Calendar No. 128

111TH CONGRESS
1st Session

SENATE

REPORT
111–60

VETERANS' HEALTH CARE AUTHORIZATION ACT OF 2009

JULY 24, 2009.—Ordered to be printed

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

R E P O R T

[To accompany S. 252]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 252), to amend title 38, United States Code, to enhance the capacity of the Department of Veterans Affairs to recruit and retain nurses and other critical health-care professionals, to improve the provision of health care to veterans, and for other purposes, reports favorably thereon, with an amendment, and recommends that the bill, as amended, do pass.

INTRODUCTION

On January 15, 2009, Chairman Akaka introduced S. 252, the proposed "Veterans' Health Care Authorization Act of 2009." S. 252 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. This bill included a majority of provisions from S. 2969, legislation introduced on May 1, 2008 by Chairman Akaka in the 110th Congress. S. 2969 was reported favorably by the Committee, S. Rpt. 110–473, with an amendment in the nature of a substitute, and was subsequently placed on the Senate Legislative Calendar on September 18, 2008. It was not taken up by the Senate prior to the adjournment of the 110th Congress.

S. 2969 as reported and S. 252 as introduced include provisions derived from a number of other bills, described below.

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. S. 2969 as reported included similar provisions as did S. 252 as introduced.

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. 2969 as reported contained similar provisions as did S. 252 as introduced. Senator Murray introduced S. 597 on March 16, 2009, which contained provisions similar to those in S. 2799.

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. S. 2969 as reported contained this program as did S. 252 as introduced.

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. 2969 as reported included similar provisions as did S. 252 as introduced.

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. S. 2969 as reported included similar provisions as did S. 252 as introduced.

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 chemical and biological tests, and would expand the study of the impact of Project Shipboard Hazard and Defense (hereinafter, "SHAD") on veterans' health. S. 2969 as reported included similar provisions as did S. 252 as introduced.

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. 2969 as reported included similar provisions as did S. 252 as introduced. S. 772, introduced April 1, 2009, by Senator Bond, includes provisions similar to S. 2963.

On May 6, 2008, Chairman Akaka introduced, by request, S. 2984, the proposed "Veterans' Benefits Enhancement Act of 2008." S. 2984 contained a number of provisions since enacted into law, but also included modifications to a number of reporting requirements, authorizations to disclose certain personal information in limited circumstances, and authorities for the operation and upkeep of the VA police force. S. 2969 as reported included similar provisions as did S. 252 as introduced.

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. S. 2969 as reported included similar provisions as did S. 252 as introduced.

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

and survivors and dependents of veterans. S. 2969 as reported included provisions derived from this legislation as did S. 252 as introduced. On February 26, 2009, Senator Burr again introduced S. 498, a bill similar to S. 3178.

On April 22, 2009, the Committee held a hearing on pending health care legislation. Testimony was offered by: Gerald M. Cross, M.D., FAPP, Principal Deputy Under Secretary for Health, Department of Veterans Affairs; Walter A. Hall, Assistant General Counsel, Department of Veterans Affairs; Joleen Clark, Chief Officer for Workforce Management and Consulting, Veterans Health Administration; Adrian Atizado, Assistant National Legislative Director, Disabled American Veterans; Ammie Hilsabeck, R.N., Oscar G. Johnson VA Medical Center (Iron Mountain, MI), on behalf of American Federation of Government Employees; Ralph Ibson, Health Policy Senior Fellow, Wounded Warrior Project; and Blake Ortner, Senior Legislative Director, Paralyzed Veterans of America.

COMMITTEE MEETING

The Committee met in open session on May 21, 2009, to consider, among other legislation, S. 252, consisting of S. 252 as introduced with a number of modifications following testimony provided at the foregoing hearing. The Committee voted by roll call to report favorably S. 252 without dissent.

SUMMARY OF S. 252 AS REPORTED

S. 252, 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. This legislation is similar to S. 2969, which was reported by the Committee on September 18, 2008, but not taken up by the Senate. Changes from S. 2969 include: refinements to the personnel sections; deletions to reflect provisions that were enacted as Pub. L. 110–387; and deletions of provisions that were introduced in S. 801.

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 under limited circumstances; 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 the appointment and practice of physicians in VA medical facilities.

TITLE II—HEALTH CARE MATTERS

Section 201 would repeal the annual reporting requirements on nurse pay and long-term planning.

Section 202 would amend the annual Gulf War research report by changing the report due date.

Section 203 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 204 would authorize VA to make disclosures from certain medical records under limited circumstances.

Section 205 would require the disclosure to the Secretary of health plan contract information and social security numbers of certain veterans receiving care from VA.

Section 206 would require the designation of a National Quality Management Officer, and a Quality Management Officer for each VA facility, would describe the responsibilities of such Officers, and would require VA to establish mechanisms for employees to submit confidential reports on matters related to quality of care in VA facilities. Further, this provision requires certain reports regarding VA quality programs and implementation of this section.

Section 207 would require a report on Department health care quality management.

Section 208 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 209 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 210 would require VA to establish an expanded study on the health impact of Project SHAD.

Section 211 would require VA to provide care and services to certain individuals in non-Department facilities under limited circumstances.

Section 212 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 213 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.

Section 309 would authorize VA to provide health care services to the newborn children of woman veterans under certain circumstances.

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, 1999, and report to Congress on their 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 require assessments of the pilot programs described in Sections 501–503.

TITLE VI—NONPROFIT RESEARCH AND EDUCATION CORPORATIONS

Section 601 would authorize multi-medical center nonprofit research and education corporations ("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 NPCs.

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 the establishment of an appropriate payee reporting threshold.

TITLE VII—OTHER MATTERS

Section 701 would expand the authority for VA police officers.

Section 702 would provide a uniform allowance for VA police officers.

BACKGROUND AND DISCUSSION

TITLE I—DEPARTMENT PERSONNEL MATTERS

Title I of the Committee bill contains a number of provisions that would amend specific personnel authorities in title 38, United States Code (U.S.C), so as to give the Secretary of Veterans Affairs additional tools to retain health care personnel, expand scholarship programs for the purposes of recruitment and retention; and authorize additional pay for executive positions within VHA, and for certain nursing positions.

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

Section 101 of the Committee bill contains provisions that would amend title 38 to remove salary restrictions at nurse and executive grades to improve recruitment and retention; improving the methodology and transparency of the computation of the locality pay scale; and establishing guidelines on the use of mandatory overtime for nurses in emergency situations.

Subsection 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.

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 Committee bill limits the application of title 38 hybrid status to those providing direct patient care services or services incident to direct patient-care services, not otherwise available to provide medical care and treatment for veterans.

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 April 22, 2009, hearing, VA supported 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, the Department 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 the Department has the capacity, resources, and responsibility to resolve the obstacles to expedited hiring under title 38.

In addition, testimony submitted by VA for the record of the April 22, 2009, Committee hearing, stated that nurse assistants, in particular, are high priority positions that have proven difficult to fill. VA supported the provisions of subsection (a)(2) of this section in its testimony, citing turnover rates of 11.1 percent for 2007 and 10.96 percent for 2008, which illustrate the great difficulty VA experiences in retaining nurse assistants.

