilateral decision to terminate or demote the employee becomes final. Under this bill, Title 38 whistleblowers will have the identical, diminished rights as every other Title 38 employees.

In summary, AFGE strongly urges the Committee to oppose S. 1117 which will have enormous unintended consequences including: (1) a vast reduction in disclosures from non-management employees regarding patient safety issues and other mismanagement; (2) additional obstacles to the VA health care system's ability to compete for physicians and other health care professionals and retain valuable clinicians already on board; and (3) increased harm to VA clinicians through retaliation and other prohibited personnel practices.

S. 469

AFGE supports S. 469, the Women Veterans and Families Health Services Act of 2015. AFGE represents dedicated medical and behavioral health care personnel in facilities across the Nation who provide specialized care to women veterans and their families. We commend Senator Murray for her continued leadership in ensuring that comprehensive health care services are available to women veterans and their families.

S. 901

AFGE supports S. 901, the Toxic Exposure Research Act of 2015. We commend Ranking Member Blumenthal and Senator Moran for their leadership on this important legislation.

S. 1085

AFGE support S. 1085, the Military and Veteran Caregiver Services Improvement Act. We commend Senator Murray for her leadership in providing adequate support to veterans' caregivers.

DRAFT BILL—JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

AFGE supports this important legislation and commends Senator Baldwin for her continued leadership on behalf of veterans by ensuring safe prescribing practices. Front-line health care professionals represented by AFGE played a vital role in disclosing improper prescribing practices at the Tomah, Wisconsin medical center. Every day, the dedicated front-line employees we represent at VA medical centers strive for maximum patient safety, including proper prescribing practices. We urge lawmakers and VA officials to include front line employees and their employee representatives on working groups, pain management boards and other groups and research efforts established under this legislation.

Thank you for the opportunity to testify on these important legislative issues.

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

S. 469, THE WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

As we're all aware, IEDs, which are generally detonated on the ground, often cause severe trauma to the sexual organs and genitourinary system. These debilitating injuries can have devastating impacts—not only to urinary and sexual function, but also on fertility. If the issue of infertility is not adequately addressed for the young men and women in uniform, it will be adding insult to injury. Thanks to the horrific wounds received in battle on behalf of our country, many servicemembers have entirely lost their reproductive capabilities or their ability to reproduce has been severely compromised.

While genitourinary organ injuries (urotrauma) do not comprise the highest percentage of battlefield injuries, they have become increasingly more common and are no less physically and psychologically devastating. Unfortunately, neither the more clinical, care-delivery aspects of research, treatment and rehabilitation of urotrauma-type injuries, nor the policy aspect of these injuries, have kept pace with the more common battlefield wounds such as amputations, or the neuropsychological wounds of war including Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury.

AMVETS suggests that the VA take a comprehensive view of the urotrauma issue by seeking ways of:

- improving the prevention of these injuries;
- improving battlefield medical procedures;
- improving the reconstruction process; and
- improving the overall management of both the functional and fertility issues resulting from urotrauma

AMVETS fully supports legislation that seeks to improve VA health care options for both male and female military/veterans to include fertility counseling and treatment.

AMVETS supports increased research, to be conducted jointly by DOD and VA, with the intent of improving VA's ability to meet the long-term reproductive health care needs of veterans who have incurred service-connected urotrauma or other line of duty injuries that affect a veterans' ability to reproduce. AMVETS feels strongly that these types of injuries are not merely health issues; they are quality of life issue as well.

AMVETS supports much of this comprehensive legislation which would specifically:

- furnish fertility treatment and counseling, including through the use of assisted reproductive technology, to a spouse, partner, or gestational surrogate of a severely wounded, ill, or injured member of the Armed Forces who has an infertility condition incurred or aggravated while serving on active duty in the Armed Forces;

• allow the member to be treated with donated gametes and pay or reimburse the reasonable costs of procuring donor gametes, if the member is unable to provide their own gametes;
• establish procedures for gamete retrieval from a member of the Armed Forces;
• give members of the Armed Forces on active duty the opportunity to cryopreserve and store their gametes prior to deployment to a combat zone at no cost to the member. AMVETS has concerns with this provision due to the myriad of ethical issues and fiscal concerns;
• direct DOD and VA to share best practices and facilitate fertility treatment and counseling referrals to eligible individuals;
• include fertility counseling and treatment within authorized VA medical services;
• authorize VA to pay the adoption expenses (for up to three adoptions);
• direct VA to report annually to Congress on the counseling and treatment provided under this Act; and (2) prescribe regulations on the furnishing of such counseling, treatment, and adoption assistance;
• direct VA to facilitate research conducted collaboratively by DOD and HHS in order to improve VA's ability to meet the long-term reproductive health care needs of veterans;
• require VA to enhance the capabilities of the VA women veterans contact center to: (1) respond to requests for assistance with accessing VA health care and benefits, and (2) refer such veterans to Federal or community resources to obtain assistance not furnished by VA;
• amend the Caregivers and Veterans Omnibus Health Services Act of 2010 regarding a pilot program of group retreat reintegration and readjustment counseling for women veterans recently separated from service to: (1) increase the number of counseling locations, and (2) extend the program; and
• establish VA programs to provide assistance to qualified veterans to obtain child care so that such veterans can receive: (1) regular mental health care services, intensive mental health care services, or other intensive health care services; and (2) readjustment counseling and related mental health services.

S. 901, THE TOXIC EXPOSURE RESEARCH ACT OF 2015

This issue is at the top of the AMVETS priorities list once again this year. Recognition of the negative health effects caused by exposure to toxic substances, while serving in the military, has made extremely slow progress over the years, yet it may potentially impact millions of American veterans and their families.

The newly formed Toxic Wounds Task Force, led by AMVETS, is a coalition of veteran and health advocacy organizations united in seeking effective preventions, diagnoses, treatments and policy solutions related to any exposure, suffered by current or former military personnel, to toxic chemicals during their military service.

Our agreed upon definition of a Toxic Wound is any adverse health condition, chronic or terminal, suffered by military personnel resulting from, or associated with, exposure to toxic substances or environmental hazards during their military service, the effects of which may not emerge until months or years after initial exposure.

Many of us have waited a life time for recognition of, and treatment for, our exposures, especially those of us stationed at Ft. McClellan and those who fought in the Persian Gulf War. Historically this issue has been dealt with on a piecemeal basis, rather than a comprehensive one, therefore AMVETS applauds your efforts to tackle this tough, yet sensitive issue with a more holistic approach.

With this in mind, AMVETS whole heartedly support this legislation which would, among other things:

• establish a National Center for the Research on the Diagnosis and Treatment of Health Conditions of the Descendants of Individuals Exposed to Toxic Substances During Service in the Armed Forces;
• establish an Advisory Board for the National Center responsible for advising the National Center, determining health conditions that result from toxic exposure and to study and evaluate cases of exposure;
• authorize the Secretary of Defense to declassify documents related to incidents in which at least 100 members of the Armed Forces were exposed to a toxic substance that resulted in at least one case of a disability caused by exposure, except when declassification would threaten national security; and
• create a National Outreach Campaign on Potential Long-Term Health Effects of Exposure to Toxic Substances by Members of the Armed Forces and their Descendants.

Last year, at the AMVETS 69th annual convention, our members approved two separate resolutions in support of legislation which addresses the critical issue of military toxic exposure.

S. 1082, THE DEPARTMENT OF VETERANS AFFAIRS ACCOUNTABILITY ACT OF 2015

This issue continues to be among our highest priorities and AMVETS fully supports this legislation which would in part:

• authorize the VA to remove or demote a VA employee based on performance or misconduct;

• also authorize the removal of such individuals from the civil service and/or the ability to demote such individuals through a reduction in grade or annual pay rate;

• give an employee the right to an appeal before the Merit Systems Protection Board within seven days of removal or demotion. An administrative judge shall have to make a final decision within 45 days of such appeal or the original decision becomes final;

• protect a VA employee from removal or demotion without the approval of the Special Counsel if the individual seeks corrective action from the Office of Special Counsel based on an alleged prohibited personnel practice;

• provide for the appointment of an individual to a permanent position within the competitive service or as a career appointee within the Senior Executive Service shall become final after an 18-month probationary period, which the Secretary may extend. Final appointment to a permanent hire shall be made by the employee's supervisor; and

• require the Government Accountability Office to study the amount of time spent by VA employees carrying out labor organizing activities and the amount of Department space used for such activities.

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

AMVETS has been actively advocating for this legislation which would in part:

• expand eligibility for the VA's family caregiver program to include members of the Armed Forces or veterans who are seriously injured or who became ill on active duty prior to September 11, 2001 (currently, limited to service after September 11, 2001);

• expand much needed services to caregivers of veterans under such program to include child care services, financial planning services, and legal services;

• terminate the support program for caregivers of covered veterans on October 1, 2020, except that any caregiver activities carried out on September 30, 2020, shall be continued on and after October 1, 2020;

• authorize the transfer of post-9/11 education assistance benefits to family members by veterans who are retired for a physical disability or who are seriously injured veterans in need of family caregiver services, without regard to length-of-service requirements;

• authorize the VA Secretary to pay special compensation on a monthly basis to seriously injured or ill veterans in need of personal care services and to their caregivers;

• authorize flexible work schedules or telework for Federal employees who are caregivers of veterans.

• amend the Public Health Service Act to designate a veteran participating in the program of comprehensive assistance for family caregivers as an adult with a special need for purposes of the lifespan respite care program; and

• establish, in the executive branch, an interagency working group to review and report on policies relating to the caregivers of veterans and members of the Armed Forces.

S. 1117, THE ENSURING VETERAN SAFETY THROUGH ACCOUNTABILITY ACT OF 2015

AMVETS fully supports this short and sweet legislation which provides a mechanism for the removal of any VA Senior Executive Service employee or medical professional for unacceptable performance or misconduct.

