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VETERANS' HEALTH CARE AUTHORIZATION ACT OF 2008

SEPTEMBER 18 (legislative day, SEPTEMBER 17, 2008.—Ordered to be printed

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

R E P O R T

together with

SUPPLEMENTAL VIEWS

[To accompany S. 2969]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 2969), to enhance the capacity of the Department of Veterans Affairs to recruit and retain nurses and other critical health care professionals, and for other purposes, having considered an amendment to the bill in the nature of a substitute, unanimously reports favorably thereon with an amendment, and an amendment to the title, and recommends that the bill, as amended, do pass.

INTRODUCTION

On May 1, 2008, Chairman Akaka introduced S. 2969, the proposed "Veterans' Health Care Authorization Act of 2008." S. 2969, as introduced, would enhance the capacity of the Department of Veterans Affairs (hereinafter, "VA") to recruit and retain nurses and other critical health care professionals.

Earlier, on October 31, 2007, Chairman Akaka introduced, by request, S. 2273, the proposed "Enhanced Opportunities for Formerly Homeless Veterans Residing in Permanent Housing Act of 2007." S. 2273 would enhance services for previously homeless veterans and for veterans at risk of becoming homeless.

On November 16, 2007, Senator Durbin introduced S. 2377, the proposed "Veterans Health Care Quality Improvement Act." S. 2377 would establish quality assurance mechanisms in VA medical

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facilities, and would create additional certification and licensure requirements for VA physicians. S. 2377 is cosponsored by Senator Obama.

On April 2, 2008, Chairman Akaka introduced S. 2796. S. 2796 would require VA to conduct a pilot program on the use of community-based organizations to ensure that transitioning veterans and their families receive the care and benefits to which they are entitled.

On April 2, 2008, Chairman Akaka introduced, by request, S. 2797. S. 2797 would authorize major medical facility projects and major medical facility leases for VA for fiscal year 2009, among other purposes related to facilities.

On April 2, 2008, Senator Murray introduced S. 2799, the proposed "Women Veterans Health Care Improvement Act of 2008." S. 2799 would require studies of the health care needs of women veterans and of the services available to them from VA, and would require expansion of the services available to women veterans. S. 2799 is cosponsored by Senators Boxer, Brown, Casey, Clinton, Hutchison, Johnson, Lincoln, Mikulski, Murkowski, Rockefeller, Schumer, and Wyden.

On April 17, 2008, Chairman Akaka introduced, by request, S. 2889, the proposed "Veterans Health Care Act of 2008." S. 2889 would allow VA to contract with community residential care programs for veterans with serious traumatic brain injuries (hereinafter, "TBI"), eliminate copayments for all hospice care, expand continuing education benefits for physicians and dentists, and allow the Secretary of Veterans Affairs (hereinafter, "Secretary") to disclose certain personal information to collect payment from third-party health plans under certain circumstances.

On April 22, 2008, Senator Harkin introduced S. 2899, the proposed "Veterans Suicide Study Act." S. 2899 would direct VA to conduct a study on suicides among veterans. S. 2899 is cosponsored by Senators Feingold, Grassley, Kerry, Klobuchar, Mikulski, Murray, Obama, Stabenow, and Tester.

On April 28, 2008, Senator Clinton introduced S. 2921, the proposed "Caring for Wounded Warriors Act of 2008." S. 2921 would create pilot programs on training, certification, and compensation for family caregivers of veterans and members of the Armed Forces withTBI, and on the provision of respite care to such veterans and servicemembers by graduate students at affiliated universities. S. 2921 is cosponsored by Senator Dole.

On April 28, 2008, Chairman Akaka introduced S. 2926, the proposed "Veterans Nonprofit Research and Education Corporations Enhancement Act of 2008." S. 2926 would authorize multi-medical center nonprofit research corporations (hereinafter, "NPCs"), clarify existing authorities, and strengthen VA oversight of NPCs.

On April 29, 2008, Senator Tester introduced S. 2937. S. 2937 would provide VA with permanent authority to provide health care for participants in certain Department of Defense (DOD) chemical and biological tests, and would expand the study of the impact of Project Shipboard Hazard and Defense (hereinafter, "Project SHAD") on veterans' health.

On May 1, 2008, Senator Bond introduced S. 2963. S. 2963 would, among other things, enhance the mental health care services available to members of the Armed Forces and veterans, and

enhance counseling and other benefits available to survivors of members of the Armed Forces and veterans. S. 2963 is cosponsored by Senators Boxer, Clinton, Collins, Dole, Domenici, Grassley, McCaskill, Murkowski, Obama, and Stevens.

On May 6, 2008, Chairman Akaka introduced, by request, S. 2984, the proposed "Veterans' Benefits Enhancement Act of 2008." S. 2984 would extend VA authorities for certain kinds of long-term care and care for veterans who participated in certain chemical and biological tests conducted by DOD, extend VA authority to continue an audit recovery program, eliminate or modify a number of reporting requirements, modify authorities relating to collections from third parties for certain medical care, authorize disclosure of certain personal information in limited circumstances, increase the threshold for major medical facility leases requiring Congressional approval from $600,000 to $1,000,000, and provide authorities for the operation and upkeep of the VA police force. S. 2984 would also address a number of matters related to veterans' benefits.

On May 8, 2008, Chairman Akaka introduced S. 3000, the proposed "Native American Veterans Access Act of 2008." S. 3000 would include Federally recognized tribal organizations in certain programs for State veterans homes.

On June 19, 2008, Ranking Member Burr introduced S. 3167. S. 3167 would clarify the conditions under which veterans, their surviving spouses, and their children may be treated as adjudicated mentally incompetent for certain purposes.

On June 23, 2008, Ranking Member Burr introduced S. 3178. S. 3178 would authorize a dental insurance program for veterans, survivors, and dependents of veterans.

On March 11, 2008, the Committee held a hearing on care for families of wounded veterans. Testimony was offered by: Col. Peter Bunce (USAF, Ret.), father of Justin Bunce, a veteran of Operation Iraqi Freedom; Robert Verbeke, father of Daniel Verbeke, a veteran of Operation Iraqi Freedom; Jackie McMichael, wife of Michael McMichael, a veteran of Operation Iraqi Freedom; Lynda Davis, PhD, Deputy Assistant Secretary of the Navy for Military Personnel Policy, Department of the Navy; Kristen Day, LCSW, Chief Consultant, Care Management and Social Work, Office of Patient Care Services, Veterans Health Administration, Department of Veterans Affairs; Jane Dulin, LCSW, Supervisor, Soldier Family Management Branch, U.S. Army Wounded Warrior Program; and Steven Sayers, PhD, Clinical Psychologist, Philadelphia VA Medical Center and Assistant Professor of Psychology in Psychiatry and Medicine, University of Pennsylvania School of Medicine.

On April 9, 2008, the Committee held an oversight hearing on personnel issues within VA. Testimony was offered by: Marisa W. Palkuti, MEd, Director, Healthcare Retention and Recruitment Office, Veterans Health Administration, Department of Veterans Affairs; Sheila M. Cullen, Director, San Francisco VA Medical Center; Steven P. Kleinglass, Director, Minneapolis VA Medical Center; Marjorie Kanof, MD, Managing Director, Health Care, Government Accountability Office; John A. McDonald, MD, PhD, Vice President for Health Sciences and Dean, University of Nevada School of Medicine, on behalf of the Association of American Medical Colleges; Valerie O'Meara, NP, VA Puget Sound Health Care System, Professional Vice President, American Federation of Government Employ-

ees Local 3197; Randy Phelps, PhD, Deputy Executive Director, American Psychological Association Practice Directorate; and Jennifer L. Strauss, PhD, Health Scientist, Center for Health Services Research in Primary Care, Durham VA Medical Center, and Assistant Professor, Department of Psychiatry and Behavioral Sciences, Duke University Medical Center, on behalf of the Friends of VA Medical Care and Health Research.

On May 21, 2008, the Committee held a hearing on pending health care legislation. Testimony was offered by: Gerald M. Cross, MD, Principal Deputy Under Secretary for Health, Department of Veterans Affairs; accompanied by Walter Hall, Assistant General Counsel; and Kathryn Enchelmayer, Director, Quality Standards, Office of Quality and Performance, Veterans Health Administration; Carl Blake, National Legislative Director, Paralyzed Veterans of America; Joseph L. Wilson, Assistant Director for Health Policy, Veterans Affairs and Rehabilitation Commission, The American Legion; Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans; Chris Needham, Senior Legislative Associate, National Legislative Service, Veterans of Foreign Wars; Stan Luke, PhD, Vice President for Programs, Helping Hands Hawaii; J. David Cox, RN, National Secretary-Treasurer, American Federation of Government Employees; Cecilia McVey, MHA, RN, Former President, Nurses Organization of Veterans Affairs; Donna Lee McCartney, Chair, National Association of Veterans' Research and Education Foundations; Thomas Berger, PhD, Chair, National PTSD and Substance Abuse Committee, Vietnam Veterans of America; and Sally Satel, MD, Resident Scholar, American Enterprise Institute.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearings, the Committee met in open session on June 26, 2008, to consider, among other legislation, an amended version of S. 2969, consisting of provisions from S. 2969 as introduced, from other legislation noted above, and several freestanding provisions. The Committee voted unanimously to report favorably S. 2969, as amended.

SUMMARY OF S. 2969 AS REPORTED

S. 2969, as reported, (hereinafter, "the Committee bill") would amend the title of the original bill, and would make numerous enhancements and expansions to VA health care and services.

TITLE I—DEPARTMENT PERSONNEL MATTERS

Section 101 would authorize VA to extend title 38, United States Code (U.S.C.), employment status to certain employees; amend salary authorities for certain VA positions; amend the statute governing certain work schedules; amend the statute governing transparency and conduct of locality pay surveys; and enhance other authorities to improve recruitment and retention of medical professionals.

Section 102 would impose limitations on overtime duty and would amend the statutes governing weekend duty and alternative work schedules for nurses.

Section 103 would reauthorize and expand certain educational assistance programs to improve recruitment and retention.

Section 104 would establish standards for appointment and practice of physicians in VA medical facilities.

TITLE II—HEALTH CARE MATTERS

Section 201 would repeal the sunset provision on the inclusion of non-institutional extended care services in the definition of medical services.

Section 202 would extend the authorities of nursing home care, research corporations, and recovery audits.

Section 203 would provide permanent authority for the provision of hospital care, medical services, and nursing home care to veterans who participated in certain chemical and biological testing conducted by DOD.

Section 204 would repeal the annual reporting requirements on nurse pay and long-term planning.

Section 205 would amend the annual Gulf War research report by changing the report due date.

Section 206 would mandate that payment by VA on behalf of a covered beneficiary for the Civilian Health and Medical Program of VA (hereinafter, "CHAMPVA") medical care shall constitute payment and eliminate any liability on the part of the beneficiary for that care.

Section 207 would modify authorities relating to collections from third parties for medical care, including care provided to children of Vietnam veterans born with spina bifida or birth defects.

Section 208 would authorize VA to make disclosures from certain medical records under limited circumstances.

Section 209 would require the disclosure to the Secretary of health plan contract information and social security numbers of certain veterans receiving care from VA.

Section 210 would require the designation of a National Quality Assurance Officer, and a Quality Assurance Officer for each VA facility.

Section 211 would require a report on Department health care quality assurance.

Section 212 would require VA to establish a pilot program on training and certification for family caregivers and personal care attendants for veterans of the Armed Forces with TBI.

Section 213 would require VA to establish a pilot program on the provision of respite care to members of the Armed Forces and veterans with TBI by students in graduate programs of education related to mental health or rehabilitation.

Section 214 would require VA to establish a pilot program on the use of community-based organizations to ensure that transitioning veterans and their families receive the care and benefits they need.

Section 215 would authorize VA to contract with appropriate entities for specialized residential care and rehabilitation for certain Operation Iraqi Freedom or Operation Enduring Freedom (hereinafter, "OIF/OEF") veterans with TBI.

Section 216 would exempt veterans receiving hospice care from copayment requirements.

Section 217 would repeal the limitation on the authority of the Secretary to conduct a widespread human immunodeficiency virus (hereinafter, "HIV") testing program.

Section 218 would authorize VA to disclose medical records to a third party for collection of charges for care or services provided for a non-service-connected disability.

Section 219 would require VA to establish an expanded study on the health impact of Project SHAD.

Section 220 would require VA to provide care and services to certain individuals in non-Department facilities under limited circumstances.

Section 221 would authorize tribal organizations to access the construction grants and per diem payments provided under the State Veterans Home Program in the same manner as other eligible entities.

Section 222 would authorize the extension of the pilot program on improvement of caregiver assistance services through fiscal year 2009.

Section 223 would require VA to establish a pilot program on the provision of dental insurance plans to veterans, survivors, and dependents of veterans.

TITLE III—WOMEN VETERANS HEALTH CARE

Section 301 would require VA to report on the barriers to women veterans' access to VA health care.

Section 302 would require VA to develop a plan to improve the provision of health care services to women veterans.

Section 303 would require an independent study on the health consequences of service in OIF/OEF for women veterans.

Section 304 would require VA to implement a program of training and certification for VA mental health care providers on care for veterans suffering from military sexual trauma.

Section 305 would require VA to establish a pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

Section 306 would require a report on full-time women veterans' program managers at VA medical centers.

Section 307 would require the Advisory Committees on Women Veterans and Minority Veterans to include women veterans recently separated from service in the Armed Forces.

Section 308 would require VA to establish a pilot program on child care for certain veterans receiving health care from VA.

TITLE IV—MENTAL HEALTH CARE

Section 401 would establish eligibility for members of the Armed Forces who served in OIF/OEF for readjustment counseling and related mental health services through the Readjustment Counseling Service of the Veterans Health Administration.

Section 402 would restore the authority of the Readjustment Counseling Service to provide referral and other assistance to former members of the Armed Forces not otherwise authorized for counseling.

Section 403 would require VA to conduct a study on suicides among veterans since January 1, 1997, and report to Congress on the findings.

Section 404 would require VA to transfer $5,000,000 to the Secretary of Health and Human Services for the Graduate Psychology Education program.

TITLE V—HOMELESS VETERANS

Section 501 would authorize VA to establish a pilot program to make grants to public and nonprofit organizations that coordinate the provision of supportive services to formerly homeless veterans residing on certain military property.

Section 502 would authorize VA to establish a pilot program to make grants to public and nonprofit organizations that coordinate the provision of supportive services to formerly homeless veterans residing in permanent housing.

Section 503 would authorize VA to establish a pilot program to make grants to public and nonprofit organizations that provide outreach to inform low-income and elderly veterans who reside in rural areas about pension benefits.

Section 504 would authorize VA to establish a pilot program on financial support of entities that provide transportation assistance, childcare assistance, and clothing assistance to veterans entitled to certain rehabilitation services.

Section 505 would require assessments of the pilot programs authorized by sections 501 through 504.

Section 506 would increase the authorization for the Homeless Grant and Per Diem (GPD) Program from $130,000,000 to $200,000,000.

TITLE VI—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

Section 601 would authorize multi-medical center NPCs, expand existing corporations to multi-medical center research corporations, amend authorities on the applicability of state law, clarify the status of corporations, and reinstate the requirement of 501(c)(3) status of corporations.

Section 602 would clarify the purpose of NPCs.

Section 603 would amend the requirements for VA and non-VA Board Members.

Section 604 would amend and clarify the provision on general powers of corporations.

Section 605 would redesignate section 7364A of title 38, U.S.C., as section 7365.

Section 606 would amend the provision on reporting by adding additional information to be reported on; amend the provision related to the confirmation of application of conflict of interest regulations to include appropriate corporation positions; and authorize establishment of an appropriate payee reporting threshold.

Section 607 would repeal the provision that sunsets the authority for corporations after December 31, 2008.

TITLE VII—CONSTRUCTION

Section 701 would authorize funds for fiscal year 2009 major medical facility projects.

Section 702 would extend the authorization for major medical facility construction projects previously authorized.

Section 703 would authorize funds for fiscal year 2009 major medical facility leases.

Section 704 would authorize the appropriation of $1,902,014,000 for the projects authorized by sections 701 through 703.

Section 705 would increase the threshold for major medical facility leases requiring congressional approval from $600,000 to $1,000,000.

Section 706 would approve the conveyance of certain non-federal land by the city of Aurora, CO, to the Secretary for construction of a VA medical facility.

TITLE VIII—MISCELLANEOUS PROVISIONS

Section 801 would expand the authority for VA police officers.

Section 802 would provide a uniform allowance for VA police officers.

Section 803 would clarify the conditions under which veterans, their surviving spouses, and their children may be treated as adjudicated mentally incompetent for certain purposes.

BACKGROUND AND DISCUSSION

TITLE I—DEPARTMENT PERSONNEL MATTERS

Title I of the Committee bill contains a variety of provisions that are designed to help ensure that VA has the workforce necessary to serve America's veterans most effectively.

Health care providers are the backbone of the VA system. Yet today, it is clear, based on information received by the Committee during its April 9, 2008, oversight hearing on the Veterans Health Administration (hereinafter, "VHA") personnel issues, entitled "Making VA the Work Place of Choice for Health Care Professionals," and from myriad other sources, that VA faces a looming shortage of health care personnel and that this situation will only worsen in the coming years without focused effort to improve VA's ability to attract and retain needed employees. A recent report by the Partnership for Public Service, titled *Where the Jobs Are: Mission Critical Opportunities for America* (2nd edition, 2007), gave the VHA poor marks for pay and benefits, and for family support. VHA also rated poorly among younger employees. To be the health care employer of choice, VA must be able to offer competitive salaries, work schedules, and benefits.

In recent years, VA has faced changing demands for health care and for increasing competition for health care professionals. The Bureau of Labor Statistics showed an 18.4 percent increase in employment in the health care industry in 2006, and noted that employment rose significantly in hospitals, ambulatory health care settings, and nursing and residential care. With an aging veteran population, and a shift towards non-institutional care, VA has increased hiring of home health aides and nurses significantly. The return of servicemembers from the conflicts in Iraq and Afghanistan has brought new demands for specialized mental health, trauma, rehabilitation, and other care.

Health care professionals employed by VA are hired under a variety of authorities—the regular, government-wide, personnel hiring authorities in title 5, United States Code (U.S.C.); the VA-specific personnel authority in title 38, U.S.C., and a hybrid employ-

ment system that relies on features of both title 5 and title 38 authorities. The employment of persons in occupations—physicians, dentists, podiatrists, chiropractors, optometrists, registered nurses, physician assistants, and expanded-function dental auxiliaries—listed in section 7401(1) of title 38, U.S.C., is governed entirely by the title 38 system. Other occupations, listed in section 7401(3), are referred to as hybrid employees.

The title 38 appointment system, established shortly after World War II, was designed to be more flexible than the title 5 system. It provides an employment process and compensation policies and practices that are helpful to VA in effectively recruiting and retaining health care providers. For example, under title 38, prospective hires are not required to go through the competition and ranking process to establish eligibility for employment, as is required under title 5.

Beginning in 1983, with the passage of the "Veterans Health Care Amendments of 1983," Public Law 98–160, Congress authorized VA to hire, advance, and pay certain health care providers under title 38, while leaving those personnel under the title 5 personnel system for other purposes. The appointment of individuals to these so-called "hybrid" occupations is governed by title 38, while pay and grievances are governed by title 5. Hybrid employees are also eligible for additional premium pay, if the Secretary determines it necessary for the purposes of recruitment and retention.

Public Law 98–160 authorized VA to appoint and advance licensed practical/vocational nurses (LPNs/LVNs), physical therapists, and respiratory therapists under the hybrid system. Additional occupations were included in 2003, under Public Law 108–170, in 2004, under Public Law 108–422, and in 2006, under Public Law 109–461.

VA has indicated that this title 38 hybrid employment system permits the Department to proactively respond to recruitment and retention issues and reduces the costs associated with these issues.

Sec. 101. Enhancement of authorities for retention of medical professionals.

Section 101 of the Committee bill, which is derived from S. 2969, as introduced, contains a number of provisions that would amend a variety of specific personnel authorities in title 38, United States Code, so as to give the Secretary additional tools to retain health care personnel.

Subsec. 101(a)—Secretarial authority to extend title 38 status to additional positions.

Background. The unique features of the title 5, title 38, and title 38 hybrid personnel systems have resulted in uneven conditions of employment for some employees working in the same occupational series and occupational groups. For example, corrective therapy Assistants, hired under title 5, provide services under the same occupational series as occupational therapy assistants and physical therapy assistants, hired as title 38 hybrids. All three work in the same organizational units providing rehabilitation therapy, but are hired and employed under different conditions.

In addition, testimony submitted by VA for the record of the May 21, 2008, Committee hearing, stated that nurse assistants, in par-

ticular, are a high priority position that has proven difficult to fill. Furthermore, turnover of nurse assistants is fairly high.

Committee Bill. Subsection (a)(1) of section 101 of the Committee bill would amend section 7401(3) of title 38, so as to give the Secretary of VA the authority to apply the title 38 hybrid employment system to additional health care occupations when such action is deemed necessary to meet recruitment or retention needs. The Secretary would be required to notify the House and Senate Committees on Veterans' Affairs and the Office of Management and Budget (OMB) 45 days prior to implementing a decision to convert an occupation to the hybrid system. Prior to Congressional and OMB notification, VA would be required to notify labor organizations representing VHA employees in occupations being considered for inclusion, in order to seek their comments.

In testimony submitted for the record of the Committee's May 21, 2008, hearing, VA indicated that it supports the provisions of this subsection as this change would give the Secretary the ability to react quickly, through the title 38 hiring process, to bring on additional employees.

Subsection (a)(2) of section 101 of the Committee bill would further amend section 7401(3) by adding nurse assistants to the list of occupations eligible for appointment under title 38. By bringing this position under the title 38 hiring process, VA will have the ability to expedite hiring to fill nurse assistant positions.

In accordance with the original purpose for a separate title 38 hiring system, it is the Committee's intent that VA continue to have the ability to expedite the hiring of certain health care personnel. The Committee is aware that, as presently implemented, the hiring process under title 38 has not proven as expeditious as intended and that concerns have been raised that adding additional professions to the list of hybrid positions could overburden the title 38 hybrid employment system. It is the Committee's belief, however, that VA has the capacity, resources, and responsibility to resolve the obstacles to expedited hiring under title 38.

In testimony submitted for the Committee's May 21, 2008, hearing, VA indicated that it supports the provisions of subsection (a)(2) of this section of the Committee bill. VA cited data showing turnover rates of 10.5 percent for 2006 and 11.1 percent for 2007, which illustrate the great difficulty VA experiences in retaining nurse assistants.

Subsec. 101(b) and (c)—Probationary periods for registered nurses, and prohibition on temporary part-time registered nurse appointments in excess of 4,180 hours.

Subsections (b) and (c) of section 101 of the Committee bill are addressed below together, as they are dependent upon each other, and address similar issues.

Subsection (b) would modify the terms of the probationary period that registered nurses must serve upon employment by VA, and subsection (c) would limit the extent of a temporary appointment of part-time registered nurses.

Background. Subsection 7403(b) of title 38, U.S.C., provides that appointments of health care providers under that section shall be for a probationary period of two years. The probationary period

serves to ensure an appropriate time of observation and vetting before an employee becomes permanent.

Currently, part-time RNs are employed by VA on a temporary basis under section 7405 of title 38. As temporary employees, they are not eligible for the same job protection and grievance rights as employees appointed under section 7403 who have completed the probationary periods. Further, when an employee transitions from full to part-time, they are considered employees under section 7405, with commensurate loss of rights and protections. Valerie O'Meara, NP, representing the American Federation of Government Employees, testified before the Committee on April 9, 2008, about her experience switching from full- to part-time status to raise a family. She explained that she lost her grievance and arbitration rights, and was not permitted to contest Reductions-In-Force decisions. Further, she described the cases of older nurses who have worked a decade or more for the VA who switch to part-time because of the stress of their job or to care for their aging parents. The Committee believes VA would benefit from retaining the expertise of these registered nurses, even on a part-time basis.

VA has been challenged to fill RN positions due to rising demand for these professionals. In testimony submitted for the record of the Committee's April 9, 2007, hearing, Ann Converso, RN, President of United American Nurses, AFL-CIO, stated that "[t]here exists a health care crisis in our country regarding the shortage of registered nurses * * *. As nurses leave the VA system, new nurses are not joining the VA at comparable rates, and patient load is increasing." According to the testimony of Sheila M. Cullen, Director, San Francisco VA Medical Center, at that same hearing, more than 29 percent of the employees at the San Francisco VA Medical Center are eligible to retire.

Committee Bill. Subsections (b) and (c) of section 101 of the Committee bill would clarify the terms of a probationary period under section 7403 of title 38, U.S.C., and address the inequity faced by part-time nurses under section 7405 of title 38.

Subsection (b) would amend section 7403(b) by adding two new paragraphs. New paragraph (2) would mandate that an appointment of a registered nurse under the section, whether on a full- or part-time basis, shall be for a probationary period of a length considered appropriate by VA but in any event no more than 4,180 hours. The intent of this provision is to establish a maximum duration of the probationary period that can be applied equitably to both full- and part-time appointments. Further, it provides the Secretary with additional authority to reduce the duration of the probationary period.

New paragraph (3) would mandate that an appointment on a part-time basis under section 7403 of a health care professional who has previously served on a full-time basis shall be without a probationary period. This provision would clarify that no registered nurse (RN), who has already served a probationary period, would be required to serve a probationary period upon switching from a full-time to a part-time appointment. The Committee sees no utility in requiring an RN who has served a probationary period on a full-time basis to serve an additional probationary period.

Subsection (c) of section 101 would amend section 7405 of title 38, to add a new subsection (g). The proposed new subsection

would specify that the appointment of an RN on a temporary part-time basis under section 7405 would be for a probationary period, as defined under section 7403(b), as would be amended by subsection (b) of section 101 of the Committee bill. Upon completion of the probationary period, the appointment would no longer be considered temporary, and would instead be considered an appointment under 7403(a). Pursuant to this change, and the completion of the probationary period, all temporary part-time appointments of RNs would be considered permanent.

It is the Committee's intent that the amendments to sections 7403 and 7405 will eliminate disincentives to part-time employment of RNs in VA. Many RNs, after serving a full career in VA, or in response to family concerns, are faced with the decision to either retire from VA or transition to part-time service. Informed by the testimony presented at the Committee hearings on April 9, 2008, and May 21, 2008, the Committee believes VA would benefit from the service that these registered nurses would provide on a part-time basis. Further, increased use of part-time registered nurses will help VA fully staff facilities and better meet the rising demand for health care services.

It is not the intent of the Committee bill to prevent or limit the hiring of part-time nurses beyond the probationary period. Rather, the Committee intends that upon completion of such period, the appointment be considered permanent, with all accompanying benefits and privileges.

Carl Blake, National Legislative Director, Paralyzed Veterans of America, in testimony before the Committee on May 21, 2008, voiced support for the provision to eliminate the probationary period for RNs who transition from full-time to part-time.

Subsec. 101(d)—Waiver of offset from pay for certain reemployed annuitants.

Subsection (d) of section 101 of the Committee bill would authorize VA to waive salary offsets for retirees who are reemployed in VHA.

Background. Under current law, the salary of a VHA employee rehired after retirement from the Federal government is reduced according to the amount of their annuity under a government retirement system. The reduction is required by sections 8344 and 8468 of title 5, U.S.C., which deal with annuity payments upon reemployment.

VHA faces a growing wave of retirements at all levels of administration and health care providers. According to VA, at the end of 2006, 56 percent of medical center directors were eligible for retirement, and by 2013 over 90 percent of these key personnel will be eligible for retirement. Many of the likely successors for the director positions, current Associate Directors, are also retirement eligible. VA projects that by 2013, 95,019 VHA employees will be eligible to retire, including 97 percent of current senior executives, 81 percent of facility Chiefs of Staff, and 91 percent of nurse executives. This rate of retirement eligibility is unprecedented, and the sudden loss of the experience and expertise of these employees would seriously limit VA's ability to deliver care.

Because reemployed annuitants receive only that portion of their salary that is above their annuity payment, there is little incentive

under the current employment system to return to VA employment. Annuitants who wish to continue working are able to receive full pay from a non-government employer, in addition to their annuity, something they can not do at VA.

In testimony before the Committee on May 21, 2008, Cecilia McVey, MHA, RN, former President of the Nurses Organization of Veterans Affairs, said that "During this time of a critical nursing shortage, it is more important than ever to keep these valuable resources to provide the best care to veterans."

Rehiring annuitants addresses issues arising from the high number of retirements facing VA. Increased employment of annuitants would potentially limit costs by reducing the use of expensive contract agreements. Retaining experienced professionals while younger employees develop their capabilities would also ensure the transfer of valuable institutional knowledge from one generation of leaders to another within VA.

A program which allows the Government Accountability Office to temporarily hire retirees, without a salary offset, for the purposes of training, education, and mentoring, has proven successful.

Committee Bill. Subsection (d) of section 101 of the Committee bill would amend section 7405 of title 38 so as to add a new subsection (g) which would authorize the Secretary to waive sections 8344 and 8468 of title 5, U.S.C., on a case-by-case basis when reemploying an annuitant on a temporary basis. This section would further require that an annuitant to whom a waiver under the proposed new section (g) is granted be subject to the provisions of chapter 71 of title 5, relating to the protection of government employees from discrimination and retaliation.

By authorizing the Secretary to waive these two sections of title 5, the Committee intends to encourage retirees to return to work at VHA. At present, many VA employees go on to work outside of VA after retiring from VA, with some even returning to work at VA on a contract basis. By eliminating the salary offset, it is the Committee's hope that there will be a significant pay incentive that will encourage annuitants to return to VA, rather than seeking employment elsewhere.

Subsec. 101(e)—Rate of basic pay for appointees to the Office of the Under Secretary for Health set to rate of basic pay for senior executive service positions.

Subsection (e) of section 101 of the Committee bill would amend section 7404(a) of title 38, U.S.C., to set the rate of basic pay for appointees to the Office of the Under Secretary for Health.

Background. Under current law, non-physician and non-dentist appointees under section 7306 of title 38, which relates to the composition of VA's Office of Under Secretary for Health, including the Director of Pharmacy Benefits Management Strategic Health Group, the Director of Dietetics, the Director of Podiatry, and the Director of Optometry, among others, serve in executive level positions that are equivalent in scope and responsibility to positions in the Senior Executive Service (SES), which includes senior managers and administrators in the VA Central Office, among others. The pay level for section 7306 appointees is adjusted each year by Executive Order, as authorized by chapter 53 of title 5, and is capped, by subsection 7404(d) of title 38, U.S.C., at the pay rate for

Level V of the Executive Schedule, currently just over $139,600 including locality pay. VA employees in the SES, on the other hand, can receive pay up to Level II of the Executive Schedule, currently $172,200.

According to VA, the disparity between pay levels for SES and non-SES employees serving in similar capacities has led to difficulties in recruiting and retaining non-SES executive level managers. Executives in these positions provide valuable input to the Under Secretary for Health (USH), and manage significant elements of VHA.

Committee Bill. Subsection (e) of section 101 of the Committee bill would amend section 7404(a) of title 38 so as to add a paragraph that would mandate that pay for certain appointees to the Office of the Under Secretary for Health be set according to the SES. This change would be effective on the first day of the first pay period beginning the day after 180 days after the date of enactment of this legislation.

This change would effectively establish that, for the purposes of basic pay, all senior executives in the Office of the Under Secretary for Health would receive pay based on Level II of the Executive Schedule. By implementing a uniform pay scale for all senior executives in that office, the Committee believes VA will be better able to recruit and retain highly qualified individuals.

This provision was developed in close cooperation with VA, and VA indicated its support for this subsection in testimony submitted for the record of the Committee's May 21, 2008, hearing.

In testimony before the Committee on May 21, 2008, Thomas Berger, PhD, Chair of the National PTSD and Substance Abuse Committee, Vietnam Veterans of America (VVA), expressed VVA's support for additional pay "to enhance recruitment and retention of top professionals to run the VA health care system."

Subsec. 101(f)—Comparability pay program for appointees to the Office of the Under Secretary for Health.

Background. VA is challenged match the compensation offered by non-Federal employers to senior executives. The past decade has seen significant changes in VA health care. In order to maintain its position as a premier health care provider, VHA will require a corps of dedicated, skilled, and experienced senior executives to carry out the responsibilities involved in delivering care to veterans. The Committee believes that VA must deal with pay inequities proactively.

Committee Bill. Subsection (f) of section 101 of the Committee bill would amend section 7410 of title 38, relating to additional pay authorities for VHA employees, so as to authorize VHA to pay "comparability pay" of not more than $100,000 per employee to non-physician/dentist section 7306 employees and VHA SES employees. This pay would be authorized so that VHA could achieve annual pay levels competitive with the private sector, and to relieve pay compression over the complex range of senior executive positions. This special pay would be in addition to all pay, awards, and performance bonuses provided under SES or 7306 authorities. Under the Committee bill, the higher special pay amounts would be reserved only for the most senior VHA executive positions and,

when added to basic pay and bonus compensation, would be capped at the annual pay of the President.

Subsec. 101(g)—Special incentive pay for Department pharmacist executives.

Background. VA is challenged match the compensation offered by non-Federal employers to senior executives, including National Pharmacist Executives (NPEs). NPEs include managers of the VA National Formulary, Directors of the Consolidated Mail Outpatient Pharmacies, Consultants to the Secretary for pharmacy issues, Network Pharmacy Benefits Managers, and the Director of Emergency Pharmacy Services. Under current law, basic salaries for NPEs are set according to the General Schedule, which caps salaries for these positions between $140,000 and $145,000, with up to $5,000 in bonuses. According to surveys conducted by VA, salary ranges for national and regional pharmacy executives are between $180,000 and $225,000. Further inducements commonly available in the private sector include profit sharing or stock options, yearly bonuses well above the $5,000 currently available from VA, recruitment and retention bonuses, and corporate vehicles for individuals in regional positions.

VA has been challenged to fill NPE positions in recent years, due largely to the pay disparity between VA and the private sector, and the lack of financial incentive to take on responsibilities at the national and regional level. In addition, applications for Chief of Pharmacy positions at VA facilities, the primary source of future NPEs, have fallen off dramatically. The Workforce Succession Strategic Plan for VHA FY 2006-2010 (October, 2005), listed pharmacists second only to RNs as national priorities for recruitment and retention.

Committee Bill. Subsection 101(g) of the Committee bill would further amend section 7410, relating to additional pay authorities, to authorize recruitment and retention special incentive pay for pharmacist executives of up to $40,000. The determination of whether to provide such pay, and its amount, would be based on: grade, step, scope and complexity of the position, personal qualifications, characteristics of the labor market concerned, and such other factors as the Secretary considers appropriate. As with the comparability pay that would be authorized by subsection (f) of the Committee bill, this provision would provide that such pay would be in addition to other pay, awards, and bonuses.

Subsec. 101(h)—Pay for physicians and dentists.

Subsection 101(h) of section 101 of the Committee bill would make three separate amendments to section 7431 of title 38, relating to pay for physicians and dentists.

Committee Bill. Paragraph (1) of subsection (h) would clarify the determination of the non-foreign cost of living adjustment (COLA), authorized by section 7431(b) of title 38, U.S.C. The COLA is provided to employees in locations with substantially higher costs of living than those of Washington, DC, and or environmental conditions that differ substantially from those in the continental United States. Similar provisions, applied to other government employees, exist in section 5941 of title 5, U.S.C.

Paragraph (1) of subsection 101(h) of the Committee bill would amend section 7431(b) so as to add a new paragraph that would provide that the non-foreign cost of living adjustment allowance authorized under section 5941 of title 5, U.S.C., shall, in the case of VA physicians and dentists, be determined as a percentage of base pay only. Section 7431(b) currently does not specify the basis for the determination of the allowance, which has led to inconsistent determinations.

Paragraph (2) of subsection (h) would amend section 7431(c)(4)(B)(i) to exempt physicians and dentists in executive leadership provisions from the panel process in determining the amount of market pay and tiers for such physicians and dentists. Market pay is "pay intended to reflect the recruitment and retention needs for the specialty or assignment * * * of a particular physician or dentist" in a VA facility. Under current law, the Secretary is to take into account the views of "an appropriate panel or board" in determining the amount of market pay for an individual physician or dentist. In cases where such physicians or dentists in question occupy executive leadership positions such as chief officers, network directors, and medical center directors, the consultation of a panel has some limitations. The small number of providers who would qualify as peers for the executive leaders results in their serving on each other's compensation panels. This amendment will provide the Secretary with discretion to identify executive physician/dentist positions that do not require a panel process.

Paragraph (3) of subsection (h) would amend section 7431(c)(7) of title 38, so as to allow an exception to the prohibition in current law on a reduction in market pay when a physician or dentist remains in the same position or assignment. The exception would allow for a reduction in market pay when there has been a change in board certification or a reduction of privileges, even when the individual remains in a position or assignment. By allowing such reduction in market pay, the Committee bill would prevent a physician or dentist from receiving additional market compensation for credentials and or privileges he or she may no longer possess.

In testimony submitted for the record of the Committee hearing on May 21, 2008, VA indicated support for the provisions in subsection 101(h) of the Committee bill.

Subsec. 101(i)—Adjustment of pay cap for nurses.

Subsection (i) of section 101 of the Committee bill relates to pay for RNs.

Background. Under current law, section 7451 of title 38 governs basic pay levels for VA RNs, and certain other VA employees. Section 7451(c)(2) mandates that the maximum rate of basic pay for any grade for a covered position, including RNs, may not exceed the maximum rate of basic pay established for positions in level V of the Executive Schedule under section 5316 of title 5, U.S.C. Level V is currently set at $139,600.

In testimony submitted for the Committee's April 9, 2008, hearing, Ms. Converso cited a "crisis in our country regarding the shortage of registered nurses." At the same hearing, Marisa W. Palkuti, M.Ed., Director, Healthcare Retention and Recruitment Office, VHA, cited a growing inadequacy in the number of health care

workers, including RNs, nationwide, and suggested that "[t]his shortfall will grow exponentially over the next 20 years."

During that hearing, Sheila M. Cullen, the then-Director of the San Francisco VA Medical Center, testified about her efforts to retain nurses. To compete with other health care employers in the region, and to address the high cost of living, Ms. Cullen has instituted salary increases for RNs between 5 and 8 percent annually in recent years.

The current level V cap often prevents VA registered nurses from receiving locality pay. Locality pay, which is in addition to basic pay, is based on compensation levels in a local labor market. When a nurse's basic pay is equal to the level V cap, no additional locality pay can be awarded, regardless of conditions in local labor market, a result that has a detrimental effect on recruitment and retention.

Committee Bill. Subsection (i) of section 101 of the Committee bill would amend section 7451(c)(2) of title 38, so as to adjust the pay cap for registered nurses and others in covered positions from Level V to Level IV. Level IV is currently set at $149,000, according to OMB. By raising the cap on nurse basic pay by $9,400, the Committee intends to provide VA with additional flexibility to compete in local labor markets. Based on testimony presented at Committee hearings, and on oversight activities, the Committee believes that additional pay would improve VA's ability to recruit and retain qualified nurses.

This provision was supported by the American Federation of Government Employees in testimony before the Committee on April 9 and May 21, 2008. Also, in testimony before the Committee on May 21, 2008, Cecilia McVey, MHA, RN, Former President of the Nurses Organization of Veterans Affairs, called for the increase in the cap on RN pay proposed by the Committee bill.

Subsec. 101(j)—Exemption for certified registered nurse anesthetists from limitation on authorized competitive pay.

Subsection (j) of section 101 of the Committee bill would allow pay for certified registered nurse anesthetists (CRNAs) to exceed the pay caps established for RNs employed by VA.

Background. As discussed above, under subsection 101(i), current law limits pay for CRNAs at level V of the Executive Schedule, currently $139,600. Additional compensation may be provided to CRNAs in the form of recruitment and/or retention bonuses. As is currently the case with RNs, the level V cap often prevents CRNAs from receiving locality pay.

In December 2007, the Government Accountability Office released a report on CRNA retention, titled "Department of Veterans Affairs (VA) medical facilities have challenges in recruiting and retaining VA CRNAs for their workforce" (GAO–08–56). GAO found that about three-fourths of all VA medical facility chief anesthesiologists responding to the survey reported that they had difficulty recruiting CRNAs. Overall, 54 percent of VA medical facility chief anesthesiologists reported temporarily closing some operating rooms and 72 percent reported delaying some elective surgeries due to difficulty fully staffing CRNAs. GAO projected that 26 percent of VA's CRNAs will either retire from or leave VA in the next 5 years. VA medical facility officials reported that the recruitment and reten-

tion challenges are caused primarily by the low level of VA CRNA salaries when compared with CRNA salaries in local market areas.

In testimony before the Committee on April 9, 2008, Ms. Cullen, and Steven P. Kleinglass, Director of the Minneapolis VA Medical Center, both discussed the challenges created by the current limit on CRNA pay. Mr. Kleinglass noted that at the Minneapolis VAMC, the VA pay scale falls behind the local medical community as a whole, and that "therefore, in theory, we should have most of our employees on a retention bonus." Ms. Cullen, in San Francisco, is prevented from offering locality pay due to the statutory limit, even though the local median salary for CRNAs is $171,334. As a result, she has had to implement the 25 percent retention incentive extensively. At the same hearing, Ms. O'Meara echoed these concerns. "Facilities around the country are finding it increasingly difficult to recruit CRNAs."

Committee Bill. Subsection (j) of section 101 of the Committee bill would further amend section 7451(c)(2) of title 38, as amended by subsection 101(i) of the Committee bill, to allow pay for CRNAs to exceed the pay caps established for RNs employed by VA.

This proposed exemption would provide VA with greater flexibility to offer additional pay to CRNAs, a necessary tool when CRNA positions prove difficult to fill due to insufficient compensation.

This proposed amendment was endorsed in testimony before the Committee on May 21, 2008, by Carl Blake, National Legislative Director, Paralyzed Veterans of America and J. David Cox, RN, National Secretary-Treasurer, American Federation of Government Employees.

Subsec. 101(k)—Locality pay scale computation.

Subsection 101(k) of the Committee bill would amend section 7451(d)(3) of title 38, U.S.C., to improve implementation and transparency of VA's locality pay system for nurses and others in covered positions.

Background. Section 7451(d) of title 38 currently authorizes a locality pay system (LPS) to address geographically-related pay issues, and to strengthen recruitment and retention of nurses and others in covered positions. That section mandates that pay for personnel in covered positions at each facility be adjusted periodically to reflect changing pay rates in local labor markets. The director of each facility is charged with using data from the Bureau of Labor Statistics (BLS) to determine prevalent pay rates, and to make necessary adjustments to the pay of nurses and others in covered positions employed by the facility in question. When BLS data are not available, the director is required to use data provided by a third party. If no third party data are available, the director is required to conduct a locality pay survey to determine prevalent pay rates. Each locality pay schedule, of which there are nearly 800, is required to be reviewed and approved by the USH.

In the report titled "Many Medical Facilities Have Challenges Recruiting and Retaining Nurse Anesthetists" (GAO–08–56, December, 2007), GAO found that, in 2005 and in 2006, over half of VA medical facilities used the LPS to determine whether to adjust VA CRNA salaries. However, in the eight VA medical facilities visited, GAO found that the majority of the facilities did not correctly

follow VA's LPS policy. Officials at these facilities did not always know or were not aware of certain aspects of the LPS policy, and VA has not provided training on the LPS to VA medical facility officials since the policy was changed in 2001. As a result, GAO found that VA medical facility officials cannot ensure that VA CRNA salaries have been adjusted as needed to be competitive. While the report dealt only with CRNAs, the conclusions regarding faulty implementation of the LPS are likely applicable to others in covered positions, based on Committee oversight activities.

The failure to properly implement the LPS runs the risk of negatively effecting recruitment and retention, and inappropriately limits the pay of nurses and others who continue their employment at VA. Further, due to a lack of transparency of the LPS process, employees do not have reasonable access to the surveys that determine locality pay.

Committee Bill. Subsection (k)(1) of section 101 of the Committee bill would add a new subparagraph (F) to section 7451(d)(3) of title 38. Proposed new subsection (F) would require the USH to provide appropriate education, training, and support to directors of Department health care facilities in the conduct and use of LPS surveys. The Committee intends for this change to address the inadequate training found by GAO.

In testimony before the Committee on April 9, 2008, Ms. O'Meara emphasized the need for adequate training in the use and implementation of the LPS. At the Committee hearing on May 21, 2008, Mr. Cox stated that "management training on the nurse locality pay process will increase compliance with the 2000 nurse locality pay law [The Veterans Benefits and Health Care Improvement Act of 2000, Public Law 106–419] that Congress enacted to address recruitment and retention."

In testimony submitted for the record of the Committee hearing on April 9, 2008, VA stated that development of web-based training to assist in the conduct of surveys was expected to be available by late summer 2008, and that additional training events are planned. The Committee believes these are important improvements in education on the LPS, but believes that additional measures may be required.

Subsection (k)(2) of section 101 of the Committee bill would add a new subparagraph (D) to section 7451(e)(4) of title 38. Under this proposed new subparagraph (D), which is intended to improve transparency in the LPS, a facility director would be required to publicize information on the methodology used in making an adjustment to rates of pay based on the LPS.

Subsection (k)(3) of section 101 of the Committee bill would further amend section 7451(e) by adding a new paragraph (6). Under current law, each facility director is required to report to the Secretary on wage-related staffing issues. Proposed new paragraph (6) would require such reports to be made available to any individual in a position included in such report, or, upon the authorization of such individual, to the representative of the labor organization representing that individual. Taken together, the Committee believes that the changes proposed by subsections (k)(2) and (3) of section 101 of the Committee bill will improve transparency of the LPS.

These amendments address concerns raised in testimony before the Committee on May 21, 2008, by Mr. Cox, and on April 9, 2008,

by Ms. O'Meara. According to Mr. Cox, "greater employee access to pay survey data will add accountability to the locality pay process to ensure that surveys are done properly and that needed pay adjustments are made."

The Committee is aware that in some facilities, access to LPS survey data is unnecessarily challenging for many employees. As Ms. O'Meara said in her testimony on April 9, 2008, "[l]ocality pay should be provided based on local labor market conditions, and be paid according to consistent rules, not on how hard employees fight for it or whether a particular manager decides to pay it."

Concerns have been raised that the Committee bill places inordinate emphasis on the conduct of LPS surveys, rather than the use of BLS or third party data, which VA prefers. The Committee recognizes the value of BLS and third party data and does not intend that facility directors conduct their own surveys when such information is available. The Committee believes that, implemented effectively and according to statute, the LPS can effectively address geographically-related pay issues, and can strengthen recruitment and retention.

Subsec. 101(l)—Increased limitation on special pay for nurse executives.

Subsection 101(l) of the Committee bill would increase the authorized limit on special pay for nurse executives.