Professional organizations have also recognized VA's need for better tools to enhance recruitment of allied health professionals. On May 26, 2009, the Committee received a letter from the Joint Commission on Allied Health Personnel in Ophthalmology (JCAHPO) supporting Section 101(a) because it would increase VA's ability to recruit and retain qualified eye care technicians. According to JCAHPO, a qualified eye care technician can improve the workload of an ophthalmologist by an average of 36%.

Subsection 101(b) and (c)—Probationary periods for registered nurses, and prohibition on temporary part-time registered nurse appointments in excess of two years.

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 the Department, and subsection (c) would limit the extent of a temporary appointment of part-time registered nurses.

Background. Subsection 7403(b) of title 38, 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 registered nurses ("RNs") are employed by the Department 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 employees transition from full to part-time, they are considered employees under 7405, with commensurate loss of rights and protections. Valerie O'Meara, R.N., 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. A March 2009 Memorandum from the Congressional Research Service indicated that VA had 1700 vacancies for registered nurses, with a projected loss of another 7600 VA Registered Nurses due to retirement by the year 2013.

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, 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 two years. The intent of this provision is to ensure equitable treatment for full and part-time nurses, which is vital to the Department's ability to recruit and retain part-time nurses.

New paragraph (3) would mandate that an appointment under section 7403 on a part-time basis 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 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), unless the part-time appointment resulted

from an academic affiliation, a research proposal or grant, or was used for non-citizens in accordance with 38 U.S.C. 7407(a). Subject to these exceptions, 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 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.

In written testimony provided to the Committee for its April 22, 2009 legislative hearing, the American Federation of Government Employees testified in support of transitioning part-time temporary employees to an appointment under 7403(a) following completion of a probationary period. Carl Blake, National Legislative Director, Paralyzed Veterans of America, in testimony before the Committee on May 21, 2008, also voiced support for the provision to eliminate the probationary period for RNs who transition from full-time to part-time.

Subsection 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 the Veterans Health Administration.

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 the Department, 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 cannot 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 the Department 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.

Subsection 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, to set the rate of basic pay for appointees to the Office of the Under Secretary of Health.

Background. Under current law, non-physician and non-dentist appointees under section 7306 of title 38, which relates to the composition of the Office of VA's 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, at the pay rate for Level V of the Executive Schedule, currently at $143,500 including locality pay. VA employees in the SES, on the other hand, can receive pay up to Level II of the Executive Schedule, currently $177,000.

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, and manage significant elements of the Veterans Health Administration.

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 or Level III of the Executive Schedule. The Secretary would be required to meet the same OPM certification criteria as is currently utilized for SES pay scales. 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 the Department, and the Department indicated its support for this subsection in testimony submitted for the Committee's April 22, 2009, 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."

Subsection 101(f)—Special incentive pay for department pharmacist executives.

Background. VA is challenged to 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 at $153,200. 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 more generous than those 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 incentives 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(f) of the Committee bill would amend section 7410 of title 38, 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. This provision would provide that such pay would be in addition to other pay, awards, and bonuses. In testimony submitted for the Committee's April 22, 2009, hearing, VA supported this provision.

Subsection 101(g)—Pay for physicians and dentists.

Subsection 101(g) 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 (g) would clarify the determination of the non-foreign cost of living adjustment (COLA), authorized by section 7431(b). 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, which are applicable to other government employees, are in section 5941 of title 5, U.S.C.

Paragraph (1) of subsection 101(g) 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 (g) 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 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 (g) would amend section 7431(c)(7) 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 Committee hearing on April 22, 2009, VA indicated support for the provisions in subsection 101(g) of the Committee bill.

Subsection 101(h)—Adjustment of pay cap for nurses.

Subsection (h) 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 $143,500.

In testimony submitted for the Committee's April 9, 2008, hearing, Ms. Converso of United American Nurses cited a "crisis in our country regarding the shortage of registered nurses." At the same hearing, Marisa W. Palkuti, MEd, Director, Healthcare Retention and Recruitment Office, Veterans Health Administration, 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 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 (h) 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 $153,200. By raising the cap on nurse basic pay, 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 VA in testimony submitted to the Committee for its April 22, 2009, hearing. 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.

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

Subsection (i) 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 the Department.

Background. As discussed above, under subsection 101(h), current law limits pay for CRNAs at level V of the Executive Schedule, currently $143,500. 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 ("GAO") 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 by 2012. VA medical facility officials reported that the recruitment and retention 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 (i) of section 101 of the Committee bill would further amend section 7451(c)(2) of title 38, as amended by subsection 101(h) of the Committee bill, to allow pay for CRNAs to exceed the pay caps established for RNs employed by the Department.

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. In addition, VA supported this provision in testimony submitted for the Committee's April 22, 2009, hearing.

Subsection 101(j)—Increased limitation on special pay for nurse executives.

This provision would amend section 7452(g)(2) to increase the limitation on special pay for nurse executives from $25,000 to $100,000.

Background. Under current law, the Secretary may provide between $10,000 and $25,000 in special pay to nurse executives at each Department health care facility and at the 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 described previously, the Committee believes that an additional financial incentive is warranted to attract highly qualified nurses to executive positions.

Committee Bill. Subsection (j) 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.

Subsection 101(k)—Locality pay scale computation.

Subsection 101(k) of the Committee bill would amend section 7451 of title 38 so as 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 Under Secretary for Health.

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 affecting 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 Under Secretary for Health 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, Pub. L. 106–419) that Congress enacted to address recruitment and retention."

In testimony submitted for the Committee hearing on April 9, 2008, the Department 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), 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. This is intended to improve transparency in 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 the Department 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.

Subsection 101(l)—Eligibility of part-time nurses for additional nurse pay.

Subsection (l) of section 101 of the Committee bill 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 8 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, 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 (l) of section 101 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 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 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 eligibility of part-time nurses for additional pay.

Subsection (l)(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 8 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 service eligible for additional overtime pay. In testimony before the Committee on April 9, 2008, Ms. O'Meara emphasized the urgency of this legislative change.

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

Subsection (m) of section 101 of the Committee bill 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 this report.

Committee Bill. Subsection (m) of section 101 of the Committee bill would amend section 7455(c)(1) 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 to the list of positions exempted from the limits imposed by section 7455(c)(1). Also, this subsection would amend the current law limitation on the permissible increase by utilizing the same formula that is applied to the cap on title 5 special rates. This change would give VA the greatest flexibility in establishing maximum rates for title 38 employees. This provision, combined with subsection (h) 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.

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

Section 102 of the Committee bill, which is derived from S. 252 as introduced, 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.

Subsection 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 medical center, on the other hand, mandatory overtime has been used only once in the past three years, an event implemented in cooperation with local bargaining union.

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 of United States Code, 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 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 written testimony before the Committee on April 22, 2009, Ammie Hilsabeck expressed AFGE's support for this provision of the Committee bill.

Subsection 102(b)—Weekend duty.

Subsection (b) of section 102 of the Committee bill would amend section 7456 of title 38, which authorizes VA to pay nurses who perform two regularly schedule 12 hour tours on the weekend for 40 hours. According to VA, this plan is typically used only when a facility has significant difficulties in securing adequate nurse staffing for the weekends.