Under the current, antiquated and morbidly dysfunctional civil service system, it's nearly impossible to dismiss or do more than slap the wrists of incompetent, ineffective and wasteful Senior Executive employees and medical professionals. This situation is no doubt largely responsible for the on-going backlog, as well as the problems of delayed benefits and inconsistent care experienced by many veterans.

AMVETS believes that no matter what ideas and policies the Secretary of the VA wants to implement, without the ability to remove deadweight executives, their hands are tied. Veterans are tired of platitudes and broken promises; the only way

to break this cycle of ineptitude and restore our veterans' faith in the 'system' is to eradicate the problem at the root—the Senior Executive level.

AMVETS fully supports any legislation which eliminates redundancy and inefficiencies within the VA or improves the care and services our veterans have earned through their service to this Nation.

H.R. 91, THE VETERAN'S I.D. CARD ACT

AMVETS supports this legislation which calls for a your efforts to provide a Veterans I.D. Card in order to:

- Provide proof of honorable military service;
- Minimize the potential of identity theft through the potential loss or theft of a form DD–214;
- Provide employers looking to hire veterans a standard way to verify any employee's military service; and
- Provide military veterans the ability to take part in the goods, services or promotional opportunities that are offered to those who are able to provide proof of military service.

AMVETS is especially supportive of this cost-neutral legislation because it will not only provide a much needed improvement over the current proof of military service document, the DD–214, but it will be carried out in a fiscally responsible way which will have minimal impact on the Veterans Administration which finds itself mired in the midst of massive claims backlogs and other issues.

DRAFT LEGISLATION, THE JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

AMVETS supports this important legislation which would:

- provide VA with some much needed tools to address the problem of overprescribing/over medicating practices;
- expand the availability of complementary and integrative, both clinical and non-clinical, in an effort to provide safer and more effective pain management services to our Nation's veterans;
- require stronger opioid prescribing guidelines and education for VA providers including stricter standards against prescribing dangerous combinations of opioids with other drugs and for prescribing opioids to patients struggling with mental health issues;
- increase coordination and communication throughout the VA with medical facilities, providers, patients and their families surrounding pain management, alternative treatments for chronic pain, and appropriate opioid therapy; and
- Holding the VA system accountable for appropriate care and quality standards through consistent internal audits as well as GAO reviews and reports to Congress.

DRAFT LEGISLATION,
THE BIOLOGICAL IMPLANT TRACKING & VETERAN SAFETY ACT OF 2015

AMVETS fully supports this legislation which would require the VA to adopt and implement a standard identification protocol for use in the tracking and management of biological implants. This legislation would help to ensure that biological implants such as, tendons, bones, ligaments, skin, eyes, or whole organs, used within the VA could be more easily and appropriately tracked from all the way from the donor to the recipient.

This critical capability to "track and trace" implants should help increase patient safety in case of product recalls (if necessary), assist with inventory management and accountability, and improve efficiencies through the implementation of a standard identification protocol.

Just as importantly, this legislation puts safeguards in place stipulating the requirements that vendors must meet in order to provide VA with both human and non-human biological implants.

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.

LETTER FROM AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

AMERICAN SOCIETY FOR REPRODUCTIVE MEDICINE

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June 24, 2015

Sen. Johnny Isakson
Chair, Senate Committee on Veterans' Affairs
Washington, DC 20510

Dear Chairman Isakson:

Thank you for the opportunity to offer a letter of support for S. 469, the Women's Veterans and Families Health Services Act of 2015. This legislation would significantly improve access to reproductive services for certain active duty military personnel and veterans who are injured in service to their country. The American Society for Reproductive Medicine is pleased that you have considered this bill for a public hearing.

ASRM is a multidisciplinary organization of nearly 8,000 medical professionals dedicated to the advancement of the science and practice of reproductive medicine. ASRM members include obstetrician/gynecologists, urologists, reproductive endocrinologists, nurses, embryologists, mental health professionals and others. As the medical specialists who present treatment options for patients and perform procedures during what is often an emotional time for them, we recognize how important a means to addressing their medical condition can be for those hoping to build their families.

ASRM solidly supports the provision of fertility services to severely wounded service members as DoD policy allows, and the extension of these services to veterans, who currently do not have the same access to treatment due to a longstanding congressional ban that prevents the Department of VA from providing these services. It is nothing but unjust to send our military personnel into harm's way and to not provide health care services to address health care needs that arise due to their service and dedication to our country. ASRM strongly supports the elimination of this inequity in coverage that affects certain disabled veterans.

FERTILITY AND STERILITY IS THE OFFICIAL JOURNAL OF THE SOCIETY
ASRM ANNUAL MEETING · OCTOBER 17-21, 2015 · BALTIMORE, MD

S. 469 would direct the Secretary of Veterans Affairs to provide fertility counseling and treatment, including in vitro fertilization, to a severely wounded, ill or injured veteran who has an infertility condition as a result of his or her active duty in the armed services. Importantly, the draft bill provides the same treatment for the veterans' spouse. Coverage for the spouse is important due to the fact that reproduction involves both male and female gametes and a female to carry a pregnancy. Therefore addressing any problem involves both the male and the female; treatment on just one of the partners is unworkable when the goal is reproduction. We find that the coverage regarding number of in vitro fertilization attempts is reasonable.

S. 469 also improves the coverage that is available to active duty members by permitting the use of donor gametes as part of the covered treatment options. For some severely injured service members, sperm or egg retrieval may be impossible. The desire to have a family is no less important to those individuals and third party collaboration as a family building option is an appropriate medical option for some infertile patients. So too, gestational surrogacy is a vital family building option for those who are injured in such a way as to make the carrying of a pregnancy impossible. The bill would permit the same benefits for similarly wounded veterans.

In addition, the bill allows coverage for the cryopreservation of gametes pre-deployment. This benefit is important for the obvious reason that any injury to the reproductive system risks the loss of the ability to have a genetic link to a child, but also because exposures to toxins during deployment can also result in infertility. Service members who have coverage for the option to cryopreserve their gametes have improved treatment options should they need infertility care.

Thank you for the opportunity to submit a statement of support for S. 469 and for your attention to this important public health issue. Our nation's military personnel and veterans deserve to have access to the full complement of infertility treatments that are available and we are pleased that this committee has recognized the need to correct the inequities that exist between the health plans available under the DoD and the Department of VA health plans and to improve the services available for both active duty personnel and veterans. ASRM is committed to working with Congress in order to pass legislation that will institute these long over-due benefits for our nation's veterans.

Sincerely,

Rebecca Z. Sokol, MD, MPH
President
American Society for Reproductive Medicine

PREPARED STATEMENT OF MILITARY OFFICERS ASSOCIATION OF AMERICA

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

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

- S. 469, Women Veterans and Families Health Services Act of 2015
- S. 901, Toxic Exposure Research Act of 2015
- S. 1085, Military and Veteran Caregiver Services Improvement Act of 2015
- S. _____, Jason Simcakoski Memorial Opioid Safety Act

S. 469, WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

MOAA is grateful to Senator Patty Murray (D-WA) for sponsoring S. 469 to improve the reproductive assistance provided by the Departments of Defense (DOD) and Veterans Affairs (VA) to severely wounded, ill or injured members of the Armed Forces, veterans, and their spouses or partners.

MOAA generally supports the bill. Our organization has advocated in recent years for reproductive services, including fertility treatment and counseling for severely wounded, ill and injured members in the DOD and VA for all Uniformed Services, including the U.S. Public Health Service (PHS) and NOAA Corps.

Senator Murray's bill would end a decade long ban in the VA of providing wounded veterans who want to have children an opportunity to fulfill that dream and ultimately lead to improving their overall quality of life and well-being. While the bill extends the services already available in the DOD under its Assisted Reproductive Services policy, MOAA is most concerned about fairness and equitability between the two heath care systems—that veterans be afforded the same level of medical care and services regardless whether the member is seeking assistive reproductive services through the VA or DOD.

Additionally, MOAA fully supports the expansion of the current pilot retreat/readjustment counseling programs for women veterans and the program to expand child care to veterans accessing medical care and adoption assistance provisions included in the bill.

MOAA generally supports S. 469, Women Veterans and Families Health Services Act of 2015 but recommends that VA and DOD assistive reproductive service programs mirror each other, providing the same level of medical care and services and that these benefits be extended to all members of the Uniformed Services, including the USPHS and NOAA Corps. Additionally, MOAA fully supports the bill provisions to extend women veterans' retreats and child care pilots and adoption assistance.

S. 901, TOXIC EXPOSURE RESEARCH ACT OF 2015

Senators Jerry Moran's (R-KS) and Richard Blumenthal's (D-CT) S. 901 is a bipartisan bill that would establish in the Department of Veterans Affairs a national center for research on the diagnosis and treatment of health conditions of the descendants of veterans exposed to toxic substances during service in the Armed Forces.

The legislation would establish the center of excellence in a VA medical center to pursue appropriate and unbiased research on the question of the potential impact on the health of first and second generation descendants of military service men and women.

MOAA respectfully recommends substituting the term "Uniformed Services" for "Armed Forces" in the bill as defined in Section 101(a)(5), 10 U.S.C. to ensure that research conducted at a designated VA Medical Center is applicable to members of the U.S. Public Health Service and the NOAA Corps of commissioned officers.

MOAA strongly supports S. 901, the Toxic Exposure Research Act of 2015.

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

MOAA applauds Senators Patty Murray (D-WA) and Susan Collins (R-ME) for long-term persistence in advancing this a bi-partisan bill that would extend special Caregiver Act (P.L. 111–163) services and support to the caregivers of certain disabled veterans of conflict periods prior to Sept. 11, 2001. For primary caregivers, services can include training, technical support, counseling, lodging and subsistence, mental health care, annual respite care, medical care under CHAMPVA and a monthly stipend. At present, those services are available only to caregivers providing support and assistance to veterans who served after 10 Sept. 2001. The legis-

lation would phase in veterans of earlier conflict periods based on a VA needs assessment.