Background. Under current law, the Secretary may provide between $10,000 and $25,000 in special pay to nurse executives at each VA health care facility and at VA Central Office. The amount is determined based on the grade of the nurse executive position, the scope and complexity of the nurse executive position, the personal qualifications of the nurse executive, the characteristics of the health care facility concerned, the nature and number of specialty care units at the health care facility concerned, demonstrated difficulties in recruitment and retention of nurse executives at the health care facility concerned, and such other factors as the Secretary considers appropriate.

Given the limits on nurse pay, most nurse executives are already paid at or near the top of their grade. As such, VA lacks the ability to provide additional financial incentive to individuals who take on the increased responsibility of executive positions. Given the systemic shortage of nurses, as discussed with respect to sections 101(i) and 101(j) of the Committee bill, the Committee believes that additional financial incentives are warranted to attract highly qualified nurses to executive positions.

Committee Bill. Subsection (l) of section 101 of the Committee bill would amend section 7452(g)(2) of title 38 so as to increase the authorized limit on special pay for nurse executives from $25,000 to $100,000.

In testimony before the Committee on May 21, 2008, Mr. Blake expressed PVA's support for this provision of the Committee bill.

Subsec. 101(m)—Eligibility of part-time nurses for additional nurse pay.

Subsection (m) of section 101 of the Committee bill, which is derived from S. 2969, would expand eligibility for additional premium pay to part-time nurses.

Background. Additional pay for nurses is authorized by section 7453 of title 38. In general, nurses are eligible for overtime pay when they work over forty hours in a week or eight hours in a day. Further additional pay is mandated for nurses who work on weekends, at night, and on holidays. Other than overtime pay, eligibility for additional pay is limited to nurses working on specified tours of duty that meet the requirements of each type of additional pay. Those nurses not assigned to a specific tour are not eligible for the additional pay associated with such tour, even if their period of service includes hours which fall within the eligible time periods. This limit affects the pay of both full- and part-time nurses, as well as nurses who are on call and not assigned to tours of duty.

Based on testimony presented at Committee hearings, and information gathered during Committee oversight activity, as discussed with respect to subsections (i) and (j) of section 101 of the Committee bill, the Committee concludes that in many facilities VA is challenged to fill nurse staff positions and some nursing tours are difficult to cover. The Committee believes that the current eligibility criteria for additional pay are too restrictive to create effective financial incentives to encourage nurses to work those tours.

Further, the current additional pay statute creates unacceptable inequities between part-time and full-time nurses. In testimony before the Committee on April 9, 2008, Ms. O'Meara cited chronic problems with implementation of additional pay requirements. She urged "the Committee to take steps to ensure that premium pay is available to all RNs who perform services on weekends or off shifts, work overtime on a voluntary or mandatory basis, or work during on call duty." By not providing part-time nurses additional pay on the same basis as full-time nurses, there is a disincentive for part-time and on-call nurses to serve during times of the day and week that are harder to staff. This is contrary to the intent of the additional pay authorities.

In addition, excluding part-time and on-call nurses from eligibility for additional pay, and denying additional pay for nurses not assigned to a specific eligible tour, creates further disparity between VA and non-VA compensation, and contributes to recruitment and retention challenges.

Committee Bill. Subsection (m) of section101 of the Committee bill would amend section 7453 of title 38 so as to expand eligibility for additional premium pay to part-time nurses.

An amendment to subsection (a) of section 7453 would provide that part-time nurses would be generally eligible for additional pay when they meet the criteria in other subsections of section 7453. Amendments to subsections (b)(concerning evening pay), (c) (concerning weekend pay), and (d) (concerning overtime pay), would, in multiple locations, replace "tour of duty" with "period of service." These changes would make any service performed during evenings or weekends, or as overtime, eligible for additional pay.

It is the Committee's intent to change the basis for additional pay from the tour to the nurse's period of service and the timing of such service. This reflects the original Congressional intent that additional pay is intended to create incentives for nurses to work at times that would otherwise be difficult to staff. The changes proposed by the Committee bill would not eliminate the utility of established tours nor would they reduce additional pay for such

tours. Rather, the changes would encourage a greater number of nurses to work during such times, and would equitably reward all nurses who do so.

In testimony before the Committee on May 21, 2008, Mr. Blake expressed the support of Paralyzed Veterans of America for the eligibility of part-time nurses to receive additional pay.

Subsection (m)(1)(D)(i) of section 101 of the Committee bill would address an inequity in eligibility for additional pay for overtime under section 7453(e) of title 38. Under current law, nurses who perform continuous service in excess of eight hours but on two different calendar days are not eligible for additional pay for overtime service. This section of the Committee bill would amend section 7453(e) to add service performed in excess of eight consecutive hours to the list of services eligible for additional overtime pay. In testimony before the Committee on April 9, 2008, Ms. O'Meara emphasized the urgency of this legislative change.

Subsec. 101(n)—Exemption of additional nurse positions from limitation on increase in rates of basic pay.

Subsection (n) of section 101 of the Committee bill, which is derived from S. 2969, would make additional health care occupations exempt from limitations on increases in rates of basic pay.

Background. Under current law, rates of basic pay for nurses and other health care providers may be increased under section 7455 of title 38. Under that section, the Secretary may determine that salary increases are necessary for the purposes of recruitment and retention, and to compete with pay for similar positions in non-Federal facilities in the same labor market.

Under subsection (c)(1) of section 7455, the amount of increase in the maximum pay rate generally is limited to two times the amount by which the original maximum exceeds the minimum, and the maximum rate as so increased may not exceed the pay rate of the Assistant Under Secretary for Health. Nurse anesthetists, pharmacists, and licensed physical therapists are exempted from this limit, based on the challenges VA faces in recruiting and retaining employees in these occupations, as discussed earlier in connection with subsections (g), (i), and (j) of section 101 of the Committee bill.

Committee Bill. Subsection (n) of section 101 of the Committee bill would amend section 7455(c)(1) of title 38 so as to make additional occupations exempt from limitations on increases in rates of basic pay. Specifically, this provision would add licensed practical nurses, licensed vocational nurses, and nursing positions otherwise covered by title 5, U.S.C., to the list of positions exempted from the limits imposed by section 7455(c)(1) of title 38. This provision, combined with subsection (i) of section 101 of the Committee bill, should ensure that VA has the pay flexibility to compete with other employers for qualified health care providers. In testimony before the Committee on April 9 and May 21, 2008, respectively, Ms. O'Meara and Mr. Cox emphasized the need for additional pay flexibility to strengthen VA's ability to compete with other employers.

Sec. 102. Limitations on overtime duty, weekend duty, and alternative work schedules for nurses.

Subsection 102 of the Committee bill, which is derived from S. 2969, would amend various provisions of title 38 so as to establish special rules for nurse staff overtime service, modify rules relating to leave during weekend duty, and change the underlying authority for alternative work schedules for nurses.

Subsec. 102(a)—Overtime duty.

Background. Under current law, the Secretary may require nurses to perform mandatory overtime in emergency situations. The Committee recognizes that this authority is essential to ensuring adequate staffing to provide patient care. However, based on oversight activities, and as discussed at the Committee hearing on April 9, 2008, it appears that, at some facilities, the use of emergency mandatory overtime is excessive and even abusive.

At the Committee hearing on April 9, 2008, Ms. O'Meara testified that "facility directors continue to invoke the emergency exception when staffing shortages are the result of easily anticipated scheduling and hiring problems." At that same hearing, testimony on this issue was received from two VA medical center directors, Steven P. Kleinglass, of the Minneapolis VA Medical Center, and Sheila M. Cullen, of the San Francisco VA Medical Center. These two facilities illustrate two different approaches to the use of the emergency mandatory overtime authority. According to Mr. Kleinglass, in Minneapolis, mandatory overtime is used to respond to a number of situations, including unplanned leave, sick leave, emergency annual leave, absenteeism, and tardiness for duty by nursing staff. At the San Francisco VA Medical Center, on the other hand, mandatory overtime has been used only once in the past three years, an event implemented in cooperation with the local bargaining unit.

The Committee is concerned that VA lacks a clear definition of "emergency" for the purposes of implementing mandatory overtime and that VA facility directors appear to have unbridled discretion on the interpretation and implementation of this authority. Without a clear definition of what constitutes allowable situations, the use of emergency authority can lead to inconsistent implementation and abuse.

Research has highlighted the danger of excessive overtime service by nurses, as well as other health care providers. In the report "Keeping Patients Safe: Transforming the Work Environment of Nurses" (2004), the Institute of Medicine recommended that "to reduce error-producing fatigue, state regulatory bodies should prohibit nursing staff from providing patient care in any combination of scheduled shifts, mandatory overtime, or voluntary overtime in excess of 12 hours in any given 24-hour period and in excess of 60 hours per 7-day period."

At least nine states have enacted legislation restricting the use of emergency mandatory overtime. In the interest of patient and employee safety and appropriate labor standards, these states limit the number of hours a nurse can be required to work, except in certain defined emergency situations.

Committee Bill. Subsection (a) of section 102 of the Committee bill would add a new section 7459 to subchapter IV of chapter 74

of title 38. This new section would limit nursing staff, including RNs, licensed practical or vocational nurses, nurse assistants appointed under title 38 or title 5, U.S.C., or any other nurse position designated by the Secretary, to no more than 40 hours of work per administrative work week (or 24 hours if such staff is covered by section 7456 of title 38), and not more than eight consecutive hours (or 12 hours if such staff is covered by sections 7456 or 7456A of title 38). Nursing staff may exceed these limits voluntarily or in emergency situations, as defined by the Committee bill.

The definition of "emergency circumstances" would be set out in subsection (c) of the proposed new section 7459. Under this subsection, the Secretary would be authorized to require mandatory overtime otherwise prohibited if the following conditions were met: (1) the work is a consequence of an emergency that could not have been reasonably anticipated; (2) the emergency is non-recurring and is not caused by or aggravated by the inattention of the Secretary or lack of reasonable contingency planning by the Secretary; (3) the Secretary has exhausted all good faith, reasonable attempts to obtain voluntary workers; (4) the nurse staff have critical skills and expertise that are required for the work; and (5) the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure. Nursing staff would not be required to work hours after the requirement for a direct role by the staff in responding to medical needs resulting from the emergency ends.

The concern has been raised by VA that the requirements of the Committee bill would unduly limit the Secretary's ability to ensure patient care and safety. The Committee agrees unequivocally that patient safety is of paramount concern. However, the Committee is concerned that undue reliance on mandatory overtime is not desirable and believes that, with reasonable contingency planning, including consultation with nurse staff, all VA facilities have the capacity to eliminate unnecessary use of emergency mandatory overtime. It is clear that many VA facilities already avoid unnecessary use of emergency mandatory overtime through effective planning for adequate nurse staffing.

Subsection (b)(2) of the proposed new section 7459 would prohibit discrimination or adverse personnel action against nursing staff if such staff were to refuse to work hours prohibited by such section. This protection has proven necessary in the many of the states which have legislatively limited mandatory overtime, including Connecticut, Maryland, Minnesota, New Jersey, and Washington.

In testimony before the Committee on May 21, 2008, Mr. Cox expressed AFGE's support for this provision of the Committee bill. He stated that these provisions "will establish a sensible and safe overtime policy that ensures that all nursing positions are equally protected."

Subsec. 102(b)—Weekend duty.

Section 102(b) of the Committee bill, which is derived from S. 2969, would modify the calculation of leave for nurses working two 12-hour tours of duty during a weekend.

Background. Section 7456 of title 38 authorizes the Secretary to provide an alternate work schedule, commonly referred to as the Baylor Plan, to nurse employees. Under this plan, an employee who

performs two regularly scheduled 12-hour tours of duty on a weekend is paid for a full forty hours. Under current law, an employee who is absent on approved sick leave or annual leave during such a regularly scheduled 12-hour tour of duty is charged for such leave at a rate of five hours of leave for three hours of absence.

The Baylor Plan is intended to be used when facilities are challenged to meet staffing needs on weekends. VA currently has no nurses employed under this plan.

Committee Bill. Section 102(b) of the Committee bill would strike section 7456(c) of title 38, to modify the calculation of leave for nurses working under the Baylor Plan. The change would specify that leave for such an employee would be charged at a rate of one to one.

The Committee expects that eliminating the current leave calculation will facilitate easier implementation of the Baylor Plan. The provision in the Committee bill was modified from an earlier version so as to address concerns raised by VA and to better achieve this goal.

Subsec. 102(c)—Alternative work schedules.

Subsection (c) of section 102 of the Committee bill, which is derived from S. 2969, would modify an existing alternative work schedule available to VA nurses.

Background. Section 7456A of title 38, U.S.C., authorizes the Secretary to provide alternative work schedules to RNs working for VA. These schedules, known as "36/40" schedules, allow VA nurses to work three regularly scheduled 12-hour tours of duty within a work week and to have that service considered for all purposes as a full 40-hour basic work week. These alternative work schedules are authorized "in order to obtain or retain the services of registered nurses."

Alternative work schedules were authorized in December 2004 by the Department of Veterans Affairs Health Care Personnel Enhancement Act of 2004, Public Law 108–445. According to the Senate report accompanying the legislation that resulted in the new law, S. Rpt. 108–375, this new authority was a response to an August 2003 request by VA so as to "enhance its ability to recruit and retain high quality nurses." In that report, the Committee noted that, based on a survey conducted in 2000 by the American Organization of Nurse Executives, inflexible scheduling was a major cause of nurse dissatisfaction. The original intent of Congress in authorizing alternative work schedules was that such schedules be widely available so as to enhance VA's ability to improve employee satisfaction and therefore be better able to recruit and retain nurses in competition with other employers.

Since the passage of Public Law 108–445, the implementation of 36/40 alternative work schedules has varied throughout the VA health care system. In testimony for the Committee hearing on April 9, 2008, VA indicated that it "encourages facility managers to use alternate work schedules for all eligible employees whenever feasible," and noted that the use of these schedules "increases VA's visibility as the employer of choice."

Some facilities, such as the San Francisco VA Medical Center, have made effective use of alternative schedules to reduce vacancy rates in nursing positions, and to improve nurse satisfaction. In

testimony before the Committee on April 9, 2008, the San Francisco VA Medical Center Director, Ms. Cullen, stated that "most new hires are highly interested in an alternative work schedule. We believe that offering an alternative work schedule improves recruitment, retention and employee satisfaction."

Mr. Kleinglass, the Director of the Minneapolis VAMC, in testimony before the Committee on April 9, 2008, noted that the use of alternative schedules at the Minneapolis VA Medical Center allows staff to "find balance between their work and home lives as they feel best suits their individual needs."

Unfortunately, based on Committee oversight work, many VA facilities have failed to make 36/40 alternative work schedules widely available. While facility directors have discretion on the implementation of these schedules, Congress intended that their use be throughout the VA health care system. In testimony before the Committee on April 9, 2008, Ms. O'Meara stated:

> As a result of delay and resistance by the VA at the national and local levels, [alternative work schedules] have failed to meet their potential for addressing VA nurse recruitment and retention problems. It seems as if the law was never passed.

Committee Bill. Subsection (c) of section 102 of the Committee bill would amend section 7456A of title 38, U.S.C., so as to modify the 36/40 alternative work schedule authorized by that section. Specifically, this section of the Committee bill would amend section 7456A(b)(1)(A) to modify the scheduling requirement for the 36/40 alternative work schedule. Currently, the 36/40 alternative work schedule is defined as "three regularly scheduled 12-hour tours of duty within a work week." The Committee bill would redefine the schedule as six regularly scheduled 12-hour periods of service within an 80-hour pay period.

The intent of this provision is to facilitate easier implementation of the alternative work schedule. In testimony for the Committee hearing on May 21, 2008, VA noted that because a work week is defined as Sunday through Saturday, it is often difficult schedule three 12-hour tours in their entirety within one work week. VA expressed support for these provisions of the Committee bill, as they would provide greater flexibility to scheduling.

By providing greater flexibility in the scheduling of the alternative work schedule, the Committee intends to facilitate and encourage wider use of such schedules. Based on hearing testimony and oversight activities, the Committee believes that by unnecessarily limiting the use of the current 36/40 alternative work schedules, VA facilities forego a valuable recruitment and retention tool, and fail to keep pace with the health care industry.

Sec. 103. Improvements to certain educational assistance programs.

Section 103 of the Committee bill, which is derived from S. XXXX, would make amendments to two existing VA Education Assistance Programs and would provide the Secretary with new authority to make repayment of educational loans for certain health professionals.

Background. Chapter 76 of title 38, U.S.C., contains numerous authorities that are designed to enhance VA's ability to attract and

retain health professions. Among these authorities are the Health Professional Scholarship Program, in Subchapter II and the Education Debt Reduction Program, in Subchapter VII.

The authorization for the programs needs to be extended in order to continue to give VA this ability, as the private sector has made recruiting health care professionals increasingly competitive. Title VII of Public Law 105–368 and Public Law 107–135 made amendments to these programs. VA currently awards Employee Incentive Scholarship Program (hereinafter "EISP") scholarships to qualifying and current employees to help VHA meet the health care staffing requirements set forth in Section 7401 of title 38, U.S.C., in which the difficulties surrounding recruitment and retention of VA health care employees is specifically addressed.

Committee Bill. Subsection (a) of section 103 of the Committee bill would amend section 7618 of title 38, U.S.C., so as to reinstate the Health Professionals Educational Assistance Program (HPEAP) through the end of 2013. The Committee believes that renewing HPEAP, which expired in 1988, will help reduce the nursing shortage in VA by enabling VA to provide scholarships to nursing personnel who, on completion of their education, will be obligated to work a year for every year of education, with a minimum obligation of two years, at a VA health care facility. This subsection would also expand eligibility for the scholarship program to all VA health personnel appointed to positions described under paragraphs (1) and (3) of section 7401 of title 38, which includes all title 38 health care employees as well as all hybrid occupations. The Committee expects that this expansion of those eligible for the scholarship program will be helpful in VA's efforts to recruit and retain employees in a number of difficult-to-fill health care occupations.

Subsection (b) of section 103 would amend three provisions in subchapter VII of chapter 76, relating to VA's Education Debt Reduction Program.

Paragraph (1) of subsection (b) would amend section 7681(a)(2) so as to add retention, along with recruitment, as a purpose of the debt reduction program.

Paragraph (2) would amend subsection (a)(1) of section 7682 and would strike subsection (c) of that section so as to make the debt reduction program available to "an" employee, not just to a "recently appointed" employee as in current law. The "recently appointed" requirement limits eligibility to employees who have been appointed within six months. VA's experience has been that this is not a sufficient period and that, in some cases, it takes more than six months for employees to become settled in their new jobs and to even become aware of this program.

Paragraph (3) would amend subsection (d) of section 7683 to increase the maximum amounts of education debt that can be forgiven, both overall and in the fourth and fifth years of participation in the debt reduction program, so as to raise the overall amount from $44,000 to $70,000, and the maximum amount in the fourth and fifth years from $10,000 to $12,000.

Subsection (c) of section 103 would authorize the Secretary, in consultation with the Secretary of Health and Human Services, to use the authorities in section 487E of the Public Health Service Loan Repayment Program for the repayment of educational loans of health professionals from disadvantaged backgrounds in order to

secure clinical research expertise in VA from such individuals. This loan repayment program is currently not available to federal employees other than those working for the National Institutes of Health. By extending this authority to VA, clinicians with medical specialization and research interests may be more likely to join VHA.

Sec. 104. Standards for appointment and practice of physicians in Department of Veterans Affairs medical facilities.

Section 104, which is derived from S. 2377, would establish a new section in title 38, U.S.C., which would set out procedures for appointing new physicians in VA, and the requisite qualifications of such physicians.

Background. Current section 7402 of title 38, U.S.C., sets forth the requirements that must be met in order for a person to be appointed as a physician with VA. Included in these requirements are that the applicant hold the degree of doctor of medicine, or doctor of osteopathy, from a university approved by the Secretary; that the applicant has completed an internship approved by the Secretary; and that the applicant be licensed to practice medicine, surgery, or osteopathy in a State.

Under subsection (f) of section 7402, any applicant who has or has had multiple licenses or certifications and has had one or more of them suspended, revoked, or surrendered for cause, is subject to employment restrictions. All applicants, with certain exceptions, must possess basic English proficiency.

VA also requires extensive disclosures from applicants, including the status of their credentials, and is permitted to deny appointment or terminate employment if that information is not disclosed. This information must be resubmitted every two years. A VA policy that took effect on January 1, 2008, requires applicants to submit an authorization to their State licensing boards to permit those boards to release records to VA. According to guidance from the Deputy Under Secretary for Health for Operations and Management dated October 10, 2007, VA Service Chiefs are required to review and document any health care practitioner's record that has been flagged. Additionally, the guidance requires Veterans Integrated Service Network (VISN) Chief Medical Officers (CMO) to review any record in the National Practitioners Data Bank relating to a practitioner that shows three or more medical malpractice payments, a single malpractice payment of $550,000 or more, or two malpractice payments totaling $1,000,000 or more. The VISN CMO is then required to review the relevant material and determine if the appointment is appropriate. A similar review occurs for any search returning negative action regarding an individual's credentials or licensing.

Current law does not require physicians to be board certified in the area in which they will practice in order to be eligible for employment with VA. VA permits facility directors and chiefs of staff to determine that an applicant is qualified based on other factors. VA believes its current requirements are in keeping with medical standards.

Physicians elsewhere in Federal service are not required to be licensed in the State in which they practice, but simply to be licensed in any State. VA makes use of telemedicine, and exchanges

physicians or allows physicians to collaborate with others in the Federal system in different States. This also occurs during certain emergency situations. Additionally, some States have licensing procedures that take more than one year to complete.

Committee Bill. Section 104 of the Committee bill would establish a new section in title 38, U.S.C.,—Section 7402A. Appointment and practice of physicians in VA medical facilities—which would set forth the procedures for appointing new physicians in VA, and the requisite or desired qualifications to practice as a VA physician. This provision would take effect immediately upon enactment, except for subsection (f) as that section pertains to physicians already employed by VA, which would go into effect 60 days after enactment, and subsection (g), relating to performance contracts with VISN directors, which would go into effect upon the start of the first cycle, beginning after the date of enactment, of performance contracts for VISN directors.

Subsection (a) of the proposed new section would require the Secretary, through the USH, to develop and promulgate minimum standards a physician must meet in order to be appointed to that position in the VHA, or to be permitted to practice in the VA medical facilities. The standards developed would be required to include the requirements outlined in the new section 7402A.

Subsection (b) of the proposed new section would require any individual seeking to be appointed as a physician within the VHA to provide the following information: a full and complete explanation of any lawsuit for medical malpractice or negligence that is pending or was brought against the applicant; any settlements agreed to as a result of a lawsuit for malpractice or negligence; and any investigation or disciplinary action against the applicant that relates to the applicant's work as a physician. The applicant must also provide authorization to the licensing board of any state where the applicant holds or has ever held a license to practice medicine, to disclose to the Secretary any records pertaining to: any lawsuit for malpractice or negligence brought against the applicant, and the details any settlements agreed to as a result; any court or administrative agency's judgment against the applicant; any disciplinary action brought against the applicant by any State body or administrative agency; any change in the status of the applicant's license to practice medicine, whether voluntary or involuntary; any open investigation of, or outstanding allegation against, the applicant; and any written notification from the State to the applicant pertaining to the potential termination of the applicant's license.

Subsection (c) of the proposed new section would require any physician appointed to practice in the VHA, after the enactment of the Committee bill, to disclose to the Secretary, within 30 days of an occurrence: a judgment against the physician for medical malpractice or negligence; a payment made as part of a settlement for a lawsuit or action previously disclosed prior to appointment; or any disposition or change in status of any issue disclosed prior to appointment. Additionally, this subsection would require any physician practicing in VHA at the time of the enactment of the Committee bill to provide authorization, within 60 days after the date of enactment, identical to the authorization required for applicants, to the State licensing board of any State where the physician has held, or currently holds, a license to practice medicine. A physician

currently practicing in the VHA would be required, as a condition of employment, to agree to disclose, within 30 days of occurrence, any future judgment against the physician or payment as part of a settlement arising from a lawsuit alleging malpractice or negligence, or the disposition or change in status of any matter disclosed pursuant to the authorization for disclosure the physician would be required to give to a State licensing board.

Subsection (d) of the proposed new section would require the director of the VISN in which an applicant seeks employment as a VA physician to conduct an investigation into the information disclosed by the applicant as required by new subsection (b). The appropriate VISN director also would be required to perform a similar investigation of any material disclosed by a VA physician employed as of the date of enactment of the Committee bill, or a physician appointed after that date who discloses information while employed by VA, as required by new subsection (c). The results of all such investigations would be required to be fully documented.

Subsection (e) of the proposed new section would require any applicant seeking to be employed as a VA physician to receive the approval of the appropriate VISN director. If the applicant has disclosed information as required by new subsection (b), the VISN director, if the director chooses to approve the applicant, would be required to certify in writing that the investigation of each issue required by new subsection (d) was completed, and the director would be required to provide a written explanation as to why any identified issue did not disqualify the applicant.

Subsection (f) of the proposed new section would require each VA medical facility that employs physicians who practice at that facility to enroll each physician in the Proactive Disclosure Service of the National Practitioners Database.

Subsection (g) of the proposed new section would require the Secretary to include in each performance contract with a VISN director, a provision that encourages the director to hire physicians who are board certified or eligible for such certification in the field in which they will be practicing when employed by VA. The Secretary would be authorized to determine the nature of this provision in the performance contracts.

The Committee believes that the requirements that would be put in place by the proposed new section 7402A are necessary to strengthen qualification standards for hiring physicians at VA and for monitoring their performance once they are working for VA. Despite the measures VA has in place regarding review of qualifications, history, and credentials, there have been incidents of physicians practicing in VA with suspended licenses and other problems with their qualifications. One of the most recent incidents of such a situation occurred at the Marion, Illinois, VA Medical Center, and that lack of appropriate review resulted in several patient deaths. The fact that VA's existing policy failed to prevent this result illustrates that additional measures to prevent under-qualified physicians from practicing medicine are needed and that it is justified to give VA's hiring practices the force of law.

TITLE II—HEALTH CARE MATTERS

Many provisions in this title are taken from S. 2984 which, as noted earlier, is a bill that was introduced at the request of the Ad-

ministration. Chairman Akaka introduced this legislation, by request. This measure was included on the agenda for the Committee's May 21, 2008, hearing on pending health care legislation, and based on testimony at that hearing, many of the provisions from that bill are included in the Committee bill, as discussed below.

Sec. 201. Repeal of sunset on inclusion of non-institutional extended care services in definition of medical services.

Section 201, which is derived from S. 2984, would repeal the existing, temporary authority for VA to provide non-institutional extended care services and, instead, include such services as part of "medical services" furnished by VA to veterans enrolled for VA care.

Background. The initial authority for VA to provide comprehensive access to alternatives to nursing home care was included in Public Law 106–117, enacted in 1999. The Congress anticipated that this authority would be helpful in giving veterans greater options instead of relying solely on traditional nursing home care. Since 1999, funding for non-institutional care for veterans has steadily increased, evidence that it is meeting the needs of an increasing number of veterans.

Committee Bill. The Committee bill would permanently include non-institutional extended care services as part of the definition of medical services under chapter 17 of title 38, U.S.C., by repealing section 1701(10), and amending section 1701(6).

The Committee believes making non-institutional care services a permanent feature of VA's medical benefits package is necessary. The health care services provided in settings that are not exclusively nursing homes are now considered to be appropriate and standard in providing for the long-term care needs of veterans.

Sec. 202. Extensions of certain authorities.

Section 202, derived from S. 2984, would extend two expiring authorities: (1) VA's obligation to furnish nursing home care to certain veterans, and (2) VA's responsibility to conduct audits of VA payments to outside providers in connection with care for veterans.

Background. In Public Law 106–117, Congress initially required that veterans requiring nursing home care for a service-connected condition, or a veteran rated 70 percent or greater, have mandatory eligibility for such care. The initial obligation expired on December 31, 2003. Later, the authority was extended for an additional five years.

Committee Bill. Subsection (a) of section 202 of the Committee bill would extend, through December 31, 2013, VA's obligation to provide nursing home care to veterans who have a service-connected disability rated at 70 percent or greater, and to veterans who need nursing home care for their service-connected disabilities.

This five-year extension would enable VA to continue to provide nursing home care and will prevent any break in needed nursing home care services.

Background. The authority for an audit recovery program was established in Public Law 108–422, enacted in 2004. This program identifies overpayments resulting from processing or billing errors as well as fraudulent charges. Recoveries made under the program are available without fiscal year limitation and are used to provide

medical care to veterans and beneficiaries in the year in which they are recovered. Currently, this authority is set to terminate on September 30, 2008.

Committee Bill. Section 202(b) of the Committee bill would extend VA's mandate in section 1703(d), of title 38, U.S.C., to conduct, through a contractual arrangement, audits of payments made by VA for care and services furnished to veterans under fee basis arrangements and other medical services contracts.

The Committee believes that the operation of a recovery audit program is consistent with good business practice and, indeed, it has proven advantageous to VA. Since 2001, VA has recouped $63,000,000 in all covered program areas, and VA projects it will recover an additional $24,000,000 if the authority is extended through 2013. An ancillary benefit of this program has been the related collection of extensive quality information on VA's claims processing capabilities. VA has used this vital information in developing and/or improving staff training, policies, and requests for and use of new technology.

Sec. 203. Permanent authority for provision of hospital care, medical services, and nursing home care to veterans who participated in certain chemical and biological testing conducted by the Department of Defense.

Section 203, which is derived from S. 2984, would make permanent VA's authority to furnish care to veterans who participated in certain chemical and biological tests conducted by the Department of Defense (DOD).

Background. According to DOD, Project SHAD was an element of a project called Project 112, which was a chemical and biological warfare test program conducted at the Deseret Test Center. DOD conducted Project 112 tests between 1962 and 1973. Project SHAD itself was a series of tests apparently designed to determine potential vulnerabilities of U.S. warships to attacks with chemical or biological warfare agents. Other Project 112 tests involved similar experiments conducted on land rather than aboard ships.

VA first learned of Project SHAD when a veteran filed a claim for service-connection for disabilities that he felt were related to his participation in those tests.

Public Law 108–170, enacted in 2003, authorized that veterans who participated in the tests receive VA care at no cost for any condition or illness that is not associated with some cause other than their participation in the testing. While that care is exempt from any otherwise applicable copayment requirements, veterans may be subject to copayments for care provided for conditions that the Secretary determines resulted from causes other than their participation in these tests. The initial authority to provide health care services to Project SHAD participants expired after December 31, 2005. The current authority expires on December 31, 2008.

Committee Bill. Section 203 of the Committee bill would remove the sunset date on the existing authority, thereby making access to VA care for these veterans permanent.

The Committee believes that the veterans who participated in this testing deserve to receive VA care and treatment at no cost to the veteran for any condition that can not be attributed to some cause other than the testing.

Sec. 204. Repeal of certain annual reporting requirements.

Section 204, which is derived from S. 2984, would repeal the requirement for VA to submit to Congress two annual reports, one relating to pay adjustments for registered nurses, and one relating to VA's long-range health planning.

Background. Public Law 101–366, The Department of Veterans Affairs Nurse Pay Act of 1990, established a reporting requirement relating to pay adjustments for registered nurses because, at that time, annual General Schedule (GS) comparability increases were extended to VA nurses at the discretion of the facility Director. However, with the subsequent enactment of Public Law 106–419, the Veterans Benefits and Health Care Improvement Act of 2000, GS comparability increases must be given to VA nurses and other health care personnel described in section 7451.

With respect to VA's long-range health care planning, VA's annual budget documents contain information on VHA's tactical and strategic goals, performance measures, and supporting activities; current and anticipated methods for serving VA's special populations; and other priorities, resource requirements and distribution methodologies. With the advent of VA's 5-Year Strategic Plan in 2004, VA's budget submission also includes the top 20 priorities for medical construction projects.

Committee Bill. Subsection (a) of section 204 of the Committee bill would repeal the requirement to report annually on any pay adjustments made to the basic pay of VA nurses and other health care personnel described in section 7451 of title 38, U.S.C. In light of the fact that covered staff receive, at a minimum, the annual increases in pay provided under the GS schedule, the Committee views this annual report as unnecessary.

Subsection (b) of this section of the Committee bill would repeal the requirement for the Secretary to annually report on VA's long-range health planning, including operation and construction plans for medical facilities. The Committee is satisfied that this report contains information that is already submitted in other reports and plans, particularly those prepared annually in connection with VA's budget request.

Sec. 205. Modifications to annual Gulf War research report.

Section 205, which is derived from S. 2984, would make changes to VA's annual report on Gulf War research.

Background. Under current law, section 707 of the Persian Gulf War Veterans' Health Status Act, Public Law 102–585, the Executive Branch, through a designated head of an appropriate department or agency, is required to report to the Committees on Veterans' Affairs of the Senate and the House of Representatives on the status and results of all research undertaken in the area of Gulf War Illnesses and the research priorities identified during the previous year. Since the requirement was enacted in 1992, the Secretary has been the official responsible for compiling and submitting this report. This report is due by March 1 of each year. Under current law, this report is a continuing obligation.

Committee Bill. Section 205 of the Committee bill would change the due date of this annual report to Congress on the research on the health effects of service during the Persian Gulf War from

March 1 to July 1 of each year, and also establish a sunset date for this reporting requirement of July 2013.

VA has testified that it is difficult if not impossible to submit the report by the current March 1 statutory deadline and it is the Committee's view that a July 1 deadline is more attainable. Imposition of a sunset date is intended to afford Congress sufficient opportunity to assess, in five year's time, whether there exists a continued need for this formal reporting requirement.

Sec. 206. Payment for care furnished to CHAMPVA beneficiaries.

Section 206, which is derived from S. 2984, would clarify the status of payments made by VA to health care providers on behalf of beneficiaries under the CHAMPVA program.

Background. CHAMPVA is a health care program in which VA shares the cost of covered health care services and supplies with eligible beneficiaries. The program is administered by Health Administration Center. To be eligible for CHAMPVA, a person must be in one of these categories: (1) the spouse or child of a veteran who has been rated permanently and totally disabled for a service-connected disability by VA; or (2) the surviving spouse or child of a veteran who died from a VA-rated service connected disability; or (3) the surviving spouse or child of a veteran who was at the time death rated permanently and totally disabled from a service connected disability; or (4) the surviving spouse or child of a service member who died in the line of duty of a cause other than willful misconduct (in most of these cases, these family members are eligible for DOD's health care program known as TRICARE).

While VA's regulations for the CHAMPVA program, located within 38 CFR (Code of Federal Regulations) section 17.55, provide for VA payments to providers under the CHAMPVA program to constitute payment in full, VA's enforcement of this regulation has been hampered by the lack of statutory authority. VA has indicated that some providers still attempt to bill beneficiaries for the difference between the billed amount and the amount payable under the CHAMPVA program.

Committee Bill. Section 206 of the Committee bill would provide that payments made by the Secretary to providers who furnish medical care to a beneficiary covered under CHAMPVA shall constitute payment in full and thereby extinguish the beneficiary's liability to the provider for that care.

Sec. 207. Payor provisions for care furnished to certain children of Vietnam veterans.

Section 207, which is derived from S. 2984, would amend two sections of title 38, U.S.C., relating to care furnished to certain children of Vietnam veterans, so as to clarify payment procedures for such care.

Background. Public Law 104–204, enacted in 1996, authorized VA to furnish health care—either directly or through contracts—to certain children of Vietnam veterans. The purpose was to provide for the special needs of certain children of Vietnam veterans who were born with the birth defect spina bifida and, in the case of children of women Vietnam veterans, other covered birth defects, possibly as the result of the exposure of one or both parents to herbicides during active service in the Republic of Vietnam during the

Vietnam era. In order to carry out this health care program, VA developed a fee for service (indemnity plan) program that provides reimbursement for medical services and supplies related to spina bifida and conditions associated with spina bifida. Currently, providers must accept VA's payment as payment in full for the services provided, but because VA's payments are based on the CHAMPVA fee payment schedule, and not actual charges, many providers no longer agree to participate in these treatment programs.

Committee Bill. Subsection (a) of section 207 of the Committee bill would amend section 1803 of title 38, U.S.C., to add a new subsection which would designate VA as the primary payer for care or services furnished to children of Vietnam veterans suffering from spina bifida or other disability associated with spina bifida. This new subsection would expressly permit the provider (or his agent) who furnished such care to seek payment from a third party payer, if the beneficiary has a health care plan that would otherwise be responsible for payment for the care and services, for the difference between the amount billed and the amount paid by the Secretary. The new subsection would prohibit the health care provider (or the provider's agent) from imposing any additional charges on the beneficiary who received the care, or the beneficiary's family, for any service or item for which the Secretary has made payment under this section. It would limit the total amount a provider could receive for furnishing care or services under this section from all payer sources to the amount billed to VA. Finally, the new subsection would require VA, upon request, to provide a third party with information concerning claims under this section.

Subsection (b) of section 207 of the Committee bill would amend section 1813 of title 38, to enact the same provisions as detailed in subsection (a) above, but, in the case of this subsection, for children of women Vietnam veterans with other specified birth defects.

It is the Committee's intention that because providers would be permitted to bill beneficiaries' health insurance for amounts not paid by VA, this would lead to potentially higher reimbursements for providers. The Committee is hopeful that this would encourage more providers to participate with VA under these programs.

Sec. 208. Disclosures from certain medical records.

Section 208, which is derived from S. 2984, would permit VA health care practitioners to disclose the relevant portions of certain VA records to surrogate decision makers who are authorized to make decisions on behalf of patients who lack decision-making capacity.

Background. Section 7332 of title 38, U.S.C., authorizes VA to disclose treatment information for drug abuse, alcoholism and alcohol abuse, HIV infection, and sickle cell anemia only for certain purposes which are set out in the section. Disclosure to surrogate decision makers for the purpose of making informed decisions regarding the treatment of patients who lack decision-making capacity, but to whom the patients had not specifically authorized release of section 7332-protected information prior to losing decision-making capacity, is not one of the specified purposes.

Committee Bill. Section 208 of the Committee bill would amend section 7332 of title 38, U.S.C., to permit VA health care practi-

tioners to disclose the relevant portions of VA records of the treatment of drug abuse, alcoholism and alcohol abuse, HIV infection, and sickle cell anemia to surrogate decision makers who are authorized to make decisions on behalf of patients who lack decision-making capacity, but to whom the patient has not specifically authorized release of section 7332-protected information prior to losing decision-making capacity. This change would allow for such disclosure only under the circumstances where the information is clinically relevant to decision that the surrogate is being asked to make. The term "representative" means the individual, organization, or other body authorized under section 7331 of title 38 and the regulations implementing that provision, to give informed consent on behalf of a patient who lacks decision-making capacity.

Sec. 209. Disclosure to Secretary of health plan contract information and social security number of certain veterans receiving care.

Section 209, which is derived from S. 2984, would add a section to chapter 17 of title 38, U.S.C., to authorize VA to require that those seeking or receiving VA health care provide certain information in connection with such care.

Background. Although VA has authority under section 1729 of title 38, U.S.C., to recover from health insurance carriers the reasonable charges for treatment of a veteran's nonservice-connected disabilities, there is no express statutory authority that requires an applicant for, or recipient of, VA medical care to provide information concerning health insurance coverage.

Under Section 7 of the Privacy Act, VA cannot deny to an individual any right, benefit, or privilege provided by law because of such individual's refusal to disclose his or her social security number. However, this prohibition does not apply with respect to any disclosure that is required by Federal statute.

Committee Bill. Section 209 would amend title 38 by adding section 1709 which would authorize the Secretary to require that applicant for, and recipients of, VA medical care and services provide their health plan contract information and social security numbers to the Secretary upon request.

Subsection (a) would require specific information on any health plan contract which provides coverage. Information that may be required regarding health plan coverage would include the name of the health plan contract, the name of the veteran's spouse, if coverage is under the spouse's health plan contract, the plan number, and the plan's group code. This authority will ensure that VA is able to obtain contract information for a particular health plan.

Subsection (b) provides that the Secretary may require applicants for, or recipients of, VA medical care or services to provide their social security numbers and those of dependents or VA beneficiaries upon whom the applicant or the recipient's eligibility is based. This subsection, in conjunction with subsection (c), discussed below, affords the Secretary the statutory authority to require applicants for, and recipients of, VA health care benefits to disclose social security numbers.

Subsection (c) provides that the Secretary would be authorized to deny the application of, or terminate the provision of medical care or services to individuals who fail to provide information requested pursuant to subsection (b). The subsection further provides that the

Secretary may reconsider the application for or reinstate the provision of care or services once the information requested pursuant to subsection (b) has been provided.

Subsection (d) provides that this section may not be construed as authority to deny medical care and treatment to an individual in a medical emergency. If a medical emergency exists, VA will not be permitted to deny eligibility for medical care or services should the applicant or recipient fail to provide health plan contract information or social security numbers.

Because eligibility for medical care and services is conditioned on the applicant or recipient's provision of health plan contract information or social security numbers, VA believes that the applicant or recipient will have an incentive to provide the requested information. VHA must match veterans' income data with the Internal Revenue Services and the Social Security Administration to carry out its income verification responsibility under section 5317 of title 38, U.S.C. Such matching requires the use of verified social security numbers. According to VHA, officials have obtained verified social security numbers for approximately 97 percent of its enrolled veterans and 86 percent of the spouses for whom income is reported. While this suggests that the voluntary reporting process is working, VHA estimates that they still have more than 1,000,000 veterans enrolled for whom no social security number has been provided. Further, VHA argues that they have been unable to match income for more than 675,000 spouses because the social security numbers have not been provided.

The Committee expects VA to provide a high degree of confidentiality for beneficiaries' health plan information and social security numbers.

Sec. 210. Enhancement of quality assurance.

Section 210 of the Committee bill, which is derived from S. 2377, would require actions to enhance VA's quality assurance efforts. Specifically, this section of the Committee bill would require that: (1) the USH (a) designate a physician to serve as VHA's principal quality assurance officer and (b) other physicians to serve as quality assurance officers for each VISN; (2) the director of each VHA facility appoint a quality assurance officer for each facility; (3) the USH establish mechanisms to allow VHA employees to submit confidential reports on matters related to health care quality; and (4) the Secretary undertake a comprehensive review of all VA quality and patient safety policies.

Background. Under current law, section 7311 of title 38, U.S.C., VA operates a quality assurance system to monitor and evaluate the quality of VA health care. That system is headed by the Chief Quality and Performance Management Officer of the National Quality and Performance Office. While a number of other entities have a role in VA quality assurance efforts, including the Office of the Inspector General, the Office of the Medical Inspector, the National Patient Safety Office, and the Office of Compliance and Business Integrity, none has a permanent oversight capacity at every VA medical center. The VA quality assurance and monitoring program, including the National Surgical Quality Improvement Program (NSQIP), have proven effective in certain situations. However, in a report titled "Quality of Care Issues, VA Medical Center,

Marion, Illinois" (January 2008), the VA Office of the Inspector General (hereinafter, "OIG") found that the quality assurance process was ineffective in many respects. The peer review process, the tracking of performance data on providers, and mortality assessments as carried out at the Marion, Illinois, VA Medical Center were all found to be deficient. The OIG concluded that:

> [T]he oversight reporting structure for quality management reviews at the Marion VAMC was fragmented and inconsistent, making it extremely difficult to determine the extent of oversight of patient quality or corrective actions taken to improve patient care. This occurred partially because quality management responsibilities were split between multiple groups at the facility with little or no management oversight.

The OIG further concluded that the Marion VAMC Surgery Service leadership was ineffective, and that communication among the nurse responsible for NSQIP at the facility, surgical providers, and the Chief of Surgery was highly ineffective, allowing multiple quality management processes to fail.

Based on information related to the Marion, IL, experience and other oversight activity, the Committee believes that VA's internal processes can ensure quality in some circumstances, but that significant improvements are necessary. Continuous and attentive monitoring is not fully in place, and facility leadership across the VA system must prioritize quality assurance.

Committee Bill. Section 210 of the Committee bill would add a new section 7311A to chapter 73 of title 38, U.S.C. This new section would require the USH to appoint a National Quality Assurance Officer, reporting directly to the Under Secretary, who would develop requirements and standards for a national quality assurance program, and prescribe regulations for its implementation.

The Committee believes that such a position would be helpful in order to ensure the thorough and uniform discharge of quality assurance requirements under such programs and activities throughout VA facilities. The USH would also be required to designate quality assurance officers for each VISN. Such officers would direct the quality assurance effort of each network and coordinate, monitor, and oversee the quality assurance programs and activities of the medical facilities in the Network.

Additionally, section 210 of the Committee bill would require each VA medical center Director to appoint a physician, from that facility, to be the quality assurance officer for that facility. The Director would be required to ensure that other clinical or administrative duties of the person appointed as the quality assurance officer are reduced so as to not interfere with the person's quality assurance duties. The quality assurance officer would report to the director of the facility and to the quality assurance officer of the VISN of which that facility is a part.

Section 210 would also require the USH to put in place a system through which VHA employees might submit reports, on a confidential basis, on quality of care matters to the quality assurance officer at the employee's facility. Such a system would provide a safe channel through which employees might report their concerns about care being furnished at the facility. Such a system should

make it possible for any such reports to receive appropriate attention and review.

This section of the Committee bill also would require the Secretary to submit a report to Congress on all policies and protocols of VA that pertain to maintenance of health care quality and protection of patient safety at VA medical facilities. This report would be required to include an assessment of NSQIP, with special emphasis on the effectiveness of the design and structure of the program's data collection, evaluation, and assessment structure, and the sufficiency of resources allocated to that program. In testimony before the Committee on May 21, 2008, Dr. Gerald Cross, Principal Deputy Under Secretary for Health, expressed VA's support for the provisions of this section of the Committee bill that would require a comprehensive review and report on health care quality and patient safety policies across the VA health care system.

Sec. 211. Reports on improvements to Department health care quality assurance.

Section 211, which is derived from S. 2377, would require the Secretary to report on VA efforts to implement the provisions of the Committee bill concerning quality assurance.

Background. There are currently no regular requirements for VA to report to Congress on VHA quality assurance efforts. This lack of effective reporting mechanisms can contribute to ineffective quality oversight. While the Inspector General performs valuable oversight of individual facilities and specific events, the Committee believes a comprehensive annual reporting requirement would more effectively ensure oversight and accountability by the Committee and the Congress.

Committee Bill. Section 211 would require the Secretary to submit a report to the Committees on Veterans' Affairs and Appropriations of the Senate and the Committees on Veterans' Affairs and Appropriations of the House of Representatives by December 15, 2009, and annually thereafter, through 2012. This report would detail VA efforts, over the preceding fiscal year, to implement the provisions of sections 104 (relating to standards for appointment and practice of VHA physicians) and 210 (relating to quality assurance officers) of the Committee bill, along with any recommendations the Secretary may have to improve the implementation of these sections or to otherwise improve the quality of VA health care. The Committee expects that this reporting requirement will lead to increased oversight of VA's efforts to improve quality assurance efforts and activities.