Committee Bill. The Committee bill would repeal subsection (c) of section 7456 which charges nurses 5 hours of leave for 3 hours of absence during a 12 hour tour of duty. In written testimony before the Committee on April 22, 2009, AFGE indicated its support for this provision.

Subsection 102(c)—Alternative work schedules.

Subsection (c) of section 102 of the Committee bill would modify an existing alternative work schedule available to VA nurses.

Background. Section 7456A of title 38 authorizes the Secretary to provide alternative work schedules to RNs working for the Department. 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 the Department 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 the Department'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 VAMC 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 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, the Department 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. The Department 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.

Section 103. Improvements to Certain Educational Assistance Programs.

Section 103 of the Committee bill would amend two existing VA Education Assistance Programs and provide the Secretary of Veterans Affairs with new authority to make repayment of educational loans for certain health professionals.

Background. Chapter 76 of title 38 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 (hereinafter "HPSP"), 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 authority, 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 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 so as to reinstate HPSP through the end of 2013. The Committee believes that renewing HPSP, which expired in 1998, 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. It also expands the use of the program to any eligible employee, not just to those recently appointed. 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 two 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 Committee's intent is that this program should be available beginning from the first date of a qualified applicant's employment. In addition, the Department had interpreted "recently appointed" to exclude any employee who had worked for VA for longer than 6 months. The new language makes it clear that eligibility for the program will not be subject to this 6 month time limit.

Subsection (c) of section 103 would authorize the Secretary of VA, 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. Funding for the repayment of educational loans under this program would have to come from VA medical care funding.

Section 104. Standards for Appointment and Practice of Physicians in Department of Veterans Affairs Medical Facilities.

Section 104, which was originally derived from S. 2377 in the 110th Congress prior to being incorporated in S. 2969, would establish a new section in title 38 setting out procedures for appointing new physicians in VA, and the requisite qualifications of such physicians.

Background. Current section 7402 of title 38 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 holds 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 is 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.

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 November 14, 2008, requires applicants to submit extensive information regarding previous malpractice claims, and authorizations to their State licensing boards to permit those boards to release records to VA.

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 1 year to complete.

Committee Bill. Section 104 of the Committee bill would establish a new section in title 38—section 7402A Appointment and practice of physicians: standards—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 Under Secretary for Health, 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 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, within 60 days after the date of enactment, to the Secretary with an authorization for state medical boards to release any information regarding pending or completed disciplinary actions or claims against a license to practice medicine. A physician currently practicing in VHA would be required, as a condition of employment, to agree to disclose, within 30 days of occurrence, any future claim or 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 an applicant seeking to be employed as a VA physician to receive the approval of the appropriate VISN director, unless a full investigation by the medical center director failed to disclose any actions described in new subsections (b),(c), and (d). In this event, the VISN Director's approval would not be required.

If an 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 are extended the privileges of practice at that facility to enroll each physician in the Proactive Disclosure Service of the National Practitioners Data base.

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 physi-

cians practicing in VA with suspended licenses and other problems with their qualifications. One of the more 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

Section 201. Repeal of certain annual reporting requirements.

Section 201, which was initially derived from S. 2984, by request legislation introduced in the 110th Congress, 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 the Veterans Health Administration'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 201 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. 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 the Department'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 the Department's budget request.

Section 202. Modifications to annual Gulf War research report.

Section 202, which is also derived from S. 2984 from the 110th Congress, 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 execu-

tive 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 of Veterans Affairs 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 202 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 5 year's time, whether there exists a continued need for this formal reporting requirement.

Section 203. Payment for care furnished to CHAMPVA beneficiaries.

Section 203, which is also derived from S. 2984 as introduced in the 110th Congress, would clarify the status of payment made by VA to health care providers on behalf of beneficiaries under the Civilian Health and Medical Program of the Department of Veterans Affairs (hereinafter, "CHAMPVA") program.

Background. CHAMPVA is a health care program under which VA shares the cost of covered health care services and supplies with eligible beneficiaries. The program is administered by the Veterans Health Administration. 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; (2) the surviving spouse or child of a veteran who died from a VA-rated service-connected disability; (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 servicemember who died in the line of duty, of a cause other than willful misconduct. Most of these cases, these family members are eligible for the Department of Defense's health care program known as TRICARE.

While VA's regulations for the CHAMPVA program, in section 17.55 of title 38 CFR, 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 a 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 203 of the Committee bill would amend section 1781 of title 38 to provide that payments made by the Secretary to providers who furnish medical care to a beneficiary covered under CHAMPVA shall constitute full payment, removing any liability for the beneficiary to the provider.

Section 204. Disclosures from certain medical records.

Section 204, which is also derived from S. 2984 from the 110th Congress, would permit VA health care practitioners to disclose the relevant portions of certain VA records to surrogate decisionmakers who are authorized to make decisions on behalf of patients who lack decisionmaking capacity.

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

Committee Bill. Section 204 of the Committee bill would amend section 7332 of title 38 to permit VA health care practitioners 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 decisionmakers who are authorized to make decisions on behalf of patients who lack decisionmaking capacity, but to whom the patient has not specifically authorized release of section 7332-protected information prior to losing decisionmaking capacity. This change would allow for such disclosure only under the circumstances where the information is clinically relevant to the 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 decisionmaking capacity.

Section 205. Disclosure to secretary of health-plan contract information and social security number of certain veterans receiving care.

Section 205, which is also derived from S. 2984 of the 110th Congress, would 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 disability, there is no express statutory authority that requires an applicant for, or a 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.

VHA must match veterans' income data with the Internal Revenue Service and the Social Security Administration to carry out its income verification responsibility under section 5317 of title 38. 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 million veterans enrolled for whom no social security number has been provided. Further, VHA notes that the Department has been unable to match income for more than 675,000 spouses because the social security numbers have not been provided.

Committee Bill. Section 205 would amend title 38 by adding a new section—section 1709. Disclosure to Secretary of health-plan contract information and social security number of certain veterans receiving care—which would authorize the Secretary of Veterans Affairs to require that applicants for, and recipients of, VA medical care and services provide their health-plan contact information and social security numbers to the Secretary upon request.

Subsection (a) of the new section 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) of the new section would provide 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) of the new section would provide that the Secretary shall deny the application for, or terminate an individual's enrollment in, VA's patient enrollment system of 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) of the new section would provide that this section may not be construed as authority to deny medical care and treatment to an individual in a medical emergency.

VA strongly supported this provision in testimony provided to the Committee for its April 22, 2009, hearing. 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, the Administration believes that the applicant or recipient will have an incentive to provide the requested information. The Committee expects VA to provide a high degree of confidentiality for beneficiaries' health plan information and social security numbers.

Section 206. Enhancement of quality management.

Section 206 of the Committee bill, which was originally derived from S. 2377 as introduced in the 110th Congress, would require actions to enhance VA's quality management efforts.

Background. Under current law, section 7311 of title 38, VA operates a quality management 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 management 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.

VA's quality management program, including the National Surgical Quality Improvement Program (NSQIP), has 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 (OIG) found that the quality management 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 between 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 the Department'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 management.