S. 1085 also would provide a wider array of services for needs which may require caregiving; place greater emphasis on mental health injuries; and, remove restrictions on who is eligible to become a caregiver.

The legislation would make veterans in the VA caregiver program eligible to transfer unused Post-911 GI Bill benefits to their dependents in recognition of the fact that a spouse might now be required to shoulder primary responsibility for the family's income.

The underlying Caregivers Act enables spouses, siblings, parents and others to provide in kind the services and support once provided by the VA itself at substantially greater cost. That's because veterans with severe disabilities were placed in institutional care.

MOAA strongly supports S. 1085, the Military and Veteran Caregiver Services Improvement Act of 2015.

S. _____, JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

The Jason Simcakoski Memorial Opioid Safety Act is an extremely important and timely piece of legislation. MOAA fully supports the draft bill and commends Senator Tammy Baldwin (D-WI) for championing a measure that will keep veterans safe and provide VA with the necessary tools to more effectively management pain services.

Generally the bill would improve the prescribing and distribution management of opioids, patient advocacy, and expand availability of complementary and integrative health in the VA medical system.

The bill is named after U.S. Marine Veteran Jason Simcakoski who died on August 30, 2014 at the Tomah Veterans Affairs Medical Center in Wisconsin from ingestion of a deadly toxic mix of drugs. The bill is offered to help prevent such tragic occurrences from happening in the future.

More specifically, this comprehensive bill focuses on:

- Implementing stricter guidelines and standards for management and training of opioid therapy by VA and DOD;
- Improving VA opioid safety measures;
- Establishing a working group on pain management and opioid therapy within VA and DOD;
- Conducting a study on carrying out a VA pharmacy lockdown program;
- Reporting and investigating the use of opioid treatment by VA;
- Establishing an Office of Patient Advocacy in VA to enhance care and improve awareness of advocacy efforts in the Department; and,
- Expanding complementary and integrative health research, education and delivery at VA medical centers.

MOAA strongly supports the Jason Simcakoski Memorial Opioid Safety Act.

MOAA thanks the Committee and the members who sponsored or co-sponsored the above measures. These provisions will go a long way toward improving the quality of health care and patient outcomes in the VA medical system. We look forward to working with the Committee to make these important provisions a matter of law.

PREPARED STATEMENT OF SUSAN TSUI GRUNDMANN, CHAIRMAN,
U.S. MERIT SYSTEMS PROTECTION BOARD

Chairman Isakson, Ranking Member Blumenthal and distinguished Members of the United States Senate Veterans' Affairs Committee ("Committee"). Thank you for the opportunity to present written testimony for the hearing record on behalf of the United States Merit Systems Protection Board ("MSPB"), an independent, quasi-judicial agency in the executive branch of the federal government. As the Chairman of MSPB, I am pleased to present written testimony for the record for this hearing on health care and benefits legislation pending before the Committee. You have asked that MSPB present written testimony for the hearing record on each agenda item for which MSPB has a position or an interest. I have identified two bills on the agenda in which MSPB has an interest:

- **S. 1082, The "Department of Veterans Affairs Accountability Act of 2015,"** introduced by Senator Rubio and cosponsored by Senators Vitter and Barrasso; and

- **S. 1117, The "Ensuring Veterans Safety Through Accountability Act of 2015,"** introduced by Senator Johnson and cosponsored by Senators Perdue, Lee, Inhofe, Daines, Flake, Crapo, Cassidy, Cruz, Toomey, Collins, Vitter, McCain, Risch, Hatch, Cochran, and Ayotte.

As an initial matter, I would like to note that under statute, MSPB is prohibited from providing advisory opinions on any hypothetical or future personnel action in the executive branch of the federal government. 5 U.S.C. § 1204(h) ("The Board shall not issue advisory opinions."). Accordingly, this testimony should not be construed as an indication of how I, any other presidentially appointed, Senate-confirmed Member of the three-Member Board at MSPB Headquarters in Washington, D.C. ("Board"), or an MSPB administrative judge would rule in any pending or future matter before MSPB. Moreover, during my time as Chairman, MSPB has not taken policy positions on legislation pending before Congress. Generally, I view MSPB's role in the federal civil service as an

independent adjudicator of appeals in accordance with legislation passed by Congress and signed into law by the president. Accordingly, I would respectfully request that the Committee consider my testimony technical in nature.

A. MSPB's Interest in the Committee Agenda Items

MSPB's interest in S. 1082 and S. 1117 derives primarily from its statutory responsibility to adjudicate appeals filed by federal employees in connection with certain adverse employment actions. Generally, after a federal agency imposes an adverse personnel action upon a federal employee, such as removal or demotion, and the federal employee chooses to exercise his or her statutory right to file an appeal with MSPB, MSPB will begin the adjudication process. In the case of a federal employee who is removed from his or her position, that individual is no longer employed by the federal government, and is not receiving pay, at the time he or she files an appeal with MSPB or at any point during the subsequent MSPB adjudication process.

Once an appeal is filed, an MSPB administrative judge[1] in one of MSPB's regional or field offices will first determine whether MSPB jurisdiction exists over the appeal. If jurisdiction does exist, the MSPB administrative judge may conduct a hearing on the merits and then issue an initial decision addressing the federal agency's case and the appellant's defenses and claims. Thereafter, either the appellant or the named federal agency may file a petition for review of the MSPB administrative judge's initial decision with the Board, which will review the initial decision and then issue a final decision of the MSPB. Both the Board and MSPB administrative judges adjudicate appeals in accordance with statutory law, federal

[1]MSPB administrative judges are federal employees under the General Schedule System employed by MSPB. MSPB administrative judges are not "administrative law judges" appointed under 5 U.S.C. § 3105 nor Article III federal judges. MSPB currently employs 67 administrative judges nationwide.

regulations, precedent from United States federal courts, including the Supreme Court of the United States and the United States Court of Appeals for the Federal Circuit, and MSPB precedent.

B. S. 1082 – The "Department of Veterans Affairs Accountability Act of 2015"

1. Authority of the Secretary of the Department of Veterans Affairs to Remove or Demote Employees Under S. 1082

In pertinent part, S. 1082 would allow the Secretary of the Department of Veterans Affairs ("Secretary" and "Department") to remove or demote an individual who is an employee of the Department if the Secretary determines the performance or misconduct of the employee warrants such removal or demotion. If the Secretary removes or demotes such an employee, the Secretary may:

- Remove the employee from the civil service (as defined in section 2101 of title 5); or
- Demote the employee by means of:
    - A reduction in grade for which the employee is qualified and that the Secretary determines is appropriate; or
    - A reduction in annual rate of pay that the Secretary determines is appropriate.

Section 2(a) of the bill provides that the procedures listed in 5 U.S.C. § 7513(b) ("Cause and Procedure") and chapter 43 of title 5 ("Performance Appraisal") "shall not apply" to a removal or demotion referred to in that section.

Under 5 U.S.C. § 7513(b)(1)-(4) and (d), a federal employee against whom certain adverse actions are proposed (including removal and demotion) is generally entitled to: 1) at least 30 days advance written notice stating the specific reasons for the federal agency's proposed action; 2) not less than 7 days to respond to the proposed adverse action; 3) be represented by an attorney or other representative before the federal agency; 4) a written decision and the specific

reasons therefor by the federal agency; and 5) file an appeal to MSPB under 5 U.S.C. § 7701.

Under 5 U.S.C. § 4303(b)(1), a federal employee who is subject to removal or a reduction in grade for unacceptable performance is generally entitled to: 1) at least 30 days advance written notice of the federal agency's proposed action identifying certain information; 2) be represented by an attorney or other representative before the federal agency; 3) a reasonable time to answer orally and in writing to the proposed adverse action; 4) a written decision by the federal agency specifying the instances of unacceptable performance which has been concurred in by an employee who is in a higher position that proposes the removal or reduction in grade; and 5) appeal to MSPB under 5 U.S.C. § 7701.

2. Expedited MSPB Appeal Rights Under S. 1082

Section 2(a) of S. 1082 permits employees who are either removed or demoted by the Secretary to appeal that personnel action to MSPB "under section 7701 of title 5." Any such appeal must be filed with MSPB "not later than seven days after the date of such removal or demotion"[2] and the MSPB will be required to refer the appeal to an MSPB administrative judge for adjudication. An MSPB administrative judge would be required to issue a decision "not later than 45 days after the date of the appeal," and that decision "shall be final" and not subject to further review, either by the Board or a United States federal court. In the event that an MSPB administrative judge does not issue a final decision within 45 days, the decision of the Secretary to remove or demote the employee becomes final and the employee has no further right to appeal.

[2] Generally, under current law, an appeal must be filed at MSPB no later than 30 days after the effective date, if any, of the action being appealed, or 30 days after the date of the appellant's receipt of the agency's decision, whichever is later. 5 C.F.R. §1201.22(b).

C. S. 1117 – The "Ensuring Veteran Safety Through Accountability Act of 2015"

S. 1117 would expand the existing authority of the Secretary to remove or demote senior executive employees at the Department – granted in Section 707 of the Veterans Access, Choice, and Accountability Act of 2014 ("2014 Act") - to positions at the Department listed in 38 U.S.C. § 7401 "that [are] not ... senior executive position[s]." Thus, in order to provide technical views on S. 1117, a brief discussion of Section 707 of the 2014 Act is first necessary.

The pertinent provisions of Section 707 of the 2014 Act are similar, however not identical, to the provisions of S. 1082 addressed above. Under Section 707 of the 2014 Act:

- The Secretary may remove an individual employed in a senior executive positon at the Department of Veterans Affairs from the senior executive position if the Secretary determines the performance or misconduct of the individual warrants removal; and

- If the Secretary so removes such an individual, the Secretary may: A) remove the individual from the civil service (as defined in section 2101 of title 5); or B) … transfer the individual from the senior executive position to a General Schedule position at any grade of the General Schedule for which the individual is qualified and that the Secretary determines is appropriate.