Sec. 212. Pilot program on training and certification for family caregiver personal care attendants for veterans and members of the Armed Forces with TBI.

Section 212 of the Committee bill, which is derived from S. 2921, would require the Secretary, in collaboration with the Secretary of Defense, to carry out a pilot program to evaluate, over a three-year period, the provision of health care training, certification and compensation to family members of veterans and members of the Armed Forces with TBI, so as to allow family members to function as personal care attendants.

Background. Currently, VA operates a Personal Care Attendant certification program at the San Diego, California, VA Medical Center for patients with spinal cord injury. According to the VHA directives, family members can be personal care providers as long as they are certified by a Spinal Cord Injury Center. Once certified, VA can compensate these family members for the services they provide at a rate not to exceed the hourly rate paid to VA nursing assistants.

There have been two prior attempts to address the issue of training family caregivers for veterans with TBI. Section 744 of Public Law 109–364, the John Warner National Defense Authorization Act of 2007 (hereinafter, "NDAA 2007"), required the establishment of a panel to develop training curricula for family members on caregiving techniques for TBI patients. Section 214 of Public Law 109–461, The Veterans Benefits, Health Care, and Information Technology Act of 2006, mandated a VA pilot program to improve caregiver assistance services, including training and certification.

Committee Bill. Section 212 of the Committee bill would require the Secretary, in collaboration with the Secretary of Defense, to carry out a 3-year pilot program in three VA medical facilities and, if the Secretaries determine it is appropriate, one DOD medical facility. In selecting locations, the Secretary would be required to attempt to locate the pilot program at VA Tier I polytrauma centers. VA currently operates four such centers at the Minneapolis, Tampa, Richmond, and Palo Alto VA medical centers. A fifth center is slated to open at the San Antonio VA Medical Center in the near future.

The Secretary would be required to develop a training program for those who would serve as personal care attendants under the pilot program. This training would be required to incorporate standards of certification programs of national brain injury care specialist organizations as well as best practices of caregiving organizations, such as the National Family Caregivers Association. This training program would be required to draw on the training curricula that were developed under NDAA 2007.

The Secretary would be responsible for determining whether a family member would be eligible for participation in the pilot program, based upon the needs of the patient, as determined by the patient's physician. A family caregiver certified as a personal care attendant under this pilot program would be eligible to be paid by VA for the care the personal care attendant provides.

The Secretary or the Secretary of Defense would be required to pay any costs of training family members of veterans or members of the armed services, respectively, to be personal care attendants. Under the pilot program, the Secretary would be allowed to provide information to a properly certified personal care attendant, including an assessment of the attendant's needs and a referral to any services provided in the attendant's community that are relevant to the attendant's needs. These services could be provided by community-based organizations, publicly funded programs, or VA. In making this assessment, the Secretary would be required, to the greatest extent practicable, to utilize existing caregiver assessment tools currently in use by VA.

The Secretary would be required to report to Congress on the pilot program within two years of the date of enactment of this Act.

The report would include the Secretary's recommendations regarding the expansion or modification of the pilot program.

This section of the Committee bill specifies that nothing within the provision would grant a right to family members to receive the training and certification under the pilot program, nor would anything prevent the Secretary from allowing a non-family member to act as personal care attendant if the patient prefers such a person to a family member.

The Committee believes that this pilot program has the potential of allowing for a more efficient and appropriate program of recovery and long-term care for those with TBIs, for whom institutional long-term care would be too intensive or otherwise inappropriate. This program would allow veterans to stay in their own homes but still receive necessary living assistance.

This proposed pilot program is supported by The American Legion, Veterans of Foreign Wars, Disabled American Veterans, Paralyzed Veterans of America, Vietnam Veterans of America, Wounded Warrior Project, and the Brain Injury Association of America.

Sec. 213. Pilot program on provision of respite care to members of the Armed Forces and veterans with TBI by students n graduate programs of education related to mental health or rehabilitation.

Section 213, which is derived from S. 2921, would require the Secretary of Veterans Affairs, in collaboration with the Secretary of Defense, to carry out a three-year pilot program to assess the feasibility and advisability of providing respite care to veterans and service members through the services of students in certain graduate education programs.

Background. There has been a marked increase in the number of family members taking on the role of primary caregiver for injured and disabled veterans since the start of the wars in Iraq and Afghanistan. This is consistent with the overall trend of long-term care moving from institutional to non-institutional settings. In response to the impact on family members furnishing care, there has also been an increasing use of non-institutional care options to relieve and assist family caregivers.

VA has a long record of entering into affiliations with academic institutions for the purposes of training clinicians, as well as for enhancing research opportunities. Academic affiliations enhance the education and experience of both VA professionals and the students attending the academic affiliates.

In testimony submitted for the Committee's May 21, 2008, hearing, the Brain Injury Association of America (BIAA), described the need for providing supportive services for family caregivers:

> Particularly in light of the fact that caregivers often report severe financial strain and frequently must give up their jobs in order to take care of their loved one with TBI, increased financial support and access to respite care for family caregivers of returning servicemembers with TBI is vital and long overdue.

BIAA cites one study that found that 47 percent of family caregivers had given up their jobs at one year after the injury occurred. At two years, that number was still 33 percent. These demands

have been linked to the occurrence of stress reaction and other physical and emotional problems.

Committee Bill. Section 213 of the Committee bill would establish a three-year pilot program to test the feasibility and advisability of using graduate students in certain mental health and rehabilitation programs to provide respite care to members of the Armed Forces and veterans with TBI. The students would provide relief to family caregivers and assist in developing cognitive and social skills in the patient.

This pilot program would be carried out at no more than ten separate locations selected by the Secretary, all of which must be VA medical facilities that are in proximity to or affiliated in some manner with an educational institution that has a graduate program in mental health or rehabilitation related field. The Secretary would be required to give special consideration to VA facilities that are Tier I polytrauma centers, and VA facilities that are in proximity to regions with large concentrations of veterans with TBI.

The Secretary would be required to recruit, train, and assign graduate students in the designated fields of education in order to provide respite care to veterans and servicemembers in the pilot program. The Secretary, in collaboration with the head of the selected graduate program, would be required to determine the amount of training required, the number of hours of care to be provided, and the requirements for successful participation for the graduate students participating in the program. The Secretary would be required to incorporate into the training program any applicable standards and protocols of national brain injury care specialist organizations, as well as recognized caregiving best practices.

For purposes of the pilot program, the Committee bill would define "respite care" as the temporary provision of care to an individual to provide relief to the regular caregiver, and the term "family member" to include friends or partners of the patient.

The Committee believes that the provision of respite care as outlined in this pilot program could be vital in further strengthening the family caregiver model a feasible system of care.

Sec. 214. Pilot program on the use of community-based organizations and local and State government entities to ensure that veterans receive care and benefits for which they are eligible.

Section 214 of the Committee bill, which is derived from S. 2796, would require VA to carry out a pilot program to study the use of community-based organizations, and local and State government entities, to help ensure that veterans receive needed care and benefits.

Background. Dr. Stanley Luke, PhD, Vice President for Programs of Helping Hands Hawaii, one of Hawaii's largest social service nonprofits and a provider of direct services to Hawaii veterans, testified before the Committee on May 21, 2008, expressing support for the pilot program contemplated by this section of the Committee bill. According to Dr. Luke, as a consequence of cultural or other factors in certain locations, VA personnel may sometimes not be most appropriate to reach out to veterans and that, in such instances, local organizations, with specific local cultural skills, may

be better able to relate to, and interact with, veterans and their families in specific locations.

Helping Hands Hawaii has attempted to assist veterans through outreach, assistance in interacting with VA, explaining eligibility and available benefits and services, and providing mental health care. The pilot program provided for under this section of the Committee bill would have VA focus more intently on this approach and study whether these efforts can be effectively replicated.

Committee Bill. Section 214 of the Committee bill would require the Secretary to establish and implement a pilot program to study the use of community-based organizations, and local and State government entities, in the provision of care and benefits to veterans. This program would specifically seek to improve coordination between community, State, and Federal providers of health care and benefits to veterans who are transitioning from military to civilian life; to make medical care and mental health care more available to veterans who are transitioning; to provide assistance to families of transitioning veterans; and to provide greater outreach to veterans and their families, and to inform them about their eligibility for, and availability of, benefits and care.

The pilot program would continue for a period of two years after enactment of the Committee bill, and be carried out at five locations that the Secretary would select. In selecting the program locations, the Secretary would be required to place special emphasis on rural areas, areas with high proportions of minority groups, areas with high proportions of individuals who have limited access to health care, and areas that are not in close proximity to an active duty military station.

The Secretary would award grants to organizations and entities for them to use in providing services under the pilot program. Any organization or entity wishing to participate in the program would be required to submit an application to the Secretary containing a description of how the program was developed in consultation with VA and a plan for the organization to coordinate activities with local, State, and Federal government agencies that provide services so as to avoid duplication of services.

The Secretary would be required to promulgate regulations governing the appropriate use of grant funds by organizations. The Secretary would also be required to submit a report on the pilot program within 180 days after the program's end. The report would include findings and conclusions, an assessment of the benefits that were provided, and any recommendations from the Secretary regarding whether to continue the pilot program.

Sec. 215. Specialized residential care and rehabilitation for certain veterans.

Section 215, which is derived from S. 2889, would authorize VA to contract for specialized residential care and rehabilitation services for certain veterans of OIF/OEF.

Background. Veterans with TBI or other serious disabilities and conditions have significant long-term care needs. These veterans may not need nursing home care, but they do not always have the resources needed to remain at home and live independently. This presents a challenge both for the veteran and the health care system.

Committee Bill. Section 215 of the Committee bill would amend title 38, U.S.C., by adding a new subsection (g) to section 1720 so as to authorize the Secretary in carrying out its community residential care program, to contract for specialized residential care and rehabilitation services for eligible veterans. Veterans covered by this provision would be veterans of OEF/OIF who: (1) suffer from TBI; (2) have an accumulation of deficits in activities of daily living and instrumental activities of daily living that affects their ability to care for themselves; and (3) would otherwise receive their care and rehabilitation in a nursing home care, which exceeds their needs.

It is the intent of the Committee that VA should have authority to provide veterans with significant long-term needs with a much more appropriate treatment setting for long-term rehabilitation services.

Sec. 216. Exemption from copayment requirement for veterans receiving hospice care.

Section 216, which is derived from S. 2889, would eliminate copayment requirements for veterans receiving VA hospice care in any setting.

Background. In 2004, with the enactment of Public Law 108–422, Congress eliminated copayment requirements for veterans receiving hospice care in VA nursing homes, but that change did not eliminate copayments for hospice care furnished in other settings. The Medicare program does not impose copayments for hospice care, regardless of the setting. The Committee does not believe that VA should require such copayments either.

Committee Bill. Section 216 would amend section 1710 of title 38, U.S.C., to eliminate copayment requirements for veterans receiving VA hospice care either in a VA hospital, or at home on an outpatient basis. The Committee bill would exempt all hospice care from copayments, thereby providing equitable treatment for all veterans receiving such care.

Sec. 217. Repeal of limitation on authority to conduct a widespread HIV testing program.

Section 217, which is derived from S. 2889, would remove a restriction in current law on VA's ability to conduct widespread testing for HIV among VA patients.

Background. Currently, section 124 of Public Law 100–322 permits VA to test a patient for HIV infection only if the veteran receives pre-test counseling and provides written informed consent for such testing. This differs from other blood testing that VA conducts routinely, which requires only a patient's verbal informed consent. VA advises that the requirements for pre-test counseling and signed consent often delay testing for HIV infection.

Committee Bill. Section 217 would repeal section 124 of Public Law 100–322. Eliminating this section from the law would bring VA's statutory HIV testing requirements in line with current guidelines issued by the Centers of Disease Control and Prevention and will not diminish patient rights, as VA would still be required to obtain the patient's verbal informed consent. Generally, informed consent requires the responsible practitioner to discuss and inform the patient about the procedure/treatment and its risks and

benefits, as well as answer any questions that patient may have about the procedure/treatment. In addition, a patient may always reject VA treatment or procedures.

The Committee believes that by eliminating section 124 of Public Law 100–322, veterans would benefit from earlier medical intervention, thereby improving the potential health outcomes of infected patients, while at the same time advancing the country's broader public health goals.

Sec. 218. Authority to disclose medical records to third party for collection of charges for provision of certain care.

Section 218, which is derived from S. 2889, would amend two provisions of title 38, U.S.C., so that VA could disclose individually-identifiable patient medical information in connection with the collection of charges for VA care or services.

Background. Under section 1729 of title 38, U.S.C., VA has authority to recover from health plans or health insurance carriers the reasonable charges for treatment of a veteran's nonservice-connected disabilities. In order to recover charges and obtain reimbursement for care, VA must submit bills or claims containing information to the health plan for the episode of care. If during the episode, the veteran was diagnosed or treated for certain conditions, this information is communicated via the bill to the health plan.

Section 5701 of title 38 permits VA to release the names and home addresses of veterans and their dependents without consent only for very limited purposes. There is some question whether disclosures for billing purposes are currently permitted under subsection (b)(6) of that section in cases in which the United States has not yet instituted litigation to collection an amount owed VA under section 1729.

Section 7332 of title 38 similarly permits VA to release indentifying information and treatment information, without prior written consent for the medical conditions covered by the section—drug abuse, alcoholism or alcohol abuse, HIV infection, or sickle cell anemia—only for certain, limited purposes specified in subsection (b) of 7332. The authorized exceptions do not include releasing identifiable patient information to a third-party health plan for collection purposes, without the patient's prior written authorization.

Committee Bill. Section 218 would add new subsections to section 5701 and 7332 of title 38, U.S.C., to authorize the Secretary to disclose individually-identifiable patient medical information without the prior written consent of a patient to a third-party health plan to collect reasonable charges under section 1729 of this title for care or services provided for a non-service-connected disability.

The amendment to section 5701 would specifically authorize disclosure of a patient's name and address information for collection purposes. Disclosure of the information other than the patient's name and address is authorized under existing authority in subsection 5701(e). Similarly, the section 7322 change would authorize disclosure of both individual identifier information and the medical information for purposes of carrying out VA's responsibilities under section 1729.

The Committee notes that such disclosures without a patient's prior written authorization are generally permitted under regulations promulgated pursuant to section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Since health plans that VA would bill for the reasonable cost of medical care under this authority are covered by the HIPAA privacy regulations, they will be able to use and disclose the patient-identifiable information provider in accordance with HIPAA.

The Committee anticipates that these changes to current law will result in higher revenue collections.

Sec. 219. Expanded study on the health impact of Project SHAD.

Section 219 of the Committee bill, which is derived from S. 2937, would require VA to contract with the Institute of Medicine of the National Academies (IOM) for an expanded study on the health impact of Project SHAD.

Background. During the period 1962–1974, the Defense Department conducted a series of tests of chemical and biological materials in water-borne settings. The tests, known as Project SHAD exposed hundreds of veterans to VX nerve gas, *E. Coli*, and other substances.

The Project SHAD tests were intended to show the vulnerability of Navy ships to chemical and biological warfare agents. By learning how those agents would disperse, military planners hoped to be able to improve procedures to protect crewmembers and decontaminate ships.

Beginning in 2002, VA contracted with IOM to conduct a study of the health effects on veterans who participated in Project SHAD (contract number No. V101(93)P–1637, T/0). While there are many known medical problems associated with repeated chemical and biological weapons exposure, the Committee is concerned that the study, which was released last year, is incomplete because it omits a number of Project SHAD veterans who were known to DOD and to VA.

Committee Bill. Section 219 of the Committee bill would require the Secretary to enter into a contract with IOM, within 90 days after the enactment of this Act, for the purposes of IOM conducting a study of the health impacts of Project SHAD on servicemembers participating in the tests. The Committee bill would require that this study include all servicemembers involved in the tests, insofar as is practicable and consistent with the requirements of conducting sound research. The Committee Bill would authorize the utilization of the results from the study "Long-Term Health Effects of Participation in Project SHAD" conducted by IOM.

Congress has previously approved unfettered, VA-provided care for veterans who participated in Project SHAD. While the Committee believes that these veterans deserve and should receive care from VA at no cost for any condition that cannot be attributed to other causes, the Committee believes there is value in examining the impact of such testing on participants in order to better understand the potential effects of other such testing.

The Committee also notes that there is value in continued research into the areas of chemical and biological weapons exposure and that VA and DOD should make every effort to identify and contact all former servicemembers who participated in Project

SHAD as well as testing that occurred during a similar time period at Edgewood Arsenal, Dugway Proving Grounds, Ft. McClellan, and Ft. Detrick.

Sec. 220. Use of non-Department facilities for rehabilitation of individuals with TBI.

Section 220 of the Committee bill would amend a recently enacted section of title 38, U.S.C., so as to specify the circumstances in which non-VA facilities would be utilized as part of the rehabilitation and community reintegration plans for veterans and members of the Armed Forces who are receiving care from VA for TBI.

Background. VA has done much in recent years to develop its capability to treat TBI. However, VA has limited experience in treating younger veterans with debilitating injuries such as TBI. As a result, Congress passed a series of VA-related provisions in NDAA 2007, the bulk of which sought to expand and enhance TBI care at VA facilities. As part of those provisions, Congress also gave VA the ability to enter into cooperative agreements with public or private entities to send certain veterans suffering with TBI to non-Department facilities for rehabilitative care. In some circumstances, VA may find the service of a non-VA facility to be better suited to providing the care required by some veterans with TBI. In the Senate-passed version of NDAA 2007, specific criteria for eligibility and standards of care were laid out, but these provisions were dropped in reconciliation negotiations with the House.

Committee Bill. Section 220 of the Committee bill would amend section 1710E of title 38, U.S.C., so as to add two new subsections that were included in the Senate-passed legislation from the NDAA 2007. Proposed new subsection (b) would specify that non-VA facilities would be used when the Secretary cannot provide treatment or services at the frequency or for the duration required by the individual plan of veteran or servicemember suffering from TBI or when the Secretary determines that it is optimal for the veteran or servicemember's recovery and rehabilitation. Proposed new subsection (d) would establish standards for the selection of a non-Department facility, requiring that the facility itself maintains care standards that have been established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with TBI.

The Brain Injury Association of America supports section 220, "as it sets forth a pivotal mechanism for enhancing cooperation between the private sector and the VA health care system. Such cooperation is vitally necessary in order to provide access to, and choice within, the full continuum of care that returning service members with TBI need and deserve."

Sec. 221. Inclusion of tribal organizations in certain programs for State veterans homes.

Section 221 of the Committee bill, which is derived from S. 3000, would include tribal organizations in certain authorities relating to State veterans' homes. The health facilities of tribal organizations would be eligible to be treated as veterans homes for funding purposes, and tribal organizations would be eligible to apply for veteran State home construction grants.

Background. State veterans homes are homes established by the States for disabled veterans in need of long-term care. They provide nursing home care, domiciliary care, and adult day care. VA partners with States in two ways to assist in funding the homes. Under Sections 1741–1743 of title 38, U.S.C., VA has the authority to carry out a per diem payment program in which it provides a portion of the daily cost of care for each veteran residing in a home. Under Sections 8131–8137 of title 38, VA has the authority to conduct a construction grant program, in which it can provide up to 65 percent of the total cost of building a home, with the States required to put up 35 percent. Under current law, tribal organizations are not considered states for the purposes of being eligible for either of these programs.

Based on the 2000 U.S. Census, VA projected in a September 2006 report that during the time period from 2005 and 2020, the number of older veterans overall will decline by 10 percent. During that same time, VA projected a nearly 60 percent increase in the number of older American Indian and Alaska Native veterans. The expected decline in the overall number of older veterans is attributed largely to the World War II and Korean War-era veteran populations, which are declining largely for age-related reasons. In contrast, American Indian veterans are much less likely to be World War II or Korean War-era, and more likely to be Vietnam-era than the overall veteran population.

As early as the 1990s, Native Americans have identified a pressing need for improved long-term care in Native communities. In 1995, the National Indian Council on Aging described long-term care as the most pressing issue facing American Indian elders. According to a survey reported in the 2002 American Indian and Alaska Native Roundtable on Long-Term Care, only 17 percent of tribes report having nursing homes available on the reservation or in the tribal community. Nineteen percent reported that their tribe was planning to create or expand long-term care services. Despite recognition of the need for long-term care, as well as interest among tribes in developing such care, Native American communities are constrained by limited federal funding and the abject poverty that characterizes much of Indian Country.

Committee Bill. Subsection (a) of section 221 of the Committee bill would amend section 8138 of title 38, U.S.C., so as to allow for the treatment of health facilities of tribal organizations, or beds within such facilities, as State veterans homes. As a result of this amendment, tribal organization health facilities would be treated in the same manner as other health facilities (or beds), with the exception of newly designated subsection (f) of section 8138, which sets September 30, 2009, as the expiration date for the treatment of new health facilities as State homes, which would not apply to the health facilities of tribal organizations.

Subsection (b) of section 221 of the Committee bill would amend title 38 in a number of ways so as to give the Secretary the authority to award construction grants to tribal organizations for the construction of State veterans homes as set forth in subchapter III of chapter 81 of title 38.

Subsection (b)(1)(A) would provide that, for the purposes of the subchapter, "tribal organization" would have the meaning given to the term in section 3765 of title 38.

Subsection (b)(1)(B) would amend section 8132 of title 38, the declaration of purpose for the subchapter, to include tribal organizations along with the "several states" as the entities to be assisted in creating State veterans homes.

Subsection (b)(1)(C) would amend title 38 by adding a new section—Section 8133A. Tribal organizations—so as to give the Secretary the express authority to award construction grants to tribal organizations. This new section would provide that grants to tribal organizations shall be awarded in the same manner as States, with certain exceptions. One such exception shall be that, for the purpose of assigning priority under subsection (c)(2) of section 8135 of title 38, if a tribal organization is located within a State that has previously applied for a construction grant, the tribal organization shall be treated as if it previously applied as well. Other exceptions may be prescribed by the Secretary to take into account the unique circumstances of tribal organizations.

Recognizing the limited long-term care options in Native American communities, as well as the sovereign status of Federally-recognized tribes, section 221 would enable the Secretary to award State veterans home grants directly to tribal organizations.

As reported by the Harvard Project on American Indian Economic Development: "Where tribes make their own decisions about what approaches to take and what resources to develop, they consistently out-perform outside decision makers." The Committee expects that, by including tribal organizations among those eligible to apply for State veteran homes grants, these organizations will be able to provide more effective long-term care for the veterans in their communities.

Sec. 222. Extension of pilot program on caregiver assistance services.

Section 222 of the Committee bill would amend section 214(d) of the Veterans Benefits, Health Care, and Information Technology Act of 2006 (Public Law 110–461) to extend the pilot program on caregiver assistance services for an additional year, to 2009.

Background. In December 2006, Congress passed S. 3421, The Veterans Benefits, Health Care, and Information Technology Act of 2006, which became Public Law 109–461. A provision of this legislation created a two-year pilot program to assist home-based caregivers of disabled veterans. At the time, spouses and family members acting as the primary caregivers for wounded veterans was a growing trend, and the need to provide supportive services to these caregivers was becomingly increasingly apparent. The intent behind the pilot was to incentivize field clinicians to create innovative, localized programs to assist caregivers in their respective communities. Along with the authorization for the pilot itself, Congress authorized $5,000,000 for the administration of the program.

VA is currently providing approximately $4,700,000 for these pilot programs to expand and improve health care education and provide needed training and resources for caregivers who assist disabled and aging veterans in their homes. This funding enhances the support and training for family members and other caregivers who work to care for these veterans.

There are currently eight caregiver projects across the country. Among the key services provided to caregivers are transportation,

respite care, case management and service coordination, assistance with personal care (bathing and grooming), social and emotional support, and home safety evaluations. Education programs teach caregivers how to obtain community resources such as legal assistance, financial support, housing assistance, home delivered meals and spiritual support.In addition, caregivers are taught skills such as time management techniques, medication management, communication skills with the medical staff and the veteran, and ways to take better care of themselves.

Many of the projects use technology, including computers, web-based training, video conferencing and teleconferencing to support the needs of caregivers who often cannot leave their homes to participate in support activities.

Committee Bill. Section 222 of the Committee bill would amend section 214(d) of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Public Law 110–461, so as to extend the pilot program on caregiver assistance services for an additional year, through the end of fiscal year 2009.

Families and other caregivers are on the front lines of efforts to care for veterans who have served this nation. Because the pilot program was enacted late in 2006, sites were announced fully one year later and the money has already been allocated to the various programs, VA needs an additional year's authorization to fully carry out the pilot program.

Sec. 223. Pilot program on provision of dental insurance plans to veterans and survivors and dependents of veterans.

Section 223 of the Committee bill, which is derived from S. 3178, would direct the Secretary to carry out a pilot program to assess the feasibility of providing a dental insurance plan to eligible veterans, survivors, and dependents of veterans.

Background. VA provides a full range of dental services at its facilities. However, under current law, section 1712 of title 38, U.S.C., dental services are only offered to certain veterans or to veterans under special circumstances. For example, veterans who have a service-connected compensable dental condition, are former prisoners of war, or who have 100 percent service-connected disabilities are eligible for any needed dental care. Other veterans are eligible only for dental care necessary to resolve problems arising in certain narrowly defined situations, such as a veteran whose dental condition is aggravating a service-related condition or who requires dental care to continue participation in a vocational rehabilitation program. In addition, CHAMPVA does not provide dental coverage for survivors and dependents of veterans receiving care under that program except under very limited circumstances. CHAMPVA, established by Public Law 93–82, is primarily a fee-for-service program that provides reimbursement for most medical care for certain eligible dependents and survivors of veterans rated permanently and totally disabled from a service-connected condition. The program reimburses providers and facilities a fixed amount for treatment given, less any co-pay from beneficiaries.

DOD administers a health care system for active duty servicemembers, military retirees, certain Reserve and National Guard members, and eligible family members under the TRICARE program. Through TRICARE, dental benefits may be provided to select

beneficiaries at military treatment facilities; for others, voluntary dental insurance coverage is available through a DOD contract with private insurers is available. Section 703 of Public Law 104–201, NDAA 2007, established the TRICARE Retiree Dental Program (TRDP) through which military retirees and their eligible family members are given the option to purchase dental coverage under a contract managed by DOD. Over 1,000,000 eligible participants have some level of dental coverage under TRDP. TRDP enrollees have access to a network of about 112,000 dental plan providers across the nation. Premiums currently range from $14 to $48 per month for an individual policy, depending on the region and type of dental plan selected.

Committee Bill. Section 223 of the Committee bill, in a free-standing provision, would require the Secretary to carry out a pilot program on the provision of dental insurance plans to veterans and survivors, and dependents of veterans.

Subsection (a) of section 223 would require the Secretary to carry out the pilot program so as to assess the feasibility and advisability of providing dental insurance.

Subsection (b) of section 223 would define the participants in the pilot program as veterans enrolled in VA's medical care system and survivors and dependents of veterans eligible for medical care under CHAMPVA.

Subsection (c) of section 223 would specify that the pilot program is to be carried out in not less than two and no more than four VISNs.

Subsection (d) of section 223 would specify that the Secretary is to contract with a dental insurer to administer the dental plan.

Subsection (e) of section 223 would require the dental plan under the pilot program to provide benefits considered appropriate by the Secretary, including diagnostic, preventative, endodontic, surgical, and emergency services.

Subsection (f) of section 223 would provide that enrollment in the dental insurance plan would be voluntary and would be for such minimum period of enrollment as the Secretary prescribes.

Subsection (g) would require the Secretary to set premiums for dental plan coverage on an annual basis and would specify that the premiums would be paid entirely by plan enrollees.

Subsection (h) of section 223 would permit the voluntary disenrollment from a dental plan if the disenrollment occurs within 30 days of the beginning of the enrollment period or, under certain allowable circumstances, such as a relocation to a jurisdiction outside a plan area or a serious medical condition preventing use of plan benefits, if the disenrollment does not jeopardize the fiscal integrity of the dental plan.

Subsection (i) of section 223 would specify that nothing regarding the pilot program will affect VA's responsibility to provide dental care under section 1712 of title 38 nor would an individual's participation in an insurance plan under the pilot program affect the individual's entitlement to dental services under that section.

Subsection (j) would specify that the dental insurance plan under the pilot program is to be administered pursuant to regulations prescribed by VA.

The Committee is interested in testing within the VA health care system the TRDP concept of supplementing dental benefits pro-

vided at government facilities with more comprehensive, voluntary dental insurance coverage financed through enrollee premiums. This concept is not meant to minimize VA's obligation to provide high quality dental services under existing requirements of law.

TITLE III—WOMEN VETERANS HEALTH CARE

Sec. 301. Report on barriers to receipt of health care for women veterans.

Section 301 of the Committee bill, which is derived from S. 2799, would require the Secretary to submit a report to Congress, no later than June 1, 2009, on the barriers to women veterans' access to VA health care.

Background. Under current law, VA is authorized to provide care to all veterans, including women veterans. While there has been some specific legislative action on certain areas of care for women veterans, such as for homeless reintegration services, the Committee believes that much more can be done. Although this approach has yielded some clear successes, there are concerns that there may be insufficient attention to ensuring uniform access to gender-specific services across the VA health care system. According to DOD, women represent approximately 17 percent of all deployed service members, and therefore are a growing portion of the veteran population.

Committee Bill. Section 301 of the Committee Bill would require VA to submit a report to Congress, not later than June 1, 2009, that would include, among other elements, information on an identification and assessment of any stigma associated with women veterans seeking mental health care, access to care for women veterans described in terms of distance to VA facilities, availability of child care, the comfort and personal safety perception of women veteran patients, the sensitivity of VA health care providers to issues affecting women veterans, and the effectiveness of outreach to women veterans.

The Committee seeks to ensure that appropriate attention and resources are directed to the needs of women veterans. For that to happen, those needs must be properly identified and described. That is the goal of this mandated study.

VA testified at the Committee's May 21, 2008, hearing on pending legislation that it was already in the process of conducting an assessment of barriers to care for women veterans. The results of that effort can either be provided to the Committee as soon as the results are available or can be made a part of the report mandated by this section of the Committee bill.

Sec. 302. Plan to improve provision of health care services to women veterans.

Section 302 of the Committee bill, which is derived from S. 2799, would require VA to develop a plan to improve the provision of health care services to women veterans, and to submit this plan to Congress no later than 18 months after enactment of the Committee bill.

Background. Public Law 102–585, enacted in 1992, authorized new and expanded services for women veterans, including counseling for sexual trauma on a priority basis, specific health services

for women, such as Pap smears, mammography, and general reproductive health care (including birth control and treatment of menopause) at many VA medical facilities.

Public Law 104–262, enacted in 1996, expanded services further to include maternity and infertility benefits. In fiscal year 1997, the USH appointed the first full-time Director for the Women Veterans Health Program. The program oversees a system of medical and psychosocial services for women.

As discussed above, in connection with section 301 of the Committee bill, the Committee is concerned that these benefits are not being furnished evenly across the VA system.

The 2008 Report of the Advisory Committee on Women Veterans found that:

> The new and complex needs of today's women veterans, particularly those who served in Operations Enduring and Iraqi Freedom, require that VA assess the effectiveness of its existing gender specific programs and initiate new ones that strategically address the many needs of this cohort in a way that is inviting, compassionate, and demonstrate a driven yield toward the best outcomes.

The burgeoning demand for care from women veterans requires that VA be fully prepared to deal with their health care needs. The estimated population of women veterans as of 2001 was 1,600,000, or about 7.2 percent of the total veteran population. Currently, women make up 14.8 percent of the active duty military force and approximately 22.8 percent of the reserve force. By 2010, they are expected to represent over 14 percent of the total veteran population. Fifty-six percent of women veterans who use VA are less than 45 years of age.

Committee Bill. Section 302 of the Committee bill would require VA to develop a plan on the provision of health care services to women veterans. The plan would include how VA intends to improve current services to women veterans, as well as how to appropriately provide for the future needs of women currently serving in OIF/OEF. As part of this plan, the Secretary would be required to identify the types of health care services that will be available to women veterans at each VA medical center, as well as what personnel would be required to provide such services. This plan would have to submitted to the two Veterans' Affairs Committees not later than 18 months after the date of enactment of the Committee bill.

It is the Committee's view that requiring VA to develop a plan is a first step to ensuring that the needs of women veterans are met, now and into the future.

Sec. 303. Independent study on health consequences of women veterans of military service in OIF/OEF.

Section 303, which is derived from S. 2799, would require the Secretary to enter into an agreement with a non-Department entity to conduct an independent study on the health consequences of service by women veterans in OIF/OEF.

Background. Public Law 98–160, enacted in 1983, established the Advisory Committee on Women Veterans (hereinafter, "Advisory Committee"). In addition, Public Law 103–446, enacted in 1994,

created the Center for Women Veterans (hereinafter, "Center"). Both entities play invaluable roles in helping to shape VA's responses to the needs and concerns of women veterans.

The Advisory Committee evaluates existing VA programs and makes recommendations for the enhancement of programs and services for women veterans while the Center oversees all VA programs for women veterans. However, neither entity is specifically charged to focus on the possible health consequences for women veterans who have served on activity duty in the Armed Forces in deployment in OIF/OEF.

There are more women serving in the U.S. Armed Forces than in any other period in American history. More than 160,000 female U.S. servicemembers have served in Iraq, Afghanistan, and the Middle East since 2003. At least 450 women servicemembers have been wounded in Iraq, more female casualties than in the Korean, Vietnam, and first Gulf Wars combined.

Another consequence of the increased number of women serving in the U.S. military is an increase in the occurrence of rape and sexual assault by their male comrades. Connie Lee Best, PhD, a Clinical Psychologist and Professor in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina testified before the Committee on April 25, 2007, noting that:

> Numerous research studies have documented rates of rape ranging from lows of six percent for active duty to rates that are significantly higher. One study found that 23% of female users of VA health care reported experiencing at least one sexual assault while in the military.

Given the extensive service of women in OIF/OEF, the Committee is of the view that VA must fully assess the health consequences of their service. Only then will VA know how best to meet their specific needs.

Committee Bill. Section 303 of the Committee bill would require the Secretary to enter into an agreement with a non-Department entity, such as the IOM, to conduct an independent study on the health consequences of service in OIF/OEF for women veterans. The study would include an examination of any and all possible environmental and occupational exposures and their effects on the general, mental, and reproductive health of women veterans who served in OIF/OEF. It would also include an analysis of all published literature on such exposures, as well as on combat trauma, including military sexual trauma. The study would be required to be completed and submitted to Congress no later than 18 months after the enactment of the Committee bill, and the Secretary would be required to submit a response to the report of the study no later than 90 days following the submission of the findings of the study.

Sec. 304. Training and certification for mental health care providers on care for veterans suffering from sexual trauma.

Section 304 of the Committee bill, which is derived from S. 2799, would require VA to implement a program for education, training, and certification for VA mental health care providers on care and counseling services for veterans suffering from military sexual trauma.

Background. Public Law 102–585, enacted in 1999, authorized VA to include outreach and counseling services for women veterans who experienced incidents of sexual trauma while serving on active duty in the military. The law was later amended by Public Law 103–452 so as to authorize VA to provide counseling related to sexual trauma to men, as well as to women. Public Law 108–422, enacted in 2004, extended VA's authority permanently to provide Military Sexual Trauma (MST) counseling and treatment to active duty service members or those serving on active duty for training.

VA has a number of strong programs geared toward mental health needs generally. However, MST is a discrete phenomenon and must be addressed as such. In addition, given the high numbers of women subjected to MST, as discussed above in connection with Section 303 of the Committee bill, the Committee believes that a more targeted approach is necessary.

Dr. Connie Best testified before the Committee in 2007 that:

> * * * the VA is staffed by some of the best mental health providers and by some with exceptional expertise in MST. However, I believe the one of the problems facing the VA in their responsibility to meet the needs of today's veterans who have experienced MST is one of sheer numbers * * *. That means more qualified and appropriately trained providers must be available. Those providers must be able to provide specialized sexual assault services and understand the interaction of sexual trauma with combat-related trauma.

Dr. Best suggested that VA should add specialized training programs for providers in the treatment of MST.

Committee Bill. Section 304 of the Committee bill would amend section 1720D of title 38, U.S.C., so as to add two new subsections.

Proposed new subsection (d) would require VA to implement a program for education, training, and certification for VA mental health care providers on care and counseling services for veterans suffering from MST. The new subsection would require that the training be carried out in a consistent manner and that it include principles of evidence-based treatment and care for sexual trauma. VA would also be required to determine the minimum qualifications necessary for mental health professionals certified under the program to provide evidence-based care and therapy to veterans for MST.

Proposed new subsection (e) would require VA to report to Congress annually on the care and counseling provided under section 1720D. Specifically, VA would provide information on the number of mental health professionals and primary care providers who have been certified under the program; the amount and nature of continuing medical education provided under such program to professionals and providers who have been so certified; the number of women veterans who received counseling and care and services from professionals and providers who have been trained or certified under the program; the number of training, certification, and continuing medical education programs operating under subsection (d); and the number of trained full-time equivalent employees required in each facility of VA to meet the needs of veterans requiring treatment and care for sexual trauma.

Finally, subsection (b) of section 304 of the Committee bill, in a freestanding provision, would require the Secretary to establish education, training, certification, and staffing standards for VA health care facilities for full-time employees who are trained to provide sexual trauma counseling and care.

Sec. 305. Pilot program on counseling in retreat settings for women veterans newly separated from service in the Armed Forces.

Section 305 of the Committee bill, which is derived from S. 2799, would require VA to carry out a pilot program to evaluate the feasibility and advisability of providing reintegration and readjustment services in group retreat settings to certain women veterans.

Background. VA operates a program of readjustment counseling which is provided through community-based facilities known as Vet Centers. Currently, there are 232 Vet Centers, located in all fifty states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands. Each provides assistance to veterans in need of readjustment counseling. The Vet Centers are managed by the Readjustment Counseling Service located in the VHA.

VA appears to appreciate the value of retreats for its employees, especially those involved in mental health issues. Recent retreats include one on the implementation of the VA's Mental Health Strategic Plan and another for those advocating recovery models of care in VISN 3.

The Committee believes that there is merit to evaluating the impact of providing reintegration assistance in retreat settings to woman veterans returning from a prolonged deployment.

Committee Bill. Section 305 of the Committee bill, in a freestanding provision, would require VA to establish, not later than six months after the date of enactment of the Committee bill, a pilot program designed to evaluate the feasibility of providing reintegration and readjustment services in a group retreat setting. Under the pilot program, which would be carried out through the Readjustment Counseling Service, these services would be provided to women veterans who are newly separated from service in the Armed Forces after a prolonged deployment. This pilot program would be required to be carried out for two years, beginning on the date the program begins, in no fewer than five locations selected by the Secretary.

Participation in the pilot program would be strictly voluntary. Services provided under the program would include information and assistance on reintegration into family, employment, and community; financial and occupational counseling; information and counseling on stress reduction and conflict resolution; and any other counseling the Secretary considers appropriate to assist the participants in reintegrating into their families and communities.

The Committee bill would authorize the appropriation of $2,000,000 annually in fiscal years 2009 and 2010 to carry out the pilot program. VA would be required to report to Congress on the pilot program no later than 180 days after completion of the program.

Sec. 306. Report on full-time Women Veterans Program Managers at medical centers.

Section 306 of the Committee bill, which is derived from S. 2799, would require the Secretary to submit to Congress a report on the employment of program managers solely for the management and oversight of women veterans' health care needs. This report would include whether or not each facility employs at least one such full-time employee.

Background. Women Veterans Program Managers are generally available at each VA facility, although not all are full-time positions.

These coordinators ensure that women veterans are afforded equal access to all services. They work to ensure that women veterans receive high quality comprehensive medical care in an environment that is sensitive to the privacy needs of women. Women Veterans Program Managers also advocate for gender-specific issues and needs.

The Committee recognizes the valuable contributions of the Women Veterans Program Managers and believes that it is essential that every VA medical center have sufficient resources to ensure that these positions are full-time.

Committee Bill. Section 306 of the Committee Bill would require the Secretary, acting through the USH, to submit a one-time report on Women Veterans Program Managers, so as to determine how many of these positions are filled on a full-time basis.

Sec. 307. Service on certain advisory committees of women recently separated from service in the Armed Forces.

Section 307 of the Committee bill, which is derived from S. 2799, would require the Secretary to appoint women veterans who are recently separated from the Armed Forces to VA's Advisory Committee on Women Veterans and to the Advisory Committee on Minority Veterans.

Background. Public Law 98–160, enacted in 1983, established the Advisory Committee on Women Veterans and set forth specific criteria for membership on the Committee, including those with service-connected disabilities, those who represent women veterans, and others. There is no specific requirement that any member of this Advisory Committee be a woman veteran who has recently separated from service in the Armed Forces.

Public Law 103–446, enacted in 1994, established the Advisory Committee on Minority Veterans and set forth specific criteria for membership on the Committee including representatives of veterans who are minority group members, individuals who are recognized authorities in fields pertinent to the needs of veterans who are minority group members, veterans who are minority group members and who have experience in a military theater of operations, and others. There is no specific requirement that any member of this Advisory Committee be a woman veteran who is also a member of a minority group and who is recently separated from service in the Armed Forces.

Committee Bill. Subsection (a) of section 307 of the Committee bill would amend section 542(a)(2)(A) so as to require the Secretary to appoint women veterans who are recently separated from the Armed Forces, to the VA Advisory Committee on Women Veterans.

Subsection (b) of section 307 of the Committee bill would require the Secretary to appoint women veterans who are also members of a minority group and recently separated from the Armed Forces to serve on the Advisory Committee on Minority Veterans.

Subsection (c) of section 307 of the Committee bill would provide that the amendments made by this section shall apply with appointments made to the two advisory committees on or after the date of enactment of the Committee bill.

Sec. 308. Pilot program on subsidies for child care for certain veterans receiving health care.

Section 308 of the Committee bill, which is derived from S. 2799, would require the Secretary to implement a pilot program to assess the feasibility and advisability of providing subsidies to certain veterans in order to allow them to purchase child care services to facilitate better access to health care from VA.

Background. There is no current authority for VA to reimburse veterans for child care expenses incurred while receiving VA medical care. The Committee recognizes that some veterans face significant barriers to receiving health care from VA and that the absence of adequate child care for those veterans who are primary caretakers of children is one such impediment. This problem can be even more daunting for veterans in that situation who are in need of intensive health care services, such as care for Post Traumatic Stress Disorder (PTSD), mental health, and other therapeutic programs.

In order to address the issue of the need for child care for its own employees, VA created the VA Child Care Subsidy Program, as authorized by Public Law 107–67, the Treasury and General Government Appropriations Act for Fiscal Year 2002. That law authorized the use of appropriated funds by executive agencies in order to provide child care services for Federal civilian employees. The VA program is needs based, with the amount of reimbursement available to an employee depending on total family income and the amount paid for child care. In order to qualify for reimbursement, children must be placed in a licensed day care, home care or before/after school program, and beneficiaries must complete and submit an application form.

The Committee believes that this existing VA program provides an excellent model for VA to emulate as it moves forward with the child care subsidies for veterans which would be authorized by this section of the Committee bill.

Committee Bill. Section 308 of the Committee bill, in a free-standing provision, would require VA to carry out a pilot program to examine what effect subsidies for child care for certain veterans receiving VA health care would have on improving access to health care services. The pilot program would be authorized for two years, beginning on the date the program begins, and would be required to be carried out in no fewer than three VISNs.

Subsidies for child care would only be available during the time period that a veteran is actually receiving specified health care services at a VA medical facility, and during the time required by the veteran to travel to and from the site of treatment. Veterans eligible for subsidies would be those who are the primary caretaker of a child or children and who are receiving regular or intensive

mental health care, or other intensive health care services determined by the Secretary as ones for which access would be improved by payment of a subsidy for child care.

The pilot program would be required to be modeled, insofar as practicable, on the VA Child Care Subsidy Program and would use the same income eligibility and payment structure as used in that program. The Secretary would be required to report on the program to Congress within six months of the conclusion of the program on the Secretary's findings and conclusions about the program, along with any recommendations the Secretary considers appropriate. The Committee bill would authorize the appropriation of $1,500,000 annually for fiscal year 2009 and 2010 for the purposes of the pilot program.

Sec. 309. Care for newborn children of women veterans receiving maternity care.

Section 309 of the Committee bill, which is derived from S. 2799, would authorize the Secretary to provide health care services, for not more than seven days after birth, to a newborn child of a woman veteran who is receiving maternity care from VA.

Background. Under current law, VA is authorized to provide maternity and infertility benefits to women veterans who enroll for VA care. Obstetrical care, excluding care for the newborn, is provided under contract.

While a veteran's care extends to maternity, prenatal, and postnatal care for female veterans, there is no authority for the provision of, or payment for, any care for the newborn child of a female veteran patient. This results in a significant gap in care for the increasing number of women veterans enrolled with VA.

The current women veteran population is predominantly pre-retirement and of child bearing age. Therefore, it is a disservice to our growing female veteran population and an inequity to not provide some newborn care.

According to various studies, the average hospital stay for low-birth weight infants (a common reason for prolonged neonatal hospital stays) ranges from 6.2 to 68.1 days, whereas the average hospital stay for average-sized infants was 2.3 days. Seven days of coverage would assist the mothers of newborns in need of simple, routine care, as well as many in need of more complex hospitalization.

Committee Bill. Section 309 of the Committee bill would add a new section—Section 1786. Care for newborn children of women veterans receiving maternity care—to Subchapter VIII of chapter 17 of title 38, U.S.C. This new section would authorize the Secretary to provide health care services, for not more than seven days after birth, to a newborn child of a woman veteran who is receiving maternity care from VA, if the mother gave birth in a VA medical facility, or in an outside facility pursuant to a contract between that facility and VA. These services would include all post-delivery care, including routine care, required by a newborn.

It is the Committee's belief that this limited but important step will help to ensure that the needs of women veterans enrolling for VA care are met in a more complete manner.

TITLE IV—MENTAL HEALTH CARE

Sec. 401. Eligibility of members of the Armed Forces who serve in Operation Iraqi Freedom or Operation Enduring Freedom for counseling and services through Readjustment Counseling Service.

Section 401, which is derived from S. 2963, would allow members of the Armed Forces, including members of National Guard or Reserves, who serve in OIF/OEF to receive services through VA's Readjustment Counseling Service.

Background. Currently, certain veterans are eligible for readjustment counseling services under section 1712A of title 38, U.S.C. Those eligible for these services include recently separated servicemembers from OIF/OEF as well as members of the National Guard or Reserves who were mobilized for service in OIF/OEF and served for the period of their mobilization. Under current law, members of the Armed Forces still on active duty are not eligible for readjustment counseling services from VA.

Committee Bill. Section 401 of the Committee bill, in a free-standing provision, would establish eligibility for readjustment counseling services for any member of the Armed Forces who serves on active duty in OIF/OEF, including a member of the National Guard or Reserves.