Committee Bill. Section 206 of the Committee bill would add a new section 7311A to chapter 73 of title 38. This new section would require the Under Secretary for Health ("USH") to appoint a National Quality Management Officer, reporting directly to the Under Secretary, who would develop requirements and standards for a national quality management program, and prescribe regulations for its implementation. The National Quality Management Officer would be responsible for developing ways of measuring quality at individual VA facilities, and ensuring that those measures were routinely monitored and analyzed.

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

Additionally, section 206 of the Committee bill would require each VA Medical Center Director to appoint a quality management officer for that facility. The Director would be required to ensure that other clinical or administrative duties of the person appointed as the quality management officer are reduced so as to not interfere with the person's quality management duties. The quality management officer would report to the Director of the facility and to the quality management officer of the VISN of which that facility is a part.

Section 206 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 management 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 of Veterans Affairs 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 the 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 M. Cross, Principal Deputy Under Secretary for Health, expressed VA's support for the provisions of this section of the Committee bill that require a comprehensive review and report on health care quality and patient safety policies across the VA health care system. In written testimony submitted for the Committee's April 22, 2009, VA stated that the Department supported the intent of these provisions.

Section 207. Reports on improvements to Department health care quality management.

Section 207, which is also derived from S. 2377 from the 110th Congress, would require the Secretary to report on VA efforts to implement the provisions of the Committee bill concerning quality management.

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

tively ensure oversight and accountability by the Committee and the Congress.

Committee Bill. Section 207 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 206 (relating to quality management 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 the Department's efforts to improve quality management efforts and activities.

Section 208. Pilot program on 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 208 of the Committee bill, which is also derived from S. 2796 from the 110th Congress, 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 the most appropriate to reach out to veterans and that, in such instances, local organizations, with 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, 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 208 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 the 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.

Section 209. Specialized residential care and rehabilitation for certain veterans.

Section 209, which was originally derived from S. 2889, by request legislation in the 110th Congress, would authorize VA to contract for specialized residential care and rehabilitation services for certain veterans of Operation Enduring Freedom and Operation Iraqi Freedom (hereinafter ("OEF" and "OIF," respectively).

Background. Some 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 209 of the Committee bill would amend title 38 section 1720 of title 38 by adding a new subsection (g) that would authorize the Secretary of Veterans Affairs, in carrying out a 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 OIF/OEF 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, which would exceed 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. VA supported this provision in its testimony submitted for the April 22, 2009, hearing.

Section 210. Expanded study on the health impact of Project Shipboard Hazard and Defense.

Section 210 of the Committee bill 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 Shipboard Hazard and Defense.

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

The 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. While there are many known medical problems associated with repeated chemical and biological weapons exposure, the Committee is concerned that the study is incomplete because it omits a number of Project SHAD veterans who were known to the Department of Defense and to VA.

Committee Bill. Section 210 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 unrestricted, VA-provided care for veterans who participated in Project SHAD. While the Committee remains committed to these veterans receiving care, the Committee also believes there is value in examining the impact of the 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 the same time period at Edgewood Arsenal, Dugway Proving Grounds, Ft. McClellan, and Ft. Detrick.

Section 211. Use of non-Department facilities for rehabilitation of individuals with Traumatic Brain Injury.

Section 211 of the Committee bill would specify the circumstances under 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. In 2007, Congress passed a series of VA-related provisions in the National Defense Authorization Act, the bulk of which sought to expand and enhance TBI care at VA facilities. As part of those provisions, Congress 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 the NDAA, specific criteria for eligibility and standards of care were set out, but those provisions were dropped in the final compromise.

Committee Bill. Section 211 of the Committee bill would amend section 1710E of title 38 so as to add two new subsections that were included in the Senate-passed version of 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 Committee notes that VA provides services for veterans with TBI currently through a variety of different mechanisms and that the authority in this section is limited to those situations in which the Secretary determines that the treatment or services offered are optimal for the recovery and rehabilitation of the individual, and where the Secretary is unable to otherwise provide such treatment or services at the frequency or for the duration prescribed. The Brain Injury Association of America supports this section, "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 servicemembers with TBI need and deserve."

Section 212. Inclusion of Federally-recognized tribal organizations in certain programs for State veterans' homes.

Section 212 of the Committee bill 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 the States in two ways to assist in funding the homes. Under Sections 1741–1743 of title 38, VA has the authority to carry

out a per diem payment program under 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 contribute 35 percent. Under current law, tribal organizations are not considered States for the purposes of eligibility for either of these programs.

Based on the 2000 U.S. Census, the Department of Veterans Affairs projected in a September 2006 report that during the time period from 2005 to 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 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 212 of the Committee bill would amend section 8138 of title 38 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), except that 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, would not apply to the health facilities of tribal organizations.

Subsection (b) of section 212 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—that would give the Secretary 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 is 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. By recognizing the limited long-term care options in Native American communities, as well as the sovereign status of federally-recognized tribes, section 212 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 decisionmakers." 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.

Section 213. Pilot program on provision of dental insurance plans to veterans and survivors and dependents of veterans.

Section 213 of the Committee bill would direct the Secretary of Veterans Affairs 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. The Department of Veterans Affairs provides a full range of dental services at its facilities. However, under section 1712 of title 38, 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.

The Department of Defense 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 Department of Defense contract with private insurers. Section 703 of Public Law 104–201, the National Defense Authorization Act for Fiscal Year 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 the Department of Defense. Over one million 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 213 of the Committee bill, in a free-standing provision with subsection (a) through (k), 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) would require the Secretary to carry out the pilot program so as to assess the feasibility and advisability of providing dental insurance.

Subsection (b) 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.

Subsections (c) and (d) would specify that the pilot program would be carried out for a period of three years in not less than two and no more than four VISNs.

Subsection (e) would specify that the Secretary is to contract with a dental insurer to administer the dental plan.

Subsection (f) 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 (g) 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 (h) 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 (i) 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 (j) 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 (k) 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 healthcare system the TRDP concept of supplementing dental benefits provided 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 MATTERS

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

Section 301 of the Committee bill, which was originally derived from S. 2799 of the 110th Congress, would require the Secretary to submit a report to Congress, no later than June 1, 2010, 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 servicemembers, and therefore are a growing portion of the veteran population.

Committee Bill. Section 301 of the Committee bill, in a free-standing provision, would require VA to submit a report to Congress, not later than June 1, 2010, that would be required to 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.

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

Section 302 of the Committee bill, which is also derived from S. 2799 of the 110th Congress, 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 Under Secretary for Health 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 1.6 million, 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, in a free-standing provision, 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 Operations Iraqi and Enduring Freedom. 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 be 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 toward ensuring that the needs of women veterans are met, now and into the future.

Section 303. Independent study on health consequences of women veterans of military service in Operation Iraqi Freedom and Operation Enduring Freedom.

Section 303, which is also derived from S. 2799 of the 110th Congress, 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 for women veterans of service on active duty in the Armed Forces in deployment 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.

More than 160,000 female U.S. servicemembers have served in Iraq, Afghanistan, and the Middle East since 2003. From March 19, 2003 through June 6, 2009, 624 women were wounded in action in OIF or OEF. Statistics were not kept by gender for wars prior to the Iraq and Afghanistan conflicts.