38 U.S.C. § 713(a)(1)(A)-(B).

Section 707 of the 2014 Act also provides that "the procedures under section 7543 of title 5 shall not apply" to removals and transfers under that section. 38 U.S.C. § (c)(1). Under 5 U.S.C. § 7543(b), senior executive service employees employed by agencies other than the Department who are subject to a charge of misconduct, neglect of duty, malfeasance, or failure to accept a directed reassignment or to accompany a position in a transfer of a function are generally entitled to the following rights: 1) at least 30 days advance written notice stating the specific reasons for the federal agency's proposed action; 2) not less than 7

days to respond to the proposed adverse action; 3) to be represented by an attorney or other representative before the federal agency; 4) a written decision and the specific reasons therefor by the federal agency; and 5) to file an appeal to MSPB under 5 U.S.C. § 7701.

Similar to S. 1082, upon either removal or transfer, a senior executive service employee of the Department may appeal to the MSPB "under section 7701 of title 5" not later than seven days after the date of such removal or transfer. Also similar to S. 1082, an MSPB administrative judge must "expedite" these appeals and issue a decision "not later than 21 days after the date of the appeal." If an MSPB administrative judge fails to issue a decision within 21 days, the Secretary's decision to either remove or transfer the senior executive service employee becomes final. Finally, a senior executive service employee of the Department has no right to appeal the MSPB administrative judge's decision to the Board or a United States federal court.

D. Views on S. 1082 and S. 1117

1. Possible Constitutional Defects With S. 1082 and S. 1117

As stated above, both S. 1082 and S. 1117 would eliminate a covered employee's right to notice and any opportunity to respond prior to the imposition of an adverse personnel action. In May 2015, MSPB released a study[3] entitled

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[3] In addition to adjudicating appeals filed by federal employees, MSPB is required under statute to:

> Conduct, from time to time, special studies relating to the civil service and to the other merit systems in the executive branch, and report to the President and to Congress as to whether the public interest in a civil service free of prohibited personnel practices is being adequately protected. 5 U.S.C. § 1204(a)(3).

What is Due Process in Federal Civil Service Employment? The report provides an overview of current civil service laws for adverse actions and, perhaps more importantly, the history and considerations behind the formation of those laws. It also explains why, according to the Supreme Court of the United States, the Constitution requires that any system which provides that a public employee may only be removed for specified causes must also include an opportunity for the employee – prior to his or her termination –to be made aware of the charges the employer will make, present a defense to those charges, and appeal the removal decision to an impartial adjudicator. We encourage Members of the Committee and their staffs who have interest in these issues to read this report[4].

In the landmark decision *Cleveland Board of Education v. Loudermill*, 470 U.S. 532 (1985), the Supreme Court held that while Congress (through statutes) or the president (through executive orders) may decide *whether to grant protections* to employees, they lack the authority to decide whether they will grant due process rights *once those protections are granted*. Stated differently, when Congress establishes the circumstances under which employees may be removed from positions (such as for misconduct or poor performance), employees have a property interest in those positions. *Loudermill*, 470 U.S. at 538-39[5]. Specifically, the *Loudermill* Court stated:

> Property cannot be defined by the procedures provided for its deprivation any more than can life or liberty. The right to due

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[4] This report can be found at: http://www.mspb.gov/netsearch/viewdocs.aspx?docnumber=1166935&version=1171499&application=ACROBAT

[5] The *Loudermill* case involved a state employee, not a federal employee. Nevertheless, while the Federal Government is covered by the Fifth Amendment and the states by the Fourteenth Amendment, the effect is the same. *See Lachance v. Erickson,* 522 U.S. 262, 266 (1998); *Stone v. Federal Deposit Insurance Corp.*, 179 F.3d 1368, 1375-76 (Fed. Cir. 1999).

> process is conferred, not by legislative grace, but by constitutional guarantee. While the legislature may elect not to confer a property interest in public employment, it may not constitutionally authorize the deprivation of such an interest, once conferred, without the appropriate procedural safeguards.

Id. at 541.

The Court explained that the "root requirement" of the Due Process Clause is that "an individual be given an opportunity for a hearing before he is deprived of any significant property interest," and that "this principle requires some kind of a hearing prior to the discharge of an employee who has a constitutionally protected property interest in his employment." *Id.* at 542.

According to the Court, one reason for this due process right is the possibility that "[e]ven where the facts are clear, the appropriateness or necessity of the discharge may not be; in such cases, the only meaningful opportunity to invoke the discretion of the decisionmaker is likely to be before the termination takes effect." *Id.* at 542. The Court further held that "the right to a hearing does not depend on a demonstration of certain success." *Id.* at 544.

I further note that the requirements of the Constitution have shaped the rules under which federal agencies may take adverse actions against federal employees, as explained by the Supreme Court of the United States, United States Courts of Appeal, and United States District Courts. Accordingly, should Congress consider modifications to federal civil service laws, many of which have been in place for more than one hundred years, MSPB respectfully submits that the discussion be an informed one, and that all constitutional requirements be considered.

Finally, I note that the constitutionality of Section 707 of the 2014 Act is currently the subject of litigation at the United States Court of Appeals for the Federal Circuit. *Helman v. Dep't. of Veterans Affairs*, Case No. 15-3086 (Fed. Cir. 2015). The plaintiff in that litigation is alleging that Section 707 is unconstitutional primarily on two grounds:

- By permitting the Department to remove a tenured federal employee without any pre-removal notice or an opportunity to respond, and by severely limiting post-removal appeal rights, Section 707 violates an employee's right to constitutional due process as articulated by the Supreme Court; and

- By removing the Board from the MSPB appellate review process and permitting MSPB administrative judges (General Schedule employees) to make a final decision binding an executive branch agency which is not reviewable by a presidential appointee, Section 707 violates the Appointments Clause contained in Article II, Section 2 of the United States Constitution.

As noted above, similar to Section 707 of the 2014 Act, Section 2(a) of S. 1082 would allow the Secretary to eliminate the requirement that the Department provide the pre-adverse action rights found in 5 U.S.C. § 7513(b) and 5 U.S.C. § 4303(b)(1). Section 1(a) of S. 1117 would also allow the Secretary to eliminate the requirement that the Department provide those rights, along with the rights provided in 5 U.S.C. § 7503 (pre-adverse action rights for employees in connection with suspensions of 14 days or less), 38 U.S.C. § 7461(b) (pre-adverse action rights for Department employees in positions listed in 5 U.S.C. § 7401 in connection with adverse actions), and 38 U.S.C. § 7462 (pre-adverse action rights for Department employees in positions listed in 5 U.S.C. § 7401 in connection with professional conduct or competence). It is my understanding the Federal Circuit is currently considering whether it has jurisdiction over the lawsuit concerning Section 707 of the 2014 Act. If it determines that jurisdiction exists, a panel of federal appellate judges will proceed to consider the merits of the claims alleged.

2. S. 1117 Could Provide MSPB Appeal Rights to Department Employees Who Currently Do Not Possess Such Rights

S. 1117 covers positions listed in 38 U.S.C. § 7401 that are "not a senior executive position." Generally, these positions involve employees who provide health care services at the Department. It is my understanding that the Department employs nearly 190,000 health care professionals. Under existing law, these employees do not possess the right to appeal adverse personnel actions to MSPB. Instead, they are subject to a separate internal disciplinary procedure provided for at 38 U.S.C. § 7461, *et seq*. Under that procedure, Department health care professionals may appeal adverse personnel actions to internal disciplinary appeal boards at the Department and thereafter to a United States federal court. Thus, if S. 1117 were enacted into law, it would provide the Secretary with the discretion to invoke a disciplinary process that would provide MSPB appeal rights to nearly 190,000 federal employees who currently do not possesses that right.

3. Permitting Appeals to MSPB "Under 5 U.S.C. § 7701"

S. 1082 and S. 1117 would allow covered employees to appeal to MSPB "under 5 U.S.C. § 7701." Section 7701 of title 5, United States Code, provides in pertinent part that "the decision of an agency shall be sustained … only if the agency's decision … is supported by a preponderance of the evidence." 5 U.S.C. § 7701(c)(1)(B). The term "preponderance of the evidence" is defined as "the degree of relevant evidence that a reasonable person, considering the record as a whole, would accept as sufficient to find that a contested fact is more likely to be true than untrue." 5 C.F.R. § 1201.4(q).

Additionally, 5 U.S.C. § 7701(c)(2)(B) provides that "an agency's decision may not be sustained … if the employee or applicant for employment shows that the decision was based on any prohibited personnel practice described in section

2302(b) [of title 5, United States Code]." Among the "prohibited personnel practices" described in section 2302(b) are illegal discrimination, 5 U.S.C. § 2302(b)(1)(A)-(E), coercion of political activity or reprisal for refusal to engage in political activity, 5 U.S.C. § 2302(b)(3), and reprisal for lawful "whistleblowing," 5 U.S.C. § 2302(b)(8). Thus, if such issues are raised by appellants as defenses in appeals filed pursuant to the language contained in S. 1082 or S. 1117, MSPB administrative judges would be required under law to consider those defenses prior to issuing a final decision within either 21 days or 45 days.

4. S. 1082's and S. 1117's Impact on MSPB's Workload

Finally, if enacted into law, S. 1082 and/or S. 1117 could have a dramatic impact on MSPB's workload and in particular, the workload of MSPB administrative judges. As stated above, under both bills, the Board is prohibited from playing any role in the appellate process. Thus, under the current language, all adjudicatory responsibility resulting from enactment of both pieces of legislation would necessarily fall on MSPB's administrative judges.

MSPB understands that, for some time now, *all* federal agencies have been asked to do more with less as a result of the fiscal climate. As the independent federal agency that receives appeals filed by federal employees, MSPB is in a unique position to observe how agencies, managers, and employees have been, and continue to be, impacted by decreasing federal budgets.