Subsection (a) of section 401 would set forth the basic eligibility for this population of servicemembers for readjustment counseling and related mental health services under section 1712A of title 38, U.S.C. These services would be provided through VA's Vet Centers.

Subsection (b) of section 401 would not require that a servicemember be currently on active duty to be eligible for these services.

Subsection (c) of section 401 would condition the eligibility for these services on regulations prescribed jointly by the Secretaries of Defense and VA.

Subsection (d) of section 401 would limit the availability of services under this section to the availability of appropriations for the provision of these services, so as to ensure that allowing a new population segment into the Vet Center system will not be a detriment to those the Vet Centers are currently serving.

The Committee recognizes that, in many parts of the active duty and reserve Armed Forces, there is stigma associated with seeking assistance in connection with mental health concerns. In light of the clear indications that many who serve in combat may experience psychological impact from such service—as shown by a 2008 Rand Corporation Study on mental health in OIF/OEF veterans, (Tanielian and Jaycox [Eds.], "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery," Santa Monica, CA: RAND Corporation, 2008.)—there appears to be significant value in allowing servicemembers still on active duty to come to VA's Vet Centers for help in dealing with such concerns.

At the same time, the Committee is concerned about placing an undue burden upon the Vet Centers, given their current responsibility to not only provide readjustment counseling to currently eligible veterans, but also to provide outreach to returning servicemembers and newly discharged veterans.

Sec. 402. Restoration of authority of Readjustment Counseling Service to provide referral and other assistance upon request to former members of the Armed Forces not authorized counseling.

Section 402 of the Committee bill, which is derived from S. 2963, would restore the authority of VA's Readjustment Counseling Service to provide referral and other assistance, upon request, to former members of the Armed Forces who have been discharged or released from active duty but who are not otherwise eligible for such counseling and services.

Background. VA was first authorized to furnish readjustment counseling services to Vietnam-era veterans in 1979 in Public Law 96–22. Included in that original authority was a provision that required VA to provide referral services and other assistance to veterans who sought readjustment counseling but who were not eligible to receive those services because of the nature of their discharge from the military or for other reasons.

This authority was repealed in 1996 in Public Law 104–262, the Veterans Health Care Eligibility Reform Act of 1996.

Committee Bill. Section 402 of the Committee bill would amend section 1712A of title 38, U.S.C., by adding a subsection (c) which would restore the provisions which require VA to provide referral services and other assistance to veterans who request readjustment counseling but who are not eligible for such services.

It is the Committee's intent that those who have been discharged under conditions other than honorable still be afforded assistance in acquiring mental health services and also in gaining review of their discharges. The Committee believes that VA should be available to provide some assistance to those who have served and are in need of readjustment assistance, even if they are not eligible for the full array of VA benefits.

Sec. 403. Study on suicides among veterans.

Section 403 of the Committee bill, derived from S. 2899, would require VA to conduct a study on suicides among veterans since January 1, 1997, and report to Congress on the findings.

Background. Numerous reports have been released in the past six months, illustrating that the rate of suicide among veterans has been steadily increasing. One such report was the RAND study (Tanielian and Jaycox [Eds.], "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery," Santa Monica, CA: RAND Corporation, 2008.), which reported that 1 in 5 veterans of the wars in Iraq and Afghanistan are returning and suffering with stress or mental health disorders, but that only half of those veterans are actually receiving treatment for these conditions.

VA's own Office of Mental Health reported that the number of suicides attempted at VA facilities increased from 492 in 2000 to 790 in 2007. Additionally, according to VA data, suicide among male veterans between 18 and 29 years of age has increased from 26.94 suicides per 100,000 to 45.82 suicides per 100,000—nearly a 100 percent increase. This is the highest rate since at least 2001.

Yet, there remains no centralized database of veteran suicides and attempts.

Committee Bill. Section 403 of the Committee bill, in a free-standing provision, would require VA to conduct a study to deter-

mine the number of veterans who died by suicide between January 1, 1997, and the date of enactment of the Committee bill.

Subsection (a) of section 403 would set forth the basic requirements for the study.

Subsection (b) of section 403 would require VA, in carrying out this study, to coordinate with DOD, Veterans Service Organizations (VSOs), the Centers for Disease Control and Prevention (CDC), and state public health offices and veterans agencies.

Subsection (c) of section 403 would require VA to submit a report to the Committees on Veterans' Affairs of the Senate and the House of Representatives on the findings of the study.

Subsection (d) of section 403 would authorize the appropriation of such sums as may be necessary to carry out the study.

Because the data show that the incidence of suicide among veterans is on the rise, the Committee believes a need exists to have more comprehensive and accurate information so this issue can be more successfully addressed.

Sec. 404. Transfer of funds to Secretary of Health and Human Services for Graduate Psychology Education program.

Section 404 would mandate the transfer of $5,000,000 from VHA accounts to the Secretary of Health and Human Services for the Graduate Psychology Education program.

Background. The Graduate Psychology Education program was established under section 755(b)(1)(J) of the Public Health Services Act. This program is the only federal program solely dedicated to training post-doctoral psychologists.

Recent studies have projected continuing high demand for psychological treatment of PTSD, TBI, and other combat-related stress disorders. Reports issued by GAO, the Department of Defense Mental Health Task Force, the Presidential Task Force on Returning Global War on Terror Heroes, IOM, and the President's Commission on Care For America's Returning Wounded Warriors, have identified shortages of trained mental health providers, detailed problems in the training pipeline, and provided recommendations concerning the workforce needed to deal with what is projected to be an increased demand for mental health care among servicemembers and veterans.

VA faces immediate challenges in recruiting mental health professionals with focused specialty training in combat-related stress disorders and post deployment readjustment. Establishing a collaborative VA-HHS training pipeline should help ensure a steady flow of specially-trained psychologists to serve the veteran population. Graduates of these training programs will continue to practice their specialty and will also be candidates for hire by VA or civilian practices that serve veteran patient populations. Many of the positions may be in rural communities where veterans, especially those from National Guard and Reserve units, often return to find VA facilities distant or community-based outpatient clinics lacking mental health professionals.

Committee Bill. Section 404 of the Committee bill would, in a freestanding provision, mandate the transfer of funds from VA to the Department of Health and Human Services (HHS) for the Graduate Psychology Education program and delineate the use of the funds and the preferences for VA health care facilities.

Subsection (a) of section 404 would require VA, no later than the September 30, 2009, to transfer $5,000,000 from accounts of VHA to HHS for the Graduate Psychology Education program.

Subsection (b) of section 404 would specify that the funds transferred by VA to HHS be used to make grants that would support the training of psychologists in the treatment of PTSD, TBI, and other combat-related psychological disorders.

Subsection (c) of section 404 would establish a preference in the awarding of grants under this provision to VA health care facilities and to graduate educational programs affiliated with VA facilities.

The Committee intends for the grantee training programs receiving support through this effort to be involved with VA clinicians and facilities as training sites, thus ensuring that the substantial services provided in the course of training will go to veterans. Ensuring an adequate supply of well-trained psychologists—specializing in combat stress disorders—is in the strong interest of the Nation, VA, and individual veterans.

TITLE V—HOMELESS VETERANS

Veterans remain one of the more disproportionately represented groups among the overall homeless population. It has been estimated that one in every three homeless persons is a veteran. Carl Blake, National Legislative Director, Paralyzed Veterans of America, testified before the Committee on May 21, 2008, that "[w]hile estimates vary, it is believed that as many as 250,000 veterans are on the street in any given night. This fact seems incomprehensible in light of the sacrifices that these men and women have made."

VA administers a number of programs aimed at combating and preventing homelessness among veterans. These programs include the provision of residential domiciliary-based care (including mental health care and substance-use disorder treatment), a grant and per diem program to assist community-based entities that serve homeless veterans, employment and job training assistance, and supported permanent housing.

The Committee has been at the forefront of the issue and has worked cooperatively with VA to expand and enhance its authority to serve this unique population. Title V of the Committee bill includes a number of provisions, some from VA, some suggested by advocates, some from legislation, all of which are designed to enhance and improve VA efforts to address the overall problem and to provide assistance to homeless veterans

Sec. 501. Pilot program on financial support for entities that coordinate the provision of supportive services to formerly homeless veterans residing on certain military property.

Section 501 of the Committee bill, which is derived from S. 2273, would authorize the Secretary to create and implement a pilot program to carry out, and evaluate the impact of, providing grants to certain organizations that will assist formerly homeless veterans living on certain government property.

Background. The National Coalition for Homeless Veterans (NCHV), in testimony before the Committee on May 21, 2008, cited VA's 2006 Community Homelessness Assessment and Local Education Networking Groups report, "The lack of affordable permanent housing is cited as the No. 1 unmet need of America's vet-

erans." This need is listed as the second highest unmet need in the 2007 report.

Currently, veterans can utilize services from organizations that are sponsored by the Homeless Grant and Per Diem (GPD) program, but organizations sponsored by this program can only provide services to a veteran for up to two years. Domiciliary Care for Homeless Veterans provides treatment and rehabilitation to homeless veterans, but the average length of stay is only four months. VA's Compensated Work Therapy/Transitional Residence program provides both a residence and employment in conjunction with work-skills training and other rehabilitation. The average stay in this program is only 174 days. VA's Supported Housing program allows VA staff to assist in locating permanent housing for veterans, but does not provide any funding or vouchers to allow VA to provide that housing.

A new VA pilot program provides loan guarantees for transitional family housing, but not permanent long-term housing. All of these programs are beneficial steps, but many veterans are still not ready for transition to independent living at the end of these programs. NCHV points out that despite these programs, "many formerly homeless veterans still cannot afford fair market rents, nor will most of them qualify for mortgages even with the VA home loan guarantee. They are, essentially, still at risk of homelessness." Dr. Gerald M. Cross, MD, Principal Deputy Under Secretary for Health at VA, testified at the Committee's May 21, 2008, hearing that military facilities that have been recently closed or had a major mission change could potentially be prime locations to house already homeless veterans or those in danger of becoming homeless.

Committee Bill. Section 501 of the Committee bill would authorize the Secretary, subject to the availability of appropriations, to carry out, and evaluate the impact of, a pilot program which would provide grants to entities that coordinate the provision of supportive services for very low income (as defined in the Resident Characteristics Report of the Department of Housing and Urban Development), formerly homeless veterans living on property that had been a military installation closed as part of the 2005 round of defense base closure and realignment under the Defense Base Closure and Realignment Act of 1990, or under subchapter III of chapter 5 of title 40, U.S.C., and which the Secretary of Defense determines, after reviewing any local authority's redevelopment plans for the property, that the property can be used to assist the homeless in accordance with any such redevelopment plan.

The program would be carried out through the provision of grants from the Secretary to public and nonprofit organizations, including faith-based organizations. The Secretary would be authorized to issue grants at not more than ten properties that had been military installations that were closed as described above. The Secretary would be required to determine and publish criteria for awarding the grants. This pilot program would span a period of five years from the program's beginning. In order to carry out this program, $3,000,000 from General Operating Expenses would be authorized for the program in each fiscal year from 2009 to 2013.

The Committee agrees with VA's position that military facilities that have been recently closed or have had a major mission change

could serve as excellent locations to house homeless veterans, or those in danger of becoming homeless. In developing economic revitalization and community development plans, local authorities could utilize grants under the program that would be established by this provision so as to aid in financing the conversion of such properties. The Committee believes that veterans with certain applicable skills—including but not limited to such occupations as carpentry, plumbing, and landscaping—could be employed in the property conversion process, or in other aspects of a community's redevelopment plan, a process that could further aid very low-income veterans. It is the Committee's belief that this combination of available housing and employment under local revitalization plans or in areas of the local economy could enable participating veterans to become self supporting.

Sec. 502. Pilot program on financial support of entities that coordinate the provision of supportive services to formerly homeless veterans residing in permanent housing.

Section 502 of the Committee bill, which is derived from S. 2273, would authorize the Secretary to implement a pilot program to carry out, and evaluate the impact of, providing grants to certain organizations for the coordination of efforts to provide supportive services from the local community to very low income, formerly homeless veterans.

Background. Currently, there are a number of community-based and/or non-profit organizations that can and do provide a variety of services to assist formerly homeless veterans with their reintegration into society. These groups, coupled with VA's current efforts to provide supportive services, seek to prevent homelessness from recurring, which is consistent with the overall direction of efforts against homelessness. The focus among both VA providers and community groups is shifting to prevention rather than reaction to homelessness occurring. This is done largely through intensive case management and collaboration with VSOs to find permanent housing for these veterans.

Committee Bill. Section 502 of the Committee bill would authorize the Secretary, subject to the availability of appropriations, to carry out, and evaluate the impact of, a pilot program which would provide grants to nonprofit and public organizations, including faith-based organizations, to coordinate providing supportive services from the local community to very low income (as defined in the Resident Characteristics Report from the Department of Housing and Urban Development), formerly homeless veterans who are residing in permanent housing. The Secretary would be authorized to award grants at up to ten locations. Locations that would qualify for grants would include any property in the United States that provides permanent housing to formerly homeless veterans. Criteria for receiving grants would be developed and published by the Secretary. This program would be conducted over a five year period, beginning at the start of the pilot program. In order to carry out this program, $3,000,000 from General Operating Expenses would be authorized for the program in each fiscal year from 2009 to 2013.

This effort, in ten communities across the nation, would further assist veterans in reintegrating into the community and becoming

self sufficient. The Committee expects that the ten locations selected for the pilot program under section 502 of the Committee bill will all be different from the locations selected for the pilot program under section 501, described above.

Joseph L. Wilson, Deputy Director of the Veterans Affairs and Rehabilitation Commission of The American Legion, described the need for the type of pilot program authorize in this section of the Committee bill and in the prior section, in his May 21, 2008, testimony before the Committee, saying "[w]hile permanent housing provides a stable base for veterans and their families the need for resources to improve their way of life is just as important * * *. These funded pilot programs will extend more opportunities for formerly homeless veterans, which in turn allow them to achieve and maintain a quality existence, deserving of their service to our country."

Sec. 503. Pilot program on financial support of entities that provide outreach to inform certain veterans about pension benefits.

Section 503 of the Committee bill, which is derived from S. 2273, would authorize the Secretary to implement a pilot program to carry out, and evaluate the impact of, providing grants to certain organizations to inform certain veterans and their spouses about VA pension benefits.

Background. A recent study, (Greg Greenberg, Joyce H. Chen, Robert A. Rosenheck, Wesley J. Kasprow. "Receipt of Disability through an Outreach Program for Homeless Veterans." Military Medicine 172, no. 5 (May 1, 2007): 461–5.), has concluded that there is an acute need for outreach to low-income and elderly veterans, and their spouses, to inform them of their potential eligibility for need-based pension benefits from VA. Some of these veterans and their spouses live in areas that are far from VA facilities, and hence are underserved in outreach from VA.

Pension benefits are given by VA to wartime veterans who have limited income, and are either 65 years of age, or older, or who are permanently and totally disabled.

Committee Bill. Section 503 of the Committee bill would authorize the Secretary to carry out, and evaluate the impact of, a pilot program which would provide grants to nonprofit or public organizations, including faith-based organizations, to provide outreach and information to low-income and elderly veterans and their spouses, who live in rural areas, of benefits and services they may qualify for under chapter 15 of title 38, U.S.C., the chapter relating to VA's needs-based pension program. The Secretary would develop criteria for awarding the grants, and publish them in the Federal Register. This program would span a period of five years from the date of its inception. In order to carry out this program, $1,275,000 from General Operating Expenses would be authorized for the program in each fiscal year from 2009 to 2013.

The Committee believes that utilizing local organizations and their existing networks would be an effective way of disseminating key information to veterans and their spouses about the VA pension program.

Sec. 504. Pilot program on financial support of entities that provide transportation assistance, child care assistance, and clothing assistance to veterans entitled to a rehabilitation program.

Section 504 of the Committee bill, which is derived from S. 2273, would authorize the Secretary to carry out a pilot program that would involve providing financial assistance to certain veterans who are eligible for rehabilitation programs under chapter 31 of title 38, U.S.C.

Background. VA found that subsistence allowances provided under chapter 31 of title 38, U.S.C., the chapter which sets forth VA's Vocational Rehabilitation Program, were insufficient for veterans to support themselves or their families while utilizing the vocational rehabilitation services provided therein. Clothing, transportation, and child care needs were specifically cited by VA as being major areas of concern for those participating in the program.

Committee Bill. Section 504 of the Committee bill would authorize the Secretary, subject to appropriations, to carry out a pilot program to examine the feasibility and advisable of providing financial assistance to eligible entities in order that those entities could establish new, or expand upon existing, programs to provide assistance to transitioning individuals who are eligible for rehabilitation programs under chapter 31 of title 38, U.S.C.

The assistance that would be provided by eligible entities under the pilot program would include: (1) transportation assistance, including providing or paying for transportation or other transportation related expenses (such as orientation to using the transportation); (2) child care assistance to enable participation in rehabilitation programs, including providing or paying for child care; and (3) clothing assistance, including help in finding suitable work clothing and providing a clothing purchase allowance.

An eligible individual under this section of the Committee bill would include a person described in section 3102 of title 38, or someone who was separated or released from active duty in the Armed Forces on or after October 1, 2006, because of a service-connected disability. A qualified individual under section 3102 would be a person who is a veteran: with a 20 percent or greater service-connected disability, incurred or aggravated after September 16, 1940; receiving medical care, from a Government facility or at Government direction, for a service-connected disability, that will likely be rated at or above 20 percent, while awaiting discharge from active duty; the Secretary believes is in need of rehabilitation because of an employment handicap; or a veteran, with a service-connected disability of 10 percent or greater, incurred or aggravated on or after September 16, 1940, and who also, in the determination of the Secretary, suffers from a serious employment handicap. Grant criteria would be established and published by the Secretary, but would have to include the kinds of projects for which grants are available, the number of projects for which grants are available, and provisions to ensure projects do not duplicate existing services. Grants would not be permitted for paying the operating costs of the receiving entities.

Eligible entities under this section of the Committee bill would include public and nonprofit organizations, including faith-based organizations which (1) have the capacity to effectively administer

a grant from the Secretary; (2) demonstrate the availability of sufficient financial resources for the establishment or expansion of programs; and (3) agree to and have the capacity to meet the pilot program's criteria as promulgated by the Secretary. Grant recipients would be selected by the Secretary based upon an organization's submission of an application which would be required to contain: (1) the amount sought; (2) plans, specifications, and the schedule for implementing the organization's program; and (3) an agreement to provide the services at accessible locations, maintain confidentiality of the records of individuals participating in the program, and establish fiscal control and accounting procedures to ensure proper disbursement and accounting.

If a grant or part of a grant under this program were unused, or if the organization does not establish a program to provide services, or ceases the program for which they were awarded a grant, the U.S. would be authorized to recover any unused amounts of awarded grants and the Secretary would be authorized to obligate any amount so recovered, without fiscal year limitation, in order to continue the pilot program. No amount could be recovered until three years from the date on which the grant was awarded. Authority for the pilot program would end three years after the date of the program's inception. Five million dollars would be allotted in each fiscal year from 2008–2010 to implement the pilot program.

It is the Committee's hope that, by increasing the benefits available to veterans under going rehabilitation, and providing this aid early, it is more likely that the veteran will successfully complete vocational rehabilitation, which could have a substantial effect on the unemployment rate among veterans, specifically disabled veterans.

Sec. 505. Assessment of pilot programs.

Section 505 of the Committee bill, which is derived from S. 2273, would require the Secretary to submit a report to Congress on each of the pilot programs detailed in sections 501–504 of the Committee bill at least one year before the end of each program's authorization. Each report would be required to contain the lessons learned by the Secretary which can be applied to other similar programs, any recommendations from the Secretary as to whether to continue the pilot program, the number of veterans and dependents served by the pilot program, an assessment of the quality of service provided by the program, the amount of funds provided to grant recipients under the program, and the names of all organizations that have received grants.

Sec. 506. Increased authorization of appropriations for comprehensive service programs.

Section 506 of the Committee bill, would increase the amount authorized for comprehensive service programs for homeless veterans, under subchapter II of chapter 20, title 38, U.S.C., from $130,000,000 annually to $200,000,000 annually. The programs referred to in this section are the GPD programs. Under this program, VA can provide grant funds to assist in the construction or renovation of a community-based, non-profit facility for the purposes of housing and providing services to homeless veterans.

These facilities' programs may also be eligible for per diem funds from VA to offset the cost of care, for each veteran they serve.

These programs have been largely successful and as such, the Committee believes that the threshold for total authorization should be increased to allow more resources to be directed to this program. The Senate Appropriations Committee included $200,000,000 for the GPD Program in the Military Construction-Department of Veterans Affairs Appropriations Bill for Fiscal Year 2009 that was reported out of Committee on July XX, 2008, subject to the passage of a corresponding increase in the authorization level.

TITLE VI—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

Title VI of the Committee bill includes a number of provisions that would amend subchapter IV of chapter 73 relating to nonprofit research and education corporations (NPCs).

NPCs were first authorized in 1988 in Public Law 100–322. Prior to 1988, it was difficult for VA to accept private or non-VA public funding for its research program. The methods in place, such as the General Post Fund, were not well-suited to this task. The General Post Fund was primarily designed to accept and administer veterans' bequests, the regulations of which made it difficult to flexibly disburse funds. Additionally, university partners who could administer funds for VA frequently had high overhead costs, reducing the amount of funding available for actual research. NPCs were designed to be a mechanism that could flexibly administer such funds, be regulated and overseen by the Federal Government, and remain affiliated with, but not part of, VA.

While NPCs were originally designed to support only VA research, Congress has since expanded their role to include support of education and training. Since that initial authority was provided, the number of NPCs that have been established has ranged from 96 to 84, with prior year revenues totaling more than $240,000,000 reported in June 2008. NPCs play a central role in VA research, making up 18 percent of VA's total research funding. Through NPCs, VA researchers access funding from, and collaborate with, DOD and the National Institutes of Health of HHS. NPCs also give VA researchers access to research support from foundations, corporations, and private organizations.

NPCs were originally intended to support the research programs of individual medical centers. This facility-specific approach effectively supports individual programs, and NPCs are essential components of many facilities' research efforts. However, in the twenty years since the inception of NPCs, the character of VA research has changed and the standards applied to nonprofit corporation governance and management have become more rigorous. Some facility research programs may simply be too small to generate a revenue stream sufficient to support the infrastructure and governance necessary to meet these standards, but the facilities would nonetheless benefit from having ready access to the benefits NPCs provide.

In general, the provisions of Title VI of the Committee bill would alter the existing law to allow for multi-medical center non-profit research corporations. Traditional NPCs are chartered in the state in which they are physically located and affiliated with one VA facility. In order to combine resources, NPCs affiliated with nearby

medical centers, possibly in different states, need the ability to form higher-revenue corporations, known as multi-medical center research corporations, without unduly imposing on the VA a requirement for multiple personnel from multiple facilities to serve on an NPC board of directors.

The Committee bill would grant authority to the Secretary to establish multi-medical center research corporations, to approve the conversion of single-facility NPCs to multi-medical center research corporations. It also details the composition of the board of directors for such corporations. The bill also would make permanent the authority of the Secretary to establish NPCs, clarify the powers of such corporations to allow them to more flexibly disburse their funds, and clarify the purposes of NPCs to remove ambiguity about their role in supporting education and training. Finally, this title would improve the oversight of NPCs, and make a clerical amendment.

Sec. 601. General authorities on establishment of corporations.

Section 601 of the Committee bill, which is derived from S. 2926, would expand authorizations for the establishment of NPCs, and clarify the definition and purpose of such corporations.

Background. Current law relating to the authority to establish NPCs, section 7361 of title 38, U.S.C., allows NPCs to be established at one VA medical center, and in one state. As discussed above, NPCs were originally intended to support the research programs of individual medical centers but that model is no longer optimal. Current law requires that NPCs be tax exempt organizations but does not specify the specific terms of that status, which has led to some confusion about the tax and regulatory status of NPCs in some states and among some stakeholders.

Committee Bill. Section 601 of the Committee bill would amend section 7361 of title 38 in a number of ways, with the principal focus on authorizing the creation of multi-medical center research corporations.

Subsection (a)(1) of section 601 would amend section 7361 so as to insert a new subsection (b) that would expressly authorize the establishment of "multi-medical center research corporations." The board of directors of a multi-medical center research corporation would have to include the director of each VA medical center involved in the corporation. A multi-medical center research corporation would be authorized to manage finances relating to research or education, or both, performed at the VA medical centers involved.

Additionally, single-facility NPCs and multi-medical center research corporations would retain unchanged their current ability to administer funds for research programs conducted at multiple facilities, regardless of whether those facilities are served by a multi-medical center research corporation. NPCs could also serve as pass-through entities for programs performed at multiple facilities.

Subsection (a)(2) of section 601 would add a new subsection (f) to section 7361 that would authorize an existing NPC to become a multi-medical center research corporation if its board of directors approves such an expansion and it is also approved by the Secretary. Ms. Donna McCartney, Chair of the National Association of Veterans' Research and Education Foundations (NAVREF) and Ex-

ecutive Director of the Palo Alto Institute for Research and Education, testified before the Committee on May 21, 2008, that this provision is necessary because:

> "* * * it will allow interested VA facilities with small research programs to join with larger ones. Or several smaller facilities may pool their resources to support management of one NPC with funds and staffing adequate to ensure an appropriate level of internal controls, including segregation of financial duties."

Subsection (b) of section 601 would further amend section 7361 by adding a new subsection (c) which would consist of the provisions of current section 7365, relating to the applicability of State law to NPCs, modified so as to specify that multi-medical center corporations operating in different states would be created under and subject to the laws of one of the States in which the corporation operates.

Subsection (c) of section 601 would further amend section 7361 by recasting as a new subsection (d)(1) a provision in subsection (a) of current section 7361 relating to the obligation of NPCs to comply only with those Federal laws, regulations, and executive orders and directives that apply to private non-profit corporations generally and by adding a new paragraph (2) to subsection (d) which would expressly provide that NPCs are not owned or controlled by, or are not an agency or instrumentality of, the United States.

Subsection (d) of section 601 would further amend section 7361 by restoring the requirement that all NPCs must operate as 501(c)(3) tax exempt organizations. This amendment is designed to eliminate confusion in some states and among some stakeholders over the tax status of NPCs. In testimony, for the record of the Committee's May 21, 2008, hearing, VA expressed support for section 601 and specifically for permitting the formation of multi-medical center research corporations.

Sec. 602. Clarification of purposes of corporations.

Section 602 of the Committee bill, which is derived from S. 2926, would clarify the purpose of NPCs to include specific reference to their role as funding mechanisms for approved research and education, in addition to their role in facilitating research and education.

Background. Current law is not specific with respect to the role of NPCs in supporting research and education, and does not include multi-medical center corporations. Further, the statute currently contains provisions that appear to allow NPCs to offer residencies and similar programs, possibly in conflict with the prohibition against nonprofit corporations conferring personal benefits on individuals.

Committee Bill. Section 602 of the Committee bill would amend section 7362 of title 38, U.S.C., in a number of ways, with the principal focus on providing that, in addition to supporting the conduct and administration of VA research projects and education activities, NPCs may support functions more generally related to VA research and education.

Subsection (a) of section 602 would amend subsection (a) of section 7362 so as to clarify that NPCs are intended to provide "a

flexible funding mechanism" for both the conduct of approved research and education at one or more VA medical centers and to fund "functions" relating to research and education. These functions would include, but not be limited to: travel to scientific conferences; recruitment of clinician investigators; improvements in laboratories; procurement of general use research equipment, and support for the institutional review board; the animal laboratory and the facility human protections program. Under current law, support for such functions often cannot be tied to specific research projects and, as such, may not be permitted.

Ms. McCartney's testimony noted that there have been differences in interpretation regarding the permissibility of NPC expenditures supporting VA research and education generally, instead of being tied directly to an approved project. This section of the Committee bill would clarify that issue.

Subsection (b) of section 602 would amend subsection (b) of section 7362 so as to make a technical modification to a defined term relating to education and training.

Subsection (c) of section 602 would further amend subsection (b) of section 7362 so as to strike a provision that allows NPCs to include, under the education function of a corporation, the employment of individuals as part of a residency or similar program. By removing this language relating to residencies and similar programs, it is not the Committee's intent that this change diminish the authority of NPCs to support elements of education and training activities for VA trainees, such as VA residents, but simply to clarify that NPCs cannot be chief sponsors of residencies, as they are neither hospitals nor academic institutions and that function may conflict with regulations governing 501(c)(3) organizations. NPCs would still be able to support education and training activities for VA trainees, and, for purposes of this section, employees of the VHA include VA trainees.

Subsection (d) of section 602 would further amend subsection (b) of section 7362 so as to clarify that NPCs are authorized to provide education and training to patients as well as families of patients. The Committee recognizes that patients' families often play a central role in the care and recovery of veteran patients. As such, education for family members directly supports the care and recovery of these veterans. The return of wounded service members from Iraq and Afghanistan, many with severe TBI or debilitating multiple traumas, is placing growing demands on family caregivers. Clarifying that NPCs can provide such education would be an important form of support for family caregivers.

Sec. 603. Modification of requirements for boards of directors of corporations.

Section 603 of the Committee bill, which is derived from S. 2926, would address the requirements for the composition of NPC boards of directors.

Background. Under current section 7363, certain non-VA personnel who serve on the board of an NPC must be familiar with issues involving medical and scientific research or education. This limits the composition of boards of directors, and prevents potential board members from serving who may have valuable business, legal, or financial expertise.

In addition, subsection (c) of section 7363 requires that members of NPC boards have no "financial relationship" with any entity that is a source of funding for VA, with the exception of governmental and non-profit entities. This phrase has been interpreted by VA as an absolute prohibition on any financial relationship on the part of a board member with a precluded entity, either in the past or present. That prohibition was included in the original NPC authorizing legislation, Public Law 100–322, in 1988. Subsequently, the Office of Government Ethics (OGE) promulgated government-wide conflict of interest regulations in 5 CFR (Code of Federal Regulations) Part 2635, and the waiver regulations required by section 208 of title 18, U.S.C., in 5 CFR Part 2640 in August 1992, and December 1996, respectively. In light of those actions by OGE, the requirements placed on NPC board members have become more onerous than those applied to many government and non-profit employees.

Further, the financial conflict of interest requirements of current subsection (c) of section 7363(c) go beyond the requirements in paragraph (1) of subsection (c) of section 7366, which state that NPC board members "shall be subject to Federal laws and regulations applicable to Federal employees with respect to conflicts of interest in the performance of official functions." Under that paragraph, NPC board members are governed by the statutory criminal code, section 208 of title 18, U.S.C., and conflict of interest regulations, 5 CFR §§ 2635.401–2635.403. Those regulations, in addition to guidance from the Internal Revenue Service and the Office of Government Ethics, provide for the permissibility of de minimus affiliations, and for the ability to recuse oneself when necessary to avoid conflicts of interest.

Committee Bill. The Committee bill would amend section 7363 of title 38, U.S.C., in a number of ways so as to describe membership in boards of multi-medical center research corporations, allow non-VA individuals with diverse backgrounds to serve on NPC boards, and to modify the provisions relating to conflicts of interest.

Subsection (a) of section 603 would amend paragraph (1) of subsection (a) of section 7363 so as to restructure the current law without changing the intent or effect except to provide that the directors of each medical center affiliated with a multi-medical center research corporation are to be members of that corporation's board of directors.

Subsection (b) of section 603 would amend paragraph (2) of subsection (a) of section 7363 so as to require that not less than two non-VA personnel be members of the board, and, in addition to those with medical or scientific expertise, would permit individuals to be on an NPC board who have backgrounds or business, legal, or financial expertise that would benefit a board.

Ms. McCartney testified that this provision of the Committee bill would substantially aid NPCs in acquiring the expertise needed to efficiently run research corporations, including legal and financial management expertise.

Subsection (c) of section 603 would amend subsection (c) of section 7363 so as to eliminate the requirement in current law that members of NPC boards have no financial relationship with any entity that is a source of funding for research or education by VA, with the exception of governmental and non-profit entities. By

eliminating the restrictions in current law, this section of the Committee bill would bring NPCs into conformity with other 501(c)(3) entities and Federal conflict of interest regulations.

Ms. McCartney emphasized the importance of this change and the Committee concurs with her view that there is no reason to hold board members of NPCs to a higher standard than what applies to similar organizations or to government employees.

Sec. 604. Clarification of powers of corporations.

Section 604 of the Committee bill, which is derived from S. 2926, would restate NPCs' authorities so as to clarify that they may accept, administer, and transfer funds for various purposes.

Background. Section 7364 of title 38, U.S.C., entitled "General powers," sets forth the core authorities of NPCs. Over the years, the incompleteness and imprecision of some of these provisions have created obstacles to the conduct of NPC business. In addition, current law is unclear and potentially contradictory on some financial and personnel issues.

Current section 7364 does not fully address the financial authorities necessary to NPCs. While the provision specifies that NPCs may accept gifts and grants, it does not mention other sources of funding common to NPCs, such as fees, reimbursements, and bequests. In some situations, VA has interpreted existing law to mean that NPCs may only accept the types of income explicitly specified in current section 7364. In addition, the authority of NPCs to utilize funds is poorly defined, as it leaves out the administration, retention, and spending of such funds.

Under current law, NPCs do not have the authority to charge non-VA attendees fees for educational or training programs nor do they have authority to retain such fees. While NPCs are tasked with facilitating education and training, and to accept funds in support of such activities, section 8154 of title 38 provides that only the Secretary has authority to conduct VA educational programs, and to charge non-VA attendees fees for such programs. That provision also specifies that the fees collected be credited to the applicable VA medical appropriation. As a result, even when non-VA attendees are willing to pay fees to contribute to the costs of educational or training events, NPCs do not have explicit authority to charge or retain such funds, a result which presents a significant obstacle to the conduct of such events.

Cooperative Research and Development Agreements (CRADAs) are agreements mandated by VA to establish the terms and conditions for certain industry-sponsored studies performed at VA medical centers and administered by NPCs. Each CRADA must be reviewed and approved by a VA attorney. Although NPCs generally handle the preliminary negotiations relating to the development of CRADAs, VA attorney review is often extensive, and can take a number of hours, incurring significant costs. While NPCs frequently have funds available to reimburse the Office of General Counsel (OGC) for these costs, OGC does not have authority to accept or retain reimbursement for its services.

Current section 7364 does not specifically address the transfer of funds between VA and NPCs for costs associated with personnel assignments under the Intergovernmental Personnel Act (IPA), under subchapter VI of chapter 33 of title 5, U.S.C. IPA assign-

ments between VA medical centers and NPCs have been common since the inception of NPCs. The assignment of NPC employees to VA has proven to be of significant benefit to VA research. In a May 2008 report titled, "Audit of Veterans Health Administration's Oversight of Nonprofit Research and Education Corporations," the VA OIG found that under current law, reimbursements from VA to NPCs, pursuant to the IPA, constitute transfers of funds appropriated to VA prohibited by subsection 7362(a) of title 38. This finding jeopardizes an important element of the partnership between VA and NPCs.

Current section 7364 authorizes NPCs to spend funds only on research projects that have been approved by the VA facility Research and Development Committee. Requiring approval prior to any expenditure of funds unduly hinders operations and planning necessary to the application or preparation for research projects, such as the costs of hiring a grant writer or study coordinator to prepare a grant proposal.

Committee Bill. Section 604 of the Committee bill would amend section 7364 of title 38, U.S.C., by striking the current sections (a) through (c) and inserting new subsections (a) through (e) which, collectively, would set forth the general powers of NPCs and clarify the relationship between VA and NPCs.

Proposed paragraph (1)(A) of new subsection (a) of section 7364 would allow NPCs to accept, administer, retain, and spend funds derived from gifts, contributions, grants, fees, reimbursements, and bequests from individuals and public and private entities. New paragraph (1)(B) would authorize NPCs to enter into contracts and agreements with individuals and public and private entities. These changes make explicit the financial authorities of NPCs, which the Committee views as consistent with the intent of the original authorizing legislation.

Proposed new paragraph (1)(C) of new subsection (a) would authorize NPCs to charge registration fees for education and training programs they administer, and to retain such funds.

Proposed paragraph (2) subsection (a) would prohibit the use of funds appropriated to VA to pay fees charged by NPCs. Taken together, these provisions would enable NPCs, and the research programs served by NPCs, to gain financial support for their educational and training programs.

Proposed paragraph (1)(D) of new subsection (a) would authorize NPCs to reimburse OGC for certain expenses of providing legal services attributable to NPC research and education agreements. With financial assistance from NPCs, OGC would be better able to staff Regional Counsel offices and the VA Central Office so as to meet the demand to review the growing number of CRADAs. Proposed new paragraph (3) of subsection (a) would further mandate that funds reimbursed to OGC by NPCs are to be used only for staff and training, and related travel, for the provision of legal services related to review of research agreements such as CRADAs.

Proposed paragraph (1)(E) of new subsection (a) is a renumbering of the text of subsection (a)(2) of current section 7364.

Proposed paragraph (1) of new subsection (b) is a renumbering of the text of the second sentence of subsection (a) of current section 7362. The language would be moved to new section 7364 in

order to group it with other provisions addressing NPC funding issues.

Proposed new paragraph (2) of subsection (b) would authorize VA to reimburse an NPC for all or a portion of the pay or benefits, or both, of an NPC employee assigned to VA under the IPA. The Committee believes that this authorization will remove any uncertainty about the appropriateness of using VA-appropriated funds to reimburse NPCs for personnel appointed to VA pursuant to the IPA in the past and going forward.

Proposed new subsection (c) of section 7364 would grant powers to NPCs allowing them to disburse limited funds for essential activities that must be accomplished prior to research project approval. Such activities would include grant proposal writing, development, and review. Currently, NPCs are not permitted to disburse any funds in support of a research program until that program has been approved by VA. The Committee believes that this restriction is impractically rigid, and hinders NPC ability to appropriately prepare for project proposals.

Proposed new subsection (d) of section 7364 would grant powers to NPCs allowing them to disburse limited funds for essential activities that must be accomplished prior to education and training activity approval. Such essential activities would include grant request writing, strategy development, creating presentations and briefings and perhaps even making deposits to reserve meeting space. Currently, NPCs are not permitted to disburse any funds in support of an education activity until that program has been approved. The Committee believes that this restriction is impractically rigid, and hinders NPCs' ability to appropriately prepare for education activities.

Proposed new subsection (e) of section 7364 would permit the USH to establish policies and procedures for the spending of funds by NPCs. These policies and procedures would be required to not only comply with applicable regulations, but also to be designed to facilitate the mission of NPCs as flexible funding mechanisms. Ms. McCartney voiced strong support for these provisions in her testimony before the Committee on May 21, 2008.

Sec. 605. Redesignation of section 7364A of title 38, U.S.C.

Section 605 of the Committee bill, which is derived from S. 2926, would redesignate section 7364A as section 7365, as a conforming amendment to the provision in section (b)(2) of section 601 of the Committee bill, which struck current section 7365 after moving the contents of that section to new subsection (c) of section 7361.

Sec. 606. Improved accountability and oversight of corporations.

Section 606 of the Committee bill, which is derived from S. 2926, would strengthen VA oversight of NPCs.

Background. VA is responsible for oversight of the NPCs, and a number of bodies carry out that duty. The Secretary established the VA Nonprofit Corporation Oversight Board in 2004 to review the activities of VA NPCs for consistency with VA policy and interests. Earlier, in 2003, VHA established the Nonprofit Research and Education Corporation Program Office (NPPO) to provide oversight of NPC activities. The NPPO is responsible for providing oversight and guidance affecting operations and financial management, per-

forming substantive reviews of the annual reports submitted by each NPC, compiling the information for VA's annual submission to Congress, improving accountability, and ensuring deficiencies are corrected. In accordance with the Chief Financial Officers (CFO) Act of 1990 (Public Law 101–576) and a 1994 General Counsel opinion, VHA's CFO also has financial oversight responsibility for NPCs.

The May 2008 OIG report discussed earlier found a number of problems with VA oversight of NPCs. The OIG found that "NPCs did not implement adequate controls to properly manage funds" and that VA failed to adequately implement "effective oversight procedures" or require "minimum control requirements for NPC activities." While the OIG did not find significant problems resulting from ineffective oversight, the report concluded that "VHA cannot be reasonably assured that the NPCs are fully complying with applicable laws or regulations or effectively managing research and education funds."

Committee Bill. Subsection (a) of section 606 of the Committee bill would amend subsection (b) of section 7366 of title 38, U.S.C., so as to require NPCs to include the corporation's most recent IRS Form 990 "Return of Organization Exempt from Income Tax" or equivalent documents, and the applicable schedules, in an NPC's annual report to the Secretary. The information in Form 990 is extensive, and would be valuable to the Secretary in the conduct of thorough oversight.

Subsection (b) of section 606 would amend subsection (c) of section 7366 so as to make the laws and regulations governing conflicts of interest within NPCs conform to laws governing similar entities, and to those governing conflicts of interest among Federal employees, as discussed above under section 603 of the Committee bill.

Subsection (c) of section 606 would amend subsection (d)(3)(c) of section 7366 so as to raise the threshold for reporting identifying information for payees from $35,000 to $50,000. Current law requires the Secretary, in annual reports to Congress, to provide identifying information on every payee paid more than $35,000. The proposed increase would make the statute governing NPC practices consistent with IRS standards for scrutinizing compensation for higher paid employees. The Committee believes that the original intent of this reporting requirement was to scrutinize large payments and compensation of higher paid employees, and that rising salaries over time have simply overtaken the current statute.

Sec. 607. Repeal of sunset.

Section 607 of the Committee bill, which is derived from S. 2926, would repeal the existing sunset on the Secretary's authority to establish NPCs.

Background. Section 7368 of title 38, U.S.C., precludes the establishment of new NPCs after December 31, 2008. VA requested that the authority to establish and administer these corporations be extended.

Committee Bill. Section 607 of the Committee bill would repeal section 7368 of title 38, U.S.C., thereby removing any limitation on the Secretary's authority to establish NPCs. The Committee believes that NPCs make a significant contribution to VA research

and medical capabilities and promote important educational activity. It is the Committee's intent that the Secretary develop approval criteria on the establishment of NPCs. Such criteria should permit the establishment of an NPC only when it would make a substantive contribution to research or education activity or both, and when it is believed that the NPC could generate sufficient revenue to support the necessary management and compliance infrastructure.

TITLE VII—CONSTRUCTION

Sec. 701. Authorization of fiscal year 2009 major medical facility projects.

Section 701 of the Committee bill, which is derived from S. 2797, would authorize the Secretary to conduct four major medical facility projects during fiscal year 2009.

The first of these projects would be the construction of an 80-bed facility in Palo Alto, California, to replace the existing acute psychiatric inpatient facility that is seismically unsafe. This construction project would not exceed $54,000,000.

The second project would be construction of an outpatient clinic in Lee County, FL, which would not exceed $131,800,000 in construction costs. This facility would serve the increasing demand for diagnostic procedures, ambulatory surgery, and specialty care.

The third project would be the construction costs associated with seismic corrections to Building 1 of the VA Medical Center in San Juan, PR, which would not exceed $225,900,000 in renovation costs.

The fourth project would be the construction of a state-of-the-art polytrauma center in San Antonio, TX, which would not exceed $66,000,000 in construction costs.

Sec. 702. Extension of authorization for Department of Veterans Affairs Medical Center, New Orleans, LA, major medical facility construction project already authorized.

Section 702 of the Committee bill, which is derived from S. 2797, would provide an extension in the previously enacted authorization for a replacement VA medical center in New Orleans, LA.

Background. The New Orleans VAMC was severely damaged by flooding from Hurricane Katrina and it was determined that it would be more cost-effective to construct a new hospital rather than try to remediate the mold in, and repair the damage to, the former hospital. A construction project to replace the facility was previously authorized by section 801 of the Veterans Benefits, Health Care, and Information Technology Act of 2006, Public Law 109–461. Under that authorization, the costs of this project were not to exceed $300,000,000.

This project has already been funded by Public Law 109–461. At the time of the initial authorization, the Congress understood that the replacement facility was intended to be co-located with the Louisiana State University (LSU) Health Sciences Center in New Orleans, and it is the Committee's understanding that this is still VA's intent. However, this current extension of the authorization has been requested by VA without regard to whether the project is in fact co-located with the LSU facility.

Committee Bill. Section 702 of the Committee bill would extend, through fiscal year 2009, the authorization for the previously authorized project to allow the renovation of the VA medical center, or the construction of a new facility, in New Orleans, Louisiana. This section would also increase the amount authorized from $300,000,000 to $625,000,000.

Sec. 703. Authorization of fiscal year 2009 major medical facility leases.

Section 703 of the Committee bill, which is derived from S. 2797, would authorize the Secretary to enter into major leases for twelve VA medical facilities, as follows:

- an outpatient clinic in Brandon, FL, for $4,326,000;
- a community-based outpatient clinic (CBOC) in Colorado Springs, CO, for $10,300,000;
- an outpatient clinic in Eugene, OR, for $5,826,000;
- the expansion of an outpatient clinic in Green Bay, WI, for $5,891,000;
- an outpatient clinic in Greenville, SC, for $3,731,000;
- a CBOC in Mansfield, OH, for $2,212,000;
- a satellite outpatient clinic in Mayaguez, PR, for $6,276,000;
- a CBOC in Southeast Phoenix, Mesa, AZ, for $5,106,000;
- interim research space in Palo Alto, CA, for $8,636,000;
- expansion of a CBOC in Savannah, GA, for $3,168,000;
- a CBOC in Northwest Phoenix, Sun City, AZ, for $2,295,000; and
- a primary care annex in Tampa, FL, for $8,652,000.

Sec. 704. Authorization of appropriations.

Section 704 of the Committee bill, which is derived from S. 2797, would authorize appropriations for the total amounts of the projects provided for in sections 701, 702, and 703 of the Committee bill. Those amounts are $477,700,000 for section 701, $625,000,000 for section 702, and $66,419,000 for section 703. Section 704 also enumerates the constraints for spending the funds allotted for sections 701 and 702, specifically that the funding for sections 701 and 702 may only come from funds appropriated for fiscal year 2009 for projects listed under those sections; funds that remain available for Construction, Major Projects for a fiscal year either before or after fiscal year 2009, which are still available for obligation; and funds appropriated for Construction, Major Projects, for fiscal year 2009 or a fiscal year either before or after fiscal year 2009 for a category of activity that is not specific to a project.

Sec. 705. Increase in threshold for major medical facility leases requiring Congressional approval.

Section 705 of the Committee bill, which is derived from S. 2984, would increase the threshold at which a lease for a medical facility is considered "major" and thus requiring Congressional approval.

Background. Section 8104(a)(2) of title 38, U.S.C., requires Congressional authorization for all major medical facility leases prior to appropriation of funds. Public Law 105–368, Section 704, amended subsection 8104(a)(3)(B) to define a major medical facility lease as one whose annual rent is greater than $600,000.