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 male servicemembers. 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 6 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, in a free-standing provision, would require the Secretary of Veterans Affairs 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 be required to 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 be required to include an analysis of all published literature on such exposures to women while serving in the Armed Forces, including combat trauma and military sexual trauma. The entity conducting the study would be required to complete and submit a report of the study to Congress no later than 18 months after entering into the agreement for the study, and the Secretary would be required to submit a response to the report of the study no later than 90 days following the receipt of the report.

Section 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 also derived from S. 2799 of the 110th Congress, would require VA to implement a program for education, training, certification and continuing medical education 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 servicemembers 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 so as to add two new subsections.

Proposed new subsection (d) would require VA to implement a program for education, training, certification and continuing medical education 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, counseling and services provided to veterans under section 1720D. Specifically, VA would be required to 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 pro-

vided under such program to professionals and providers who have been so certified; the number of women veterans who received counseling, 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 the Department 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 equivalent employees who are trained to provide sexual trauma treatment and care.

Section 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 also derived from S. 2799 of the 110th Congress, 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 US Virgin Islands. Each provides assistance to veterans in need to readjustment counseling. The Vet Centers are managed by the Readjustment Counseling Service located in the Veterans Health Administration.

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 180 days after the date of enactment of the Committee bill, a pilot program designed to evaluate the feasibility of providing reintegration and readjustment services in group retreat settings to women veterans who are recently 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 million annually in fiscal years 2010 and 2011 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.

Section 306. Report on full-time women veterans program managers at medical centers.

Section 306 of the Committee bill, which is also derived from S. 2799 of the 110th Congress, 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, in a free-standing provision, would require the Secretary, acting through the Under Secretary for Health, 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.

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

Section 307 of the Committee bill, which is also derived from S. 2799 of the 110th Congress, would require the Secretary to appoint women veterans who are recently separated from the Armed Forces, to the Department'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 the 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) of title 38so 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 amend section 544(a)(2)(A) so as to 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.

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

Section 308 of the Committee bill, which is also derived from S. 2799 of the 110th Congress, 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 currently no 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 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 $1.5 million annually for fiscal year 2010 and 2011 for the purposes of the pilot program.

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

Section 309 of the Committee bill, which is also derived from S. 2799 of the 110th Congress, 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 statutory scheme results in a significant gap in care for the increasing number of women veterans enrolled with VA.

The current women veteran population is predominantly of child bearing age. Therefore, it is a disservice to the 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, entitled "Care for newborn children of women veterans receiving maternity care"—to Subchapter VIII of chapter 17 of title 38. 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 the Department. 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

Section 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 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. Adrian Atizado representing the Disabled American Veterans, testified before the Committee on April 22, 2009:

> According to VA, as of August 2008, over 945,000 OEF/OIF servicemembers have separated from military service. Of those, over 400,000 OEF/OIF veterans have sought VA health care since 2002, and over 178,483 have received a diagnosis of a possible mental health disorder. Within that group, 105,465 have been given a probable diagnosis of Post Traumatic Stress Disorder (PTSD).

While recently separated OIF/OIF veterans and members of the National Guard or Reserves who were mobilized for service in OIF/OEF who served their period of mobilization, are eligible for readjustment counseling services from VA under section 1712A of title 38, members of the Armed Forces still on active duty are not eligible for these services.

Committee Bill. Section 401 of the Committee bill, in a free-standing provision consisting of four subsections, 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) 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. These services would be provided through VA's Vet Centers.

Subsection (b) would specify that there is no requirement that a servicemember be currently on active duty to be eligible for these services.

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

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

The Committee recognizes that among many in the active duty and reserve Armed Forces, there is a stigma associated with seeking assistance in connection with mental health concerns. In light of the clear indication 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 Congitive 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.

Section 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 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 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.

Section 403. Study on suicides among veterans.

Section 403 of the Committee bill would require VA to conduct a study on suicides among veterans since January 1, 1999, and report to Congress on the findings.

Background. Numerous reports have illustrated that the rate of suicide among veterans is steadily increasing. One such report was the RAND study noted above 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 Office of Mental Health reported that the number of suicides attempted at VA facilities increased from 492 in 2000 to 790

in 2007. The Army reported seven confirmed and 17 suspected suicides in January 2009. This number of suicides would surpass the number of troops killed in combat for the same month in Iraq and Afghanistan combined. Between 1995 and 2007, there have been over 2,200 suicides among active-duty servicemembers. Despite these increases, there remains no centralized database of veteran suicides and attempts.

Committee Bill. Section 403 of the Committee bill, in a freestanding provision consisting of four subsections, would require VA to conduct a study to determine the number of veterans who died by suicide between January 1, 1999, and the date of enactment of the Committee bill.

Subsection (a) would set forth the basic requirement for the study.

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

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

Because the data shows that the incidence of suicide among veterans is at record levels, the Committee believes a need exists to have more comprehensive and accurate information so this problem can be more successfully addressed.

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

Section 404 would mandate the transfer of $5 million from VHA accounts to the Secretary of Health and Human Services (HHS) 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 DOD Mental Health Task Force, the Presidential Task Force on Returning Global War on Terror Heroes, the Institute of Medicine, 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.

Committee Bill. Section 404 of the Committee bill would, in a freestanding provision consisting of three subsections, 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) would require VA, no later than the September 30, 2010, to transfer $5,000,000 from accounts of VHA to HHS for the Graduate Psychology Education program.

Subsection (b) 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 disorders.

Subsection (c) 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 expects that 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.

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.

Dean Stoline, testifying for The American Legion before the Committee on January 28, 2009, spoke of the substantial needs of this population:

> * * * there are approximately 154,000 homeless veterans on the street each night. This number, compounded with 300,000 servicemembers entering the private sector each year since 2001 with at least a third of them potentially suffering from mental illness, requires that intensive and numerous programs to prevent and assist homeless veterans are available.

Many of these homeless veterans are returning from the conflicts in Iraq and Afghanistan. VA reported that almost 3000 OIF/OEF homeless veterans were treated at VA medical centers over that past four years.

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 abuse 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 worked cooperatively with VA to expand and enhance its authority to serve this particular population. Title V of the Committee bill includes a number of provisions, some proposed by 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

Section 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 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 veterans." 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 VA Grant and Per Diem 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." Gerald M. Cross, M.D., 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, in a free-standing provision consisting of six subsections, would authorize the Secretary, subject to the availability of appropriations, to carry out, and evaluate the impact of, a pilot program which would pro-

vide grants to entities that coordinate the provision of supportive services for very low income formerly homeless veterans.

Subsection (a) authorizes the Secretary to award grants to public and nonprofit organizations to coordinate supportive services to low-income formerly homeless veterans residing in permanent housing that is located on qualifying properties as part of a pilot program.

Subsection (b) defines qualifying property as 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. The Secretary of Defense must determine, 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.

Subsection (c) requires the Secretary to prescribe criteria and requirements for grants under this section and to publish such criteria and requirements in the Federal Register.

Subsection (d) limits the duration of the pilot program to five years after the date of the commencement of the program.

Subsection (e) defines "very low income" to have the same meaning as that used by the Department of Housing and Urban Development.

Subsection (f) authorizes the appropriation of not more than $3,000,000 in each fiscal year from 2010 through 2014 to carry out the pilot program.