While practically all federal agencies have been negatively impacted by budget decreases, I believe MSPB has been especially hard hit. During Fiscal Year 2013, MSPB administrative judges adjudicated 6,340 appeals, with an average case processing time of 93 days per appeal. During Fiscal Year 2014, MSPB administrative judges adjudicated 16,354 appeals, with an average case processing time of 262 days per appeal. These increases between Fiscal Years 2013 and 2014 were due directly to the massive influx of appeals filed at MSPB as

a result of federal agency-imposed employee furloughs, resulting from government-wide "sequestration" during Fiscal Year 2013, as mandated by the Budget Control Act of 2011. A "furlough of 30 days or less" is an adverse action which a federal employee has a statutory right to appeal to MSPB. 5 U.S.C. § 7512(5). Additionally, MSPB is required under statute to process and adjudicate every appeal filed by a federal employee. During a three-month period in Fiscal Year 2013, federal employees filed more than 32,000 appeals as a result of sequestration-related furloughs. MSPB continues to process and adjudicate these appeals.

As stated above, if S. 1117 were enacted into law, nearly 190,000 federal employees who currently do not possess MSPB appeal rights could be provided with right such rights. If the Secretary were to remove or demote even 2% covered employees under the expanded authority, MSPB could be required to adjudicate nearly 4,000 additional appeals[6] within an expedited time frame of 21 days. With existing resources and staffing, it is difficult to imagine how MSPB administrative judges could process and adjudicate these appeals in the time frame provided without placing most other appeals filed by non-Department employees on hold.

Moreover, the time frames provided in S. 1117 (21 days) and S. 1082 (45 days) to adjudicate appeals will make proper adjudication extremely difficult for MSPB administrative judges. In our limited experience adjudicating appeals filed under Section 707 of the 2014 Act, MSPB has observed that these appeals tend to be high profile in nature, involve complicated issues, and generally include a variety of disciplinary charges by the federal agency and defenses by the employee. An MSPB administrative judge could be required to address numerous discovery issues, hold a hearing, and issue a written decision, all within 21 days.

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[6] 4,000 appeals would represent more than half of the total appeals filed by appellants government-wide in most fiscal years prior to Fiscal Year 2013.

Because there is no review by either the Board or a United States federal court, and because the Secretary's decision becomes final in the absence of an MSPB decision, MSPB administrative judges understandably will feel pressured to address each and every aspect of the appeal in as thorough a manner as possible, especially given that these appeals involve federal employees who have been removed from the civil service. For instance, in a recent appeal involving a Department senior executive service employee in Phoenix, Arizona, the MSPB administrative judge's written decision totaled 61 pages. Application of this degree of effort in a large number of cases would be extremely difficult given MSPB's current staffing and resources.

Accordingly, I would respectfully request that this Committee give serious consideration to providing MSPB administrative judges more time to adjudicate appeals filed pursuant to the current language of either S. 1082 or S. 1117. As noted above, individuals who have been removed from their positions are not employed by the federal government – and thus receive no pay – during the entirety of the MSPB adjudication process. Thus, federal taxpayers are in no way burdened by the length of time it takes MSPB to adjudicate appeals involving removals.

This concludes my written testimony for the hearing record. I am happy to address any questions for the record that Members of the Committee may have.

PREPARED STATEMENT OF THE NATIONAL ALLIANCE ON MENTAL ILLNESS

NAMI, the National Alliance on Mental Illness, is the Nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. Part of our mission is to support our military, past and present, who are dealing with mental health issues. In support of that mission, we will often support policy that can improve the lives of our military servicemembers, veterans and their families.

As an organization, we have become aware of the increasing number of veterans, like U.S. Marine veteran Jason Simcakoski, who have been prescribed both Benzodiazepines and opioids; and about the serious complications that can arise from their use. Jason Simcakoski died at the age of 35 on August 30, 2014 from the mixed drug toxicity of Benzodiazepines and opioids. Unfortunately, we also know that he is not the only veteran to die as a result of mixed drug toxicity under the care of doctors at the Department of Veterans Affairs.

Although these types of medications are deemed safe and effective when taken as directed, when opioid pain relievers like oxycodone, hydrocodone, hydromorphone, or morphine are combined with other drugs that depress Central Nervous System activity, such as benzodiazepine's—it can present serious or even life-threatening problems for those who are taking them. NAMI's concern goes to the issue of veteran's morbidity and mortality with the combined prescription of opioid painkillers and drugs in the benzodiazepine (BZD) class: best known examples are Librium, Valium, Xanax, and Ativan. Like opioid-based pain medications, BZDs are addictive. They are prescribed by mental health providers treating Post-Traumatic Stress Disorder (PTSD), Military Sexual Trauma (MST), depression, anxiety, and panic disorder. They are also used in the treatment of seizure disorders, insomnia, and alcohol withdrawal.

In a National Institute of Health study in 2011 by Macey et al., it was found that approximately two-thirds of OEF/OIF veterans with pain issues were prescribed opioids over a one-year timeframe, and that over one-third were prescribed opioids on a long-term basis. This study extends prior literature documenting high rates of opioid use among OEF/OIF veterans suffering from war-related injuries (Clark et al., 2009; Wu et al., 2010). The researchers found that despite prescribers adhering to guidelines for the treatment of chronic pain there were a high number of opioid prescribed veterans with concurrent benzodiazepine prescriptions. Macey et al. found that 33% of long-term opioid users in their study were concurrently prescribed benzodiazepines.

An additional December 2014 report was put out by the Drug Abuse Warning Network (DAWN). Their report found that combining benzodiazepines with opioid pain relievers significantly increased the risk of a more serious emergency department visit outcome. These facts suggest that individuals are at risk and that the baseline risks are high enough to suggest a public health concern. We are aware that concurrent use of opioids and benzodiazepines pose a formidable challenge for clinicians who manage chronic pain and mental health issues. However, what makes this issue serious is that veterans with chronic pain who use opioid analgesics along with benzodiazepines have been found to be at higher risk for fatal and nonfatal overdose and to have more aberrant behaviors (Gudin et al., 2013).

According to a May 2014 VA Office of Inspector General (OIG) report (No. 14–00895–163) on opioid therapy practices, it was found that approximately 64% of veterans prescribed take-home opioids had been diagnosed with mental health issues. A subset of these veterans received prescriptions for Benzodiazepines. According to the report "the concurrent use of Benzodiazepines and opioids can be dangerous because both depress the central nervous system. Benzodiazepines have been strongly associated with death from opioid overdose."

Given the findings, coming up with a solution and a better way to monitor the prescribing practices of physicians is critical. Co-administration of these agents produces an increase in rates of adverse events, overdose, and deaths, warranting close monitoring. NAMI believes that the veterans in this country deserve safe and responsible health care to recover from the physical and emotions wounds of combat.

Based on this information and the gravity of the issues discussed in the studies we've discussed, NAMI supports Senator Tammy Baldwin's announcement of the Jason Simcakoski Memorial Opioid Act, calling for better coordination of care throughout the VA, increased scrutiny of prescriptions of opioids and benzodiazepines for our military veterans receiving care through the Department of Veteran's Affairs, and increased accountability for quality standards through appropriate audits and reporting. NAMI also deeply appreciates the Committee's proven commitment to ensuring that the physical and mental healthcare needs of our Nation's veterans are met quickly, effectively, and completely and that future deaths from

mixed drug toxicity are prevented. We look forward to working with Senator Baldwin and the Senate Committee on Veteran's Affairs to help achieve those outcomes.

PREPARED STATEMENT OF CAROLYN N. LERNER, SPECIAL COUNSEL, UNITED STATES OFFICE OF SPECIAL COUNSEL

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

Thank you for the opportunity to submit written testimony on behalf of the Office of Special Counsel (OSC). OSC protects the merit system for over 2 million civilian employees in the federal government. We do this with a staff of approximately 140 employees and among the smallest budgets of any federal law enforcement agency.

Congress has tasked OSC with four distinct mission areas. First, we investigate and prosecute alleged prohibited personnel practices, such as retaliation for whistleblowing. Second, we provide a safe and secure channel for employees to disclose waste, fraud, abuse, and threats to public health or safety. Third, we enforce the Hatch Act, which keeps the federal workplace free from political coercion and improper partisan politics. Finally, OSC plays a critical role in enforcing the Uniformed Services Employment and Reemployment Rights Act (USERRA), helping to ensure that service members and veterans are free from discrimination and are reemployed into their proper positions when returning from active duty to the federal civil service.

We offer the following views on the potential impact of S. 1082 and S. 1117 on OSC's efforts to protect whistleblowers.

S. 1082 – Department of Veterans Affairs Accountability Act of 2015

The "Department of Veterans Affairs Accountability Act of 2015" provides the Secretary of Veterans Affairs with additional authority to remove or demote VA employees based on their performance or misconduct. The Act prohibits the Secretary from using the new expedited disciplinary action authority if an employee has a complaint pending with OSC, "without the approval of the Special Counsel." We understand the intent of this provision is to allow OSC to review a pending whistleblower complaint and ensure that any expedited removal or demotion is not retaliatory.

While well-intended, this provision is likely to result in a massive increase in the number of claims filed with OSC by VA employees. If all VA employees are subject to an expedited disciplinary process, we anticipate that a significant percentage of the VA workforce of over 300,000 employees will preemptively file claims with OSC to guard against the possibility of being fired or demoted. With our limited staff and resources, this will make it extraordinarily difficult for OSC to manage our caseload effectively, and to separate the meritorious whistleblower cases from those that are filed primarily to stall an anticipated or feared disciplinary action.

The percentage of OSC cases filed by VA employees is already overwhelming, and continues to climb. OSC has jurisdiction over the entire federal government. Yet, in 2015, nearly 40% of our incoming cases will be filed by VA employees. For the first time, the number of VA cases filed at OSC has surpassed the Department of Defense, which has over twice the number of employees as the VA. We expect this trend to continue into 2016.