Section 8104(b) of title 38, U.S.C., requires VA to notify and submit a prospectus for all major medical facility leases exceeding the $600,000 threshold.

Committee Bill. Section 705 of the Committee bill would amend section 8104(a)(3)(B) so as to increase to $1,000,000 the threshold at which the lease of a medical facility by VA would be considered a "major medical facility lease" under section 8104 of title 38, U.S.C., and, thus requiring Congressional approval.

It is the Committee's view that this modification simply reflects changes in the market costs and would give VA greater flexibility to commence such projects.

Sec. 706. Conveyance of certain non-Federal land by City of Aurora, CO, to Secretary for construction of veterans medical facility.

Section 706 of the Committee bill, which is derived from S. 3030, directs the Secretary of the Interior to take steps to facilitate the transfer of a parcel of land in Aurora, CO, to VA for use in connection with the construction of a VA medical facility there.

Background. The parcel of land that is proposed for transfer to VA under section 706 of the Committee bill was originally Federal land, belonging to the U.S. Army Garrison Fitzsimons, Adams County, CO, and was ceded to the city of Aurora on May 24, 1999. In 2004, as part of the Capital Asset Realignment for Enhanced Services (CARES) study of VA's infrastructure, then-Secretary Anthony J. Principi submitted to Congress a series of recommendations for closures, consolidations, and new construction. The construction of a new hospital in the Denver, CO, area was part of this new plan, to be carried out in cooperation with DOD and the University of Colorado.

However, due to the skyrocketing costs of the project and the shifting trends in health care delivery from inpatient to outpatient settings, VA conducted another review of needs in the area and drew up a revised plan for the Denver area and VISN 19 that included a large ambulatory clinic in Denver, leasing two floors of inpatient space in a new University of Colorado bed tower, and expansions of outlying clinics within the Network. At this time, there has been no conclusion as to which plan will move forward. Either way, the land transfer must occur in order to give VA the flexibility to commence with whichever project Congress authorizes.

Committee Bill. Section 706 of the Committee bill would require the Secretary of the Interior, within 60 days of enactment of this Act, to allow the city of Aurora, CO, to donate an area of land to the Federal government for the purposes of constructing a VA medical facility.

TITLE VIII—MISCELLANEOUS PROVISIONS

Sec. 801. Expansion of authority for Department of Veterans Affairs police officers.

Section 801 of the Committee bill, which is derived from S. 2984, would expand certain authorities set out in title 38, U.S.C., relating to VA police officers so as to better reflect the current scope of their duties and responsibilities.

Background. When originally enacted, section 902 of title 38, U.S.C., was formulated in a manner that suited a health care sys-

tem that delivered the majority of its services in centralized campus environments. As a result, VA police officers rarely had official business off VA property. Today, however, VA medical facilities now include large campuses, urban hospitals, CBOCs, and storefront Vet Centers. VA's increasingly decentralized delivery points for care necessitate that VA police officers travel frequently among VA facilities and off-campus sites. This includes travel off Department property to conduct administrative portions of investigations, such as interviewing witnesses or crime victims. It also includes travel off-campus to bring about the safe return of high-risk patients who have eloped and are a danger to themselves or others. The responsibilities of VA police officers also extend to responding to emergencies and disasters at the local, regional, and national levels.

Because the jurisdiction of VA police officers is limited by current law to Department property, VA police officers are not able to carry their Department-issued weapons off property when conducting official business or on official travel.

Committee Bill. Subsection (a)(1) of section 801 of the Committee bill would amend section 902(a) of title 38, U.S.C., so as to permit VA police officers to: (1) carry VA-issued weapons, including firearms, while off VA property in an official capacity or while in official travel status; (2) conduct investigations, on and off VA property, of offenses that may have been committed on VA property, consistent with agreements with affected local, state, or Federal law enforcement agencies; (3) carry out, as needed and appropriate, any of the duties described in section 902(a)(1), as revised, when engaged in such duties pursuant to other Federal statutes; and (4) execute any arrest warrant issued by a competent judicial authority.

Subsection (a)(2) of section 801 would further amend section 902 of title 38 to specify that the powers granted to VA police officers be exercised in accordance with guidelines approved by the Secretary and the Attorney General of the United States.

Under current law, a VA officer who observes criminal activity beyond Department property cannot legally respond when a VA patient or provider is the victim. It is the Committee's view that this limitation unduly restricts the ability of VA police to fully carry out their assigned responsibilities. Extending these authorities would be consistent with powers Congress has granted to other Federal law enforcement officers, such as those in the Federal Protective Service, the Department of Homeland Security, Pentagon Force Protection Agency, and the United States Capitol Police.

Sec. 802. Uniform allowance for Department of Veterans Affairs police officers.

Section 802 of the Committee bill, which is derived from S. 2984, would amend title 38, U.S.C., so as to modify the authority of VA to pay an allowance to VA police officers for the purchase of uniforms.

Background. VA employs approximately 2,600 uniformed police officers. VA uniformed police officers are generally paid approximately $40,000 per year. Under current law, which was enacted in 1991, VA may pay no more than $200 per fiscal year, with authority to increase the amount to $400 in one fiscal year. Because there

has been no increase since 1991, VA uniformed police officers have to pay out of their own funds to supplement their initial uniform purchases and maintain their uniforms. The Office of Personnel Management (OPM) has published new regulations to increase the authorized uniform allowance for other, non-VA Federal police officers to $800 for initial and annual purchases.

Committee Bill. Section 802 of the Committee bill would amend section 903(b) of title 38, U.S.C., which governs the uniform allowance for VA police officers, to limit the allowable amount to the lesser of: (1) the amount prescribed by the OPM; or (2) the estimated or actual costs as determined by periodic surveys conducted by VA. The provision would also amend section 903(c) of title 38 to provide that the allowance established under subsection (b) of section 902 of title 38, as modified by the Committee bill, shall be paid at the beginning of an officer's appointment for those appointed on or after October 1, 2008, and for other officers at the request of the officer, subject to the fiscal year limitations established in subsection (b), as modified by the Committee bill.

The Committee believes that in order to compete for good candidates to become VA police officers and to retain those already employed by VA, there is a need to increase the uniform allowance and for VA to ensure that the annual allowance remains at an appropriate level.

Sec. 803. Conditions for treatment of veterans, their surviving spouses, and their children as adjudicated mentally incompetent for certain purposes.

Section 803 of the Committee bill, which is derived from S. 3167, would clarify the conditions under which veterans, their surviving spouses, and their children may be treated as adjudicated mentally incompetent for certain purposes.

Background. The Federal Gun Control Act of 1968 (hereinafter, "GCA") and subsequent amendments established categories of persons who are prohibited from receiving or possessing firearms. Included among the categories is any person who has been "adjudicated as a mental defective or who has been committed to a mental institution." Part 478.11 of title 27, Code of Federal Regulations (CFR), defines the meaning of the phrase "adjudicated as a mental defective" as follows:

> (a) a determination by a court, board, commission, or other lawful authority that a person, as a result of marked subnormal intelligence, or mental illness, incompetency, condition, or disease: (1) is a danger to themselves or others; or (2) lacks the capacity to contract or manage his own affairs.

The regulation was later codified with the enactment of Section 3(2) of Public Law 110–180, the "NICS Improvement Amendments Act of 2007."

The Brady Handgun Violence Prevention Act of 1993 (hereinafter, the "Brady Act") required the Attorney General to establish a system to assist federally licensed gun dealers in determining whether a gun buyer is prohibited under the GCA from purchasing a firearm. The system developed pursuant to the Brady Act, known as the National Instant Criminal Background Check System (here-

inafter, "NICS"), is a computerized database operated by the Federal Bureau of Investigation (FBI) NICS Section. The NICS can be queried by gun dealers to determine whether the name of a prospective buyer is on the list and, therefore, legally prohibited from purchasing a firearm.

The Brady Act also requires Federal agencies to, upon the request of the Attorney General, submit to the NICS information on persons prohibited from purchasing a firearm. The Attorney General made such a request to VA in 1998. Under a memorandum of understanding entered into between the FBI and VA, VA agreed to make available for inclusion on the NICS database information about VA beneficiaries who are determined to be mentally incompetent on account of their inability to contract or manage their own affairs pursuant to part 3.353 of title 38, CFR. Determinations of incompetency under part 3.353 result in an appointment of a fiduciary.

The evidence gathered to support a finding of incompetency under part 3.353 of VA's regulations is used to inform a judgment about whether a beneficiary is capable of managing their VA benefit payments. No evidence is gathered as part of this process to inform a judgment about whether a beneficiary presents a danger to themselves or others, or whether they should be prohibited from purchasing, possessing, or operating a firearm. Furthermore, although beneficiaries are entitled to a hearing once notified that it is proposed they will be determined incompetent, the initial hearing is before VA personnel, not an independent authority.

Since 1998, VA has shared information with NICS on over 116,325 beneficiaries for whom it has appointed a fiduciary, including veterans, surviving spouses, and dependent children of veterans. The total number of cases sent to NICS from all Federal agencies as of April 30, 2008, is 117,280, meaning that VA beneficiaries constitute the overwhelming majority of individuals referred to NICS by the Federal government. This is so despite the fact that other agencies, such as the Social Security Administration, appoint fiduciaries to manage benefit payments for their beneficiaries in a manner similar to VA's process.

U.S. States and territories may also submit information to the NICS about individuals who have been adjudicated mental defective under the GCA. In total, 435,520 names have been submitted as of April 30, 2008, although only eight states are responsible for 99.5 percent of the submissions. California, Virginia, and Michigan alone have sent 87 percent of the total. A quick survey of the process used by some states to submit the names of individuals to the NICS is illustrative of the variation involved. For instance, in Michigan a court must enter an order declaring someone a mental defective or incompetent. In Texas, the NICS process is triggered after a criminal court reports incompetency. California sends information to the NICS on those who have been involuntarily committed to a mental institution, afforded a hearing, and who are held for a 3-day period at a mental institution.

The Committee is concerned that VA's process for sharing beneficiary information with the NICS is not only uniquely targeted within the Federal government, but it also appears to be unique among states who share information with the NICS. Whereas VA uses government employees to, indirectly, make NICS decisions,

many states rely on a judicial authority. Whereas VA's threshold for determining an individual mentally incompetent is whether they can manage their financial affairs, many states rely on a far more stringent standard. The Committee, therefore, proposes to raise the standard within VA while still remaining faithful to the overarching purpose of the NICS which is to keep people who are dangerous to themselves or others from purchasing a firearm.

Committee Bill. Section 803 of the Committee Bill would amend chapter 55 of title 38, U.S.C., by adding a new section to clarify that in any case arising out of VA's administration of benefits under title 38, a veteran, surviving spouse, or child who is mentally incapacitated, deemed mentally incompetent, or experiencing an extended loss of consciousness, shall not be considered adjudicated as a mental defective under the GCA without the order or finding of a judge, magistrate, or other judicial authority of competent jurisdiction that such individual is a danger to him- or herself or others.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee based on information supplied by the CBO, estimates that enactment of the Committee bill would, relative to current law, increase discretionary spending by $7.2 billion over the 2009–2013 period, assuming appropriation of the specified and estimated amounts. The Committee bill could affect direct spending and revenues, but CBO estimates that impact would not be significant. Enactment of the Committee bill would not affect receipts and would not affect the budget of state, local or tribal governments.

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

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, August 11, 2008.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2969, the Veterans Health Care Authorization Act of 2008.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D'Monte.

Sincerely,

PETER R. ORSZAG,
Director.

Enclosure.

S. 2969—Veterans Health Care Authorization Act of 2008

Summary: S. 2969 would make several changes to existing veterans' health care programs and create a number of new health care programs for veterans. The bill also would authorize the Department of Veterans Affairs (VA) to construct or lease several

medical facilities. In total, CBO estimates that implementing the bill would cost $7.2 billion over the 2009–2013 period, assuming appropriation of the specified and estimated amounts. Enacting the bill could affect direct spending and revenues, but CBO estimates that impact would not be significant.

S. 2969 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary impact of S. 2969 is shown in the Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Table 1.—Estimated Budgetary Impact of S. 2969, Veterans Health Care Authorization Act of 2008

	By fiscal year, in millions of dollars—					
	2009	2010	2011	2012	2013	2009–2013
CHANGES IN SPENDING SUBJECT TO APPROPRIATION [a]						
Estimated Authorization Level	1,519	745	1,230	1,730	2,269	7,495
Estimated Outlays	423	1,010	1,538	1,943	2,315	7,231

[a] In addition to the effects on spending subject to appropriation shown in this table, CBO estimates that enacting section 801 of S. 2969 would increase direct spending and revenues by less than $500,000 a year.

Basis of estimate: For this estimate, CBO assumes that the legislation will be enacted near the start of fiscal year 2009, that the authorized and estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for similar programs. (S. 2969 also would authorize the appropriation of $5 million in 2008 for a pilot program providing assistance to veterans eligible for rehabilitation programs; however, those amounts are not included in this cost estimate because CBO assumes that no further appropriations will be provided in 2008 for such programs.)

Spending subject to appropriation

CBO estimates that implementing S. 2969 would cost $7.2 billion over the 2009–2013 period, assuming appropriation of the specified and estimated amounts (see Table 2). Most of the bill's estimated costs stem from provisions that would extend authorities related to providing nursing home care and authorizations of appropriations for medical construction projects.

Extension of Current Authorities. Sections 201, 202, and 203 would extend several authorities for VA to provide health care to certain veterans and to perform certain audits. In total, CBO estimates that implementing those provisions would cost $3.8 billion over the 2009–2013 period, assuming appropriation of the estimated amounts.

Table 2.—Components of Discretionary Spending Under S. 2969

	By fiscal year, in millions of dollars—					
	2009	2010	2011	2012	2013	2009–2013
Extension of Current Authorities						
Estimated Authorization Level	136	355	739	1,157	1,609	3,996
Estimated Outlays	122	333	701	1,115	1,564	3,835
Construction of Medical Facilities						
Estimated Authorization Level	1,159	20	20	20	20	1,239
Estimated Outlays	100	321	378	285	120	1,204

Table 2.—Components of Discretionary Spending Under S. 2969—Continued

	By fiscal year, in millions of dollars—					
	2009	2010	2011	2012	2013	2009–2013
Testing for HIV						
Estimated Authorization Level	43	114	188	265	343	953
Estimated Outlays	38	107	181	257	335	918
Homeless Veterans						
Authorization Level	70	70	70	70	70	350
Estimated Outlays	63	70	70	70	70	343
Pilot Program for Dental Insurance						
Estimated Authorization Level	10	65	85	85	85	330
Estimated Outlays	9	60	83	85	85	322
Education Assistance						
Estimated Authorization Level	28	47	62	68	74	279
Estimated Outlays	25	45	60	67	74	271
Medical Personnel						
Estimated Authorization Level	27	27	28	28	28	139
Estimated Outlays	24	27	27	28	28	134
Pilot Programs						
Estimated Authorization Level	26	21	9	7	7	70
Estimated Outlays	24	22	10	7	7	70
Health Care for Female Veterans						
Estimated Authorization Level	6	12	14	15	15	62
Estimated Outlays	6	11	13	14	15	59
Expanded Eligibility for Vet Centers						
Estimated Authorization Level	6	6	5	4	4	25
Estimated Outlays	5	6	5	4	4	24
Specialized Residential and Rehabilitation Care						
Estimated Authorization Level	2	3	5	6	8	24
Estimated Outlays	2	3	5	6	8	24
Quality Assurance Officers						
Estimated Authorization Level	3	3	3	3	3	15
Estimated Outlays	2	3	3	3	3	14
Uniforms for Police Officers						
Estimated Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Hospice Care						
Estimated Authorization Level	*	*	*	*	*	2
Estimated Outlays	*	*	*	*	*	2
Study on Suicides						
Estimated Authorization Level	1	*	0	0	0	1
Estimated Outlays	1	*	0	0	0	1
Other Provisions						
Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Total Changes						
Estimated Authorization Level	1,519	745	1,230	1,730	2,269	7,495
Estimated Outlays	423	1,010	1,538	1,943	2,315	7,231

Notes: Components may not sum to totals because of rounding; * = less than $500,000.

Nursing Home Care. Section 202(a) would extend, through December 31, 2013, a requirement that VA provide nursing home care to veterans who have a disability rating of 70 percent or greater or those who require such care for a service-connected disability. Under current law, that requirement expires on December 31, 2008.

According to VA, the department spent about $1.2 billion on such care in 2007. VA provided nursing home care to disabled veterans under other permanent authorities before the requirement in current law was enacted, but that care was provided at the discretion of the Secretary of Veterans Affairs. CBO expects that if the requirements of 38 U.S.C. 1710A are not extended, VA would continue to provide care in the near term to most disabled veterans

eligible under that authority, but that VA would gradually revert to providing more limited nursing home care under previously used authorities. Therefore, after adjusting for inflation, CBO estimates that extending this requirement would have initial costs of about $115 million in 2009 growing to $1.5 billion by 2013, assuming appropriation of the estimated amounts.

Noninstitutional Extended Care. Section 201 would make permanent a provision in current law that allows VA to provide noninstitutional extended care to veterans through December 31, 2008. According to VA, the department spent about $45 million on such care in 2007. VA has indicated that it has existing authority under other provisions of current law to provide noninstitutional extended care, but those authorities are limited and would affect VA's ability to provide the current level of services. After adjusting for inflation, CBO estimates that extending this requirement would have initial costs of $5 million in 2009, growing to almost $60 million by 2013, assuming appropriation of the estimated amounts.

Participants in Chemical and Biological Testing. From 1962 to 1973, the Department of Defense (DOD) conducted certain tests to determine the vulnerability of personnel, buildings, and ships to various biological and chemical threats. Veterans who were exposed to agents used in those tests are eligible to receive free health care from VA, though copayments are required for treatment of diseases or injuries that are obviously not related to military service. The authority to provide this benefit expired on December 31, 2007. Section 203 would make this authority permanent.

Based on data from VA that about 300 such veterans received health care in 2007 at an average cost of $5,800, CBO estimates that implementing this section would cost $1 million in 2009 and $9 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

Audits of Medical Services Contracts. Section 202(b) would extend through 2013 a provision in current law that allows VA to perform audits of its contracts to provide medical care and services outside the department. Under current law, the authority will expire on September 30, 2008. Those audits are designed to allow VA to reduce errors and fraud related to payments under the contracts. Any additional collections generated by audits are retained and spent by the department. Based on information from VA regarding recent audits, CBO estimates that extending this authority to conduct audits would have no net budgetary impact, as it would allow VA to collect and spend $9 million a year.

Construction of Medical Facilities. Title VII would authorize funding for constructing, renovating, improving, or leasing several medical facilities by VA. CBO estimates that implementing title VII would cost $1.2 billion over the 2009–2013 period, assuming appropriation of the authorized and estimated amounts.

Section 704 would specifically authorize the appropriation in 2009 of $1.1 billion for five large construction projects and $56 million for leasing 11 clinics or other facilities. Based on information from VA's 2009 budget request for leasing medical facilities, CBO expects that VA would enter into 20-year lease agreements for those facilities. As a result, CBO estimates that in addition to the specified amounts authorized to be appropriated in 2009, VA would

have additional costs of about $20 million a year starting in 2010. (Costs are higher in 2009 than in other years because VA would pay the lessors additional amounts in the first year of the lease for necessary improvements and upgrades.) In addition, section 705 would increase the threshold for major construction projects that require Congressional approval from $600 million to $1 billion.

Testing for Human Immunodeficiency Virus (HIV). Section 217 would eliminate a rule prohibiting VA from conducting widespread testing for HIV infection in the population of veterans who use VA health care facilities. It also would eliminate current requirements for separate written consent for HIV tests and pre- and post-test counseling.

Based on data from VA, CBO estimates that under section 217 the number of HIV tests administered by VA would increase significantly, from the current annual level of about 125,000 tests to 200,000 in 2009 and to 250,000 a year over the 2010–2013 period. Based on studies of veterans enrolled in VA health care, CBO expects that increased testing would lead to an increase in the number of newly diagnosed veterans and that those veterans would be identified earlier in the course of the disease.[1] We expect that people who are tested for HIV at, and receive general care in, VA health care facilities would prefer to maintain continuity of care with VA health care providers, and thus would be treated by VA for HIV disease. Based on data from VA and the Kaiser Family Foundation, CBO estimates that the average cost of treatment in 2009 would be $18,000 per patient in the early stages of HIV infection, and $35,000 per patient in the advanced stages of the disease.

CBO estimates that under the bill, VA would start providing comprehensive HIV treatment to an additional 1,600 newly diagnosed veterans in 2009 at an average cost of $27,000 per person. By 2013, CBO estimates that the number of additional veterans being treated for HIV would grow to about 12,000. Because an increasing proportion of those veterans would be diagnosed in the early stages of the disease when treatment is least expensive, the average cost of treatment, before considering the effects of inflation, would decrease over time. Adjusting for inflation, CBO estimates that implementing section 217 would cost about $920 million over the 2009–2013 period, assuming appropriation of the necessary funds.

Homeless Veterans. Section 506 would authorize additional appropriations of $70 million a year for existing programs to care for homeless veterans. Under current law, VA makes grants and per diem payments to entities that provide outreach, rehabilitation, transitional housing, counseling, training, and other assistance to homeless veterans. CBO estimates that implementing this provision would cost about $345 million over the 2009–2013 period, assuming appropriation of the specified amounts.

Pilot Program for Dental Insurance. Section 223 would require VA to implement a pilot program to provide dental insurance to all enrolled veterans and their survivors and dependents. VA would be

[1] Ronald O. Valdiserri, Fred Rodriguez, and Mark Holodniy, "Frequency of HIV Screening in the Veterans Health Administration: Implications for Early Diagnosis of HIV Infection," AIDS Education and Prevention, vol. 20, no. 3 (2008), pp. 258–264; and Douglas K. Owens and others, "Prevalence of HIV Infection Among Inpatients and Outpatients in Department of Veterans Affairs Health Care Systems: Implications for Screening Programs for HIV," American Journal of Public Health, vol. 97, no. 12 (2007), pp. 2173–2178.

directed to carry out the program in at least two but no more than four Veterans Integrated Services Networks (VISNs; regional networks of medical facilities). CBO estimates that implementing this provision would cost about $320 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

The bill would require VA to contract with a dental insurer who would administer the program. However, the bill would grant VA wide discretion in designing several critical parameters of the pilot program, such as the covered benefits, requirements for enrollment and disenrollment, and premiums. Veterans would be required to pay premiums and copayments. For purposes of this estimate, CBO assumes that the pilot program would be carried out at three VISNs and that the pilot program would be similar to the TRICARE Dental Program, which is available to reservists, their family members, and active-duty servicemembers. CBO expects that VA would experience an initial surge in enrollment as people who may have delayed addressing their dental needs would avail themselves of that opportunity, but that those individuals would disenroll soon after their needs were met.

CBO estimates that the program would begin accepting enrollees around the middle of fiscal year 2009, and based on the participation rates for the TRICARE program, that about 12,000 veterans, survivors, and dependents would join that year. We estimate that enrollment would rise to 78,000 in 2010 and 97,000 in 2011 before stabilizing at a level of about 90,000 a year.

The TRICARE program pays an annual maximum of $1,200 for nonorthodontic services, and many diagnostic and preventive services do not count toward the cap. Based on costs for the TRICARE program and for dental care provided by VA to a limited number of veterans, CBO estimates that in 2009 VA would pay about $800 per enrollee under the pilot program. After adjusting for inflation, CBO estimates that the pilot program would have initial costs of about $10 million in 2009 and that costs would rise to around $60 million by 2010, before stabilizing at $85 million a year thereafter.

Education Assistance. Three separate provisions in section 103 would authorize VA to provide scholarships and assistance with education loans to certain employees. In total, CBO estimates that enacting those provisions would cost about $270 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

Health Professionals Scholarship Program. Section 103(a) would reinstate a scholarship program for health professionals that expired in 1998. The provision would give VA the authority to provide funds to cover tuition, fees, and other costs related to their education. In exchange for financial assistance, recipients would be obligated to work at VA for a specified period of time.

Based on information from VA, CBO estimates that after a six-month period to establish the program, VA would grant about 125 awards in 2009 with an average award of $46,000. In the following years, CBO estimates VA would grant 250 new awards a year. Based on information from VA, CBO expects that scholarships would last an average of two years. After adjusting for an estimated 6 percent annual increase in tuition and other costs, CBO estimates that implementing this provision would cost $6 million in

2009 and $105 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

Debt Reduction. Two other provisions of section 103 would allow VA to assist its employees in repaying their education loans. Subsection (b) would expand the use of VA's Education Debt Reduction Program by increasing the maximum amounts payable over a five-year period from $44,000 to $60,000 and expanding eligibility from those recently appointed to all employees involved in direct patient care. About 6,500 employees currently receive an average annual benefit of $5,800 under this program. Based on information from VA, CBO estimates that 450 additional employees each year would receive an average amount of $8,725 a year for five years and that employees currently eligible (about 6,500) also would receive the higher annual benefit. After adjusting for inflation, CBO estimates that implementing this provision would cost $17 million in 2009 and $132 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

The second provision, subsection 103(c), would allow certain clinical researchers at VA who have disadvantaged backgrounds to use a National Institutes of Health (NIH) program for repayment of education loans. The NIH program provides up to $35,000 in assistance per employee. Based on information from VA, CBO estimates that 100 employees each year would receive an average amount of $30,000 a year over three years. Assuming appropriation of the estimated amounts, CBO estimates that implementing this provision would cost $3 million in 2009 and $35 million over the 2009–2013 period.

Medical Personnel. Section 101 contains several provisions that would affect pay for medical personnel. In total, CBO estimates that implementing those provisions would cost about $135 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

Pay Comparable to Private Sector. Section 101(f) would allow VA to pay additional compensation of up to $100,000 a year to certain employees to match salary levels paid in the private sector. Based on information from VA, CBO estimates that the department would pay an average additional amount of $62,500 a year to about 170 people, at a cost of about $11 million a year.

Overtime Pay. Section 101(m) would loosen certain pay restrictions, thereby allowing nurses, physician assistants, and certain other employees to earn additional pay for evening or weekend work. Under current law, employees can earn additional pay for working evenings or weekends only on their regular tour of duty. The bill would allow such pay for any evening or weekend hours worked, even if those were occasional or ad-hoc. In 2007, such employees worked roughly 1.8 million hours of overtime at an average overtime rate of about $50 an hour. CBO estimates that under current law VA does not pay night or weekend differentials for 75 percent of those hours (1.4 million hours). After adjusting for inflation, CBO estimates that under the bill VA would pay additional night differentials of $5 per hour for about 485,000 hours and weekend differentials of $13 per hour for 385,000 hours, for a total annual costs of about $8 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

Higher Pay for Nurses. Subsections 101(i) and 101(j) would increase the pay caps for registered nurses and certified registered nurse anesthetists. Based on information from VA, CBO estimates that the department would pay an average additional amount of $12,000 a year to about 400 nurses at a cost of about $5 million a year. Subsection (l) would increase the maximum special pay for nurse executives from $25,000 to $100,000. Based on information from VA, CBO estimates that the department would pay an average additional amount of $10,000 to about 135 nurse executives at a cost of about $1 million a year. In total, CBO estimates that implementing those three provisions would increase pay for nurses by $6 million a year.

Incentive Pay for Pharmacist Executives. Section 101(g) would allow VA to pay additional compensation of up to $40,000 a year to pharmacist executives as a recruitment and retention tool. Based on information from VA, CBO estimates that the department would pay an additional $40,000 a year to 40 people at a cost of about $2 million a year.

Increased Pay Scale for Appointees. Section 101(e) would allow VA to pay certain appointees using a higher pay scale. Based on information from VA, CBO estimates that the department would pay an average additional amount of $3,500 to about 70 people, at an annual cost of about $250,000 a year.

Pilot Programs. Several sections of S. 2969 would require VA to carry out pilot programs to provide or pay for health care and related benefits. In total, CBO estimates that enacting those provisions (not including the dental pilot program, which is discussed above) would cost about $70 million over the 2009–2013 period, assuming appropriation of the specified and estimated amounts.

Personal Care Attendants. Section 212 would require VA to implement a pilot program to train and certify family caregivers of veterans and servicemembers with Traumatic Brain Injuries (TBI) to serve as personal care attendants, and to compensate such family members for the care they would provide. The program would operate at three VA facilities for a period of three years. Based on information from VA, CBO expects that the department would use existing contracts with home health agencies to provide training and certification, that roughly 50 family members a year would become family care attendants, and the department would pay them about $45,000 a year. CBO estimates that implementing the pilot would cost $6 million over the 2009–2013 period.

Respite Care. Section 213 would require VA to implement a pilot program to use graduate students from schools affiliated with VA to provide respite care to veterans and servicemembers with TBI. VA has indicated that it would be unable to implement this provision, as it would violate existing agreements for academic affiliations. Therefore, CBO estimates this provision would have no cost.

Transition Assistance. Section 214 would require VA to implement a pilot program to provide grants to community-based organizations and state and local entities that provide assistance to veterans transitioning to civilian life. The program would operate in five locations for a period of two years. VA currently provides such assistance through Vet Centers. Based on information from VA regarding spending on Vet Centers, CBO estimates that imple-

menting that pilot would cost $6 million over the 2009–2013 period.

Caregiver Assistance. Section 222 would extend through 2009, and authorize the appropriation of $5 million for, an existing pilot program to assist caregivers of veterans. The program provides a variety of services such as education and training, transportation, respite care, home care services, adult-day health care (a therapeutically-oriented outpatient program that provides health maintenance and rehabilitative services), and hospice care. CBO estimates that extending that pilot program by one year would cost $5 million over the 2009–2013 period.

Counseling for Female Veterans. Section 305 would require VA to implement a pilot program providing counseling in group retreat settings to female veterans who have recently separated after lengthy deployments, and would authorize the appropriation of $2 million per year for 2009 and 2010 for that purpose. CBO estimates that this pilot program would cost $4 million over the 2009–2013 period.

Child Care. Section 308 would require VA to implement a pilot program providing child care for certain female veterans who use VA medical facilities, and would authorize the appropriation of $1.5 million per year for 2009 and 2010 for that purpose. CBO estimates that this pilot program would cost $3 million over the 2009–2013 period.

Homeless Veterans. Title V would require VA to carry out four separate pilot programs to provide outreach and various services to homeless veterans and would authorize the appropriation of $45 million over the 2009–2013 period for those purposes. CBO estimates that implementing those pilot programs would cost $45 million over the 2009–2013 period.

Health Care for Female Veterans. Title III of the bill would authorize several programs targeted to women veterans. CBO estimates that implementing those provisions would cost about $60 million over the 2009–2013 period, assuming appropriation of the authorized and estimated amounts.

Training for Mental Health Providers. Section 304 would require VA to educate, train, and certify mental health professionals who specialize in treating sexual trauma. VA has indicated that it has ongoing training for such providers through 2009; under the bill, such training would be extended permanently. Based on information from VA's Office of Mental Health Services, CBO estimates that VA would need 40 employees a year to provide training an annual cost of about $8 million a year.

Care for Newborns. Section 309 would allow VA to provide care for up to seven days to the newborn children of female veterans who receive maternity care through the department. Based on data from VA, CBO estimates that about 2,000 babies would become eligible for such care in 2009 at an average cost of $2,650 per baby. After adjusting for inflation and population growth—the number of female veterans of child-bearing age is expected to rise in future years—CBO estimates that implementing this provision would cost $30 million over the 2009–2013 period.

Study on Health Consequences of Service in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF). Section 303 would require VA to contract with an outside entity to conduct

a study on the health consequences facing female OIF/OEF veterans as a result of their service. Based on information from VA, CBO estimates that implementing this provision would cost $1 million over the 2009–2013 period.

Expanded Eligibility for Vet Centers. Section 401 would allow members of the Armed Forces, including reservists, who served in OIF/OEF to receive readjustment counseling and related services through VA's Vet Centers. Vet Centers are community-based counseling centers that provide free mental health services to combat veterans and their families. According to VA data, there are about 232 centers nationwide, and they served roughly 165,000 veterans in 2007. In 2008, Vet Centers received $131 million in appropriated funds.

DOD data on OIF/OEF deployments indicate that roughly 1 million servicemembers are currently or have previously been deployed and are nonveterans. After adjusting for expected separations (OIF/OEF veterans are eligible under current law) and smaller expected deployments starting in 2009, CBO estimates that of those remaining, about a third would seek mental health services. However, DOD indicates that servicemembers are already offered free on- and off-base counseling similar to that provided through Vet Centers. Therefore, CBO estimates that about 14,000 servicemembers (5 percent of those seeking mental health services) would use Vet Centers in 2009 and that the number of users would decline to about 6,000 in 2013. Using a per person cost of $415 in 2009 (about half the expected cost for veterans) and adjusting for annual inflation, CBO estimates that implementing this provision would cost about $24 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

Specialized Residential and Rehabilitation Care. Section 215 would require VA to contract with appropriate entities to provide specialized care to OIF/OEF veterans whose TBI are so severe that they cannot live independently and would otherwise require nursing home care. According to VA, some veterans with TBI but without sufficient family support or financial means to afford private residential care often end up in nursing homes that do not provide appropriate care. Under the bill, VA would place such veterans in specialized programs that would provide appropriate residential and rehabilitation care.

Based on information from VA regarding the number of such veterans and the cost of their care, CBO estimates that in 2009, VA would pay roughly $84,000 for care provided to 20 veterans with TBI. After adjusting for inflation, CBO estimates that over the 2009–2013 period, VA would pay for care provided to about 50 veterans a year at an average annual cost of $5 million, and that implementing this provision would cost $24 million over that period, assuming appropriation of the estimated amounts.

Quality Assurance Officers. Section 210 would require VA to designate board-certified physicians as quality assurance officers in its 135 medical facilities. Under current law, VA has nurses serving in those positions. Based on information from VA, CBO expects that in most facilities the department would be able to re-allocate clinical and administrative duties to designate currently-employed physicians for those roles. However, CBO estimates that about 25 facilities would need to hire physicians at a net additional cost to

the department of $100,000 per person (the cost to replace a nurse with a physician), and that implementing this provision would cost $14 million over the 2009–2013 period, assuming appropriation of the estimated amounts.

Uniforms for Police Officers. Section 802 would double the uniform allowances payable to about 2,600 department police officers from $400 for initial purchases and $200 for recurring purchases to $800 and $400 respectively. CBO estimates that implementing this provision would cost about $1 million a year over the 2009–2013 period, assuming availability of appropriated funds.

Hospice Care. Section 216 would prohibit VA from collecting copayments from veterans receiving hospice care. This prohibition would apply to care received at both inpatient and outpatient facilities. Depending upon where veterans receive hospice care, copayments range from $15 per day to a maximum of $97 per day. Most veterans receiving this type of care from VA are not charged copayments—only veterans whose disabilities are unrelated to their military service and whose incomes are above a certain level are required to make copayments.

Based on information from VA that fewer than 450 veterans made copayments averaging about $800 last year for hospice care, CBO estimates that implementing this provision would decrease collections by less than $500,000 each year and by about $2 million over the 2009–2013 period. Those collections are recorded as offsets to discretionary appropriations. As part of the annual appropriations process, the Congress gives VA authority to spend those collections. Therefore, maintaining the same level of health care services for veterans would necessitate additional funding each year to make up for the loss of copayments under this bill. Thus, implementing this provision would cost less than $500,000 in 2009 and about $2 million over the 2009–2013 period.

Study on Suicides. Section 403 would require VA to conduct a study and report to the Congress on the number of veterans who died by suicide between 1997 and the date of enactment of the bill. VA would be required to coordinate with DOD, veterans service organizations, the Centers for Disease Control and Prevention, and state public health offices and veterans agencies. Based on information from VA, CBO estimates that implementing this provision would cost $1 million in 2009 and less than $500,000 in 2010, assuming availability of appropriated funds.

Other Provisions. Several sections of the bill, when taken individually, would have no significant impact on spending subject to appropriation (most would have costs, but a few would have savings). Taken together, CBO estimates that implementing the following provisions would cost $1 million a year, assuming availability of appropriated funds:

- Sections 204 would repeal a reporting requirement pertaining to nurses' pay.
- Section 205 would modify a reporting requirement pertaining to Gulf War veterans.
- Section 209 would require veterans receiving care through the department to provide their Social Security number as well as pertinent information about their coverage through other health plans. Based on information from VA, CBO estimates that under the bill the department would be able to better match patient records with

those of Internal Revenue Service and the Social Security Administration, and would collect an additional $100 each from roughly 36,500 veterans. Those additional collections of $4 million a year would be retained by the department and spent on medical care and services.

• Section 211 would require annual reports on the quality of the department's physicians and health care.

• Section 218 would allow VA to disclose the names and addresses of veterans and servicemembers who use VA care to third-party insurers, so that VA can recover the costs of such care. Based on a VA field survey, CBO estimates that under the bill the department would collect an additional $9 million a year. Those amounts would be retained by the department and spent on medical care and services.

• Section 219 would require an expanded study on the health impact of chemical and biological testing conducted by DOD in the 1960s and 70s.

• Section 220 would modify authority granted to VA under Public Law 110–181 to pay for care provided to veterans with TBI to conform with how VA is implementing the program under current law.

• Section 306 would require a report on full-time managers of programs for female veterans.

• Section 404 would require VA to transfer $5 million to the Secretary of Health and Human Services for a psychology education program.

• Title VI would modify several authorities pertaining to research and education corporations and permanently extend VA's authority to establish such corporations. According to VA, those corporations are private, nonprofit entities that are prohibited from using appropriated funds and rely solely on cash or in-kind donations.

Direct spending and revenues

Section 801 would enhance the law enforcement authorities of VA police officers. Because those prosecuted and convicted under section 801 of the bill could be subject to criminal fines, the federal government might collect additional fines if the legislation is enacted. Criminal fines are recorded as revenues, then deposited in the Crime Victims Fund, and later spent. CBO expects that any additional revenues and direct spending would not be significant because of the relatively small number of cases likely to be affected. Therefore, enacting the bill would have no significant effects on direct spending or revenues.

Intergovernmental and private sector impact

S. 2969 contains no intergovernmental or private-sector mandates as defined in UMRA. State, local, and tribal governments that provide assistance to veterans would benefit from grant and program activities authorized in the bill.

Previous CBO estimate: On July 28, 2008, CBO transmitted a cost estimate for H.R. 6445 as ordered reported by the House Committee on Veterans' Affairs on July 16, 2008. Section 217 of S. 2969 is similar to section 6 of H.R. 5856, and their estimated costs are identical.

On May 12, 2008, CBO transmitted a cost estimate for H.R. 5856 as ordered reported by the House Committee on Veterans' Affairs on April 30, 2008. Title VII of S. 2969 is similar to H.R. 5856, but the House act would authorize funding for additional facilities and CBO estimated it would cost $2.2 billion over the 2009–2013 period ($1 billion more than title VII of S. 2969), assuming appropriation of the specified and estimated amounts.

On August 23, 2007, CBO transmitted a cost estimate for S. 1233, as ordered reported by the Senate Committee on Veterans' Affairs on June 27, 2007. Sections 103(a) and 216 of S. 2969 are similar to sections 601 and 309 of S. 1233 respectively. CBO estimates that the scholarship program authorized by S. 2969 would require a six-month start-up period and would grant fewer scholarships in the first year. The cost estimates for the provisions affecting hospice care are identical; however S. 2969 assumes a later enactment date.

On July 27, 2007, CBO transmitted a cost estimate for H.R. 2874 as ordered reported by the House Committee on Veterans' Affairs on July 17, 2007. Section 203 of S. 2969 is similar to section 4 of H.R. 2874. The cost estimates are identical; however S. 2969 assumes a later enactment date.

Estimate prepared by: Federal Costs: Sunita D'Monte and Alexis Miller (226 2840); Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum (225 3220); Impact on the Private Sector: Daniel Frisk (226 2900).

Estimate approved by: Theresa Gullo, Deputy Assistant Director for Budget Analysis.

Regulatory Impact Statement

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

Tabulation of Votes Cast in Committee

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs at its June 26, 2008, meeting ordered S. 2969, reported favorably to the Senate by voice vote. One amendment was accepted by voice vote.

Agency Report

On May 21, 2008, Gerald M. Cross, MD, Principal Deputy Under Secretary for Health, Department of Veterans Affairs, appeared before the Committee and submitted testimony on various bills incorporated into the Committee bill. In addition, on July 8, 2008, VA provided views on S. 2969. Excerpts of both the testimony and Department views are reprinted below:

STATEMENT OF GERALD M. CROSS, MD, FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on a number of bills that would affect Department of Veterans Affairs (VA) programs of benefits and services. With me today are Walter A. Hall, Assistant General Counsel, and Kathryn Enchelmayer, Director, Quality Standards, Office of Quality and Performance. I am pleased to provide the Department's views on 14 of the 17 bills under consideration by the Committee. Unfortunately, we received S. 2963 too late to include in our written statement, but we will provide views and costs for the record. In addition, the Administration's position is currently under review for S. 2969. Therefore, it is not included in our written statement and we will forward those views as they are available. Similarly, the Administration is still developing its position on S. 2926 and we will provide those views for the record. I will now briefly describe the 14 bills, provide VA's comments on each measure and estimates of costs (to the extent cost information is available), and answer any questions you and the Committee members may have.

Mr. Chairman, today's agenda includes four bills that consist of legislative proposals the Administration submitted to the Congress: S. 2273; S. 2797; S. 2889, and S. 2984. Thank you for introducing these bills at our request. We believe each bill would significantly enhance the health care services we provide to veterans as well as our means of furnishing these benefits. I will begin my testimony by addressing the major health care related provisions in these important bills.

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S. 2273—"ENHANCED OPPORTUNITIES FOR FORMERLY HOMELESS VETERANS RESIDING IN PERMANENT HOUSING ACT OF 2007"

S. 2273 would authorize VA to conduct two five-year pilot grant programs under which public and non-profit organizations (including faith-based and community organizations) would receive funds for coordinating the provision of local supportive services for very low income, formerly homeless veterans who reside in permanent housing. Under one of the pilot programs, VA would provide grants to organizations assisting veterans residing in permanent housing located on military property that the Secretary of Defense closed or slated for closure as part of the 2005 Base Realignment and Closure program and ultimately designated for use in assisting the homeless. The other pilot program would provide grants to organizations assisting veterans residing in permanent housing on any property across the country. Both programs would require the Sec-

retary to promulgate regulations establishing criteria for receiving grants and the scope of supportive services covered by the grant program.

In 1987, when VA began its specific assistance to veterans who were homeless, few recognized that long-term or permanent housing with supportive services was necessary to return these veterans to full function. It is now well understood that the provision of long-term housing coupled with needed supportive services is vital to enable them to lead independent lives in their communities. Although supportive services are widely available to these veterans through VA and local entities, most housing assistance that is available to them is limited to temporary or transitional housing. Generally sources of long-term housing for these veterans are lacking. Military facilities recently slated for closure or major mission changes may provide an excellent site for long-term or permanent housing for these vulnerable veterans who remain at risk of becoming homeless. Local redevelopment authorities could take these VA grant programs into account when designing their local plans to convert the property for use in assisting formerly homeless veterans. This would not only help the veterans but also enhance the community's efforts at economic revitalization. We estimate the costs associated with each of these pilots to be $375,000 in Fiscal Year 2009 and $11,251,000 over a five-year period.

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S. 2797—AUTHORIZATION OF FISCAL YEAR 2009 MAJOR MEDICAL FACILITY PROJECTS

Section 1 would authorize the following four major medical construction projects:

- Construction of an 80-bed replacement facility in Palo Alto, California, in an amount not to exceed $54,000,000;
- Construction of an Outpatient Clinic in Lee County, Florida to meet the increased demand for diagnostic procedures, ambulatory surgery, and specialty care, in an amount not to exceed $131,800,000;
- Seismic Corrections on Building 1 in San Juan, Puerto Rico, in an amount not to exceed $225,900,000; and,
- Construction of a state-of-the-art polytrauma health care and rehabilitation center in San Antonio, Texas, in an amount not to exceed $66,000,000.

Section 2 would authorize the following major medical facility projects:

- Replacement of the VA Medical Center in Denver, Colorado, in an amount not to exceed $769,200,000.
- Restoration, new construction or replacement of the medical center facility in New Orleans, Louisiana, in an amount not to exceed $625,000,000.

VA received authorization for lesser sums under Public Law 109–461 for these two major projects. In February 2008 we requested authorization in the amount of $769.2 million for the Denver-replacement project. However, the Department has identified an alternative option to purchase land and construct the new Denver

VA facility while also leasing beds from the University of Colorado Hospital. Since our fiscal year 2009 major-facility-authorization request was submitted in February, we met with officials of the University of Colorado and the new University of Colorado Hospital (UCH) to discuss how best to replace the services and improve the access now being provided by the aging VA Medical Center in Denver. We are still finalizing the details of this approach, but our preliminary analysis shows that it would be better, for several reasons, to lease space in the inpatient unit that UCH plans to build and to have VA's new state-of-the- art health care facility focus on the provision of primary and specialty care, outpatient surgery, and nursing home care. This proposed and innovative VA partnership with UCH would also extend to the sharing of certain adjunct inpatient resources, such as laboratory and medical-imaging services, and include VA's leasing research space from the University of Colorado Denver. The leased inpatient space would be staffed by VA health-care professionals and accessed via a separate VA entrance and lobby. In all respects to our patients, it would be a VA facility. This change in construction plans would more effectively increase and improve veterans' access to care throughout the Rocky Mountain region. As part of this strategy, we would need to additionally seek authority to enter into a contract for a lease for an outpatient clinic in Colorado Springs, Colorado; the revised amount for this lease would exceed the current request. We will provide Committee the final authorization amounts needed for these projects shortly.

Section 3 would authorize VA to enter into leases for the following twelve facilities:

- Brandon, Florida, Outpatient Clinic, $4,326,000;
- Colorado Springs, Colorado, Community-Based Outpatient Clinic, $3,995,000; (the final amount needed for this project is pending)
- Eugene, Oregon, Outpatient Clinic, $5,826,000;
- Green Bay, Wisconsin, Expansion of Outpatient Clinic, $5,891,000;
- Greenville, South Carolina, Outpatient Clinic, $3,731,000;
- Mansfield, Ohio, Community-Based Outpatient Clinic, $2,212,000;
- Mayaguez, Puerto Rico, Satellite Outpatient Clinic, $6,276,000;
- Mesa, Arizona, Southeast Phoenix Community-Based Outpatient Clinic, $5,106,000;
- Palo Alto, California, Interim Research Space, $8,636,000;
- Savannah, Georgia, Expansion of Community-Based Outpatient Clinic, $3,168,000;
- Sun City, Arizona, Northwest Phoenix Community-Based Outpatient Clinic, $2,295,000; and,
- Tampa, Florida, Primary Care Annex, $8,652,000.