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.

Section 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 would authorize the Secretary to implement a similar pilot program providing supportive services to homeless veterans residing in permanent housing on properties not qualifying under Section 501's pilot program.

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, an approach consistent with the overall direction that efforts against homelessness are moving in. The focus among both VA providers and community groups is shifting to prevention rather than reaction to homelessness occurring. In VA's case, this is done largely through intensive case management and collaboration with veterans service organizations to find permanent housing for formerly homeless veterans.

Committee Bill. Section 502 of the Committee bill authorizes the Secretary to carry out a pilot program to make grants to public and nonprofit organizations to coordinate supportive services for veterans residing in permanent housing.

Subsection (a) would authorize the Secretary, subject to the availability of appropriations, to award up to 10 grants to public and nonprofit organizations to coordinate the provision of supportive services to veterans residing in permanent housing on qualifying properties.

Subsection (b) defines qualifying properties under this subsection as properties in the United States on which permanent housing is provided to formerly homeless veterans, as determined by the Secretary.

Subsection (c) requires the Secretary to prescribe criteria and requirements for grants under this section and to publish such criteria and requirements in the Federal Register.

Subsection (d) limits the duration of the pilot program to five years after the date of the commencement of the program.

Subsection (e) identifies the definition of "very low income" to be that found in the Resident Characteristics Report issued annually by the Department of Housing and Urban Development.

Subsection (f) authorizes appropriations of not more than $3,000,000 in each of the fiscal years 2010 through 2014 to carry out the purposes of this section.

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(a) 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."

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

Section 503 of the Committee bill 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.), 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 informing certain veterans and their spouses about VA pension benefits.

Subsection (a) authorizes the Secretary to carry out 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 VA pension benefits and services for which they may qualify for under chapter 15 of title 38, U.S.C.

Subsection (b) requires the Secretary to prescribe criteria and requirements for grants under this section and to publish such criteria and requirements in the Federal Register.

Subsection (c) limits the duration of the pilot program to five years after the date of the commencement of the program.

Subsection (d) authorizes appropriations of not more than $1,275,000 in each of the fiscal years 2010 through 2014 to carry out the purposes of this section.

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.

Section 504. Assessment of pilot programs.

Section 504 of the Committee bill would require the Secretary to submit a report to Congress on each of the pilot programs detailed in sections 501–503 of the Committee bill at least 1 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.

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 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 vet-

erans' 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 million 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, the Department of Defense and the National Institutes of Health of the Department of Health and Human Services. 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 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.

Section 601. General authorities on establishment of corporations.

Section 601 of the Committee bill 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, 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 Executive 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 April 22, 2009, hearing, VA expressed support for section 601 and specifically for permitting the formation of multi-medical center research corporations.

Section 602. Clarification of purposes of corporations.

Section 602 of the Committee bill, which is derived from S. 2926 in the 110th Congress, 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 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 Veterans Health Administration 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 servicemembers 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.

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

Section 603 of the Committee bill 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 (hereinafter "OGE") promulgated governmentwide conflict of interest regulations in 5 CFR 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 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.

Section 604. Clarification of powers of corporations.

Section 604 of the Committee bill 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, 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 assignments 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 Office of the Inspector General (hereinafter, "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, 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 (C) of new subsection (a)(1) 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 (D) of new subsection (a)(1) 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 (E) of new subsection (a)(1) 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 Interagency Personnel Agreement. The Committee believes that this authorization will remove any uncertainty about the appropriateness of using VA 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 Under Secretary for Health 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. VA also supported this provision in its testimony for the record of the Committee's April 22, 2009 hearing.

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

Section 605 of the Committee bill, 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.

Section 606. Improved accountability and oversight of corporations.

Section 606 of the Committee bill 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 (hereinafter, "NPPO") to provide oversight of NPC activities. The NPPO is responsible for providing oversight and guidance affecting operations and financial management, performing 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 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 can-

not 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 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.

Section 607. Repeal of sunset.

This provision repeals Section 7368, which prohibited the creation of NPCs after December 31, 2008. This is necessary to permit the formation of multicenter NPCs as otherwise authorized within Title VI of the Committee bill.

TITLE VII—MISCELLANEOUS PROVISIONS

Section 701. Expansion of authority for Department of Veterans Affairs police officers.

Section 701 of the Committee bill would expand certain authorities set out in title 38 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 was formulated in a manner that suited a health care system 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, Community Based Outpatient Clinics, and storefront Vet Centers. VA's increasingly decentralized delivery points for care necessitates 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 701 of the Committee bill would amend section 902(a) of title 38 so as to permit VA police officers to: (1) carry VA-issued weapons, including firearms, while off Department property in an official capacity or while in official travel status; (2) conduct investigations, on and off Department property, of offenses that may have been committed on Department property, consistent with agreements with affected local, state, or Federal law enforcement agencies; and (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 701 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, the Pentagon Force Protection Agency, and the United States Capitol Police. The Fraternal Order of Police expressed support for this provision in a letter to Chairman Akaka and Ranking Member Burr. The Committee requested input from the Department of Justice on this provision, which was not provided by the date of this report.

Section 702. Uniform allowance for Department of Veterans Affairs police officers.

Section 702 of the Committee bill as incorporated into S. 252, would amend title 38 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. 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 702 of the Committee bill would amend section 903(b) of title 38, 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. VA supported this provision in testimony for the Committee's April 22, 2009 hearing.

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 almost $900 million over the 2010–2014 period, assuming appropriation of the necessary amounts. The Committee bill would not increase direct spending, based on information supplied by the CBO. 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, July 16, 2009.

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. 252, the Veterans Health Care Authorization Act of 2009.

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

Sincerely,

DOUGLAS W. ELMENDORF,
Director.

Enclosure

S. 252, Veterans Health Care Authorization Act of 2009

Summary: S. 252 would make several changes to existing veterans' health care programs and create a number of new health care programs for veterans. In total, CBO estimates that implementing the bill would cost almost $900 million over the 2010–2014 period, assuming appropriation of the specified and estimated

amounts. Enacting the bill would affect direct spending and revenues, but CBO estimates that impact would not be significant.

S. 252 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. 252 is shown in the following table. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—					
	2010	2011	2012	2013	2014	2010–22014
CHANGES IN SPENDING SUBJECT TO APPROPRIATION [a]						
Pilot Program for Dental Insurance:						
Estimated Authorization Level	10	65	85	85	85	330
Estimated Outlays	9	59	82	84	85	319
Health Care for Female Veterans:						
Estimated Authorization Level	37	34	30	31	34	166
Estimated Outlays	34	33	30	31	34	162
Education Assistance:						
Estimated Authorization Level	11	27	39	43	48	168
Estimated Outlays	10	25	37	42	47	161
Medical Personnel:						
Estimated Authorization Level	18	18	19	19	20	94
Estimated Outlays	16	18	19	19	20	92
Quality Management:						
Authorization Level	25	25	0	0	0	50
Estimated Outlays	23	25	2	0	0	50
Pilot Programs:						
Estimated Authorization Level	10	10	7	7	7	41
Estimated Outlays	10	10	7	7	7	41
Expanded Eligibility for Vet Centers:						
Authorization Level	10	9	6	6	6	37
Estimated Outlays	9	9	6	6	6	36
Specialized Residential and Rehabilitation Care:						
Authorization Level	2	3	5	6	8	24
Estimated Outlays	2	3	5	6	8	24
Studies:						
Authorization Level	3	0	0	0	0	3
Estimated Outlays	3	*	0	0	0	3
Uniforms for Police Offices:						
Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Other Provisions:						
Authorization Level	1	1	1	1	1	5
Estimated Outlays	1	1	1	1	1	5
Total Changes:						
Estimated Authorization Level	128	193	193	199	210	923
Estimated Outlays	118	184	190	197	209	898

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

[a] In addition to the effects on spending subject to appropriation shown in this table, CBO estimates that enacting S. 252 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 2010, that the authorized and estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for similar programs.