This provision could add significantly to an already unsustainable caseload. Without significant additional resources for OSC and the ability to quickly process non-meritorious claims, this provision could negatively impact whistleblower protection efforts by tying up our limited resources on thousands of preemptive and otherwise non-meritorious complaints brought by VA workers. If Congress provides the Secretary with this additional authority, we recommend that Congress also provide OSC with the authority to quickly process complaints brought by VA employees, without the procedural and notice requirements of section 1214 of title 5.

S. 1117 – Ensuring Veteran Safety Through Accountability Act of 2015

The "Ensuring Veteran Safety Through Accountability Act of 2015" provides the Secretary with largely the same authority as S. 1082. However, the Secretary's authority extends only to the VA's healthcare workforce appointed under title 38 (and not to those employees appointed under title 5), and does not explicitly reference the authority of OSC to block an expedited removal or demotion. Because of this, the number of VA employees who file preemptive claims with OSC may be somewhat smaller. Nevertheless, we remain very concerned about the impact this Act would have on our caseload, as summarized above.

In conclusion, the VA workforce accounts for a significant percentage of all cases pending at OSC. OSC has acted to protect dozens of these workers from retaliation for blowing the whistle on threats to patient health and safety. In many of these cases, we secured relief for the whistleblower on an expedited basis, utilizing a program we established in partnership with the VA to promote timely relief for victims of retaliation.

As the Committee considers these pending bills, we encourage you also to consider the impact on OSC, and to provide us with the resources and tools needed to continue to seek timely and significant relief for VA whistleblowers.

LETTER FROM BARBARA L. COLLURA, PRESIDENT & CEO, RESOLVE: THE NATIONAL INFERTILITY ASSOCIATION

June 24, 2015

Senator Johnny Isakson
Committee on Veterans' Affairs
U.S. Senate
Washington, D.C. 20510

Dear Chairman Isakson:

Thank you for the opportunity to provide this statement of support regarding S. 469, the Women Veterans and Families Health Services Act of 201S, legislation that will vastly improve reproductive treatment provided to members of the armed services and our veterans. This is incredibly important legislation for our wounded warriors who expect our government to care for them if they are injured in their service to our country. The ability to procreate is the most basic and fundamental desire of human beings. If that ability is damaged as a result of their service, then we owe it to them to provide access to medical treatments that will allow them to become a parent.

RESOLVE: The National Infertility Association was founded in 1974 to provide information, support, awareness and advocacy for women and men living with infertility. RESOLVE is the oldest and largest patient advocacy organization in the U.S. and the only patient organization advocating for access to infertility services for our active duty military and veterans. We applaud the committee for discussing this important topic.

S. 469 provides for certain disabled veterans to access in vitro fertilization (IVF). Right now the Veterans Administration is prohibited from providing access to IVF, which causes a critical gap in coverage since that same benefit is offered to wounded service-members still covered under TRICARE. While the TRICARE supplemental benefit for certain wounded service-members is needed, most of those who could benefit from IVF transition to the Veteran's health system and by the time they are ready to become a parent, they discover that the VA does not provide access to IVF. This legislation will fix this gap in service and solve a major problem facing our disabled veterans.

This bill also provides for access to reproductive care for the spouse of a veteran. While the VA is not responsible for the healthcare of spouses and dependents, reproduction is unique in that male and female gametes (sperm and egg) are needed as well as a female to carry the pregnancy. Only providing care to the male or female does not work – both must be treated.

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This bill also improves the current supplemental coverage offered by TRICARE in allowing for the use of donor egg or sperm, and the use of a gestational carrier surrogate, if needed. If the wounded service-member or Veteran is a female, allowing the use of a gestational carrier may be their only option to have a child that may be genetically linked to themselves or their partner.

This bill also offers an important benefit to those service-members who are deployed: the ability to preserve their sperm or eggs and cryopreserve them for later use. This is critically important as they be exposed to chemicals or toxins while deployed or be injured and become infertile. Having cryopreserved their own gametes for future use not only allows them the chance of having a biological child, but can improve their treatment options and the chance of success post-deployment.

We applaud the committee for discussing this important issue for our veterans. We stand ready to work with Congress to get this important legislation passed as quickly as possible. Our Veterans are waiting – we owe it to them to fix this coverage gap with the VA and let them access the advanced medical care that they need and so deserve.

Sincerely,

Barbara L. Collura
President & CEO

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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. 469, WOMEN VETERANS AND FAMILIES HEALTH SERVICES ACT OF 2015

This legislation would expand the Department of Veterans Affairs' (VA) and the Department of Defense's (DOD) authority to furnish fertility treatments to servicemembers and veterans who have lost their ability to have children as a direct result of their service-connected injuries. The VFW strongly supports this legislation and would like to offer recommendations to strengthen it, which we hope the Committee will consider.

Due to the widespread use of improvised explosive devices during the wars in Iraq and Afghanistan, both female and male servicemembers have suffered from spinal cord, reproductive, and urinary tract injuries. Many of these veterans hope to one day start families, but their injuries prevent them from conceiving. When these veterans seek fertility treatment from VA, they are told VA services are very limited. In fact, VA is prohibited from providing certain fertility treatments like In Vitro Fertilization. Active duty servicemembers have more fertility options, but DOD's authorities are also limited by who can be treated and what type of treatments they can receive. This legislation would correct this inequity between veterans and servicemembers and expand the options currently available.

Service-connected infertility is not limited to those who have suffered reproductive organ and spinal cord injuries. Other injuries and illnesses, such as Traumatic Brain Injuries and mental health conditions, are known to cause infertility. Veterans with such conditions deserve the same opportunity to start a family as their fellow veterans who have suffered injuries to their reproductive organs. The VFW is glad this legislation would include all "severely wounded, ill, or injured" veterans and servicemembers who have infertility conditions incurred or aggregated by their military service.

Additionally, veterans may have personal objections to assisted reproductive technologies such as In Vitro Fertilization and would like to pursue other options. The VFW believes that VA and DOD must have the authority to provide veterans the fertility treatment options that are best suited for their particular circumstances. For that reason, we support this legislation's inclusion of non-assisted reproductive technology modalities, such as adoption.

This legislation would also require DOD to cryopreserve a veteran's genetic material for up to a year following a veteran's retirement, separation or release from active duty. Starting a family is a life changing decision that takes time and should not be hastily made. The VFW strongly supports giving veterans the opportunity to delay such a decision. However, we urge the Committee to expand the one year window. When totaled, a veteran's recovery, education and career advancement may cause them to wait years before they are physically and financially prepared to start a family. The VFW recommends that veterans be allowed to cryopreserve their genetic material for a minimum of 10 years. This will prevent veterans from feeling rushed into making family planning decisions before they are ready.

This legislation would also extend VA's successful counseling in retreat setting program for transitioning women veterans. The VFW supported the original program established by the Caregivers and Veterans Omnibus Health Services Act of 2010 and believes it is an invaluable tool to help newly discharged women veterans seamlessly transition back into civilian life. For this reason, we recommend that the Committee amend this legislation to make the program permanent.

Another successful program created by the Caregivers and Omnibus Health Services Act of 2010 is the VA childcare pilot program. This program has been well received by veterans at all four pilot sites and has also contributed to the success of other VA health care programs. The VFW has heard from veterans who say they could not have completed their treatment programs if not for the services offered through VA's childcare pilot program. The VFW is glad this legislation would expand this important program to every VA medical center.

S. 901, TOXIC EXPOSURE RESEARCH ACT OF 2015

The VFW supports this legislation, which would establish an advisory board and national center to research the health effects of toxic exposures on the descendants of individuals who were exposed to toxic substances during their military service.

In its report "Veterans and Agent Orange: 2012 Update," the Institute of Medicine (IOM) stated that "the amount of research providing reliable information on the consequences of paternal exposure is extremely sparse not only for [Agent Orange] but also for the full array of environmental agents that may pose threats to the health of future generations." With the existing body of research on this topic, VA has established the Spina Bifida Program to provide health care and benefits to the children of certain Vietnam veterans who were born with spina bifida—an extremely debilitating neural tube birth defect. VA also provides health care and benefits to children of women Vietnam veterans born with certain birth defects.

However, exposure to toxic substances is not limited to Vietnam veterans. We believe VA has the responsibility to research whether the descendants of other veterans who have been exposed to toxic substances, such as those who were exposed to open air burn pits, chemicals during the Gulf War, and the approximately 650,000 veterans and family members who now qualify for VA health care benefits as a result of their exposure to contaminated water in Camp Lejeune, are at risk of developing adverse health conditions.

For far too long, veterans have struggled to obtain VA benefits for chronic health conditions that are associated with their military exposures. The VFW strongly believes the descendants of those veterans should not be forced to wait years for the care they need. This legislation would prevent this by ensuring VA devotes the proper time and resources to make objective and evidence-based determinations regarding the health conditions of a veteran's descendants who are associated with toxic exposures.

S. 1082, DEPARTMENT OF VETERANS AFFAIRS ACCOUNTABILITY ACT OF 2015

The VFW supports this legislation, which would authorize VA to hold employees at all levels accountable for malfeasants or poor performance. The VFW believes VA and Congress must collaborate to identify and fix what is broken within VA, hold employees appropriately accountable to the maximum extent of the law, and do everything possible to restore veterans' faith in their VA.

While this Committee focuses on giving VA the authority to fire bad employees, it must also look for ways to improve VA's ability to hire good employees. VA will not have the staff needed to care for veterans if it disposes of bad employees without the ability to quickly fill vacancies. Unfortunately, the Federal Government's long hiring process puts VA at a disadvantage when recruiting and retaining the best and brightest medical professionals.