Section 4 would authorize for appropriation the sum of $477,700,000 for fiscal year 2009 for construction of the four major medical projects listed in Section 1 and $1,394,200,000 for the two projects listed in Section 2. Section 4 would also authorize for appropriation for fiscal year 2009 $60,114,000 from the Medical Facilities account for the leases listed in Section 3. However, we will likely revise our request for both those Section 2 construction

projects and the Section 3 leases. Our final recommendation on the amounts will be provided to the Committee shortly.

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S. 2889—"VETERANS HEALTH CARE ACT OF 2008"

Mr. Chairman, you have asked us to testify on sections 2, 3, 4, 5, and 6, of S. 2889. Section 2 would authorize VA to contract for specialized residential care and rehabilitation services for veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) who: (1) suffer from traumatic brain injury, (2) have an accumulation of deficits in activities of daily living and instrumental activities of daily living that affects their ability to care for themselves, and (3) would otherwise receive their care and rehabilitation in a nursing home. These veterans do not require nursing home care, but they generally lack the resources to remain at home and live independently. This legislation would enable VA to provide them with long-term rehabilitation services in a far more appropriate treatment setting than we are currently authorized to provide. VA estimates the discretionary cost of section 2 to be $1,427,000 in fiscal year 2009 and $79,156,000 over a 10-year period.

Section 3 would require VA to provide full-time VA physicians and dentists the opportunity to continue their professional education through VA-sponsored continuing education programs. It would also authorize VA to reimburse these employees up to $1000 per year for continuing professional education that is not available through VA-sources. Currently, VA is required by statute to reimburse each of these individuals up to $1000 per year for expenses they incur in obtaining continuing education, even though VA has the capacity and resources to meet most of their professional continuing education needs in-house. Enactment of section 3 would result in cost-savings to VA, while serving as an effective recruitment and retention tool for the Veterans Health Administration. We estimate section 3 would result in discretionary savings of $8,700,000 in fiscal year 2009 and a total discretionary savings of $87,000,000 over a 10-year period.

Section 4 would eliminate co-payment requirements for veterans receiving VA hospice care either in a VA hospital or at home on an outpatient basis. In 2004, Congress amended the law to eliminate copayment requirements for hospice care furnished in a VA nursing home. Section 4 would result in all VA hospice care being exempt from copayment requirements, regardless of setting. Projected discretionary revenue loss is estimated to be $149,000 in fiscal year 2009 and $1,400,000 over 10 years.

Section 5 would repeal outdated statutory requirements that require VA to provide a veteran with pre-test counseling and to obtain the veteran's written informed consent prior to testing the veteran for HIV infection. Those requirements are not in line with current guidelines issued by the Centers for Disease Control and Prevention and other health care organizations, which, with respect to the issue of consent, consider HIV testing to be similar to other blood tests for which a patient need only give verbal informed consent. According to many VA providers, the requirements for pre-

test counseling and prior written consent delay testing for HIV infection and, in turn, VA's ability to identify positive cases that would benefit from earlier medical intervention. As a result, many infected patients unknowingly spread the virus to their partners and are not even aware of the need to present for treatment until complications of the disease become clinically evident and, often, acute. Testing for HIV infection in routine clinical settings no longer merits extra measures that VA is now required by law to provide. Many providers now consider HIV to be a chronic disease for which continually improving therapies exist to manage it effectively. Repealing the 1988 statutory requirements would not erode the patient's rights, as VA would, just like with tests for all other serious conditions, still be legally required to obtain the patient's verbal informed consent prior to testing. VA estimates the discretionary costs associated with enactment of section 5 to be $73,680,000 for fiscal year 2009 and $301,401,000 over a 10-year period.

Section 6 would amend sections 5701 and 7332 of title 38, United States Code, to authorize VA to disclose individually-identifiable patient medical information without the prior written consent of a patient to a third-party health plan to collect reasonable charges under VA collections authority for care or services provided for a non-service-connected disability. The section 5701 amendment would specifically authorize disclosure of a patient's name and address information for this purpose. The section 7332 amendment would authorize disclosure of both individual identifier information and medical information for purposes of carrying out the Department's collection responsibilities. VA estimates that enactment of section 6 will result in net discretionary savings of $9,025,000 in fiscal year 2009 and $108,858,000 over ten years.

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S. 2984—"VETERANS BENEFITS ENHANCEMENT ACT OF 2008"

This bill includes several important program authority extensions, including VA's mandate to provide nursing home care to veterans with service-connected disabilities rated 70 percent or more and to veterans whose service-connected disabilities require such care; VA's authority to establish research corporations; and VA's mandate to conduct audits of payments made under fee basis agreements and other medical services contracts. We urge the Committee to take action on all of the expiring authorities contained in the bill. Costs associated with these extensions will be paid from future discretionary appropriations. In the case of the audit-recovery program, we estimate discretionary recoveries in the amount of $9 million for fiscal year 2008 and a ten-year total in recoveries of $70 million.

A significant provision of S. 2984 would permit VA health care practitioners to disclose the relevant portions of VA records of the treatment of drug abuse, alcoholism and alcohol abuse, infection with the human immunodeficiency virus, and sickle cell anemia to surrogate decision makers who are authorized to make decisions on behalf of patients who lack decision-making capacity, but to whom the patient had not specifically authorized release of that legally

protected information prior to losing decision-making capacity. It would, however, allow for such disclosure only under circumstances when the practitioner deems such content necessary for the representative to make an informed decision regarding the patient's treatment. This provision is critical to ensure that a patient's surrogate has all the clinically relevant information needed to provide full and informed consent with respect to the treatment decisions that the surrogate is being asked to make.

Another key provision would authorize VA to require that applicants for, and recipients of, VA medical care and services provide their health-plan contract information and social security numbers to the Secretary upon request. It would also authorize VA to require applicants for, or recipients of, VA medical care or services to provide their social security numbers and those of dependents or VA beneficiaries upon whom the applicant or recipient's eligibility is based. Recognizing that some individuals do not have social security numbers, the provision would not require an applicant or recipient to furnish the social security number of an individual for whom a social security number has not been issued. Under this provision, VA would deny the application for medical care or services, or terminate the provision of, medical care or services, to individuals who fail to provide the information requested under this section. However, the legislation provides for the Secretary to reconsider the application for, or reinstate the provision of, care or services once the information requested under this section has been provided. Of note, this provision makes clear that its terms may not be construed to deny medical care and treatment to an individual in a medical emergency.

Although VA has authority under 38 U.S.C. § 1729 to recover from health insurance carriers the reasonable charges for treatment of a veteran's nonservice-connected disabilities, there is no permanent provision in title 38 to require an applicant for, or recipient of, VA medical care to provide information concerning health insurance coverage. This provision would ensure that VA obtains the health-plan contract information from the applicant for, or recipient of, medical care or services.

Moreover, social security numbers enable VHA to make accurate and efficient medical care eligibility determinations and to instantaneously associate medical information with the correct patient by matching those social security numbers against records of other entities. Medical care eligibility determinations may be based on such factors as qualifying military service, service-connected disabilities, and household income. VHA may obtain or verify such information from internal VA components such as the Veterans Benefits Administration (VBA) which currently has authority to require social security numbers for compensation and pension benefits purposes, and outside sources, such as the Department of Defense (DOD), Internal Revenue Service and Social Security Administration. The availability of social security numbers ensures accurate matches of an individual's information with both internal and external sources. The income verification match programs are wholly dependent on social security numbers.

Be assured that VA will provide the same high degree of confidentiality for the beneficiaries' health plan information and social

security numbers as it provides to patients' medical information in its records and information systems. There are no direct costs associated with this provision other than administrative costs associated with collecting revenue. Those costs will be paid from future discretionary appropriations.

Mr. Chairman, I now move to address the other bills on the agenda today.

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S. 2377—"VETERANS HEALTH CARE QUALITY IMPROVEMENT ACT"

S. 2377 is an excessively prescriptive bill that would impede the fundamental operations and structure of VHA. We have very recently provided the Committee with a copy of the Department's views on H.R. 4463, the identical House companion bill. Our views letter provides our detailed discussion of every provision. We would like to take this opportunity to discuss the provisions that cause us the most concern.

The requirement that within one year of appointment each physician practicing at a VA facility (whether through appointment or privileging) be licensed to practice medicine in the State where the facility is located is particularly troubling and we believe harmful to the VA system. VA strongly objects to enactment of this provision. VHA is a nationwide health care system. By current statute, to practice in the VA system, VA practitioners may be licensed in any State. If this requirement were enacted, it would impede the provision of health care across State borders and reduce VA's flexibility to hire, assign and transfer physicians. This requirement also would significantly undermine VA's capacity and flexibility to provide telemedicine across State borders. VA makes extensive use of telemedicine. In addition, VA's ability to participate in partnership with our other Federal health care providers would be adversely impacted in times such as the aftermath of Hurricanes Katrina and Rita, where we are required to mobilize members of our medical staff in order to meet regional crises.

Currently, physicians who provide medical care elsewhere in the Federal sector (including the Army, Navy, Air Force, U.S. Public Health Service Commissioned Corps, U.S. Coast Guard, Federal Bureau of Prisons and Indian Health Service) need not be licensed where they actually practice, so long as they hold a valid State license. Requiring VA practitioners to be licensed in the State of practice would make VA's licensure requirements inconsistent with these other Federal health care providers and negatively impact VA's recruitment ability relative to those agencies. In addition, many VA physicians work in both hospitals and community-based outpatient clinics. Many of our physicians routinely provide care in both a hospital located in one State and a clinic located in another State. A requirement for multiple State licenses would place VA at a competitive disadvantage in recruitment of physicians relative to other health care providers.

Although the provision would allow physicians one year to obtain licensure in the State of practice, many States have licensing requirements that are cumbersome and require more than one year to meet. Such a requirement could disrupt the provision of patient

care services while VA physicians try to obtain licensure in the State where they practice or transfer to VA facilities in States where they are licensed. The potential costs of this disruption are unknown at this time.

Further, we are not aware of any evidence of a link between differences in State licensing practices and quality of patient care. In 1999, the General Accounting Office reviewed the effect on VA's health care system that a requirement for licensure in the State of practice would have. The GAO report concluded, in part, that the potential costs to VA of requiring physicians to be licensed in the State where they practice would likely exceed any benefit, and that quality of care and differences in State licensing practices are not directly linked. See GAO/HEHS–99–106, "Veterans' Affairs Potential Costs of Changes in Licensing Requirement Outweigh Benefit" (May 1999).

Another provision would provide that physicians may not be appointed to VA unless they are board certified in the specialties of practice. However, this requirement could be waived (not to exceed one year) by the Regional Director for individuals who complete a residency program within the prior two year period and provide satisfactory evidence of an intent to become board certified. VA strongly opposes this provision of S. 2377. Current law does not require board certification as a basic eligibility qualification for employment as a VA physician. VA policy currently provides that board certification is only one means of demonstrating recognized professional attainment in clinical, administrative or research areas, for purposes of advancement. However, we actively encourage our physicians to obtain board certification. Facility directors and Chiefs of Staff must ensure that any non-board certified physician, or physician not eligible for board certification, is otherwise well qualified and fully capable of providing high quality care for veteran patients. VA should be given considerable flexibility regarding the standards of professional competence that it requires of its medical staff, including the requirement for specialty certification. Were this measure enacted, it could have a serious chilling effect on our ability to recruit very qualified physicians. At this point in time, VA has physician standards that are in keeping with those of the local medical communities.

Moreover, the bill would provide that the board certification and in-State licensure requirements would take effect one year after the date of the Act's enactment for physicians on VA rolls on the date of enactment. This would at least temporarily seriously disrupt VA's operations if physicians are unable to obtain board certification and in-State licensure within one year, or are unable to transfer to a State where they are licensed.

Mr. Chairman, we want to emphasize that we support the intent of several provisions of S. 2377 and have already been taking actions to achieve many of the same goals. We would welcome the opportunity to meet with the Committee to discuss recent actions we have undertaken to improve the quality of care across the system, including program oversight related measures.

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S. 2383—PILOT PROGRAM PROVIDING MOBILE HEALTH CARE AND OTHER SERVICES

S. 2383 would require the Secretary, acting through the Director of the Office of Rural Health (DORH), to conduct a pilot program to furnish outreach and health care services to veterans residing in rural areas through the use of a mobile system equipped with appropriate program staff and supplies. The mobile system would have to be capable of furnishing the following services:

- counseling and education services on how to access VA health care, educational, pension, and other VA benefits;
- assistance to veterans in completing paperwork needed to enroll in VA's health care system;
- prescriptions for, and delivery of, medications;
- mental health screenings to identify potential mental health disorders, particularly for veterans returning from deployment overseas in OEF/OIF;
- job placement assistance and information on employment or training opportunities;
- substance abuse counseling; and
- bereavement counseling for families of active duty servicemembers who were killed in the line of duty while on active service.

Staffing for the mobile system would be required to include VA physicians; nurses; mental health specialists; casework officers; benefits counselors, and such other personnel deemed appropriate by the Secretary. To the extent practicable, personnel and resources from area community-based outpatient clinics could be used to assist in this effort. The bill sets forth a number of requirements related to the development and coordination of the pilot program as well as to the conduct of the mobile system (including the minimum frequency of visits to rural areas participating in the pilot programs).

S. 2383 would also mandate that the Secretary act jointly with the Secretary of Defense to identify veterans not enrolled in, or otherwise being cared for by, VA's health care system. VA would be further required to coordinate efforts with county and local veterans service officers to inform those veterans of upcoming visits by the mobile unit and the concomitant opportunity to complete paperwork for VA benefits. The bill would authorize $10 million to be appropriated for the mobile system each of fiscal years 2008 through 2010.

VA does not support S. 2383, because it is not necessary and is duplicative of ongoing efforts by the Department. VA's Office of Rural Health is already in the process of standing up a mobile system by which to provide medical care and services to veterans residing in rural areas, and VA's Vet Centers are already using mobile units to furnish readjustment counseling services. The Vet Centers and VBA also have in place extensive outreach program targeted at these veterans. VA has recently created a Task Force to review the adequacy of the assets and resources dedicated to these efforts thus far. Particularly with respect to the mobile system, we urge the Committee to refrain from taking action on the bill until we have sufficient experience with this model of delivery

to ascertain its effectiveness and to identify and cure any deficiencies. We would be glad to brief the Committee on our activities to date.

As a technical matter, the duration of the pilot program is unclear, but we assume it is three years based on the terms of the bill's provision authorizing appropriations for fiscal years 2008–2010. Additionally, medications are currently mailed to these veterans and so it is not necessary to provide those benefits through a mobile system.

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S. 2573—"VETERANS MENTAL HEALTH TREATMENT FIRST ACT"

Mr. Chairman, S. 2573 is a very ambitious bill that would provide the Department with significant new tools to maximize and reward a veteran's therapeutic recovery from certain service-related mental health conditions, and, to the extent possible, reduce the veteran's level of permanent disability from any of the covered conditions. The goal of the legislation is to give the veteran the best opportunity to reintegrate successfully and productively into the civilian community.

Specifically, S. 2573 would require the Secretary to carry out a mental health and rehabilitation program for a veteran who has been diagnosed by a VA physician with any of the following conditions:

- Post Traumatic Stress Disorder (PTSD);
- depression; or
- anxiety disorder

that is service-related, as defined by the bill. The bill would also cover a diagnosis of a substance use disorder related to service-related PTSD, depression, or anxiety. For purposes of this program, a covered condition would be considered to be service-related if: (1) VA has previously adjudicated the disability to be service-connected; or (2) the VA physician making the diagnosis finds the condition plausibly related to the veteran's active service. S. 2573 would also require the Secretary to promulgate regulations identifying the standards to be used by VA physicians when determining whether a condition is plausibly related to the veteran's active military, naval, or air service.

The bill sets forth conditions of participation for the veterans taking part in the program. If a veteran has not filed a VA claim for disability for the covered condition, the veteran would have to agree not to submit a VA claim for disability compensation for the covered condition for one year (beginning on the date the veteran starts the program) or until the date on which the veteran completes his or her treatment plan, whichever date is earlier.

If the veteran has filed a disability claim but it has not yet been adjudicated by the Department, the veteran could elect either to suspend adjudication of the claim until he or she completes treatment or to continue with the claims adjudication process. As discussed below, the stipend amounts payable to the veteran under the program will depend on which election the veteran makes.

If the veteran has a covered condition that has been adjudicated to be service connected, then the individual would have to agree

not to submit a claim for an increase in VA disability compensation for one year (beginning on the date the veteran starts the program) or until the date the veteran completes treatment, whichever is earlier.

S. 2573 would establish a financial incentive in the form of "wellness" stipends to encourage participating veterans to obtain VA care and rehabilitation before pursuing, or seeking additional, disability compensation for a covered condition. The amount of the stipend would depend on the status of the veteran's disability claim. If the veteran has not filed a VA disability claim, VA would pay the veteran $2000 upon commencement of the treatment plan, plus $1500 every 90 days thereafter upon certification by the VA clinician that the veteran is in substantial compliance with the plan. This recurring stipend would be capped at $6000. The veteran would receive an additional $3000 at the conclusion of treatment or one year after the veteran begins treatment, whichever is earlier.

If the veteran has filed a disability claim that has not yet been adjudicated, the participating veteran who elects to suspend adjudication of the claim until he or she completes treatment would receive "wellness" stipends in the same amounts payable to veterans who have not yet filed a disability claim. If the participating veteran elects instead to continue with the claims adjudication process, the veteran would receive "wellness" stipends in the same amounts payable to veterans whose covered disabilities have been adjudicated and found to be service-connected: $667 payable upon the veteran's commencement of treatment and $500 payable every 90 days thereafter upon certification by the veteran's clinician that the individual is in substantial compliance with the plan. Recurring payments would be capped at $2000, and the veteran would receive $1000 when treatment is completed or one year after beginning treatment, whichever is earlier.

If the Secretary determines that a veteran participating in the program has failed to comply substantially with the treatment plan or any other agreed-upon conditions of the program, the bill would require VA to cease payment of future "wellness" stipends to the veteran.

Finally, S. 2573 would limit a veteran's participation in this program to one time, unless the Secretary determines that additional participation in the program would assist in the remediation of the veteran's covered condition.

VA does not support S. 2573. While philosophically we discern and appreciate the aims of the bill, particularly the holistic and integrated approach to the receipt of VA benefits, this is a very complex proposal that requires further in-depth study of all of the bill's implications, including those related to cost. In addition, we have numerous concerns with the bill as currently drafted.

S. 2573 assumes that early treatment intervention by VA health care professionals for a covered condition would be effective in either reducing or stabilizing the veteran's level of permanent disability from the condition, thereby reducing the amount of VA disability benefits ultimately awarded for the condition. No data exist to support or refute that assumption.

With the exception of substance abuse disorders, we are likewise unaware of any data to support or refute the bill's underlying assumption that paying a veteran a "wellness stipend" will ensure the patient's compliance with his or her treatment program. Although there is a growing trend among health insurance carriers or employers to provide short-term financial incentives for their enrollees or employees to participate in preventive health care programs (e.g., reducing premiums for an enrollee who participate in a fitness program, loses weight, or quits smoking), we are unaware of any data establishing that these and similar financial incentives produce long-term cost-savings to the carrier or employer. It would be extremely difficult, if not impossible, to quantify savings or offsets because there is no way to know whether a particular patient's health status would have worsened without VA's intervention and whether the intervention directly resulted in a certain or predictable total amount in health care expenditure savings. We would experience the same difficulties trying to identify what would have been the level of disability and costs of care for a particular veteran had he or she not participated in the early clinical intervention program established by S. 2573.

Providing these mental health care benefits independent of the medical benefits package provided to enrolled veterans gives rise to other concerns. A veteran's mental health and physical health are integral, and it would be very difficult to discern if certain conditions or physical manifestations that may result from or be related to a mental health condition are covered by S. 2573. As a provider, VA would need to assume that this bill would cover needed care for physical conditions that result from, or are associated with, the covered mental health condition under treatment. (Our approach would be similar to the approach taken under the Department's authority in 38 U.S.C. § 1720D to provide both counseling and care needed to treat psychological conditions resulting from sexual trauma.) For instance, recent scientific literature has linked heart disease to stress. Heart disease might at some point be linked to depression, PTSD and/or anxiety disorder. We believe that unless the scientific literature conclusively rules out an association between a covered mental health condition and the veteran's physical condition, the veteran should receive the benefit of the doubt. This could expand the scope of S. 2573 beyond the drafter's intent, because the types of physical conditions considered by the scientific community to be associated with mental health conditions could expand over time. Should this happen, S. 2573 could lead to VA essentially operating two different health care systems based on separate sets of eligibility criteria, undermining the accomplishments achieved under VA health care reform.

It is also troubling to us that S. 2573 would require VA to treat specific diseases and not the veteran as a whole. This approach places VA practitioners in the difficult and untenable position of being able to identify conditions they cannot treat. This creates a particularly serious ethical dilemma for the practitioner who knows that his or her veteran-patient has no other access to the needed health care services. In our view, authority to treat specific diseases—and not the person—is counter to the principles of patient-centered and holistic medicine.

The "wellness" stipends, themselves, raise several complex issues. None of VA's current benefits systems is equipped to administer such a novel benefit, and no current account appears to be an appropriate funding source from which to pay them. After much grappling with the issue, we have concluded that because the bill would amend only chapter 17 of title 38, United States Code, these stipends would have to be administered by VHA and paid from funds made available for medical care.

There would be significant indirect costs as well. VHA currently lacks the IT infrastructure, expertise, and staff to administer monetary benefits. Administering the easiest of monetary benefits would be challenging for VHA, but it is nearly insurmountable in connection with this bill, which calls for a very complex, nationwide patient tracking and monitoring system that also has the capacity to administer payments at different points in time for veterans participating in the program. The fact that the duration of each veteran's treatment plan is highly individualized only complicates the requirements of such a system-design, as does the fact that the bill would permit some veterans to receive treatment (and payment) extensions.

As a result, we do not believe that S. 2573 would be cost-effective as currently drafted. The maximum we could pay any veteran under the bill would be $11,000; however, it is reasonable to assume that the costs associated with designing, operating, and administering such a complex benefit program would far surpass the actual amounts we would pay out to the veterans (individually or collectively).

S. 2573 also places our physicians and practitioners in the difficult position of determining whether their patients will receive wellness stipends available under the program. It is quite atypical for a VA physician's clinical determination to have direct financial implications or consequences for his or her patients. VA physicians and practitioners seek to help their veteran-patients attain maximum functioning as quickly as clinically possible. S. 2573 would create potential conflict for our health care practitioners. They should focus solely on issues of health care and not feel pressure to grant requests for extensions of treatment in order to maximize the amount of money patients receive under the program.

It would also be difficult to define "substantial compliance," for purposes of S. 2573, in a way that is measurable and objective as well as not easily amenable to fraud or abuse. For instance, substantial compliance could be defined in part by a veteran stating that he or she took prescribed medications as ordered by the physician and VA could confirm the veteran obtained refills in a timely manner. But that information does not actually verify that the patient in fact ingested the medication or did so as prescribed. There would unavoidably be some patients whose motivation for participating in this program is strictly financial, and they would invariably find ways to circumvent whatever criteria we establish in order to receive their stipends. Although these payments would not be sizeable, they are sufficient to entice some patients who would not otherwise access VA's health care system to participate in the program. We fear these patients would cease their treatment and

stop accessing needed VA services once their treatment and payments end.

Finally, if the use of "wellness" stipends were able to produce reliable, positive results in terms of patients' compliance or outcomes, there would then be a demand to extend this reward system to other VA treatment programs. And once a benefit is provided, it is difficult to ever repeal it. We say this only to point out that the cost implications in the out-years could be very difficult to estimate accurately.

Costing this bill is very complex, as there is no way for us to determine the total number of veterans who would participate in the pilot program, in which year they would enter the program, their ultimate disability status, and the amount of medical care they would each require. We estimate the increase in medical administrative costs for every 40,000 new veterans entering the VA system to be $280 million per year in addition to $293,340,000 per year in maximum stipend payments. The estimated one-time cost for eligible living veterans is $6,712,891,046. These costs do not factor in the costs of developing the IT infrastructure needed to administer the benefit. In light of these serious concerns and the bill's unknown total cost implications, we are unable to supports its enactment.

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S. 2639—"ASSURED FUNDING FOR VETERANS HEALTH CARE ACT"

S. 2639 would establish, by formula, the annual level of funding for all VHA programs, activities, and functions (excluding the construction, acquisition, and alteration of VA medical facilities and provision of grants to assist States in the construction or alteration of State home facilities).

VHA funding for fiscal year 2008 (the first fiscal year covered by the bill) would be automatically established at 130 percent of the amounts obligated by VHA (for all its activities, programs, and functions) for fiscal year 2006. Thereafter, VHA funding would be automatically determined by a fixed formula. The formula would, generally speaking, be based on the number of enrollees each year and the number of other persons receiving VA care during the preceding year multiplied by a fixed per capita amount. The per capita amount would be adjusted annually in accordance with increases in the Consumer Price Index.

It has been VA's long-standing position that we do not support the concept of using a fixed formula to determine VHA funding. We believe that it is inappropriate and unworkable to apply an inflexible formula to a health care system that, by its very nature, is dynamic. The provision of care evolves continually to reflect advances in state of the art technologies (including pharmaceuticals) and medical practices. It is not possible to estimate the concomitant costs or savings resulting from those evolving changes. Moreover, patients' health status, demographics, and usage rates are each subject to distinct trends that are difficult to predict. The proposed formula would not take into account any changes in these and other important trends. As such, there is no certainty that the amount of funding dictated by the proposed formula would be ap-

propriate to the demands that will be placed on VA's health care system in the upcoming years.

Use of an automatic funding mechanism would also eliminate the valuable opportunity that members of the Congress and the Executive Branch have to carry out their responsibility to identify and directly address the health care needs of veterans through the budget process. It could also depress the Department's incentive to improve its operations and be more efficient. It is important to note that S. 2639 would not ensure open enrollment, as the Department would still be required to make an annual enrollment decision. That decision would directly affect the number of enrolled veterans and thus the amount of funding calculated under the formula. Finally, references to "guaranteed funding" in the legislation may give the public the false impression that VA is being provided full funding for VA health care. It is not possible to determine whether the amount determined by the formula would be adequate. Because of S. 2639's potential for all of these unanticipated and unintended serious consequences, we continue to favor the current discretionary funding process that uses actuarially-based budget estimates to project the future health care needs of enrolled veterans.

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S. 2796—PILOT PROGRAM USING COMMUNITY BASED ORGANIZATIONS TO INCREASE THE COORDINATION OF VA SERVICES TO TRANSITIONING VETERANS

S. 2796 would require the Secretary to carry out a two-year pilot grant program (at five VA medical centers) to assess the feasibility of using community-based organizations to increase the coordination of VA benefits and services to veterans transitioning from military service to civilian life, to increase the availability of medical services available to these veterans, and to provide their families with their own readjustment services. Specifically, grantees could use grant funds to operate local telephone hotlines; organize veterans for networking purposes; assist veterans in preparing applications for VA benefits; provide readjustment assistance to families of veterans transitioning from military life to civilian life; provide outreach to veterans and their families about VA benefits; and coordinate the provision of health care and other benefits being furnished to transitioning veterans.

VA does not support S. 2796, because it is duplicative of the Department's ongoing efforts. Vet Centers are already providing much of the outreach, readjustment counseling services, and family support services that would be required by this bill. Additionally, VA case managers and federal recovery coordinators already coordinate the delivery of health care and other VA services available to veterans transitioning from military service to civilian life, including supportive services for their families. VA is committing ever increasing resources to these ends. Use of grant funds to establish local hotlines would duplicate and dilute the effectiveness of VA's central hotlines. The duplicated efforts required by the bill would likely create significant confusion for the beneficiary. Further, funding family readjustment services wholly unrelated to the vet-

eran's readjustment needs would divert medical care funds needed for veterans' health care.

To the extent the Secretary determines external resources are necessary to provide the services described in the bill, VA already has the necessary authority to contract for them. We favor using contracts instead of grants, as the former allow VA to respond to changing local needs. That approach also gives us an accurate way to project the cost of the services. S. 2796, on the other hand, would not. It would also not be cost-effective as it is likely that a grant awarded under the program would be for an amount significantly less than the cost VA incurs in administering the grant. We also note the bill would not include authority for VA to recapture unused grant funds in the event a grantee fails to provide the services described in the grant.

We note further that when selecting pilot sites the Secretary would have to consider medical centers that have "a high proportion of minority groups and individuals who have experienced significant disparities in the receipt of health care." We are uncertain what this language means and on what basis such a determination would be based.

Although the proposed pilot project is limited to five VA medical centers, the scope of the uses for the grant funds is very broad, and the bill does not specify the number and amount of the grants to be awarded. We are unable to estimate the cost estimate of S. 2796 due to the bill's lack of specificity.

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S. 2799—"WOMEN VETERANS HEALTH CARE IMPROVEMENT ACT OF 2008"

In general, title I of S. 2799 would require VA to conduct a number of studies related to health care benefits for women veterans. Section 101 would require VA, in collaboration with VHA's War-Related Injury and Illness Study Centers, to contract for an epidemiologic cohort (longitudinal) study on the health consequences of combat service of women veterans who served in OEF/OIF. The study would need to include information on their general, mental, and reproductive health and mortality and include the provision of physical examinations and diagnostic testing to a representative sample of the cohort.

The bill would require VA to use a sufficiently large cohort of women veterans and require a minimum follow-up period of ten years. The bill also would require VA to enter into arrangements with the Department of Defense (DOD) for purposes of carrying out this study. For its part, DOD would be required to provide VA with relevant health care data, including pre-deployment health and health risk assessments, and to provide VA access to the cohort while they are serving in the Armed Forces.

Mr. Chairman, we do not support section 101. It is not needed. A longitudinal study is already underway. In 2007, VA initiated its own 10-year study, the "Longitudinal Epidemiologic Surveillance on the Mortality and Morbidity of OIF/OEF Veterans including Women Veterans." Several portions of the study mandated by section 101 are already incorporated into this project and planning for

the actual conduct of the study is underway. The study has already been approved to include 12,000 women veterans. However, section 101 would require us to expand our study to include women active duty servicemembers. We estimate the additional cost of including these individuals in the study sample to be $1 million each year and $3 million over a 10-year period.

Section 102 would require VA to conduct a comprehensive assessment of the barriers to the receipt of comprehensive VA health care faced by women veterans, particularly those experienced by veterans of OEF/OIF. The study would have to research the effects of 9 specified factors set forth in the bill that could prove to be barriers to access to care, such as the availability of child care and women veterans' perception of personal safety and comfort provided in VA facilities.

Neither do we support section 102. It is not necessary because a similar comprehensive study is already underway. VA contracted for a "National Survey of Women veterans in fiscal year 2007-2008," which is a structured survey based on a pilot survey conducted in VISN 21. This study is examining barriers to care (including access) and includes women veterans of all eras of service. Additionally, it includes women veterans who never used VA for their care and those who no longer continue to use VA for their health care needs. We estimate no additional costs for section 102 because VA's own comparable study is underway, with $975,000 in funding committed for fiscal years 2007 and 2008.

Section 103 would require VA to conduct, either directly or by contract, a comprehensive assessment of all VA programs intended to address the health of women veterans, including those related to PTSD, homelessness, substance abuse and mental health, and pregnancy care. As part of the study, the Secretary would have to determine whether the following programs are readily available and easily accessed by women veterans: health promotion programs, disease prevention programs, reproductive health programs, and such other programs the Secretary specifies. VA would also have to identify the frequency such services are provided; the demographics of the women veteran population seeking such services; the sites where the services are provided; and whether waiting lists, geographic distance, and other factors obstructed their receipt of any of these services.

In response to the comprehensive assessment, section 103 would further require VA to develop a program to improve the provision of health care services to women veterans and to project their future health care needs. In so doing, VA would have to identify the services available under each program at each VA medical center and the projected resource and staffing requirements needed to meet the projected workload demands.

Section 103 would require a very complex and costly study. While we maintain data on veteran populations receiving VA health care services that account for the types of clinical services offered by gender, VA's Strategic Health Care Group for Women Veterans already studies and uses available data and analyses to assess and project the needs of women veterans for the Under Secretary for Health. Furthermore, we lack current resources to carry out such a comprehensive study within the 18-month time-frame. We would

therefore have to contract for such a study with an entity having, among other things, significant expertise in evaluating large health care systems. This is not to say that further assessment is not needed. We recognize there may well be gaps in services for women veterans, especially given that VA designed its clinics and services based on data when women comprised a much smaller percentage of those serving in the Armed Forces. However, the study required by section 103 would unacceptably divert significant funding from direct medical care. Section 103 would have a cost of $4,354,000 in fiscal year 2008.

Section 104 would require VA to contract with the Institute of Medicine (IOM) for a study on the health consequences of women veterans' service in OEF/OIF. The study would need to include a review and analysis of the relevant scientific literature to ascertain environmental and occupational exposure experienced by women who served on active duty in OEF/OIF. It would then have to address whether any associations exist between those environmental and occupational exposures and the women veterans' general health, mental health, or reproductive health.

We do not object to section 104. We suggest the language be modified to allow VA to decide which organization is best situated to carry out this study (taking into account the best contract bid). While IOM has done similar studies in the past, this provision would unnecessarily foreclose the possibility of using other organizations. We estimate the one-time cost of section 104 to be $1,250,000, which can be funded from existing resources.

Section 201 would authorize VA to furnish care to a newborn child of a woman veteran who is receiving VA maternity care for up to 30 days after the birth of the child in a VA facility or a facility under contract for the delivery services. We can support this provision with modifications. As drafted, the provision is too broadly worded. We believe this section should be modified so that it applies only to cases where a covered newborn requires neonatal care services immediately after delivery. The bill language should also make clear that this authority would not extend to routine baby well-baby services.

We are currently unable to estimate the costs associated with section 201 without data on projected health care workload demands and future utilization requirements. We have contracted for that data and we will forward the estimated costs for this section as soon as they are available.

Section 202 would require the Secretary to establish a program for education, training, certification and continuing medical education for VA mental health professionals furnishing care and counseling services for military sexual trauma (MST). VA would also be required to determine the minimum qualifications necessary for mental health professionals certified under the program to provide evidence-based treatment. The provision would establish extremely detailed reporting requirements. VA would also have to establish education, training, certification, and staffing standards for VA health care facilities for full-time equivalent employees who are trained to provide MST services.

We do not support the training-related requirements of section 202 because they are duplicative of existing programs. In fiscal

year 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MSTrelated training and education opportunities nationwide. VA also hosts an annual four-day long training session for 30 clinicians in conjunction with the National Center for PTSD, which focuses on treatment of the after-effects of MST. VA also conducts training through monthly teleconferences that attract 130 to 170 attendees each month. VA has recently unveiled the MST Resource Homepage, a Web page that serves as a clearinghouse for MST-related resources such as patient education materials, sample power point trainings, provider educational opportunities, reports of MST screening rates by facility, and descriptions of VA policies and benefits related to MST. It also hosts discussion forums for providers. In addition, VA primary care providers screen their veteran-patients, particularly recently returning veterans, for MST, using a screening tool developed by the Department. We are currently revising our training program to further underscore the importance of effective screening by primary care providers who provide clinical care for MST within primary care settings.

We object strongly to the requirement for staffing standards. Staffing-related determinations must be made at the local level based on the identified needs of the facility's patient population, workload, staffing, and other capacity issues. Retaining this flexibility is essential to permit VA and individual facilities to respond to changing needs and available resources. Imposition of national staffing standards would be an utterly inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 203 would require the Secretary to establish, through the National Center for PTSD, a similar education, training, and certification program for health care professionals providing evidence-based treatment of PTSD and other co-morbid conditions associated with MST to women veterans. It would require VA to provide these professionals with continuing medical education, regular competency evaluations, and mentoring.

VA does not support section 203 because it is duplicative of, and would divert resources from, activities already underway by the Department. VA is strongly committed to making state-of-the-art, evidence-based psychological treatments widely available to veterans and this is a key component of VA's Mental Health Strategic Plan. We are currently working to disseminate evidence-based psychotherapies for a variety of mental health conditions throughout our health care system. There are also two programs underway to provide clinical training to VA mental health staff in the delivery of certain therapies shown to be effective for PTSD, which are also recommended in the VA/DOD Clinical Practice Guidelines for PTSD. Each training program includes a component to train the professional who will train others in this area, to promote wider dissemination and sustainability over time.

Section 204 would require the Secretary, commencing not later than six months after the date of enactment, to carry out a two-year pilot program, at no fewer than three VISN sites, to pay veterans the costs of child care they incur to travel to and from VA facilities for regular mental health services, intensive mental

health services, or other intensive health care services specified by the Secretary. The provision is gender-neutral. Any veteran who is a child's primary caretaker and who is receiving covered health care services would be eligible to participate in the pilot program. VA does not support this provision. Although the inability to secure child care may be a barrier to access to care for some veterans, funding such care would divert those funds from direct patient care. We estimate the cost of section 204 to be $3 million.

Section 205 would require VA, not later than six months after the date of enactment, to conduct a pilot program to evaluate the feasibility of providing reintegration and readjustment services in a group retreat setting to women veterans recently separated from service after a prolonged deployment. Participation in the pilot would be at the election of the veteran. Services provided under the pilot would include, for instance, traditional VA readjustment counseling services, financial counseling, information on stress reduction, and information and counseling on conflict resolution.

VA has no objection to section 205; however, we are unclear as to the purpose of and need for the bill. We note the term "group retreat setting" is not defined. We would not interpret that term to include a VA medical facility, as we do not believe that would meet the intent of the bill. We also assume this term would not include Vet Centers as we could not limit Vet Center access to any one group of veterans. Moreover, many Vet Centers, such as the one in Alexandria, Virginia, are already well designed to meet the individual and group needs of women veterans. Section 205 would have no costs.

Section 206 would require the Secretary to ensure there is at least one full-time employee at each VA medical center serving as a women veterans program manager. We strongly support this provision. The position of the women veterans program manager has evolved from an overseer of local programs to ensure access to care for women veterans to a position requiring sophisticated management and administrative skills necessary to execute comprehensive planning for women's health issues and to ensure these veterans receive quality care as evidenced, in part, by performance measures and outcome measurements. The duties of this position will only continue to grow as we strive to expand services to women veterans. Thus, we believe there is support for the dedication of a full-time employee equivalent at every VA medical center. We estimate section 206 would result in additional costs of $7,131,975 for fiscal year 2010 and $86,025,382 over a 10-year period.

Next, section 207 would require the Department's Advisory Committee on Women Veterans, created by statute, to include women veterans who are recently separated veterans. It would also require the Department's Advisory Committee on Minority Veterans to include recently separated veterans who are minority group members. These requirements would apply to committee appointments made on or after the bill's enactment. We support section 207. Given the expanded role of women and minority veterans serving in the Armed Forces, the Committees should address the needs of these cohorts in carrying out their reviews and making their rec-

ommendations to the Secretary. Having their perspective may help project both immediate and future needs.

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S. 2824—COLLECTIVE BARGAINING RIGHTS FOR REVIEW OF ADVERSE ACTIONS

The major provision of S. 2824 would make matters relating to direct patient care and the clinical competence of clinical health care providers subject to collective bargaining. It would repeal the current restriction on collective bargaining, arbitrations, and grievances over matters that the Secretary determines concern the professional conduct or competence, peer review, or compensation of Title 38 employees. The Secretary would also be required to bargain over direct patient care and clinical competency issues, the processes VA uses to assess Title 38 professionals' clinical skills, and the discretionary aspects of Title 38 compensation, including performance pay, locality pay, and market pay. Because they would be negotiable these matters would also be subject to nonclinical, non-VA third-party review.

VA strongly opposes this provision. Prior to 1991, Title 38 professionals did not have the right to engage in collective bargaining at all. The current restriction on collective bargaining rights is a sound compromise between VA's mission—best serving the needs of our nation's veterans—and the interest of Title 38 physicians, nurses, and other professionals in engaging in collective bargaining. Importantly, Congress recognized that the Secretary, as the head of the VA health care system, would be in the best position to decide when a particular proposal or grievance falls within one of the statutory areas excluded from bargaining. Such determinations should not be legislated. Neither should they be made by a non-clinical third party who is not accountable for assuring the health and safety of the veterans the Department is responsible for. If the Secretary and the Under Secretary for Health are going to be responsible and accountable for the quality of care provided to and the safety of veterans, they must be able to determine which matters affect that care. They must be able to establish standards of professional conduct by and competency of our clinical providers based on what is best for our veterans rather than what is the best that can be negotiated or what an arbitrator decides is appropriate. The Under Secretary for Health has been delegated the authority to make these discretionary determinations. VA has not abused this discretionary authority. Since 1992, there have been no more than 13 decisions issued in a one-year period and, in most cases, even far fewer decisions than that. This is particularly striking given the number of VA health care facilities and bargaining unit employees at those facilities. We are therefore at a loss to understand the need for this provision.

S. 2824 would also transfer VA's Title 38 specific authorities, namely the right to make direct patient care and clinical competency decisions, assess Title 38 professionals' clinical skills, and determine discretionary compensation for Title 38 professionals, to independent third-party arbitrators and other non-VA nonclinical labor third parties who lack clinical training and understanding of

health care management to make such determinations. For instance, labor grievance arbitrators and the Federal Service Impasses Panel would have considerable discretion to impose a clinical or patient care resolution on the parties. VA would have limited, if any, recourse if such an external party erred in its consideration of the clinical or patient care issue. The exceptions to collective bargaining rights for Title 38 employees identify areas that directly impact VA's ability to manage its health care facilities and monitor the professional conduct and competence of its employees; management actions concerning these areas must be reserved for VA professionals.

This bill would allow unions to bargain over, grieve, and arbitrate subjects that are even exempted from collective bargaining under Title 5, including the manner by which an employee is disciplined and the determination of the amount of an employee's compensation. That would be unprecedented in the Federal government. Such a significant change in VA's collective bargaining obligations would adversely impact VA's budget and management rights; it would also skew the current balance maintained between providing beneficial working conditions for Title 38 professionals and meeting patient care needs, jeopardizing the lives of our veterans. There would be no costs associated with this provision.

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S. 2921—CARING FOR WOUNDED WARRIORS ACT OF 2008

Section 2 would require the Secretary to conduct up to three pilot programs, in collaboration with the Secretary of Defense, to assess the feasibility of training and certifying family caregivers to be personal care attendants for veterans and members of the of the Armed Forces suffering from TBI. VA would be required to determine the eligibility of a family member to participate in the pilot programs, and such a determination would have to be based on the needs of the veteran or servicemember as determined by the patient's physician. The training curricula would be developed by VA and include applicable standards and protocols used by certification programs of national brain injury care specialist organizations and best practices recognized by caregiver organizations. Training costs would be borne by VA, with DOD required to reimburse VA at TRICARE rates for the costs of training family members of servicemembers. Family caregivers certified under this program shall be eligible for VA compensation and may receive assessments of their needs in the role of caregiver and referrals to community resources to obtain needed services.

VA does not support section 2. Currently, we are able to contract for caregiver services with home health and similar public and private agencies. The contractor trains and pays them, affords them liability protection, and oversees the quality of their care. This remains the preferable arrangement as it does not divert VA from its primary mission of treating veterans and training clinicians.

Section 3 would require VA, in collaboration with DOD, to carry out a pilot program to assess the feasibility of providing respite care to family caregivers of servicemembers and veterans diagnosed with TBI, through the use of students enrolled in graduate

education programs in the fields of mental health or rehabilitation. Students participating in the program would, in exchange for graduate course credit, provide respite relief to the servicemember's or veteran's family caregiver, while also providing socialization and cognitive skill development to the servicemember or veteran. VA would be required to recruit these students, train them in the provision of respite care, and work with the heads of their graduate programs to determine the amount of training and experience needed to participate in the pilot program.

We do not support section 3, which we recognize is an effort to compel VA to use existing arrangements with affiliated academic institutions as a novel means of providing respite care to family caregivers of TBI patients. Individuals providing respite care do not require advanced degrees, only appropriate training. Respite care is an unskilled type of service that does not qualify for academic credit or serve to meet any curricula objectives in the graduate degree programs related to mental health or rehabilitation. Further, section 3 would require VA to use graduate students in roles that are not permissible under academic affiliation agreements, and we have serious doubts this proposal would be acceptable to graduate schools.

Moreover, VA has a comprehensive respite care program. We also have specialized initiatives underway for TBI patients to reduce the strain on their caregivers, which overlap with this bill. Plus we provide respite care by placing the veteran in a local VA facility for the duration of the respite period. Veterans may receive up to 30 days of respite care per year. We estimate the costs of S. 2921 to be $39,929,000 for fiscal year 2010 and $790,374,000 over a ten-year period.

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S. 2899—"VETERANS SUICIDE STUDY ACT"

S. 2899 would require the Secretary to conduct a study to determine the number of veterans who have committed suicide between January 1, 1997, and the date of the bill's enactment. The study would have to be carried out in coordination with the Secretary of Defense, Veterans Service Organizations, the Centers for Disease Control and Prevention, and State public health offices and veterans agencies. The bill would require the Secretary to submit a report to Congress on his findings within 180 days of the bill's enactment.

VA understands the intent of the Senate in proposing S. 2899. However, we would like to make the Senate aware of the difficulties in accomplishing the legislation's intent—and what VA is doing, and intends to do, to improve our ability to obtain and report on suicide numbers.

At present, determining suicide rates among veterans is a challenging puzzle. Multiple data sources must be used, and data must be carefully checked and rechecked. Each system helps obtain a piece of the complicated puzzle that constitutes the process of accurately estimating rates of veteran suicides. These are time-consuming processes—but they are the best ways VA knows to obtain aggregate data on suicide.

VA relies on multiple sources of information to identify deaths that are potentially due to suicide. This includes VA's own Beneficiary Identification and Records Locator Subsystem, called BIRLS; records from the Social Security Administration; and data compiled by the National Center for Health Statistics in its National Death Index (NDI).

Calculating suicide rates specifically for veterans is made even more difficult by the fact that the National Death Index does not include information about whether a deceased individual is a veteran or not. NDI is simply a central computerized index of death record information on file in the vital statistics offices of every state. The Index is compiled from computer files submitted by State vital statistics offices. Death records are added to the file annually, about twelve months after the end of a calendar year.

Given that the NDI does not indicate veteran status, VA regularly submits requests for information to NDI. VA sends NDI a list of all patients who have not been treated at any VA medical centers in the past twelve months and before, to see if they are still among the living. NDI checks this list against their records, and tells VA which veterans have died, and the cause of their death as listed on the veterans' death certificates. From this information, VA is able to learn the approximate number of veterans under its care who have died of suicide, and to use that information to make comparisons on rates of suicide among those veterans and all other Americans.