Spending subject to appropriation

CBO estimates that implementing S. 252 would cost $898 million over the 2010–2014 period, assuming appropriation of the specified and estimated amounts.

Pilot Program for Dental Insurance. Section 214 would require the Department of Veterans Affairs (VA) to implement a pilot program to provide dental insurance to all enrolled veterans and their survivors and dependents. VA would be directed to carry out the 3-year 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 2010–2014 period, assuming appropriation of the estimated amounts.

The bill would require VA to contract with a dental insurer who would administer the program. Veterans would be required to pay premiums and copayments. However, the bill would grant VA wide discretion in designing several critical parameters of the program, such as the covered benefits, requirements for enrollment and disenrollment, and premiums. For purposes of this estimate, CBO assumes that the pilot program would be carried out at three VISNs and that the program would be similar to the TRICARE Dental Program, which is available to reservists, their family members, and active-duty servicemembers.

CBO estimates that the program would begin accepting enrollees around the middle of fiscal year 2010, 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 2011 and 97,000 in 2012 before stabilizing at a level of about 90,000 a year.

The TRICARE program pays up to $1,200 a year 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 2010 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 $9 million in 2010, rising to $59 million in 2011, before stabilizing at slightly more than $80 million a year thereafter.

Health Care for Female Veterans. Title III of the bill would authorize several programs targeted to women veterans. CBO estimates that implementing that title would cost $162 million over the 2010–2014 period, assuming appropriation of the authorized and estimated amounts.

Care for Newborns. Section 309 would authorize 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 6,600 babies would become eligible for such care in 2010 at an average cost of $2,770 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 $102 million over the 2010–2014 period.

Training for Mental Health Providers. Section 304 would require VA to educate, train, and certify mental health professionals who specialize in treating sexual trauma. Based on information from

VA's Office of Mental Health Services, CBO estimates that VA would need 66 employees a year to provide training at a cost of $46 million over the 2010–2014 period.

Report and Study on Female Veterans. Section 301 would require the Secretary to conduct a study of the barriers faced by women veterans in receiving VA health care. Based on information from VA, CBO estimates that implementing this provision would cost $3 million over the 2010–2014 period.

Section 303 would require VA to contract with an outside entity to conduct a study on the health consequences facing female veterans of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) as a result of their service. Based on information from VA, CBO estimates that implementing this provision would cost $4 million over the 2010–2014 period.

Counseling for Female Veterans. Section 305 would require VA to implement a pilot program to provide 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 2010 and 2011 for that purpose. CBO estimates that this pilot program would cost $4 million over the 2010–2014 period.

Child Care. Section 308 would require VA to implement a pilot program to provide child care for certain female veterans who use VA medical facilities, and would authorize the appropriation of $1.5 million per year for 2010 and 2011 for that purpose. CBO estimates that this pilot program would cost $3 million over the 2010–2014 period.

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 $161 million over the 2010–2014 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 100 awards in 2010 with an average award of $46,000. In the following years, CBO estimates VA would grant 200 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 5.5 percent annual increase in tuition and other costs, CBO estimates that implementing this provision would cost $5 million in 2010 and $82 million over the 2010–2014 period, assuming appropriation of the estimated amounts.

Debt Reduction. Two other provisions of section 103 would allow VA to help employees repay education loans. Subsection (b) would expand eligibility for the Education Debt Reduction Program from those recently appointed to all employees involved in direct patient care. In 2008, about 6,500 employees received an average annual benefit of $5,800 under this program, which reimburses employees over a five-year period. Based on information from VA, CBO esti-

mates that 450 additional employees each year would become eligible. After adjusting for inflation, CBO estimates that implementing this provision would cost $44 million over the 2010–2014 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 an annual benefit of up to $35,000 per employee. Based on information from VA, CBO estimates that 100 new 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 $35 million over the 2010–2014 period.

Medical Personnel. Section 101 contains several provisions that would affect compensation for medical personnel. In total, CBO estimates that implementing those provisions would cost $92 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Overtime Pay. Section 101(l) 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 they were occasional or ad-hoc. In 2008, such employees worked roughly 1.8 million hours of overtime at an average overtime rate of about $55 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 $6 per hour for about 485,000 hours and weekend differentials of $15 per hour for 385,000 hours, for a total cost of $46 million over the 2010–2014 period, assuming appropriation of the estimated amounts.

Higher Pay for Nurses. Subsections 101(h) and 101(i) 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 $10,000 a year to about 560 nurses at a cost of $6 million a year. Subsection (j) 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 $7 million a year.

Incentive Pay for Pharmacist Executives. Section 101(f) 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 for a total cost of $8 million over the 2010–2014 period.

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 $14,000 to about 40 people, for a total cost of $3 million over the 2010–2014 period.

Quality Management. Section 206 would require VA to designate a quality management officer (QMO) for each of its 135 medical facilities and VISNs as well as a principal QMO who would report directly to the Undersecretary for Health. VA already has QMOs serving at all levels specified in the bill. This section also would authorize the appropriation of $25 million each year in 2010 and 2011 for assessing the reliability of existing measures of the quality of VA care and developing a new aggregate metric. CBO estimates that implementing this provision would cost $50 million over the 2010–2014 period, assuming appropriation of the authorized amounts.

Pilot Programs. Several sections of S. 252 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 $41 million over the 2010–2014 period, assuming appropriation of the specified and estimated amounts.

Homeless Veterans. Title V would require VA to carry out three separate pilot programs to provide outreach and various services to homeless veterans and would authorize the appropriation of $36 million over the 2010–2014 period for those purposes. CBO estimates that implementing those pilot programs would cost $35 million over the 2010–2014 period.

Transition Assistance. Section 208 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 similar assistance through Vet Centers. Vet Centers are community-based counseling centers that provide free mental health services to combat veterans and their families. Based on information from VA regarding spending on Vet Centers, CBO estimates that implementing that program would cost $6 million over the 2010–2014 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. According to VA data, there are currently 232 centers nationwide, and they served roughly 167,000 veterans in 2008. In 2009, Vet Centers received $185 million in appropriated funds.