In our report, "Hurry Up and Wait," we highlight deficiencies in VA human resources practices, outlining several recommendations to improve the hiring process and customer service training. Section 203 of the Veterans Access, Choice and Accountability Act of 2014 called for a Technology Task Force to perform a review of the Department of Veterans Affairs' scheduling system and software development. In their review, the Northern Virginia Technology Council (NVTC) reinforced our concerns that VA's hiring process moves too slowly. NVTC suggested that VA aggressively redesign its human resources processes by prioritizing efforts to recruit, train, and retain clerical and support staff.

The VFW looks forward to working with Congress to expedite passage of this legislation and find workable solutions to VA human resources' issues to ensure VA can move quickly to fire employees who put veterans at risk, while quickly hiring the best applicants to set VA on a path to restore veterans' trust in the system.

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

The VFW strongly supports this legislation, which would greatly enhance the services provided to caregivers of servicemembers and veterans who were severely disabled in the line of duty. Family caregivers choose to put their lives and careers on hold, often accepting great emotional and financial burdens, and the VFW believes that our Nation owes them the support they need and deserve. This bill would accomplish this in a number of ways, including extending benefits to caregivers of veterans with service-connected illnesses, offsetting the costs of their child care, providing them with financial advice and legal counseling, expanding their respite care options, and allowing veterans who participate in the VA caregiver program to transfer their Post-9/11 G.I. Bill benefits to their family members.

Perhaps most significantly, this legislation would extend caregiver eligibility to severely injured and ill veterans of all eras. This is a desperately needed change that the VFW has long supported. Severely wounded and ill veterans of all conflicts have made incredible sacrifices, and all family members who care for them are equally deserving of our recognition and support. The fact that caregivers of previous era veterans are currently excluded from the full complement of program benefits implies that their service and sacrifices are not as significant, and we believe this is wrong. We support the five year phase-in plan, which would incrementally grant program eligibility based on the severity of the veteran's conditions, as we believe this would give VA the opportunity to responsibly expand and improve the program without compromising services to current beneficiaries.

The VFW believes that extending caregiver benefits to veterans of all ages is not only a matter of fairness, but one of fiscal responsibility as well. It seems logical that the ability of veterans to remain in their homes receiving care from family members would allow them to avoid nursing home care which is far more expensive. According to VA's Fiscal Year 2015 Budget Request, VA spent more than $5 billion providing institutional care in fiscal year 2014. The average per diem cost for a VA Community Living Center was $971.97, totaling over $350,000 per veteran, per year. At contracted community nursing homes, VA spends over $90,000 per veteran, per year. The VA contribution for a veteran at state-run nursing homes averages over $45,000 per veteran, per year. On the other hand, the Congressional Budget Office estimates that the average cost of benefits to a primary caregiver would total only $33,000 per year. While we recognize that CBO is not able to consider potential savings when calculating cost, we contend that expansion of the Family Caregiver program could produce real savings to VA in the long run.

The VFW hears from our members often about Family Caregiver Program eligibility, and their message is clear: they strongly support expanding full caregiver benefits to veterans of all eras. As an intergenerational veterans' service organization that traces its roots to the Spanish American War, this is not surprising. Our members are combat veterans from World War II, the wars in Korea and Vietnam, the Gulf War, and various other short conflicts, in addition to current era veterans. They rightly see no justifiable reason to exclude otherwise deserving veterans from program eligibility simply based on the era in which they served. For this reason, the VFW urges Congress to swiftly pass the Military and Veteran Caregiver Services Improvement Act of 2015.

S. 1117, ENSURING VETERAN SAFETY THROUGH ACCOUNTABILITY ACT OF 2015

The VFW appreciates the intent of this legislation, which would improve accountability by holding title 38 employees accountable for poor performance or wrongdoing.

In order to restore veterans' faith in their VA, there is no doubt that VA must undergo a culture change. Like most places, VA employees work in an environment the rewards specific outcomes based on specific performance standards. Last year we learned that these outcomes had become unattainable for VA employees throughout the country. But instead of evaluating why standards could no longer be met, local VA leaders put pressure on employees to achieve the unattainable. Thus employees were left with two options—be a poor performer or find a way to do the impossible. Now VA is left with an employee-base that has been trained to believe that doing the wrong thing is right. This is why VA should not hastily dismiss low-level and medical support employees who have been coerced into misrepresenting data or hiding the truth.

However, VA staff at all levels who have been entrusted with the lives and wellbeing of veterans should be held to higher standards than other Federal employees. Unlike, their counterparts at other Federal agencies, when medical support assistants and other title 5 employees at VA medical facilities commit malfeasants, veterans' lives are at risk. Thus, VA's authority to hold employee's accountable should not be limited to SES and title 38 employees. For this reason, the VFW prefers S. 1082, which would authorize VA to hold all VA employees accountable for their poor performance or wrongdoing.

S. 1641, THE JASON SIMCAKOSKI MEMORIAL OPIOID SAFETY ACT

The VFW supports this legislation, which would reduce VA's reliance of pharmacotherapy to treat mental health and complex pain conditions; strengthen VA's patient advocate program; expand VA research, education, and delivery of complementary and alternative medicine (CAM) treatments, and improve VA hiring and internal audits.

Too often, the VFW hears stories of veterans who have been prescribed high doses of ineffective medications to treat their mental health conditions. Countless veterans have experienced first-hand the dangerous side of pharmacotherapy. Many of these medications, if incorrectly prescribed, have been proven to render veterans incapable of interacting with their loved ones and even contemplate suicide. With the expanding evidence of the efficacy of non-pharmacotherapy modalities, such as psychotherapy and CAM, VA must ensure it affords veterans the opportunity to access effective treatments that minimize adverse outcomes.

Timely and accessible mental health care is crucial to ensuring veterans have the opportunity to successfully integrate back into civilian life. With more than 1.4 million veterans receiving specialized VA mental health treatment each year, VA must ensure such services are safe and effective. VA has made a concerted effort to change its health care providers' dependence on pharmacotherapy to treat mental health conditions and manage pain. In 2011, the Minneapolis VA Medical Center launched its Opioid Safety Initiative. Aimed at changing the prescribing habits of providers, the Opioid Safety Initiative educates providers on the use of opioids, serves as a tool to taper veterans off high-dose opioids, and offers them alternative—non-pharmacotherapy—modalities for pain management. Unfortunately, the VA has failed to produce a notable change since implementing the Opioid Safety Initiative system-wide. This legislation includes much needed reforms to ensure VA's clinical practice guidelines for pain management are appropriate and includes the proper compliance mechanisms, such as the pain management boards, to ensure such guidelines a carried out.

The VFW has consistently heard from veterans that their patient advocates are ineffective or seek to protect the medical facility's leadership instead of addressing their concerns. For this reason, we strongly support title II, which would to create the Office of Patient Advocacy and make other improvement to VA's patient advocacy program. The VFW believes that patient advocates cannot effectively meet their obligations to veterans if their chain of command includes VA medical facility staff that is responsible for the actions and policies they are required to address. In its markup of this bill, the VFW recommends that the Committee explicitly state that the Department's patient advocates would be reassigned to report directly to the Office of Patient Advocacy and no longer fall under the chain of command of local medical center leadership.

With the growing body of research on the efficacy of CAM therapies, such as biofeedback, mindfulness meditation, and other non-pharmacologic approaches to treating mental health conditions and manage pain, the VFW believes that more work must be done to ensure veterans are afforded the opportunity to receive these safe and effective alternatives to pharmacotherapy. This legislation would make significant strides toward ensuring veterans who are tapered off high-dose medications have effective alternatives.

H.R. 91, VETERAN'S I.D. CARD ACT

The VFW appreciates the intent of H.R. 91, which would require VA to issue identification (ID) cards to veterans for use as validation of veteran status. However, the VFW believes that states are better suited to provide ID cards verifying veteran status. The infrastructure already exists within each state's Department of Motor Vehicles to provide picture ID cards to its citizens, whereas the VA would have to expand its capability to accommodate the increase in veteran requests for such cards.

Forty-eight states and the District of Columbia already provide ID cards with a veteran indicator. The remaining two states are in the process of implementing laws that require them to issue such cards. The VFW is glad to see all fifty states and the District of Columbia have made this a priority and believes it is no longer necessary or beneficial for VA to duplicate such efforts. Additionally, requiring VA to issue ID cards to millions of veterans would impede its ability to provide veteran health identification (VHID) cards to veterans who are eligible for VA health care benefits. Veterans who have waited months, if not years, for their veterans' benefits should not be forced to wait in a backlog for VHID cards.

Furthermore, duplicating state efforts may result in veterans being eligible for a state ID but not a VA ID, or vice versa. As referred to this Committee, H.R. 91 would require VA to issue an ID to any honorably discharged veteran. However, honorable service is not a precondition for veteran identifiers on ID in most states. This would be a source of contention for veterans who would be recognized as a veteran by one entity but not the other. Amending the legislation to include all veteran who received an other than dishonorable discharge would exacerbate this issue, because VA would be required to make eligibility determinations for veterans who receive administrative, other than honorable and bad conduct discharges. VA already

makes such determinations when veterans apply for VA benefits. The VFW is concerned that VA takes too long to make these determination now, and we fear veterans who are waiting to access their VA benefits will have to wait longer because VA would be inundated with eligibility determinations for ID card applicants.

Draft Legislation to Expand the Availability of Prosthetic and Orthotic Care for Veterans and to Submit a Report on Laotian Military Support of the Armed Forces During the Vietnam War

The VFW supports section 1 of this legislation, which would authorize VA to establish partnerships to expand the availability of prosthetic and orthotic care for veterans.

Orthotists and prosthetists are vital to ensuring VA provides the prosthetics care and services veterans need and deserve. In 2014, VA provided 17.5 million prosthetic items and services to more than three million veterans and estimates a growing demand in future years. The VFW strongly supports expanding the availability of orthotic and prosthetic care for veterans. For this reason, we believe the Committee should amend this legislation by adding a service-requirement for health care professionals who benefit from this program, similar to service requirements under other health professional educational assistance programs.