This information tells VA about the suicide rates among veterans under its care, but says nothing about the rates of suicide among veterans who are not currently in the system. For those veterans, an even more complicated process has to be followed in order to estimate rates. VA obtains regular updates from the Department of Defense's Defense Manpower Data Center on soldiers separating from the military. Those new veterans immediately become part of total population and suicide calculations.

Additionally, the Department will, among other things, also systematically assess its efforts to inform funeral directors about the importance of determining whether or not a person who has died of suicide is or is not a veteran, and what sorts of information to consider in making that determination. Finally, VA will investigate working directly with state vital records offices, as the NDI does, to obtain information on veteran suicides directly from them.

VA asks that the Senate give us time to complete these actions before requiring any study of the numbers of suicides among veterans. We are "pushing the envelope" to get the most accurate data available on suicides in the shortest possible time frame, and we commit to sharing that data with Congress as soon as it becomes available.

We estimate the cost of this bill to be $1,580,006 in fiscal year 2008 and $2,078,667 over a 10-year period.

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S. 2937—PERMANENT TREATMENT AUTHORITY FOR VETERANS WHO PARTICIPATED IN CERTAIN DOD TESTING

Section 1 would make permanent the Secretary's authority to provide needed inpatient, outpatient, and nursing home care to a veteran who participated in a test conducted by the Department of Defense (DOD) Deseret Test Center as part of its chemical and biological warfare testing program conducted from 1962–1973, for any condition or illness possibly associated with such testing at no cost to the veteran. This authority will expire after December 31, 2008.

VA supports section 1, which we note is identical to our own proposal in S. 2984. We estimate the discretionary cost of this provision to be $4,458,000 in fiscal year 2009 and $144,434,000 over a 10-year period.

Section 2 would require the Secretary, not later than 90 days after the date of the Act's enactment, to enter into a contract with IOM to conduct an expanded study on the health impact of participation in Project Shipboard Hazard and Defense (Project SHAD). Such a study should include, to the extent practicable, all veterans who participated in Project SHAD. VA does not support this provision, as we doubt that an expanded study could be conducted by IOM or any other organization because IOM has already thoroughly studied the health of SHAD veterans and made a concerted attempt to identify all involved veterans for its study.

Mr. Chairman, this concludes my prepared statement. I would be pleased to answer any questions you or any of the members of the Committee may have.

THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, July 21, 2008

Hon. DANIEL A. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: On May 21, 2008, you chaired a hearing to receive comments on 17 healthcare-related bills that were before the Committee. At the hearing, the Department testified on 14 of the bills. We stated that we needed additional time to coordinate the Administration's positions on S. 2926, S. 2963, and S. 2969. With this letter, we are providing views for the record on S. 2926 and S. 2963. The Administration's views on S. 2969 are being transmitted to you by separate letter.

S. 2926—VETERANS RESEARCH AND EDUCATION CORPORATIONS ENHANCEMENT ACT OF 2008

S. 2926 contains many clarifying and technical provisions; however, we will discuss only the substantive provisions of the bill. The most important change to be accomplished by S. 2926 is contained in Section 2. It would amend 38 U.S.C. § 7361 to allow two or more medical centers, with the concurrence of the Secretary, to form a Multi-Medical Center Research Corporation (MMCRC). The MMCRC would be authorized to support research and education projects at the two or more medical centers that had formed it.

This section would also allow an existing non-profit research corporation (NPC), with the approval of the medical centers involved and the Secretary, to expand into a MMCRC. Under current law, a VA medical center may establish an NPC that is authorized to facilitate approved research and education projects at that medical center.

This provision of section 2 would not change the requirement that four members of senior management of one medical center, the Director, the Chief of Staff and, as appropriate, the Assistant Chiefs of Staff for Research and for Education, will serve on the board of the NPC. Rather, it would provide that this core group be augmented by the medical center director from each of the other facilities to be served by that NPC. This would provide VA with one official from each facility served by the MMCRC who may be held accountable by VA. It would require the NPC boards to decide whether their NPCs should evolve into MMCRCs and require them to obtain VA approval. This would ensure that the board has accepted the responsibilities that an MMCRC entails and that VA has considered whether the arrangement is reasonable and in the best interests of the Department.

Section 2(c) would make clear that NPCs are subject to VA oversight and regulation, but not under the direct control of the Department. It would also expressly provide that the NPCs are not "owned or controlled by the United States" or "an agency or instrumentality of the United States." This is currently made clear only in the legislative history of the statute.

Section 3 would clarify that NPCs may support VA research and education generally. More specifically, it would amend 38 USC 7362 to state that NPCs may support "functions related to the conduct of" VA research and education—but still only VA research and education—not just administer approved research or education projects. Currently, the corporations may facilitate only VA-approved research and education projects.

Section 4 would broaden the qualifications for the non-VA board members to include business, legal and financial backgrounds, thus allowing NPCs to use these board positions to acquire the legal and financial expertise needed to ensure sound governance and financial management. Currently, the law requires that there be members of the board of directors of an NPC who are not Federal employees and who "are familiar with issues involving medical and scientific research or education."

Section 4 would also update the conflict of interest provision currently in section 7363(c) of title 38, United States Code, which prevents individuals from serving on the board if they are "affiliated with, employed by, or have any other financial relationship with" a for-profit entity that is a source of funding for VA research.

Section 5 would enhance several powers of the NPCs. Section 5(a) collects in one place all discussion of NPC powers and makes several important clarifications. First, it would provide NPCs with authority to retain fees charged to non-VA attendees for educational programs in order to cover the costs of attendance by such participants. Current law authorizes NPCs to facilitate education, but does not authorize them to retain fees charged to non-VA attendees for educational programs they administer.

Second, it would permit the NPCs to reimburse the VA Office of General Counsel (OGC) for resources necessary for prompt review of Cooperative Research and Development Agreements (CRADAs). This would permit Regional Counsel offices to address the growing volume of CRADAs, the form of agreement mandated by VA to establish terms and conditions for industry-sponsored studies performed at VA medical centers and administered by NPCs. Under the bill, any such reimbursements would be used by OGC for only staffing and training in connection with such legal services.

Third, section 5(a) of the bill would permit NPCs to expend funds for necessary planning purposes, prior to approval of a research project or education program by VA, such as the expenses of preparing a grant proposal. Currently, the NPCs can assist VA with funding only for research or education projects that have already been approved by VA.

Section 5(b) would continue the proscription on VA transfer of appropriated funds to NPCs, but would make explicit the authority of a medical center to "reimburse the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 5." This would codify that reimbursements from VA to NPCs pursuant to Intergovernmental Personnel Act (IPA) assignments are allowable.

Section 7 would increase NPC reporting requirements to include IRS Form 990, which contains a wealth of information about revenues and expenditures as well as major programmatic accomplishments. Section 8 would eliminate the sunset clause on establishing new NPCs.

We support the provision in section 2 of S. 2926 that would authorize the establishment of new multi-center non-profit research corporations (NPCs) and the consolidation of existing single facility NPCs into multi-facility NPCs. This would offer the prospect of NPC-assistance in funding research projects to VA medical centers (VAMCs) that are unable to support their own dedicated corporation. This provision would also provide the system with the tools needed to consolidate or close NPCs that are too small to institute proper internal controls without the loss of the funding support for VA research and education programs that the NPCs provide. By requiring the Director of all VAMCs supported by an NPC to sit on its board of directors, the provision would provide this beneficial increased flexibility without sacrificing VA oversight.

With respect to the draft bill's remaining provisions, however, we ask the Committee to defer further action on this draft bill in order to give the Department an opportunity to address underlying structural issues and to formulate policy related to the governance and finance of the VA affiliated non-profit research corporations. A steering committee has been chartered by the Veterans Health Administration Office of Research and Development, to provide recommendations regarding governance, oversight, and finance issues related to the corporations by the end of the fiscal year. We will be happy to provide you with a copy of their final report and recommendations.

S. 2963—VA Mental Health and Other Benefits Extended to Members of the Armed Forces

Section 1 of the bill would require the Secretary of the Department of Veterans Affairs (VA), acting through the Under Secretary for Health, to carry out a program to provide scholarships to individuals pursuing education or training in behavioral health care specialties critical to the operations of the Department's Vet Centers. Individuals eligible for the program would include those pursing education or training leading to licensure or certification in behavioral health care specialties, which the Secretary deems are critical to the operation of the Vet Centers and who otherwise meet other criteria or requirements established by the Secretary. The amount of any scholarship provided under the program would be determined by the Secretary; however, the total amount available for all the scholarships provided under the program in any fiscal year could not exceed $2 million.

In exchange for the scholarship, an individual participating in the program would be required to enter into an agreement with the Secretary and fulfill a service obligation in a Vet Center, as specified in the agreement. Section 1 would also require these agreements to include repayment provisions in the event the individual does not fulfill the service obligation. The bill would also specify that these scholarships are to be paid from amounts made available to VA for the provision of readjustment benefits.

VA supports the concept of using scholarships for this purpose; however, this provision is unnecessary. Under existing authority, we could establish by regulation a special scholarship program for individuals pursuing degrees in mental health specialties and require those individuals to agree to serve for a specified period in VA's Vet Centers. The current program is used very successfully to recruit individuals for difficult-to-recruit and difficult-to-retain health care positions throughout the country. We believe it is essential to target scholarships to difficult-to-recruit and difficult-to-retain occupations across the Veterans Health Administration system, rather than limiting scholarships to specific facilities.

We note that current law provides express terms governing a participant's service obligation and liability if a breach occurs at any phase in the program. These statutory provisions help ensure that VA is able to reap the benefits of tangible and intangible investments made by the Department. In addition, current law imposes treble damages for a scholarship participant who fails to complete the service obligation. In sharp contrast, section 1 would require VA to promulgate regulations relating to repayment of the amount of a scholarship provided under this section. Imposing significant penalties for those who breach their service obligations helps VA to deter individuals from using VA as an interest-free, tax-free educational loan program. Section 1 provides no effective means of ensuring that VA will receive the benefit of the participants' professional services as VA employees. Finally, because Vet Centers are currently funded through the medical care appropriations we believe the cost of such scholarship program shall be funded from the same appropriations, rather than the readjustment benefits program.

We estimate the cost of section 1 to be $2,313,938 for fiscal year 2009 and $24,483,918 over a 10-year period.

Section 2 of S. 2963 would extend eligibility for VA's readjustment counseling and related services provided through the Department's Vet Centers to members of the Armed Forces, including members of the National Guard or Reserve, who serve on active duty in Operation Enduring Freedom or Operation Iraqi Freedom (OEF/OIF). Service members would be eligible for the readjustment counseling services even if they are on active duty at the time they receive them. They would have to also meet eligibility requirements prescribed jointly by the Secretary of Veterans Affairs and the Secretary of Defense.

VA supports section 2. We can most effectively address the readjustment needs of former combat-theater service members who are still on active duty through early intervention—even before they are discharged. With our expertise, we can help prepare them for many of the common readjustment problems experienced by veterans with combat service. Extending readjustment counseling and related services to this population may also help to resolve problems that otherwise might prevent some of them from pursuing long-term military careers. We note that VA provides these services in a confidential setting and in a manner that helps to reduce any concern that an active-duty military member may have about any stigma related to seeking counseling or other mental health services. Thus, we see significant benefits to this section.

We also note that, by operation of law, these service members' immediate family members would remain eligible for certain family-support services while the service member is on active duty. These services would be provided only to the extent that they are needed for, or in furtherance of, the active-duty member's successful readjustment to civilian life.

The Department estimates the cost of section 2 to be $14,791,000 for fiscal year 2009 and $178,418,309 over a 10-year period. The increased fiscal year 2009 workload resulting from this proposal can be absorbed within the fiscal year 2009 President's Budget request, which includes funding for the establishment of 39 new Vet Centers.

Section 3 would require the Secretary to provide referral services at Vet Centers to individuals who have been discharged or released from active military, naval, or air service but who are not eligible to receive readjustment counseling and related services. It would also require VA to advise these individuals of their right to apply to the appropriate military, naval, or air service for review and upgrade of their discharge status.

VA does not support section 3. Vet Centers provide readjustment counseling and related services to veterans who: (1) meet the title 38 definition of veteran (i.e., "a person who served in the active military, naval, or air service, and who was discharged or released therefore under conditions other than dishonorable)"; and (2) served in a combat theater. It is unclear whether this provision is intended to address all of those with "less than honorable" discharges. If so, the language of this section is exceptionally broad and would broaden eligibility for these referral services to non-com-

bat veterans. These clarifications need to be made before VA can develop a position and cost estimate for the provision.

Section 4 would require that the suicide by certain former members of the Armed Forces that occurs during the two-year period beginning on the date of separation or retirement from the Armed Forces be treated as a death in the line of duty for purposes of survivors' eligibility for certain benefits. The former Armed Forces members who would be covered are those "with a medical history of a combat-related mental health condition or Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI)." The benefits that would be covered under section 4 are "[b]urial benefits," Survivor Benefit Plan benefits under title 10, United States Code, "[b]enefits under the laws administered by the Secretary of Veterans Affairs," and Social Security Act benefits. Furthermore, for purposes of benefits under section 4, the date of death would be considered to be the date of separation or retirement from the Armed Forces, except that, for purposes of determining "the scope and nature of the entitlement," the date of death would be considered to be the date of the suicide. We believe this last provision would provide the date of death for purposes of determining the effective date of an award or amount of benefits, although this is not clear from the bill's language. Essentially, under section 4, the suicide of a covered individual would be treated as a service-connected death for VA benefit purposes.

Although VA supports the concept of section 4 and recognizes its compassionate intent, we cannot support this provision because it may have a negative impact. In some cases, the veterans' combat-related mental health conditions may make them susceptible to considering suicide. Knowing survivor benefits would be awarded to their spouses and children might exacerbate their conditions, making them even more susceptible to acting on their suicide ideations. Their illnesses may cause them to reject any opportunity to obtain medical assistance, believing instead that their families will benefit more from their suicide. This might especially be the case for those who feel overwhelmed by their obligation to provide for their families.

We also have several technical concerns with section 4. Subsection (b) identifies the covered former Armed Forces members as those "with a medical history of a combat-related mental health condition or [PTSD] or [TBI]." It is unclear from the language whether the adjective "combat-related" is meant to modify PTSD and TBI as well as mental health condition. The statement of the bill's sponsor upon introducing the bill suggests so. "This legislation guarantees benefits * * * provided they have a documented medical history of a combat-related mental-health condition, including PTSD or TBI." 154 Cong. Rec. S3716 (daily ed. May 1, 2008). However, the bill language should be clarified.

Subsection (c)(1) identifies "[b]urial benefits" as one of the covered benefits, but fails to specify from which Federal department or agency. We note that subsection (c)(3) identifies as covered benefits "[b]enefits under the laws administered by [VA]," which would cover VA burial benefits and therefore implies that subsection (c)(1) refers to another agency. Again, the introductory statement of the bill's sponsor suggests a solution to this interpretive question. "The

Service Member's survivor will be entitled to the same * * * active duty burial benefits that they would have received" had the former service member died on active duty, id., but clarification of the bill language may be in order.

VA is still in the process of developing costs for section 4.

Section 5 would require DOD to carry out a grant program for non-profit organizations furnishing support services to survivors of deceased service members and veterans. As to this section, VA defers to the views of the Secretary of Defense.

The Office of Management and Budget advises that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely yours,

JAMES B. PEAKE, M.D.

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THE SECRETARY OF VETERANS AFFAIRS,
Washington, DC, August 8, 2008.

Hon. DANIEL K. AKAKA,
Chairman,
Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: I am pleased to respond to your July 8, 2008, request for the views of the Department of Veterans Affairs (VA) on the amendment proposed by Ranking Republican Member Richard Burr to S. 2969, 110th Congress. As you are aware, the Committee recently approved an amended version of S. 2969, which is now entitled the "Veterans Health Care Authorization Act of 2008." Senator Burr's amendment, which was incorporated in the amended bill, would add a new section 5511 to title 38, United States Code, relating to the Brady Handgun Violence Prevention Act, Public Law 103–159 (Brady Act). Because the amendment in its current form does not directly affect VA programs, such an amendment would be more appropriate for inclusion in title 18 of the United States Code.

The amendment relates to enforcement of 18 U.S.C. § 922, which is administered by the Department of Justice (DOJ). Specifically, the amendment would affect the manner in which DOJ implements 18 U.S.C. § 922, which prohibits certain persons from receiving firearms. The amendment does not affect VA's provision of benefits to veterans and their families. Because the substance of the amendment relates to matters within DOJ's jurisdiction, as drafted, it is more appropriate for inclusion in title 18.

At the request of the Attorney General pursuant to section 103(e)(1) of the Brady Act, VA provides DOJ with information concerning persons VA finds to be "mentally incompetent"—a finding VA bases solely on a person's ability to contract or manage his or her affairs in the context of VA benefits. VA's role with respect to the Brady Act is limited to providing DOJ such requested information; VA does not determine whether such information should prohibit a person from possessing firearms. DOJ is responsible for determining whether persons reported by VA or other Federal agencies are prohibited by 18 U.S.C. § 922 from possessing firearms.

The amendment would provide that a veteran, surviving spouse, or child found mentally incompetent by VA would not be deemed to fall within the prohibition of 18 U.S.C. § 922 unless a judicial authority has determined that the individual is a danger to himself or herself or others. You have requested VA's views concerning how this Department would implement the requirement for a judicial finding. We note that the language of the amendment would not direct VA to obtain such findings. VA does not implement or enforce the provisions of 18 U.S.C. § 922 that would be affected by the requirement for a judicial finding under this amendment. Moreover, as VA's process for making incompetency determinations is administrative, as opposed to judicial, VA could not implement the requirement for a judicial finding.

You have also requested information concerning the number of instances per year in which VA determines that an individual is a danger to himself or herself or others. As discussed above, VA does not make such determinations. VA competency determinations are made under 38 C.F.R. § 3.353 based solely on evaluation of whether the individual "lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitation." Although VA medical staff might, in isolated instances, offer opinions regarding an individual's mental status and potential for harm when requested with regard to state court proceedings, such medical opinions, like VA's competency determinations, are neither VA determinations of danger to self or others nor adjudications of mental defectiveness under 18 U.S.C. § 922. Consequently, VA currently has no system for identifying or collecting data on such matters.

Because the amendment itself would not impose any additional reporting or implementation responsibilities, there would be no direct costs associated with this amendment.

In summary, VA believes the amendment, as drafted, is more appropriate for inclusion in title 18 of the United States Code because it does not directly affect VA programs. Because the amendment pertains directly to a title 18 program, the Committee may wish to accord DOJ an opportunity to provide views on this legislation.

We are sending a copy of this report to Ranking Member Burr.

The Office of Management and Budget has advised that there is no objection to the submission of this report from the standpoint of the Administration's program.

Sincerely yours,

JAMES B. PEAKE, M.D.

* * * * * * *

SUPPLEMENTAL VIEWS OF HON. DANIEL K. AKAKA, CHAIRMAN

I am submitting Supplemental Views to express my concerns about section 803 of the Committee bill, which would change VA's actions in fulfilling the Department's responsibilities under the Brady Handgun Violence Prevention Act, Public Law 103–159, and that law's implementing regulations as set forth in a Memorandum of Understanding between VA and the Department of Justice.

This provision was added to the Committee bill by an amendment offered by the Committee's Ranking Minority Member, Senator Burr. Senator Burr's amendment was derived from S. 3167, which he introduced on June 19, 2008, after the Committee had completed its legislative hearings related to the Committee's June 26, 2008, markup. As a consequence of that timeline, the Committee was unable to secure any testimony or other input on the provision prior to the markup. Subsequent to the markup, I sought official views on this provision, first from the Department of Veterans Affairs and then, once those views were received, from the Department of Justice. VA's official views are included in this report.

I begin by noting that I am not on the Judiciary Committee nor do I have any other reason to have strong familiarity with the Brady Act. Because I do not have that background, there are many questions that I would have sought to have answered in a hearing, were it to be established that this measure belongs in our Committee rather than in Judiciary. On that point, I agree that S. 3167, as drafted, was appropriately referred to the Veterans' Affairs Committee, but I do not agree that the subject matter belongs in our Committee.

For example, one question—how do the changes made by the NICS Improvement Amendments Act of 2007, Public Law 110–180, which was just signed earlier this year, change VA's process for providing names to the Department of Justice? I have seen the changes made by that Act described as:

> Prevent[ing] use of federal "adjudications" that consist only of medical diagnoses without findings that the people involved are dangerous or mentally incompetent.

This description, which was applauding the new law, went on to say that this change would ensure that purely medical records are never used in NICS. Gun ownership rights would only be lost as a result of a finding that the person is a danger to themselves or others, or *lacks the capacity to manage his own affairs* [emphasis added]. That last test seems to me to be fully consistent with what VA has been doing for a number of years. If that is correct—and I acknowledge, frankly, that I am not certain, nor do I believe that the Veterans' Affairs Committee knows, because there has been no

hearing—the reason for making a change to the current practice is not clear to me.

What effect will the standard included in the amendment—requiring adjudication by "a judge, magistrate, or other judicial authority" that someone is a "danger to him- or herself"—have on VA's ability to provide input to the NICS? Will this change result in a delay in providing notification to NICS of the names of individuals who are not in a position to purchase a firearm? Is this the standard applied by other governmental organizations? Again, I do not know the answer, because there was no hearing.

VA's current actions to provide input to NICS are done in accordance with provisions in title 27 of the Code of Federal Regulations which spell out the requirements of the law. In the relevant regulation, 27 CFR 478.11, the term in the law—"adjudicated as a mental defective"—is defined to include those determined by "a lawful authority" to lack "mental capacity to contract or manage his own affairs." It is the names of those who VA has found meet that standard that VA has been reporting to the Department of Justice. To characterize VA's actions as arbitrary and unfair, as was done during the Committee markup, is wrong. Perhaps the implementing regulations should be changed—again, a task for a Committee other than the Veterans' Affairs Committee—but it is hard to fault VA's compliance with the regulations.

My last concern with this provision, and the process by which it was brought before the Committee, goes to the question of urgency. As I noted above, the legislation from which the amendment was derived was introduced one week prior to a previously-scheduled markup. The amendment addresses a practice that dates back to 1998. What possible reason exists for suggesting that there is an urgent need to address this issue? Rather than proceeding in haste, and in the wrong Committee, I believe that the legislation should have been considered in the normal course by the Judiciary Committee.

* * * * * * *

CHANGES IN EXISTING LAW

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, changes in existing law made by the Committee bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38. VETERANS' BENEFITS

PART I. GENERAL PROVISIONS

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CHAPTER 5. AUTHORITY AND DUTIES OF THE SECRETARY

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Subchapter III. Advisory Committees

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SEC. 542. ADVISORY COMMITTEE ON WOMEN VETERANS

(a)(1) The Secretary shall establish an advisory committee to be known as the Advisory Committee on Women Veterans (hereinafter in this section referred to as "the Committee").

(2)(A) The Committee shall consist of members appointed by the Secretary from the general public, including—

(i) representatives of women veterans;

(ii) individuals who are recognized authorities in fields pertinent to the needs of women veterans, including the gender-specific health-care needs of women; [and]

(iii) representatives of both female and male veterans with service-connected disabilities, including at least one female veteran with a service-connected disability and at least one male veteran with a service-connected disability[.] *; and*

(iv) women veterans who are recently separated from service in the Armed Forces.

* * * * * * *

SEC. 544. ADVISORY COMMITTEE ON MINORITY VETERANS

(a)(1) The Secretary shall establish an advisory committee to be known as the Advisory Committee on Minority Veterans (hereinafter in this section referred to as "the Committee").

(2)(A) The Committee shall consist of members appointed by the Secretary from the general public, including—

(i) representatives of veterans who are minority group members;

(ii) individuals who are recognized authorities in fields pertinent to the needs of veterans who are minority group members;

(iii) veterans who are minority group members and who have experience in a military theater of operations; [and]

(iv) veterans who are minority group members and who do not have such experience[.] *; and*

(v) women veterans who are minority group members and are recently separated from service in the Armed Forces.

* * * * * * *

CHAPTER 9. SECURITY AND LAW ENFORCEMENT ON PROPERTY UNDER THE JURISDICTION OF THE DEPARTMENT

* * * * * * *

SEC. 902. ENFORCEMENT AND ARREST AUTHORITY OF DEPARTMENT POLICE OFFICERS

(a)(1) Employees of the Department who are Department police officers shall, with respect to acts occurring on Department property[, enforce]—

(A) *enforce* Federal laws;

(B) *enforce* the rules prescribed under section 901 of this title; [and]

(C) [subject to paragraph (2), traffic and motor vehicle laws of a State or local government within the jurisdiction of which such Department property is located.] *enforce traffic and motor vehicle laws of a State or local government (by issuance of a citation for violation of such laws) within the jurisdiction of which such Department property is located as authorized by an express grant of authority under applicable State or local law;*

(D) carry the appropriate Department-issued weapons, including firearms, while off Department property in an official capacity or while in an official travel status;

(E) conduct investigations, on and off Department property, of offenses that may have been committed on property under the original jurisdiction of Department, consistent with agreements or other consultation with affected local, State, or Federal law enforcement agencies; and

(F) carry out, as needed and appropriate, the duties described in subparagraphs (A) through (E) of this paragraph when engaged in duties authorized by other Federal statutes.

[(2) A law described in subparagraph (C) of paragraph (1) may be enforced under such subparagraph only as authorized by an express grant of authority under applicable State or local law. Any such enforcement shall be by the issuance of a citation for violation of such law.]

(2) [(3)] Subject to regulations prescribed under subsection (b), a Department police officer may make arrests on Department property for a violation of a Federal law or any rule prescribed under section 901(a) of this title *, and on any arrest warrant issued by competent judicial authority*.

(b) * * *

(c) [The Secretary shall consult with the Attorney General before prescribing regulations under paragraph (1) of subsection (b).] *The powers granted to Department police officers designated under this section shall be exercised in accordance with guidelines approved by the Secretary and the Attorney General.*

(d) * * *

SEC. 903. UNIFORM ALLOWANCE

(a) * * *

[(b) The amount of the allowance that the Secretary may pay under this section—

[(1) may be based on estimated average costs or actual costs;

[(2) may vary by geographic regions; and

[(3) except as provided in subsection (c), may not exceed $ 200 in a fiscal year for any police officer.]

(b)(1) The amount of the allowance that the Secretary may pay under this section is the lesser of—

(A) the amount currently allowed as prescribed by the Office of Personnel Management; or

(B) estimated costs or actual costs as determined by periodic surveys conducted by the Department.

(2) During any fiscal year no officer shall receive more for the purchase of a uniform described in subsection (a) than the amount established under this subsection.

(c) [The amount of an allowance under this section may be increased to an amount up to $ 400 for not more than one fiscal year in the case of any Department police officer. In the case of a person who is appointed as a Department police officer on or after January 1, 1990, an allowance in an amount established under this subsection shall be paid at the beginning of such person's employment as such an officer. In the case of any other Department police officer, an allowance in an amount established under this subsection shall be paid upon the request of the officer.] *The allowance established under subsection (b) shall be paid at the beginning of a Department police officer's employment for those appointed on or after October 1, 2008. In the case of any other Department police officer, an allowance in the amount established under subsection (b) shall be paid upon the request of the officer.*

PART II. GENERAL BENEFITS

* * * * * * *

CHAPTER 17. HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I. GENERAL

Sec.

1701. Definitions.

* * * * * * *

1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care.

* * * * * * *

SUBCHAPTER VIII. HEALTH CARE OF PERSONS OTHER THAN VETERANS

* * * * * * *

1786. Care for newborn children of women veterans receiving maternity care.

Subchapter I. General

SEC. 1701. DEFINITIONS

* * * * * * *

(6) The term "medical services" includes, in addition to medical examination, treatment, and rehabilitative services, the following:

(A) Surgical services.

(B) Dental services and appliances as described in sections 1710 and 1712 of this title.

(C) Optometric and podiatric services.

(D) Preventive health services.

(E) Noninstitutional extended care services, including alternatives to institutional extended care which the Secretary may furnish directly, by contract, or through provision of case management by another provider or payor.

(F) ⟦(E)⟧ In the case of a person otherwise receiving care or services under this chapter—

(i) wheelchairs, artificial limbs, trusses, and similar appliances;

(ii) special clothing made necessary by the wearing of prosthetic appliances; and

(iii) such other supplies or services as the Secretary determines to be reasonable and necessary.

(G) ⟦(F)⟧ Travel and incidental expenses pursuant to section 111 of this title.

* * * * * * *

⟦(10)(A) During the period beginning on November 30, 1999, and ending on December 31, 2008, the term "medical services" includes noninstitutional extended care services.

⟦(B) For the purposes of subparagraph (A), the term "noninstitutional extended care services" means such alternatives to institutional extended care which the Secretary may furnish

(i) directly, (ii) by contract, or (iii) (through provision of case management) by another provider or payor.]

* * * * * * *

SEC. 1703. CONTRACTS FOR HOSPITAL CARE AND MEDICAL SERVICES IN NON-DEPARTMENT FACILITIES

* * * * * * *

(d)(4) The authority of the Secretary under this subsection terminates on [September 30, 2008] *September 30, 2013*.

* * * * * * *

SEC. 1709. DISCLOSURE TO SECRETARY OF HEALTH-PLAN CONTRACT INFORMATION AND SOCIAL SECURITY NUMBER OF CERTAIN VETERANS RECEIVING CARE

(a) REQUIRED DISCLOSURE OF HEALTH-PLAN CONTRACTS.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary such current information as the Secretary may require to identify any health-plan contract (as defined in section 1729(i) of this title) under which such individual is covered, to include, as applicable—

(A) the name, address, and telephone number of such health-plan contract;

(B) the name of the individual's spouse, if the individual's coverage is under the spouse's health-plan contract;

(C) the plan number; and

(D) the plan's group code.

(2) The care described in this paragraph is—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services; or

(C) other medical care under laws administered by the Secretary.

(b) REQUIRED DISCLOSURE OF SOCIAL SECURITY NUMBER.—(1) Any individual who applies for or is in receipt of care described in paragraph (2) shall, at the time of such application, or otherwise when requested by the Secretary, submit to the Secretary—

(A) the individual's social security number; and

(B) the social security number of any dependent or Department beneficiary on whose behalf, or based upon whom, such individual applies for or is in receipt of such care.

(2) The care described in this paragraph is—

(A) hospital, nursing home, or domiciliary care;

(B) medical, rehabilitative, or preventive health services; or

(C) other medical care under laws administered by the Secretary.

(3) This subsection does not require an individual to furnish the Secretary with a social security number for any individual to whom a social security number has not been assigned.

(c) FAILURE TO DISCLOSE SOCIAL SECURITY NUMBER.—(1) The Secretary shall deny an individual's application for, or may terminate an individual's enrollment in, the system of patient enrollment established by the Secretary under section 1705 of this title, if such individual does not provide the social security number required or requested to be submitted pursuant to subsection (b).

(2) Following a denial or termination under paragraph (1) with respect to an individual, the Secretary may, upon receipt of the information required or requested under subsection (b), approve such individual's application or reinstate such individual's enrollment (if otherwise in order), for such medical care and services provided on and after the date of such receipt of information.

(d) CONSTRUCTION.—Nothing in this section shall be construed as authority to deny medical care and treatment to an individual in a medical emergency.

Subchapter II. Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

SEC. 1710. ELIGIBILITY FOR HOSPITAL, NURSING HOME, AND DOMICILIARY CARE

* * * * * * *

(e)(1)(A) * * *

* * * * * * *

(3) Hospital care, medical services, and nursing home care may not be provided under or by virtue of subsection (a)(2)(F)—

(A) in the case of care for a veteran described in paragraph (1)(A), after December 31, 2002;

(B) in the case of care for a veteran described in paragraph (1)(C), after December 31, 2002; *and*

(C) in the case of care for a veteran described in paragraph (1)(D) who—

(i) is discharged or released from the active military, naval, or air service after the date that is five years before the date of the enactment of the National Defense Authorization Act for Fiscal Year 2008 [enacted Jan. 28, 2008], after a period of five years beginning on the date of such discharge or release; or

(ii) is so discharged or released more than five years before the date of the enactment of that Act and who did not enroll in the patient enrollment system under section 1705 of this title before such date, after a period of three years beginning on the date of the enactment of that Act**[**; and**]**.

[(D) in the case of care for a veteran described in paragraph (1)(E), after December 31, 2007.**]**

(f)(1) The Secretary may not furnish hospital care or nursing home care *(except if such care constitutes hospice care)* under this section to a veteran who is eligible for such care under subsection (a)(3) of this section unless the veteran agrees to pay to the United States the applicable amount determined under paragraph (2) or (4) of this subsection.

* * * * * * *

(g)(1) The Secretary may not furnish medical services *(except if such care constitutes hospice care)* under subsection (a) of this section (including home health services under section 1717 of this title) to a veteran who is eligible for hospital care under this chapter by reason of subsection (a)(3) of this section unless the veteran agrees to pay to the United States in the case of each outpatient

visit the applicable amount or amounts established by the Secretary by regulation.

* * * * * * *

SEC. 1710A. REQUIRED NURSING HOME CARE

* * * * * * *

(d) The provisions of subsection (a) shall terminate on [December 31, 2008] *December 31, 2013*.

* * * * * * *

SEC. 1710E. TRAUMATIC BRAIN INJURY: USE OF NON-DEPARTMENT FACILITIES FOR REHABILITATION

(a) COOPERATIVE AGREEMENTS.— * * *

(b) COVERED INDIVIDUALS.—The care and services provided under subsection (a) shall be made available to an individual—

(1) who is described in section 1710C(a) of this title; and

(2)(A) to whom the Secretary is unable to provide such treatment or services at the frequency or for the duration prescribed in such plan; or

(B) for whom the Secretary determines that it is optimal with respect to the recovery and rehabilitation for such individual."

(c) [(b)] AUTHORITIES OF STATE PROTECTION AND ADVOCACY SYSTEMS.— * * *

(d) STANDARDS.—The Secretary may not provide treatment or services as described in subsection (a) at a non-Department facility under such subsection unless such facility maintains standards for the provision of such treatment or services established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with traumatic brain injury.

SEC. 1712A. ELIGIBILITY FOR READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES.

* * * * * * *

(c) Upon receipt of a request for counseling under this section from any individual who has been discharged or released from active military, naval, or air service but who is not otherwise eligible for such counseling, the Secretary shall—

(1) provide referral services to assist such individual, to the maximum extent practicable, in obtaining mental health care and services from sources outside the Department; and

(2) if pertinent, advise such individual of such individual's rights to apply to the appropriate military, naval, or air service, and to the Department, for review of such individual's discharge or release from such service.

SEC. 1720. TRANSFERS FOR NURSING HOME CARE; ADULT DAY HEALTH CARE

* * * * * * *

(g) The Secretary may contract with appropriate entities to provide specialized residential care and rehabilitation services to a veteran of Operation Enduring Freedom or Operation Iraqi Freedom who the Secretary determines suffers from a traumatic brain injury, has an accumulation of deficits in activities of daily living and instrumental activities of daily living, and because of these deficits,

would otherwise require admission to a nursing home even though such care would generally exceed the veteran's nursing needs.

* * * * * * *

SEC. 1720D. COUNSELING AND TREATMENT FOR SEXUAL TRAUMA

* * * * * * *

(d)(1) The Secretary shall implement a program for education, training, certification, and continuing medical education for mental health professionals to specialize in the provision of counseling and care to veterans eligible for services under subsection (a). In carrying out the program, the Secretary shall ensure that all such mental health professionals have been trained in a consistent manner and that such training includes principles of evidence-based treatment and care for sexual trauma.

(2) The Secretary shall determine the minimum qualifications necessary for mental health professionals certified by the program under paragraph (1) to provide evidence-based treatment and therapy to veterans eligible for services under subsection (a) in facilities of the Department.

(e) The Secretary shall submit to Congress each year a report on the counseling and care and services provided to veterans under this section. Each report shall include data for the preceding year with respect to the following:

(1) The number of mental health professionals and primary care providers who have been certified under the program under subsection (d), and the amount and nature of continuing medical education provided under such program to professionals and providers who have been so certified.

(2) The number of women veterans who received counseling and care and services under subsection (a) from professionals and providers who have been trained or certified under the program under subsection (d).

(3) The number of training, certification, and continuing medical education programs operating under subsection (d).

(4) The number of trained full-time equivalent employees required in each facility of the Department to meet the needs of veterans requiring treatment and care for sexual trauma.

(5) Such other information as the Secretary considers appropriate.

(f) **[**(d)**]** In this section, the term "sexual harassment" means repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character.

* * * * * * *

Subchapter VIII. Health Care of Persons Other Than Veterans

SEC. 1781. MEDICAL CARE FOR SURVIVORS AND DEPENDENTS OF CERTAIN VETERANS

(a) * * *

* * * * * * *

(e) Payment by the Secretary under this section on behalf of a covered beneficiary for medical care shall constitute payment in full

and extinguish any liability on the part of the beneficiary for that care.

* * * * * * *

SEC. 1786. CARE FOR NEWBORN CHILDREN OF WOMEN VETERANS RECEIVING MATERNITY CARE

(a) IN GENERAL.—The Secretary may furnish health care services described in subsection (b) to a newborn child of a woman veteran who is receiving maternity care furnished by the Department for not more than 7 days after the birth of the child if the veteran delivered the child in—

(1) a facility of the Department; or

(2) another facility pursuant to a Department contract for services relating to such delivery.

(b) COVERED HEALTH CARE SERVICES.—Health care services described in this subsection are all post-delivery care services, including routine care services, that a newborn requires.

CHAPTER 18. BENEFITS FOR CHILDREN OF VIETNAM VETERANS AND OTHER VETERANS

Subchapter I. Children of Vietnam Veterans Born With Spina Bifida

* * * * * * *

SEC. 1803. HEALTH CARE

* * * * * * *

(b) * * *

(c) Where payment by the Secretary under this section is less than the amount of the charges billed, the health care provider or agent of the health care provider may seek payment for the difference between the amount billed and the amount paid by the Secretary from a responsible third party to the extent that the provider or agent thereof would be eligible to receive payment for such care or services from such third party, but—

(1) the health care provider or agent for the health care provider may not impose any additional charge on the beneficiary who received the medical care, or the family of such beneficiary, for any service or item for which the Secretary has made payment under this section;

(2) the total amount of payment a provider or agent of the provider may receive for care and services furnished under this section may not exceed the amount billed to the Secretary; and

(3) the Secretary, upon request, shall disclose to such third party information received for the purposes of carrying out this section.

(d) ⟦(c)⟧ For the purposes of this section—

* * * * * * *

SEC. 1813. HEALTH CARE

* * * * * * *

(b) * * *

(c) SEEKING PAYMENT FROM THIRD PARTIES.—Where payment by the Secretary under this section is less than the amount of the

charges billed, the health care provider or agent of the health care provider may seek payment for the difference between the amount billed and the amount paid by the Secretary from a responsible third party to the extent that the health care provider or agent thereof would be eligible to receive payment for such care or services from such third party, but—

(1) the health care provider or agent for the health care provider may not impose any additional charge on the beneficiary who received medical care, or the family of such beneficiary, for any service or item for which the Secretary has made payment under this section;

(2) the total amount of payment a provider or agent of the provider may receive for care and services furnished under this section may not exceed the amount billed to the Secretary; and

(3) the Secretary, upon request, shall disclose to such third party information received for the purposes of carrying out this section.

(d) ⟦(c)⟧ DEFINITIONS.— * * *

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CHAPTER 20. BENEFITS FOR HOMELESS VETERANS

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Subchapter II. Comprehensive Service Programs

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SEC. 2013. AUTHORIZATION OF APPROPRIATIONS

There is authorized to be appropriated to carry out this subchapter ⟦$130,000,000⟧ *$200,000,000* for fiscal year 2007 and each fiscal year thereafter.

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PART IV. GENERAL ADMINISTRATIVE PROVISIONS

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CHAPTER 51. CLAIMS, EFFECTIVE DATES, AND PAYMENTS

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CHAPTER 55. MINORS, INCOMPETENTS, AND OTHER WARDS

Sec.

5501. Commitment actions.

* * * * * * *

5510. Annual report.

5511. Conditions for treatment of veterans, their surviving spouses, and their children as adjudicated mentally incompetent for certain purposes.

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SEC. 5501. COMMITMENT ACTIONS

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SEC. 5510. ANNUAL REPORT

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SEC. 5511. CONDITIONS FOR TREATMENT OF VETERANS, SURVIVING SPOUSES, AND CHILDREN AS ADJUDICATED MENTALLY INCOMPETENT FOR CERTAIN PURPOSES

In any case arising out of the administration by the Secretary of laws and benefits under this title, a veteran, surviving spouse, or child who is mentally incapacitated, deemed mentally incompetent, or experiencing an extended loss of consciousness shall not be considered adjudicated as a mental defective under subsection (d)(4) or (g)(4) of section 922 of title 18 without the order or finding of a judge, magistrate, or other judicial authority of competent jurisdiction that such veteran, surviving spouse, or child is a danger to him- or herself or others.

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CHAPTER 57. RECORDS AND INVESTIGATIONS

Subchapter I. Records

SEC. 5701. CONFIDENTIAL NATURE OF CLAIMS

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(l) Under regulations that the Secretary shall prescribe, the Secretary may disclose the name or address, or both, of any individual who is a present or former member of the Armed Forces, or who is a dependent of a present or former member of the Armed Forces, to a third party, as defined in section 1729(i)(3)(D) of this title, in order to enable the Secretary to collect reasonable charges under section 1729(a)(2)(E) of this title for care or services provided for a non-service-connected disability.

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PART V. BOARDS, ADMINISTRATIONS, AND SERVICES

CHAPTER 73. VETERANS HEALTH ADMINISTRATION-ORGANIZATION AND FUNCTIONS

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SUBCHAPTER II. GENERAL AUTHORITY AND ADMINISTRATION

Sec.

7311. Quality assurance.

7311A. Quality assurance officers.

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SUBCHAPTER IV. RESEARCH CORPORATIONS

* * * * * * *

7365. [7364A.] Coverage of employees under certain Federal tort claims laws.

[7365. Applicable State law]

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[7368. Expiration of authority.]

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Subchapter II. General Authority and Administration

SEC. 7311. QUALITY ASSURANCE

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(b)(1) * * *

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(4) As part of the quality assurance program, the Under Secretary for Health shall establish mechanisms through which employees of Veterans Health Administration facilities may submit reports, on a confidential basis, on matters relating to quality of care in Veterans Health Administration facilities to the quality assurance officers of such facilities under section 7311A(b) of this title. The mechanisms shall provide for the prompt and thorough review of any reports so submitted by the receiving officials.

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SEC. 7311A. QUALITY ASSURANCE OFFICERS

(a) NATIONAL QUALITY ASSURANCE OFFICER.—(1) The Under Secretary for Health shall designate an official of the Veterans Health Administration to act as the principal quality assurance officer for the quality assurance program required by section 7311 of this title. The official so designated may be known as the "National Quality Assurance Officer of the Veterans Health Administration" (in this section referred to as the "National Quality Assurance Officer").

(2) The National Quality Assurance Officer shall report directly to the Under Secretary for Health in the discharge of responsibilities and duties of the Officer under this section.

(3) The National Quality Assurance Officer shall be the official within the Veterans Health Administration who is principally responsible for the quality assurance program referred to in paragraph (1). In carrying out that responsibility, the Officer shall be responsible for—

(A) establishing and enforcing the requirements of that program; and

(B) carrying out such other responsibilities and duties relating to quality assurance in the Veterans Health Administration as the Under Secretary for Health shall specify.

(4) The requirements under paragraph (3) shall include requirements regarding the following:

(A) A confidential system for the submittal of reports by Veterans Health Administration personnel regarding quality assurance at Department facilities.

(B) Mechanisms for the peer review of the actions of individuals appointed in the Veterans Health Administration in the position of physician.

(C) Mechanisms for the accountability of the facility director and chief medical officer of each Veterans Health Administration medical facility for the actions of physicians in such facility.

(b) QUALITY ASSURANCE OFFICERS FOR VISNS.—(1) The Regional Director of each Veterans Integrated Services Network (VISN) shall appoint an official of the Network to act as the quality assurance officer of the Network.

(2) The quality assurance officer for a Veterans Integrated Services Network shall report to the Regional Director of the Veterans Integrated Services Network, and to the National Quality Assurance Officer, regarding the discharge of the responsibilities and duties of the officer under this section.

(3) The quality assurance officer for a Veterans Integrated Services Network shall—

(A) direct the quality assurance office in the Network; and

(B) coordinate, monitor, and oversee the quality assurance programs and activities of the Administration medical facilities in the Network in order to ensure the thorough and uniform discharge of quality assurance requirements under such programs and activities throughout such facilities.

(c) QUALITY ASSURANCE OFFICERS FOR MEDICAL FACILITIES.—(1) The director of each Veterans Health Administration medical facility shall appoint a quality assurance officer for that facility.

(2) The official appointed as a quality assurance officer for a facility under this subsection shall be a practicing physician at the facility. If the official appointed as quality assurance officer for a facility has other clinical or administrative duties, the director of the facility shall ensure that those duties are sufficiently limited in scope so as to ensure that those duties do not prevent the officer from effectively discharging the responsibilities and duties of quality assurance officer at the facility.

(3) The quality assurance officer for a facility shall report directly to the director of the facility, and to the quality assurance officer of the Veterans Integrated Services Network in which the facility is located, regarding the discharge of the responsibilities and duties of the quality assurance officer under this section.

(4) The quality assurance officer for a facility shall be responsible for designing, disseminating, and implementing quality assurance programs and activities for the facility that meet the requirements established by the National Quality Assurance Officer under subsection (a).

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Subchapter III. Protection of Patient Rights

SEC. 7332. CONFIDENTIALITY OF CERTAIN MEDICAL RECORDS

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(b)(2) * * *

(A) * * *

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(F)(i) To a representative of a patient who lacks decision-making capacity, when a practitioner deems the content of the given

record necessary for that representative to make an informed decision regarding the patient's treatment.

(ii) In this subparagraph, the term "representative" means an individual, organization, or other body authorized under section 7331 of this title and its implementing regulations to give informed consent on behalf of a patient who lacks decision-making capacity.

(G) To a third party, as defined in section 1729(i)(3)(D) of this title, to collect reasonable charges under section 1729(a)(2)(E) of this title for care or services provided for a non-service-connected disability.

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Subchapter IV. Research Corporations

SEC. 7361. AUTHORITY TO ESTABLISH; STATUS

(a) The Secretary may authorize the establishment at any Department medical center of a nonprofit corporation to provide a flexible funding mechanism for the conduct of approved research and education at the medical center. ⟦Except as otherwise required in this subchapter or under regulations prescribed by the Secretary, any such corporation, and its directors and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives which apply generally to private nonprofit corporations.⟧ Such a corporation may be established to facilitate either research or education or both research and education.

(b)(1) Subject to paragraph (2), a corporation established under this subchapter may facilitate the conduct of research, education, or both at more than one medical center. Such a corporation shall be known as a "multi-medical center research corporation".