The VFW has no official position on section 2, which would require VA to determine whether Laotian military forces supported the United States during the war in Vietnam.

DRAFT LEGISLATION, BIOLOGICAL IMPLANT TRACKING AND VETERAN SAFETY ACT

The VFW support this legislation, which would require VA to purchase biological implants that meet Food and Drug Administration (FDA) standards and develop a tracking system for such implants.

VA has an obligation to ensure veterans receive the highest quality care possible. This includes ensuring that the care veterans receive from VA meets industry standards and does not place veterans at risk. That is why the VFW was concerned when GAO reports found that VA may not be able to locate recalled or defective biological implants that it has furnished. The VFW supports efforts to prevent veterans from receiving defective or contaminated biological implants and ensure VA is able to identify veterans who have received implants that may need to be replaced.

While, the VFW believes it is important to ensure veterans receive high quality care, we firmly believe that they should not be required to wait unreasonably long periods of time for their care because of slow bureaucratic processes. That it is why we recommend the Committee amend this legislation to ensure VA is authorized to use all of its purchasing authorities when furnishing biological implants.

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

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

STATEMENT FOR THE RECORD

OF THE

WOUNDED WARRIOR PROJECT

BEFORE THE

COMMITTEE ON VETERANS AFFAIRS

UNITED STATES SENATE

JUNE 24, 2015

Chairman Isakson, Ranking Member Blumenthal, and Members of the Committee:

Thank you for inviting Wounded Warrior Project® (WWP) to provide our views on pending veterans' legislation today. Several of the measures under consideration directly relate to policy priorities of injured service members and caregivers and we are encouraged to see their consideration. What follows are our comments on those bills.

S. 469 – The Women Veterans and Families Health Services Act of 2015

WWP thanks the Committee specifically for the opportunity to provide our thoughts regarding the fertility treatments provided by the Department of Veterans Affairs (VA). In our decade-long experience working daily with this generation of wounded warriors and their families, we believe that there is a serious, unmet need to provide reproductive services and adoption assistance to assist in helping severely wounded, ill, or injured veterans who have service-incurred infertility conditions to have children.

Families play a critical role in wounded veterans' reintegration, recovery, and rehabilitation. Military families have a unique culture, and learn to live with the shared sacrifices that come with military service. Those who return from war with visible or invisible wounds that prevent them from having children can find the transition home even more challenging.

Blasts from widespread use of improvised explosive devices in Iraq and Afghanistan, particularly in the case of warriors on foot patrols, have increasingly resulted not only in traumatic amputations of at least one leg, but also in pelvic, abdominal or urogenital wounds.[1] While not widely recognized, the number and severity of genitourinary injuries has increased over the course of the war, with more than 12% of all admissions in 2010 involving associated genitourinary injuries.[2] With that increase has come not only Department of Defense (DoD) acknowledgement of the impact of genitourinary injuries on warriors' psychological and reproductive health,[3] but the adoption of a policy authorizing and providing implementation guidance on assisted reproductive services for severely or seriously injured active duty service members.[4] DoD's policy, set forth in revisions to its TRICARE Operations Manual, applies to service members of either gender who have lost the natural ability to procreate as a result of neurological, anatomical, or physiological injury. The policy covers assistive reproductive technologies (including sperm

and egg retrieval, artificial insemination, and in vitro fertilization) to help reduce the disabling effects of the service member's condition to permit procreation with the service member's spouse.[5]

For veterans, however, VA coverage is very limited in scope. The regulation describing the scope of VA's "medical benefits package" states explicitly that in vitro fertilization is excluded[6] and that "[c]are will be provided only…[as] needed *to promote, preserve, or restore the health* of the individual…(italics added)."[7] Consistent with that limiting language, the VA's benefits handbook advises women veterans with regard to health coverage that "…infertility evaluations and limited treatments are also available."[8]

The VA's policy of providing only "limited" services to veterans unable to procreate likely rests on at least two grounds. First, the VA has long construed its authority as limited to "treatment" of a disability, and as not extending to procedures that did not "treat" the underlying disability but were aimed at "overcoming" it. The VA's references to "limited treatment" likely also reflect a view that its statutory health care role is one of providing services to the veteran (and the veteran only), and thus does not extend to procedures or advanced technologies that involve not only the veteran, but a spouse or partner.

In a departure from longstanding policy, the VA stated last year that "[t]he provision of Assisted Reproductive Services (including any existing or future reproductive technology that involves the handling of eggs or sperm) is in keeping with VA's goal to restore the capabilities of Veterans with disabilities to the greatest extent possible and to improve the quality of Veterans' lives."[9] In its statement, VA also expressed support in principle for legislation authorizing VA to provide assistive reproductive services to help a severely wounded veteran with an infertility condition incurred in service and that veteran's spouse or partner have children. It conditioned that support, however, on "assurance of the additional resources that would be required."[10] While these advanced interventions require resources, cost should not be a barrier as it relates to this country's obligation to young warriors who sustained horrific battlefield injuries that impair their ability to father or bear children.

WWP supports this bill, and urges the Committee to enact legislation that brings parity to veterans who are unable to conceive because of the warrior's severe service-incurred injury or illness to receive fertility counseling and treatment, including assisted reproductive services, similar to services provide to active duty service members.[11]

S. 1085 – The Military and Veteran Caregiver Services Improvement Act of 2015

In working daily with family members of disabled warriors who have sustained severe or catastrophic injuries, WWP continues to see the profound toll the lack of assistance can take on caregivers. While caring for severely disabled warriors—sometimes for years and without assistance—many caregivers have left their jobs, exhausted savings, and suffered tremendous strain to their own health in order to provide the very best care for their warrior.

Five years ago, this Committee passed historic legislation (Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163; Caregiver Law) that established the framework for a VA program that now provides critical support to caregivers of seriously disabled veterans. That legislation recognized the risk that the extraordinary toll of caregiving could overwhelm the caregiver—whether physically, emotionally, or financially—and result in unwanted, but very costly, institutionalization for the service member. The Caregiver Law established the framework for the Department of Veterans Affairs' (VA)

Caregiver Program, which now provides critical services and support to over 19,000 caregivers of injured veterans.

We appreciate S.1085's attempts to improve the Caregiver Program by extending those critical services to veterans of all conflict eras. Before extending the Caregiver Program, however, we feel that Congress should address several long-standing, unresolved issues that continue to frustrate caregivers already in the program.

Specifically, vagueness and ambiguity in VA's final caregiver regulations have resulted in wide variability in determinations of eligibility and support, with evidence of clearly erroneous decisions creating hardship. The final regulations, for example, leave "appeal rights" unaddressed (including appeals from adverse determinations of law), and set unduly strict criteria for determining a need for caregiving for veterans with severe behavioral health conditions, including veterans with Traumatic Brain Injury (TBI). In addition, the vagueness of the regulations, in terms of clinical decision-making, engenders arbitrary, inconsistent implementation. These are serious issues that we feel should be addressed prior to extending the Caregiver Program.

We ask your help in resolving these long-outstanding concerns, as well as in easing the Veterans Benefits Administration (VBA) reporting and oversight requirements on Veterans Health Administration-recognized (VHA) caregivers who are also fiduciaries for their loved ones.[12]

Conclusion

WWP envisions a future in which the most successful, well-adjusted generation of injured service members in our nation's history not only survives, but also thrives. This vision requires sustained public support, and relevant programs and services for veterans and their caregivers. Helping injured service members requires a lifetime of commitment. WWP commits to serving this population for their lifetime, and working with Congress and the Administration to realize this vision.

Thank you for the opportunity to comment on these important bills.

The mission of Wounded Warrior Project® (WWP) is to honor and empower Wounded Warriors. WWP's purpose is to raise awareness and to enlist the public's aid for the needs of injured service members, to help injured service men and women aid and assist each other, and to provide unique, direct programs and services to meet their needs. WWP is a national, nonpartisan organization headquartered in Jacksonville, Florida. To get involved and learn more, visit www.woundedwarriorproject.org.

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[1] Dismounted Complex Injury Task Force, "Dismounted Complex Blast Injury: Report of the Army Dismounted Complex Injury Task Force," 1 (June 18, 2011) available at: http://www.armymedicine.army.mil/reports/DCBI%20Task%20Force%20Report%20%28Redacted%20Final%29.pdf.
[2] Id. at 16.
[3] Id.

[4] Asst. Secretary of Defense (Health Affairs) & Director of TRICARE Management Activity, Memorandum on Policy for Assisted Reproductive Services for the Benefit of Seriously or Seriously Ill/Injured (Category II or III) Active Duty Service Members (April 3, 2012) available at: http://www.veterans.senate.gov/upload/DOD_reproductive_letter.pdf.
[5] Dept. of Defense, TRICARE Operations Manual 6010.56-M, Chapter 17, Section 3, para. 2.6 (Sept. 19, 2012).
[6] 38 C.F.R. § 17(c)(2).
[7] 38 C.F.R. § 17(b) (Emphasis added).
[8] Department of Veterans Affairs, "Federal Benefits for Veterans, Dependents and Survivors" available at http://www.va.gov/opa/publications/benefits_book/benefits_chap01.asp
[9] *Health and Benefits Legislation Hearing Before the S. Comm. on Veterans Affairs*, 112th Cong. (2012).
[10] Id.
[11] To learn more about the how important fertility issues are to wounded service members, visit http://www.woundedwarriorproject.org/programs/policy-government-affairs/key-policy-priorities/objective-3-optimal-long-term-rehabilitative-care/initiative-4.aspx.
[12] WWP submitted a Statement for the Record on the VA Caregiver Program in December 2014, accessible online here: http://www.woundedwarriorproject.org/media/723028/veterans_affairs__caregiver_program-_assessing_current_prospects_and_future_possibilities.pdf. For more information about the challenges facing this generation of caregivers, visit: http://www.woundedwarriorproject.org/programs/policy-government-affairs/key-policy-priorities.aspx.

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