(2) The board of directors of a multi-medical center research corporation under this subsection shall include the official at each Department medical center concerned who is, or who carries out the responsibilities of, the medical center director of such center as specified in section 7363(a)(1)(A)(i) of this title.

(3) In facilitating the conduct of research, education, or both at more than one Department medical center under this subchapter, a multi-medical center research corporation may administer receipts and expenditures relating to such research, education, or both, as applicable, performed at the Department medical centers concerned.

(c) Any corporation established under this subchapter shall be established in accordance with the nonprofit corporation laws of the State in which the applicable Department medical center is located and shall, to the extent not inconsistent with any Federal law, be subject to the laws of such State. In the case of any multi-medical center research corporation that facilitates the conduct of research, education, or both at Department medical centers located in different States, the corporation shall be established in accordance with the nonprofit corporation laws of the State in which one of such Department medical centers is located.

(d)(1) Except as otherwise provided in this subchapter or under regulations prescribed by the Secretary, any corporation established under this subchapter, and its officers, directors, and employees,

shall be required to comply only with those Federal laws, regulations, and executive orders and directives that apply generally to private nonprofit corporations.

(2) A corporation under this subchapter is not—

(A) owned or controlled by the United States; or

(B) an agency or instrumentality of the United States.

(e) ⟦(b)⟧ If by the end of the four-year period beginning on the date of the establishment of a corporation under this subchapter the corporation is not recognized as an entity the income of which is exempt from taxation under *section 501(c)(3) of* the Internal Revenue Code of 1986, the Secretary shall dissolve the corporation.

(f) A corporation established under this subchapter may act as a multi-medical center research corporation under this subchapter in accordance with subsection (b) if—

(1) the board of directors of the corporation approves a resolution permitting facilitation by the corporation of the conduct of research, education, or both at the other Department medical center or medical centers concerned; and

(2) the Secretary approves the resolution of the corporation under paragraph (1).

SEC. 7362. PURPOSE OF CORPORATIONS

(a) ⟦Any corporation established under this subchapter shall be established solely to facilitate⟧ *A corporation established under this subchapter shall be established to provide a flexible funding mechanism for the conduct of approved research and education at one or more Department medical centers and to facilitate functions related to the conduct of* research as described in section 7303(a) of this title and education and training as described in sections 7302, 7471, 8154, and 1701(6)(B) of this title in conjunction with the applicable Department medical center *or centers*. ⟦Any funds received by the Secretary for the conduct of research or education at the medical center other than funds appropriated to the Department may be transferred to and administered by the corporation for these purposes.⟧

(b) For purposes of this section, the term ⟦"education and training"⟧ *"education" includes education and training and* means the following:

(1) In the case of employees of the Veterans Health Administration, such term means work-related instruction or other learning experiences to—

(A) improve performance of current duties;

(B) assist employees in maintaining or gaining specialized proficiencies; and

(C) expand understanding of advances and changes in patient care, technology, and health care administration.

⟦Such term includes (in the case of such employees) education and training conducted as part of a residency or other program designed to prepare an individual for an occupation or profession.⟧

(2) In the case of veterans under the care of the Veterans Health Administration, such term means instruction or other learning experiences related to improving and maintaining the health of veterans ⟦to patients and to the families⟧ *and in-*

cludes education and training for patients and families and guardians of patients.

SEC. 7363. BOARD OF DIRECTORS; EXECUTIVE DIRECTOR

(a) The Secretary shall provide for the appointment of a board of directors for any corporation established under this subchapter. The board shall include—

(1) [the director of the medical center, the chief of staff of the medical center, and as appropriate, the assistant chief of staff for research for the medical center and the assistant chief of staff for education for the medical center, or, in the case of a facility at which such positions do not exist, those officials who are responsible for carrying out the responsibilities of the medical center director, chief of staff, and, as appropriate, the assistant chief of staff for research and the assistant chief of staff for education; and] *with respect to the Department medical center—*

(A)(i) the director (or directors of each Department medical center, in the case of a multi-medical center research corporation);

(ii) the chief of staff; and

(iii) as appropriate for the activities of such corporation, the associate chief of staff for research and the associate chief of staff for education; or

(B) in the case of a Department medical center at which one or more of the positions referred to in subparagraph (A) do not exist, the official or officials who are responsible for carrying out the responsibilities of such position or positions at the Department medical center; and

(2) subject to subsection (c), *not less than two* members who are not officers or employees of the Federal Government [and who are familiar with issues involving medical and scientific research or education, as appropriate] *and who have backgrounds, or business, legal, financial, medical, or scientific expertise, of benefit to the operations of the corporation*.

(b) * * *

(c) An individual appointed under subsection (a)(2) to the board of directors of a corporation established under this subchapter may not be affiliated with[, employed by, or have any other financial relationship with] *or employed by* any entity that is a source of funding for research or education by the Department unless that source of funding is a governmental entity or an entity the income of which is exempt from taxation under the Internal Revenue Code of 1986.

SEC. 7364. GENERAL POWERS

[(a) A corporation established under this subchapter may—

[(1) accept gifts and grants from, and enter into contracts with, individuals and public and private entities solely to carry out the purposes of this subchapter; and

[(2) employ such employees as it considers necessary for such purposes and fix the compensation of such employees.

[(b) A corporation established under this subchapter may not spend funds for a research project unless the project is approved in accordance with procedures prescribed by the Under Secretary

for Health for research carried out with Department funds. Such procedures shall include a peer review process.

[(c)(1) A corporation established under this subchapter may not spend funds for an education activity unless the activity is approved in accordance with procedures prescribed by the Under Secretary for Health.

[(2) The Under Secretary for Health shall prescribe policies and procedures to guide the expenditure of funds by corporations under paragraph (1) consistent with the purpose of such corporations as flexible funding mechanisms.]

(a)(1) A corporation established under this subchapter may, solely to carry out the purposes of this subchapter—

(A) accept, administer, retain, and spend funds derived from gifts, contributions, grants, fees, reimbursements, and bequests from individuals and public and private entities;

(B) enter into contracts and agreements with individuals and public and private entities;

(C) subject to paragraph (2), set fees for education and training facilitated under section 7362 of this title, and receive, retain, administer, and spend funds in furtherance of such education and training;

(D) reimburse amounts to the appropriation account of the Department for the Office of General Counsel for any expenses of that Office in providing legal services attributable to research and education agreements under this subchapter; and

(E) employ such employees as the corporation considers necessary for such purposes and fix the compensation of such employees.

(2) Fees charged under paragraph (1)(C) for education and training described in that paragraph to individuals who are officers or employees of the Department may not be paid for by any funds appropriated to the Department.

(3) Amounts reimbursed to the Office of General Counsel under paragraph (1)(D) shall be available for use by the Office of the General Counsel only for staff and training, and related travel, for the provision of legal services described in that paragraph.

(b)(1) Except as provided in paragraph (2), any funds received by the Secretary for the conduct of research or education at a Department medical center or centers, other than funds appropriated to the Department, may be transferred to and administered by a corporation established under this subchapter for such purposes.

(2) A Department medical center may reimburse the corporation for all or a portion of the pay, benefits, or both of an employee of the corporation who is assigned to the Department medical center if the assignment is carried out pursuant to subchapter VI of chapter 33 of title 5.

(c) Except for reasonable and usual preliminary costs for project planning before its approval, a corporation established under this subchapter may not spend funds for a research project unless the project is approved in accordance with procedures prescribed by the Under Secretary for Health for research carried out with Department funds. Such procedures shall include a scientific review process.

(d) Except for reasonable and usual preliminary costs for activity planning before its approval, a corporation established under this subchapter may not spend funds for an education activity unless the activity is approved in accordance with procedures prescribed by the Under Secretary for Health.

(e) The Under Secretary for Health may prescribe policies and procedures to guide the spending of funds by corporations established under this subchapter that are consistent with the purpose of such corporations as flexible funding mechanisms and with Federal and State laws and regulations, and executive orders, circulars, and directives that apply generally to the receipt and expenditure of funds by nonprofit organizations exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986.

SEC. *7365.* [7364A.] COVERAGE OF EMPLOYEES UNDER CERTAIN FEDERAL TORT CLAIMS LAWS

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[SEC. 7365. APPLICABLE STATE LAW

[Any corporation established under this subchapter shall be established in accordance with the nonprofit corporation laws of the State in which the applicable medical center is located and shall, to the extent not inconsistent with any Federal law, be subject to the laws of such State.]

SEC. 7366. ACCOUNTABILITY AND OVERSIGHT

(a) * * *

[(b) Each such corporation shall submit to the Secretary an annual report providing a detailed statement of its operations, activities, and accomplishments during that year. A corporation with revenues in excess of $300,000 for any year shall obtain an audit of the corporation for that year. A corporation with annual revenues between $10,000 and $300,000 shall obtain an independent audit of the corporation at least once every three years. Any audit under the preceding sentences shall be performed by an independent auditor. The corporation shall include the most recent such audit in the corporation's report to the Secretary for that year.]

(b)(1) Each corporation shall submit to the Secretary each year a report providing a detailed statement of the operations, activities, and accomplishments of the corporation during that year.

(2)(A) A corporation with revenues in excess of $300,000 for any year shall obtain an audit of the corporation for that year.

(B) A corporation with annual revenues between $10,000 and $300,000 shall obtain an audit of the corporation at least once every three years.

(C) Any audit under this paragraph shall be performed by an independent auditor.

(3) The corporation shall include in each report to the Secretary under paragraph (1) the following:

(A) The most recent audit of the corporation under paragraph (2).

(B) The most recent Internal Revenue Service Form 990 "Return of Organization Exempt from Income Tax" or equivalent and the applicable schedules under such form.

(c)(1) Each member of the board of directors of a corporation established under this subchapter, *each officer and* each employee of such a corporation[, and each employee of the Department who is involved in the functions of the corporation during any year] shall be subject to Federal [laws and] regulations applicable to Federal employees with respect to conflicts of interest in the performance of official functions.

(2) Each corporation established under this subchapter shall each year submit to the Secretary a statement signed by the executive director of the corporation verifying that each *officer,* director and employee has certified awareness of the laws and regulations referred to in paragraph (1) and of the consequences of violations of those [laws and] regulations [in the same manner as Federal employees are required to so certify].

(d) * * *

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(3) * * *

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(C) if the amount expended with respect to any payee exceeded [$35,000] *$50,000*, information that identifies the payee.

[SEC. 7368. EXPIRATION OF AUTHORITY

[No corporation may be established under this subchapter after December 31, 2008.]

CHAPTER 74. VETERANS HEALTH ADMINISTRATION—PERSONNEL

SUBCHAPTER I. APPOINTMENTS

Sec.

7401. * * *

7402. * * *

7402A. Appointment and practice of physicians: standards.

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SUBCHAPTER IV. PAY FOR NURSES AND OTHER HEALTH-CARE PERSONNEL

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7459. Nursing staff: special rules for overtime duty.

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Subchapter I. Appointments

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SEC. 7401. APPOINTMENTS IN VETERANS HEALTH ADMINISTRATION

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(3) Audiologists, speech pathologists, and audiologist-speech pathologists, biomedical engineers, certified or registered respiratory therapists, dietitians, licensed physical therapists, licensed practical or vocational nurses, *nurse assistants,* medical instrument technicians, medical records administrators or specialists, medical records technicians, medical technologists,

dental hygienists, dental assistants, nuclear medicine technologists, occupational therapists, occupational therapy assistants, kinesiotherapists, orthotist-prosthetists, pharmacists, pharmacy technicians, physical therapy assistants, prosthetic representatives, psychologists, diagnostic radiologic technologists, therapeutic radiologic technologists, social workers, marriage and family therapists, licensed professional mental health counselors, blind rehabilitation specialists, [and blind rehabilitation outpatient specialists] *blind rehabilitation outpatient specialists, and such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention needs of the Department subject to the following requirements:*

(A) Not later than 45 days before the Secretary appoints any personnel for a class of health care occupations that is not specifically listed in this paragraph, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and the Office of Management and Budget notice of such appointment.

(B) Before submitting notice under subparagraph (A), the Secretary shall solicit comments from any labor organization representing employees in such class and include such comments in such notice.

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SEC. 7402A. APPOINTMENT AND PRACTICE OF PHYSICIANS: STANDARDS

(a) IN GENERAL.—The Secretary shall, acting through the Under Secretary for Health, prescribe standards to be met by individuals in order to qualify for appointment in the Veterans Health Administration in the position of physician and to practice as a physician in medical facilities of the Administration. The standards shall incorporate the requirements of this section.

(b) DISCLOSURE OF CERTAIN INFORMATION BEFORE APPOINTMENT.—Each individual seeking appointment in the Veterans Health Administration in the position of physician shall do the following:

(1) Provide the Secretary a full and complete explanation of the following:

(A) Each lawsuit, civil action, or other claim (whether open or closed) brought against the individual for medical malpractice or negligence (other than a lawsuit, action, or claim closed without any judgment against or payment by or on behalf of the individual).

(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

(C) Each investigation or disciplinary action taken against the individual relating to the individual's performance as a physician.

(2) Submit a written request and authorization to the State licensing board of each State in which the individual holds or has held a license to practice medicine to disclose to the Sec-

retary any information in the records of such State on the following:

(A) Each lawsuit, civil action, or other claim brought against the individual for medical malpractice or negligence covered by paragraph (1)(A) that occurred in such State.

(B) Each payment made by or on behalf of the individual to settle any lawsuit, action, or claim covered by subparagraph (A).

(C) Each medical malpractice judgment against the individual by the courts or administrative agencies or bodies of such State.

(D) Each disciplinary action taken or under consideration against the individual by an administrative agency or body of such State.

(E) Any change in the status of the license to practice medicine issued the individual by such State, including any voluntary or nondisciplinary surrendering of such license by the individual.

(F) Any open investigation of the individual by an administrative agency or body of such State, or any outstanding allegation against the individual before such an administrative agency or body.

(G) Any written notification by the State to the individual of potential termination of a license for cause or otherwise.

(c) DISCLOSURE OF CERTAIN INFORMATION FOLLOWING APPOINTMENT.—(1) Each individual appointed in the Veterans Health Administration in the position of physician after the date of the enactment of this section shall, as a condition of service under the appointment, disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

(A) A judgment against the individual for medical malpractice or negligence.

(B) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed under paragraph (1) or (2) of subsection (b).

(C) Any disposition of or material change in a matter disclosed under paragraph (1) or (2) of subsection (b).

(2) Each individual appointed in the Veterans Health Administration in the position of physician as of the date of the enactment of this section shall do the following:

(A) Not later than the end of the 60-day period beginning on the date of the enactment of that Act and as a condition of service under the appointment after the end of that period, submit the request and authorization described in subsection (b)(2).

(B) Agree, as a condition of service under the appointment, to disclose to the Secretary, not later than 30 days after the occurrence of such event, the following:

(i) A judgment against the individual for medical malpractice or negligence.

(ii) A payment made by or on behalf of the individual to settle any lawsuit, action, or claim disclosed pursuant to subparagraph (A) or under this subparagraph.

(iii) Any disposition of or material change in a matter disclosed pursuant to subparagraph (A) or under this subparagraph.

(3) Each individual appointed in the Veterans Health Administration in the position of physician shall, as part of the biennial review of the performance of the physician under the appointment, submit the request and authorization described in subsection (b)(2). The requirement of this paragraph is in addition to the requirements of paragraph (1) or (2), as applicable.

(d) INVESTIGATION OF DISCLOSED MATTERS.—(1) The Director of the Veterans Integrated Services Network (VISN) in which an individual is seeking appointment in the Veterans Health Administration in the position of physician shall perform an investigation (in such manner as the standards required by this section shall specify) of each matter disclosed under subsection (b) with respect to the individual.

(2) The Director of the Veterans Integrated Services Network in which an individual is appointed in the Veterans Health Administration in the position of physician shall perform an investigation (in a manner so specified) of each matter disclosed under subsection (c) with respect to the individual.

(3) The results of each investigation performed under this subsection shall be fully documented.

(e) APPROVAL OF APPOINTMENTS BY DIRECTORS OF VISNS.—(1) An individual may not be appointed in the Veterans Health Administration in the position of physician without the approval of the Director of the Veterans Integrated Services Network in which the individual will first serve under the appointment.

(2) In approving the appointment under this subsection of an individual for whom any matters have been disclosed under subsection (b), a Director shall—

(A) certify in writing the completion of the performance of the investigation under subsection (d)(1) of each such matter, including the results of such investigation; and

(B) provide a written justification why any matters raised in the course of such investigation do not disqualify the individual from appointment.

(f) ENROLLMENT OF PHYSICIANS WITH PRACTICE PRIVILEGES IN PROACTIVE DISCLOSURE SERVICE.—Each medical facility of the Department at which physicians are extended the privileges of practice shall enroll each physician extended such privileges in the Proactive Disclosure Service of the National Practitioners Data Base.

(g) ENCOURAGING HIRING OF PHYSICIANS WITH BOARD CERTIFICATION.—(1) The Secretary shall, for each performance contract with a Director of a Veterans Integrated Services Network (VISN), include in such contract a provision that encourages such director to hire physicians who are board eligible or board certified in the specialty in which the physicians will practice.

(2) The Secretary may determine the nature and manner of the provision described in paragraph (1).

SEC. 7403. PERIOD OF APPOINTMENTS; PROMOTIONS

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(b)(1) [Appointments] *Except as otherwise provided in this subsection, appointments* described in subsection (a) shall be for a probationary period of two years.

(2) An appointment of a registered nurse under this chapter, whether on a full-time basis or a part-time basis, shall be for a probationary period ending upon the completion by the person so appointed of a number of hours of work pursuant to such appointment that the Secretary considers appropriate for such appointment but not more than 4,180 hours.

(3) An appointment described in subsection (a) on a part-time basis of a person who has previously served on a full-time basis for the probationary period for the position concerned shall be without a probationary period.

(4) [(2)] The record of each person serving under such an appointment in the Medical, Dental, and Nursing Services shall be reviewed from time to time by a board, appointed in accordance with regulations of the Secretary. If such a board finds that such person is not fully qualified and satisfactory, such person shall be separated from the service.

* * * * * * *

SEC. 7404. GRADES AND PAY SCALES

(a)*(1) The annual* [The annual] rates or ranges of rates of basic pay for positions provided in section 7306 of this title shall be prescribed from time to time by Executive order as authorized by chapter 53 of title 5 or as otherwise authorized by law.

(2) The pay [The pay] of physicians and dentists serving in positions to which an Executive order applies [under the preceding sentence] *under paragraph (1)* shall be determined under subchapter III of this chapter instead of such Executive order.

(3) The minimum rate of basic pay for a position to which an Executive order applies under paragraph (1) and is not described by paragraph (2) may not be less than the lowest rate of basic pay payable for a Senior Executive Service position under section 5382 of title 5.

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SEC. 7405. TEMPORARY FULL-TIME APPOINTMENTS, PART-TIME APPOINTMENTS, AND WITHOUT-COMPENSATION APPOINTMENTS

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(g)(1) Employment of a registered nurse on a temporary part-time basis under subsection (a)(1) shall be for a probationary period ending upon the completion by the person so employed of a number of hours of work pursuant to such employment that the Secretary considers appropriate for such employment but not more than 4,180 hours.

(2) Upon completion by a registered nurse of the probationary period described in paragraph (1)—

(A) the employment of such nurse shall—

(i) no longer be considered temporary; and

(ii) be considered an appointment described in section 7403(a) of this title; and

(B) the nurse shall be considered to have served the probationary period required by section 7403(b).

(h)(1) The Secretary may waive the application of sections 8344 and 8468 of title 5 (relating to annuities and pay on reemployment) or any other similar provision of law under a Government retirement system on a case-by-case basis for an annuitant reemployed on a temporary basis under the authority of subsection (a) in a position described under paragraph (1) of that subsection.

(2) An annuitant to whom a waiver under paragraph (1) is in effect shall not be considered an employee for purposes of any Government retirement system.

(3) An annuitant to whom a waiver under paragraph (1) is in effect shall be subject to the provisions of chapter 71 of title 5 (including all labor authority and labor representative collective bargaining agreements) applicable to the position to which appointed.

(4) In this subsection:

(A) The term "annuitant" means an annuitant under a Government retirement system.

(B) The term "employee" has the meaning under section 2105 of title 5.

(C) The term "Government retirement system" means a retirement system established by law for employees of the Government of the United States.

* * * * * * *

SEC. 7410. ADDITIONAL PAY AUTHORITIES

(a) IN GENERAL.—The Secretary may [The Secretary may] authorize the Under Secretary for Health to pay advance payments, recruitment or relocation bonuses, and retention allowances to the personnel described in paragraph (1) of section 7401 of this title, or interview expenses to candidates for appointment as such personnel, in the same manner, and subject to the same limitations, as in the case of the authority provided under sections 5524a, 5706b, 5753, and 5754 of title 5.

(b) COMPARABILITY PAY FOR APPOINTEES TO THE OFFICE OF THE UNDER SECRETARY FOR HEALTH.—(1) The Secretary may authorize the Under Secretary for Health to provide comparability pay of not more than $100,000 per year to individuals of the Veterans Health Administration appointed under section 7306 of this title who are not physicians or dentists and to individuals who are appointed to Senior Executive Service positions (as such term is defined in section 3132(a) of title 5) to achieve annual pay levels for such individuals that are comparable with annual pay levels of individuals with similar positions in the private sector.

(2) Comparability pay under paragraph (1) for an individual is in addition to all other pay, awards, and performance bonuses paid to such individual under this title.

(3) Except as provided in paragraph (4), comparability pay under paragraph (1) for an individual shall be considered basic pay for all purposes, including retirement benefits under chapters 83 and 84 of title 5, and other benefits.

(4) Comparability pay under paragraph (1) for an individual shall not be considered basic pay for purposes of adverse actions under subchapter V of this chapter.

(5) Comparability pay under paragraph (1) may not be awarded to an individual in an amount that would result in an aggregate amount of pay (including bonuses and awards) received by such individual in a year under this title that is greater than the annual pay of the President.

(c) SPECIAL INCENTIVE PAY FOR DEPARTMENT PHARMACIST EXECUTIVES.—(1) In order to recruit and retain highly qualified Department pharmacist executives, the Secretary may authorize the Under Secretary for Health to pay special incentive pay of not more than $40,000 per year to an individual of the Veterans Health Administration who is a pharmacist executive.

(2) In determining whether and how much special pay to provide to such individual, the Under Secretary shall consider the following:

(A) The grade and step of the position of the individual.

(B) The scope and complexity of the position of the individual.

(C) The personal qualifications of the individual.

(D) The characteristics of the labor market concerned.

(E) Such other factors as the Secretary considers appropriate.

(3) Special incentive pay under paragraph (1) for an individual is in addition to all other pay (including basic pay) and allowances to which the individual is entitled.

(4) Except as provided in paragraph (5), special incentive pay under paragraph (1) for an individual shall be considered basic pay for all purposes, including retirement benefits under chapters 83 and 84 of title 5, and other benefits.

(5) Special incentive pay under paragraph (1) for an individual shall not be considered basic pay for purposes of adverse actions under subchapter V of this chapter.

(6) Special incentive pay under paragraph (1) may not be awarded to an individual in an amount that would result in an aggregate amount of pay (including bonuses and awards) received by such individual in a year under this title that is greater than the annual pay of the President.

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Subchapter III. Pay for Physicians and Dentists

SEC. 7431. PAY

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(b) * * *

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(5) The non-foreign cost of living adjustment allowance authorized under section 5941 of title 5 for physicians and dentists whose pay is set under this section shall be determined as a percentage of base pay only.

* * * * * * *

(c) * * *

* * * * * * *

(4)(A) * * *

(B)(i) In determining the amount of the market pay for a particular physician or dentist under this subsection, and in determining a tier (if any) to apply to a physician or dentist

under subsection (e)(1)(B), the Secretary shall consult with and consider the recommendations of an appropriate panel or board composed of physicians or dentists (as applicable). *The Secretary may exempt physicians and dentists occupying administrative or executive leadership positions from the requirements of the previous sentence.*

* * * * * * *

(7) No adjustment of the amount of market pay of a physician or dentist under paragraph (6) may result in a reduction of the amount of market pay of the physician or dentist while in the same position or assignment at the medical facility of the Department [concerned.] *concerned, unless there is a change in board certification or reduction of privileges.*

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Subchapter IV. Pay for Nurses and Other Health-Care Personnel

SEC. 7451. NURSES AND OTHER HEALTH-CARE PERSONNEL: COMPETITIVE PAY

* * * * * * *

(c)(1) * * *

(2) The maximum rate of basic pay for any grade for a covered position may not exceed the maximum rate of basic pay established for positions in [level V] *level IV* of the Executive Schedule under section 5316 of title 5. *The maximum rate of basic pay for a grade for the position of certified registered nurse anesthetist pursuant to an adjustment under subsection (d) may exceed the maximum rate otherwise provided in the preceding sentence.*

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(d)(3)(A) * * *

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(F) The Under Secretary for Health shall provide appropriate education, training, and support to directors of Department health care facilities in the conduct and use of surveys, including the use of third-party surveys, under this paragraph.

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(e)(4) * * *

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(D) In any case in which the director conducts such a wage survey during the period covered by the report and makes adjustment in rates of basic pay applicable to one or more covered positions at the facility, information on the methodology used in making such adjustment or adjustments.

(E) [(D)] In any case in which the director, after finding that there is, or is likely to be, in accordance with criteria established by the Secretary, a significant pay-related staffing problem at that facility for any covered position, determines not to conduct a wage survey with respect to that position, a state-

ment of the reasons why the director did not conduct such a survey.

* * * * * * *

(e)(5) * * *

(6)(A) Upon the request of an individual described in subparagraph (B) for a report provided under paragraph (4) with respect to a Department health-care facility, the Under Secretary for Health or the director of such facility shall provide to the individual the most current report for such facility provided under such paragraph.

(B) An individual described in this subparagraph is—

(i) an individual in a covered position at a Department health-care facility; or

(ii) a representative of the labor organization representing that individual who is designated by that individual to make the request.

* * * * * * *

[(f) Not later than March 1 of each year, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report regarding any pay adjustments under the authority of subsection (d) effective during the 12 months preceding the submission of the report. Each such report shall set forth, by health-care facility, the percentage of such increases and, in any case in which no increase was made, the basis for not providing an increase.**]**

(f) **[**(g)**]** For the purposes of this section, the term "health-care facility" means a medical center, an independent outpatient clinic, or an independent domiciliary facility.

SEC. 7452. NURSES AND OTHER HEALTH-CARE PERSONNEL: ADMINISTRATION OF PAY

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(g)(1) * * *

(2) The amount of special pay paid to a nurse executive under paragraph (1) shall be not less than $10,000 or more than **[**$25,000**]** *$100,000*.

* * * * * * *

SEC. 7453. NURSES: ADDITIONAL PAY

(a) In addition to the rate of basic pay provided for nurses, **[**a nurse**]** *a full-time nurse or part-time nurse* shall receive additional pay as provided by this section.

(b) A nurse performing service **[**on a tour of duty**]**, any part of which is within the period commencing at 6 postmeridian and ending at 6 antemeridian, shall receive additional pay for each hour of **[**service on such tour**]** *such service* at a rate equal to 10 percent of the nurse's hourly rate of basic pay if at least four hours **[**of such tour**]** *of such service* fall between 6 postmeridian and 6 antemeridian. When less than four hours **[**of such tour**]** *of such service* fall between 6 postmeridian and 6 antemeridian, the nurse shall be paid the differential for each hour of service performed between those hours.

(c) A nurse performing service **[**on a tour of duty**]**, any part of which is within the period commencing at midnight Friday and

ending at midnight Sunday, shall receive additional pay for each hour of [service on such tour] *such service* at a rate equal to 25 percent of such nurse's hourly rate of basic pay.

(d) * * *

(e)(1) A nurse performing officially ordered or approved hours of service in excess of 40 hours in an administrative workweek, or in excess of [eight hours in a day] *eight consecutive hours*, shall receive overtime pay for each hour of such additional service. The overtime rates shall be one and one-half times such nurse's hourly rate of basic pay.

* * * * * * *

(5) * * *

(A) such travel occurs during such nurse's [tour of duty] *period of service*; or

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SEC. 7454. PHYSICIAN ASSISTANTS AND OTHER HEALTH CARE PROFESSIONALS: ADDITIONAL PAY

(b)(1) * * *

* * * * * * *

(3) Employees appointed under section 7408 of this title [shall be entitled to additional pay on the same basis as provided for nurses in section 7453(c) of this title.] *performing service on a tour of duty, any part of which is within the period commencing at midnight Friday and ending at midnight Sunday, shall receive additional pay in addition to the rate of basic pay provided such employees for each hour of service on such tour at a rate equal to 25 percent of such employee's hourly rate of basic pay.*

(c) * * *

SEC. 7455. INCREASES IN RATES OF BASIC PAY

* * * * * * *

(c)(1) The amount of any increase under subsection (a) in the maximum rate for any grade may not (except in the case of nurse anesthetists, *licensed practical nurses, licensed vocational nurses, and nursing positions otherwise covered by title 5,* pharmacists, and licensed physical therapists) exceed by two times the amount by which the maximum for such grade (under applicable provisions of law other than this subsection) exceeds the minimum for such grade (under applicable provisions of law other than this subsection), and the maximum rate as so increased may not exceed the rate paid for individuals serving as Assistant Under Secretary for Health.

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SEC. 7456. NURSES: SPECIAL RULES FOR WEEKEND DUTY

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[(c) A nurse described in subsection (b)(1) who is absent on approved sick leave or annual leave during a regularly scheduled 12-hour tour of duty shall be charged for such leave at a rate of five hours of leave for three hours of absence.]

(c) [(d)] The Secretary shall prescribe regulations for the implementation of this section.

SEC. 7456A. NURSES: ALTERNATE WORK SCHEDULES

(a) * * *

(b) [36/40] *72/80* work schedule.

(1)(A) Subject to paragraph (2), if the Secretary determines it to be necessary in order to obtain or retain the services of registered nurses at any Department health-care facility, the Secretary may provide, in the case of nurses employed at such facility, that such nurses who work [three regularly scheduled 12-hour tours of duty within a work week shall be considered for all purposes to have worked a full 40-hour basic work week.] *six regularly scheduled 12-hour periods of service within a pay period shall be considered for all purposes to have worked a full 80-hour pay period.*

(B) A nurse who works under the authority in subparagraph (A) shall be considered a 0.90 full-time equivalent employee in computing full-time equivalent employees for the purposes of determining compliance with personnel ceilings.

(2)(A) Basic and additional pay for a nurse who is considered under paragraph (1) to have worked a full [40-hour basic work week] *80-hour pay period* shall be subject to subparagraphs (B) and (C).

(B) The hourly rate of basic pay for a nurse covered by this paragraph for service performed as part of a [regularly scheduled 36-hour tour of duty within the work week] *scheduled 72-hour period of service within the bi-weekly pay period* shall be derived by dividing the nurse's annual rate of basic pay by 1,872.

(C) The Secretary shall pay overtime pay to a nurse covered by this paragraph who—

(i) performs a period of service in excess of such nurse's [regularly scheduled 36-hour tour of duty within an administrative work week] *scheduled 72-hour period of service within an administrative pay period*;

(ii) for officially ordered or approved service, performs a period of service in excess of 8 hours on a day other than a day on which such nurse's [regularly scheduled 12-hour tour of duty] *scheduled 12-hour period of service* falls;

(iii) performs a period of service in excess of 12 hours for any day included in the [regularly scheduled 36-hour tour of duty work week] *scheduled 72-hour period of service pay period*; or

(iv) performs a period of service in excess of 40 hours during an administrative work week.

(D) The Secretary may provide a nurse to whom this subsection applies with additional pay under section 7453 of this title for any period included in a [regularly scheduled 12-hour tour of duty] *scheduled 12-hour period of service*.

(3) A nurse who works a work schedule described in this subsection who is absent on approved sick leave or annual leave during a [regularly scheduled 12-hour tour of duty] *scheduled 12-hour period of service* shall be charged for such leave at a rate of ten hours of leave for every nine hours of absence.

7459. NURSING STAFF: SPECIAL RULES FOR OVERTIME DUTY

(a) LIMITATION.—Except as provided in subsection (c), the Secretary may not require nursing staff to work more than 40 hours (or 24 hours if such staff is covered under section 7456 of this title) in an administrative work week or more than eight consecutive hours (or 12 hours if such staff is covered under section 7456 or 7456A of this title).

(b) VOLUNTARY OVERTIME.—(1) Nursing staff may on a voluntary basis elect to work hours otherwise prohibited by subsection (a).

(2) The refusal of nursing staff to work hours prohibited by subsection (a) shall not be grounds to discriminate (within the meaning of section 704(a) of the Civil Rights Act of 1964 (42 U.S.C. 2000e–3(a))) against the staff, dismissal or discharge of the staff, or any other adverse personnel action against the staff.

(c) OVERTIME UNDER EMERGENCY CIRCUMSTANCES.—(1) Subject to paragraph (2), the Secretary may require nursing staff to work hours otherwise prohibited by subsection (a) if—

(A) the work is a consequence of an emergency that could not have been reasonably anticipated;

(B) the emergency is non-recurring and is not caused by or aggravated by the inattention of the Secretary or lack of reasonable contingency planning by the Secretary;

(C) the Secretary has exhausted all good faith, reasonable attempts to obtain voluntary workers;

(D) the nurse staff have critical skills and expertise that are required for the work; and

(E) the work involves work for which the standard of care for a patient assignment requires continuity of care through completion of a case, treatment, or procedure.

(2) Nursing staff may not be required to work hours under this subsection after the requirement for a direct role by the staff in responding to medical needs resulting from the emergency ends.

(d) NURSING STAFF DEFINED.—In this section, the term "nursing staff" includes the following;

(1) A registered nurse.

(2) A licensed practical or vocational nurse.

(3) A nurse assistant appointed under this chapter or title 5.

(4) Any other nurse position designated by the Secretary for purposes of this section.

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CHAPTER 76. HEALTH PROFESSIONALS EDUCATIONAL ASSISTANCE PROGRAM

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Subchapter II. Scholarship Program

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SEC. 7612. ELIGIBILITY; APPLICATION; AGREEMENT

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(b)(1) * * *

(2) A qualifying field of education or training for purposes of this subchapter is education or training leading to employment [(under

section 7401 of this title) as any of the following:] *as an appointee under paragraph (1) or (3) of section 7401 of this title.*

[(A) A physician, dentist, podiatrist, optometrist, nurse, physician assistant, or expanded function dental auxiliary.

[(B) A psychologist described in section 7401(3) of this title or a certified or registered respiratory therapist, licensed physical therapist, or licensed practical or vocational nurse.]

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SEC. 7618. EXPIRATION OF PROGRAM

The Secretary may not furnish scholarships to new participants in the Scholarship Program after [December 31, 1998] *December 31, 2013*.

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Subchapter VII. Education Debt Reduction Program

SEC. 7681. AUTHORITY FOR PROGRAM

(a) IN GENERAL.—

(1) * * *

(2) The purpose of the Education Debt Reduction Program is to assist in the recruitment *and retention* of qualified health care professionals for positions in the Veterans Health Administration for which recruitment or retention of an adequate supply of qualified personnel is difficult.

(b) * * *

SEC. 7682. ELIGIBILITY

(a) ELIGIBILITY.—An individual is eligible to participate in the Education Debt Reduction Program if the individual—

(1) is [a recently appointed] *an* employee in the Veterans Health Administration serving in a position (as determined by the Secretary) providing direct-patient care services or services incident to direct-patient care services for which recruitment or retention of qualified health-care personnel (as so determined) is difficult; and

* * * * * * *

[(c) RECENTLY APPOINTED INDIVIDUALS.—For purposes of subsection (a), an individual shall be considered to be recently appointed to a position if the individual has held that position for less than 6 months.]

SEC. 7683. EDUCATION DEBT REDUCTION

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(d) MAXIMUM ANNUAL AMOUNT.—(1) Subject to paragraph (2), the amount of education debt reduction payments made to a participant under the Education Debt Reduction Program may not exceed [$44,000] *$60,000* over a total of five years of participation in the Program, of which not more than [$10,000] *$12,000* of such payments may be made in each of the fourth and fifth years of participation in the Program.

* * * * * * *

PART VI. ACQUISITION AND DISPOSITION OF PROPERTY

CHAPTER 81. ACQUISITION AND OPERATION OF HOSPITAL AND DOMICILIARY FACILITIES; PROCUREMENT AND SUPPLY; ENHANCED-USE LEASES OF REAL PROPERTY

SUBCHAPTER I. ACQUISITION AND OPERATION OF MEDICAL FACILITIES

Sec.

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[8107. Operational and construction plans for medical facilities.]

* * * * * * *

SUBCHAPTER III. STATE HOME FACILITIES FOR FURNISHING DOMICILIARY, NURSING HOME, AND HOSPITAL CARE

* * * * * * *

8133A. Tribal organizations.

* * * * * * *

Subchapter I. Acquisition and Operation of Medical Facilities

* * * * * * *

SEC. 8104. CONGRESSIONAL APPROVAL OF CERTAIN MEDICAL FACILITY ACQUISITIONS

(a)(1) * * *

(2) * * *

(3) * * *

(A) * * *

(B) The term "major medical facility lease" means a lease for space for use as a new medical facility at an average annual rental of more than [$600,000] *$1,000,000*.

* * * * * * *

[SEC. 8107. OPERATIONAL AND CONSTRUCTION PLANS FOR MEDICAL FACILITIES

[(a) In order to promote effective planning for the efficient provision of care to eligible veterans, the Secretary, based on the analysis and recommendations of the Under Secretary for Health, shall submit to each committee an annual report regarding long-range health planning of the Department. The report shall be submitted each year not later than the date on which the budget for the next fiscal year is submitted to the Congress under section 1105 of title 31.

[(b) Each report under subsection (a) shall include the following:

[(1) A five-year strategic plan for the provision of care under chapter 17 of this title to eligible veterans through coordinated networks of medical facilities operating within prescribed geographic service-delivery areas, such plan to include provision of services for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) through

distinct programs or facilities of the Department dedicated to the specialized needs of those veterans.

[(2) A description of how planning for the networks will be coordinated.

[(c) The Secretary shall submit to each committee not later than January 31 of each year a report showing the location, space, cost, and status of each medical facility (1) the construction, alteration, lease, or other acquisition of which has been approved under section 8104(a) of this title, and (2) which was uncompleted as of the date of the last preceding report made under this subsection.

[(d)(1) The Secretary shall submit to each committee, not later than January 31 of each year, a report showing the current priorities of the Department for proposed major medical construction projects. Each such report shall identify the 20 projects, from within all the projects in the Department's inventory of proposed projects, that have the highest priority and, for those 20 projects, the relative priority and rank scoring of each such project and the projected cost of such project (including the projected operating costs, including both recurring and nonrecurring costs). The 20 projects shall be compiled, and their relative rankings shall be shown, by category of project (including the categories of ambulatory care projects, nursing home care projects, and such other categories as the Secretary determines).

[(2) The Secretary shall include in each report, for each project listed, a description of the specific factors that account for the relative ranking of that project in relation to other projects within the same category.

[(3) In a case in which the relative ranking of a proposed project has changed since the last report under this subsection was submitted, the Secretary shall also include in the report a description of the reasons for the change in the ranking, including an explanation of any change in the scoring of the project under the Department's scoring system for proposed major medical construction projects.]

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Subchapter III. State Home Facilities for Furnishing Domiciliary, Nursing Home, and Hospital Care

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SEC. 8131. DEFINITIONS

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(5) The term "tribal organization" has the meaning given such term in section 3765 of this title.

SEC. 8132. DECLARATION OF PURPOSE

The purpose of this subchapter is to assist the several States *and tribal organizations* to construct State home facilities (or to acquire facilities to be used as State home facilities) for furnishing domiciliary or nursing home care to veterans, and to expand, remodel, or alter existing buildings for furnishing domiciliary, nursing home, adult day health, or hospital care to veterans in State homes.

SEC. 8133. AUTHORIZATION OF APPROPRIATIONS

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SEC. 8133A. TRIBAL ORGANIZATIONS

(a) AUTHORITY TO AWARD GRANTS.—The Secretary may award a grant to a tribal organization under this subchapter in order to carry out the purposes of this subchapter.

(b) MANNER AND CONDITION OF GRANT AWARDS.—(1) Grants to tribal organizations under this section shall be awarded in the same manner, and under the same conditions, as grants awarded to the several States under the provisions of this subchapter, subject to such exceptions as the Secretary shall prescribe for purposes of this subchapter to take into account the unique circumstances of tribal organizations.

(2) For purposes of according priority under subsection (c)(2) of section 8135 of this title to an application submitted under subsection (a) of such section, an application submitted under such subsection (a) by a tribal organization of a State that has previously applied for award of a grant under this subchapter for construction or acquisition of a State nursing home shall be considered under subparagraph (C) of such subsection (c)(2) an application from a tribal organization that has previously applied for such a grant.

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SEC. 8138. TREATMENT OF CERTAIN HEALTH FACILITIES AS STATE HOMES

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(d) * * *

(e)(1) A health facility (or certain beds in a health facility) of a tribal organization is treatable as a State home under subsection (a) in accordance with the provisions of that subsection.

(2) Except as provided in paragraph (3), the provisions of this section shall apply to a health facility (or certain beds in such facility) treated as a State home under subsection (a) by reason of this subsection to the same extent as health facilities (or beds) treated as a State home under subsection (a).

(3) Subsection (f) shall not apply to the treatment of health facilities (or certain beds in such facilities) of tribal organizations as a State home under subsection (a).

(f) [(e)] The Secretary may not treat any new health facilities (or any new certain beds in a health facility) as a State home under subsection (a) after September 30, 2009.

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VETERANS' BENEFITS AND SERVICES ACT OF 1988

(Public Law 100–322, as amended; 38 U.S.C. 7333 Note)

TITLE I. HEALTH-CARE PROGRAMS

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Part C. Matters Relating to AIDS

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[SEC. 124. RESTRICTION ON TESTING FOR INFECTION WITH THE HUMAN IMMUNODEFICIENCY VIRUS.

[(a) GENERAL RULE.—Except as provided in subsection (b), the Secretary of Veterans Affairs may not during any fiscal year conduct a widespread testing program to determine infection of humans with the human immunodeficiency virus unless funds have been appropriated to the Department of Veterans Affairs specifically for such a program during the fiscal year.

[(b) VOLUNTARY TESTING.—(1) The Secretary shall provide for a program under which the Department of Veterans Affairs offers each patient to whom the Department is furnishing health care or services and who is described in paragraph (2) the opportunity to be tested to determine whether such patient is infected with the human immunodeficiency virus.

[(2) Patients referred to in paragraph (1) are—

[(A) patients who are receiving treatment for intravenous drug abuse,

[(B) patients who are receiving treatment for a disease associated with the human immunodeficiency virus, and

[(C) patients who are otherwise at high risk for infection with such virus.

[(3) Subject to the consent requirement in paragraph (4) and unless medically contraindicated, the test shall be administered to each patient requesting to be tested for infection with such virus.

[(4) A test may not be conducted under this subsection without the prior informed and separate written consent of the patient tested. The Secretary shall provide pre- and post-test counseling regarding the acquired immune deficiency syndrome and the test to each patient who is administered the test.]

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PERSIAN GULF WAR VETERANS' HEALTH STATUS ACT

(Public Law 102–585; 106 Stat. 4943; 38 U.S.C. 527 Note)

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TITLE VII. PERSIAN GULF WAR VETERANS' HEALTH STATUS

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SEC. 707. COORDINATION OF HEALTH-RELATED GOVERNMENT ACTIVITIES ON THE PERSIAN GULF WAR

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(c) REPORTS.—

(1) [Not later than March 1 of each year] *Not later than July 1, 2008, and July 1 of each of the fivefollowing years*, the head of the department or agency designated under subsection

(a) shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on—

(A) the status and results of all such research activities undertaken by the executive branch during the previous year; and

(B) research priorities identified during that year.

* * * * * * *

VETERANS BENEFITS, HEALTH CARE, AND INFORMATION TECHNOLOGY ACT OF 2006

(Public Law 109–461; 38 U.S.C. 1710B Note)

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TITLE II. HEALTH MATTERS

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SEC. 214. PILOT PROGRAM ON IMPROVEMENT OF CAREGIVER ASSISTANCE SERVICES.

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(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Department of Veterans Affairs $5,000,000 for [each of fiscal years 2007 and 2008] *each of the fiscal years 2007 through 2009* to carry out the pilot program authorized by this section.

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CONSOLIDATED APPROPRIATIONS ACT, 2008

(Public Law 110–161; 121 Stat. 2276)

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DIVISION I. MILITARY CONSTRUCTION AND VETERANS AFFAIRS AND RELATED AGENCIES APPROPRIATIONS ACT, 2008

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TITLE IV. GENERAL PROVISIONS

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SEC. 410. CONVEYANCE OF CERTAIN NON-FEDERAL LAND.

[(a) In this section:

[(1) The term "City" means the City of Aurora, Colorado.

[(2) The term "deed" means the quit claim deed—

[(A) conveyed by the Secretary to the City; and

[(B) dated May 24, 1999.

[(3) The term "non-Federal land" means—

[(A) parcel I of the Fitzsimons Army Medical Center, Colorado; and

[(B) the parcel of land described in the deed.

[(4) The term "Secretary" means the Secretary of the Interior.

[(b)(1) In accordance with paragraph (2), to allow the City to convey by donation to the United States the non-Federal land to be used by the Secretary of Veterans Affairs for the construction of a veterans medical facility.

[(2) In carrying out paragraph (1), with respect to the non-Federal land, the Secretary shall forego exercising any rights provided by the—

[(A) deed relating to a reversionary interest of the United States; and

[(B) any other reversionary interest of the United States.

[This division may be cited as the "Military Construction and Veterans Affairs and Related Agencies Appropriations Act, 2008".]

(a) DEFINITIONS.—In this section:

(1) CITY.—The term "City" means the City of Aurora, Colorado.

(2) DEED.—The term "deed" means the quit-claim deed—

(A) conveyed to the City by the Secretary (acting through the Director of the National Park Service); and

(B) dated May 24, 1999.

(3) NON-FEDERAL LAND.—The term "non-Federal land" means—

(A) parcel I of the former United States Army Garrison Fitzsimons, Adams County, Colorado, as more specifically described in the deed; and

(B) the parcel of land described in the deed.

(4) SECRETARY.—The term "Secretary" means the Secretary of the Interior.

(b) DUTY OF SECRETARY.—To allow the City to convey by donation to the United States the non-Federal land to be used by the Secretary of Veterans Affairs for the construction of a veterans medical facility, not later than 60 days after the date of enactment of this section, the Secretary shall execute each instrument that is necessary to release all rights, conditions, and restrictions re-tained by the United States in and to the non-Federal land conveyed in the deed.

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