Data from the Department of Defense (DOD) on OIF/OEF deployments indicate that roughly 1.1 million servicemembers are currently or have previously been deployed and are nonveterans (that is, they are still on active duty or in the reserves). After adjusting for expected separations (OIF/OEF veterans are eligible under current law) and smaller expected deployments starting in 2011, CBO estimates that of those remaining, about a third would seek mental health services. However, DOD indicates that servicemembers are already offered free counseling similar to that provided through Vet Centers. Therefore, CBO estimates that about 18,500 servicemembers (5 percent of those seeking mental health services) would use

Vet Centers in 2010 and that the number of users would decline to about 9,000 in 2014. Using a per person cost of $550 in 2010 (about half the expected cost for veterans, because servicemembers also have access to free DOD counseling) and adjusting for annual inflation, CBO estimates that implementing this provision would cost $36 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Specialized Residential and Rehabilitation Care. Section 209 would require VA to contract with appropriate entities to provide specialized care to OIF/OEF veterans whose Traumatic Brain Injuries (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 2010, VA would initially care for 20 veterans with TBI at a cost of roughly $84,000 per person. After adjusting for inflation, CBO estimates that over the 2010–2014 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 necessary amounts.

Studies. Section 211 would require an expanded study on the health impact of chemical and biological testing conducted by DOD in the 1960s and 1970s. Based on information from VA regarding a similar ongoing study, CBO estimates that implementing this provision would cost about $2 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

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 2010 and less than $500,000 in 2011, assuming availability of appropriated funds.

Together, CBO estimates that those two studies would cost $3 million over the 2010–2014 period, assuming appropriation of the necessary amounts.

Uniforms for Police Officers. Section 702 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 2010–2014 period, 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 have a net cost of $1 million a year, assuming availability of appropriated funds:

• Sections 201 would repeal a reporting requirement pertaining to nurses' pay.
• Section 202 would modify a reporting requirement pertaining to Gulf War veterans.
• Section 205 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 the 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 207 would require annual reports on the quality of the department's physicians and health care.
• Section 210 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 212 would modify authority granted to VA under Public Law 110–181 to pay for care provided to veterans with TBI to conform to how VA is implementing the program under current law.
• Section 306 would require a report on managers of programs for female veterans.
• Section 404 would require VA to transfer $5 million to the Secretary of Health and Human Services for an education program in psychology.

Direct spending and revenues

Section 701 would enhance the law enforcement authorities of VA police officers. Because those prosecuted and convicted under 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.

In addition, section 603 would authorize certain VA research and education facilities to charge fees for education and training programs. Those fees would be retained and spent by the facilities, and CBO estimates that enacting this provision would have no net significant effect on direct spending.

Intergovernmental and private-sector impact: S. 252 contains no intergovernmental or private-sector mandates as defined in UMRA. State, local, and tribal governments that provide assistance to veterans would benefit from grants and other programs authorized in the bill.

Previous CBO estimate: On June 16, 2009, CBO transmitted a cost estimate for H.R. 1211, the Women Veterans Health Care Improvement Act, as ordered reported by the House Committee on

Veterans' Affairs on June 10, 2009. Sections 101, 201, 202, and 203 of H.R. 1211 are similar to sections 301, 309, 304, and 308 of S. 252 respectively, as are their estimated costs.

Estimate prepared by: Federal Costs: Sunita D'Monte; Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum; Impact on the Private Sector: Elizabeth Bass.

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 following is a tabulation of votes cast in person or by proxy by Members of the Committee on Veterans' Affairs at its May 21, 2009, meeting. On that date, the Committee ordered S. 252 reported favorably to the Senate by roll call vote, without dissent. The Committee bill was agreed to by a 14 to 0 vote.

Yeas	Senator	Nays
X (by proxy)	Mr. Rockefeller	
X	Mrs. Murray	
X (by proxy)	Mr. Sanders	
X	Mr. Brown	
X	Mr. Webb	
X	Mr. Tester	
X	Mr. Begich	
X	Mr. Burris	
X (by proxy)	Mr. Specter	
X	Mr. Burr	
X	Mr. Isakson	
X (by proxy)	Mr. Wicker	
X	Mr. Johanns	
	Mr. Graham	
X	Mr. Akaka, Chairman	
14	TALLY	0

AGENCY REPORT

On April 22, 2009, Gerald M. Cross, M.D., Principal Deputy Under Secretary for Health, Department of Veterans Affairs, appeared before the Committee and submitted testimony on the Committee bill. Excerpts of the testimony are reprinted below:

PREPARED STATEMENT OF GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Good Afternoon 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 Joleen Clark, Chief Workforce Management and Consulting Officer for VHA.

* * * * * * *

S. 252 "VETERANS HEALTH CARE AUTHORIZATION ACT OF 2009"

S. 252 contains seven separate titles addressing a wide range of issues including personnel matters, homeless veterans, nonprofit research and education corporations and many health care matters including provisions specific to mental health and women veterans health care. Title I contains several provisions intended to enhance VA's ability to recruit and retain nurses and other health-care professionals and set certain standards for appointment and practice of physicians. These provisions are virtually identical to those reported in S. 2969 from the 110th Congress. We appreciated the opportunity to work with Committee staff on the prior bill and to provide technical comments and operational observations. We note that the reported bill and now Title I of S. 252 address many of our concerns and comments. However, there are several provisions we cannot support.

Section 101 contains provisions for the enhancement of authorities for retention of medical professionals.

Secretarial Authority to Extend Hybrid Status to Additional Occupations Subsection (a) would provide the Secretary authority to extend hybrid status to additional occupations. It would add "nurse assistants" to the list of so-called hybrid occupations for which the Secretary is authorized to appoint and to determine qualifications and rates of pay under title 38. In addition, it would authorize the Secretary to extend hybrid status to "such other classes of health care occupations as the Secretary considers necessary for the recruitment and retention needs of the Department" subject to a requirement to provide 45 days' advance notice to the Veterans' Affairs Committees and OMB. Before providing such notice, VA would be required to solicit comments from unions representing employees in such occupations.

VA favors such a provision. Nursing Assistants are critical to the Veterans Health Administration's (VHA) ability to provide care for a growing population of older veterans, who are high-acuity patients and/or frail elderly requiring 24-hour nursing care. Turnover

data, 11.1 percent for 2007 and 10.96 percent for 2008, illustrate the great difficulty VA experiences in retaining this occupation. It is increasingly critical for VHA to be able to quickly and easily employ these nurse extenders. The same holds true for other hard-to-recruit health care occupations. This bill would give the Secretary the ability to react quickly when it is determined that these authorities would be useful to help recruit and retain a critical occupation without seeking additional legislative authority. However, the bill language should be modified to specifically apply to occupations that clearly involve the delivery of health care. In addition, because this authority involves the conversion of title 5 occupations to title 38 hybrids, the 45-day notice requirement should be modified to add OPM. Thus, we recommend modifying subsection 2(a) of the bill to read:

> (a) SECRETARIAL AUTHORITY TO EXTEND TITLE 38 STATUS TO ADDITIONAL POSITIONS.
> (1) IN GENERAL.—Paragraph (3) of section 7401 of title 38, United States Code, is amended by striking "and blind rehabilitation outpatient specialists." and inserting in its place the following: "blind rehabilitation outpatient specialists, and such other classes of health care occupations who
> (A) are employed in the Administration (other than administrative, clerical, and physical plant maintenance and protective services employees);
> (B) are paid under the General Schedule pursuant to section 5332 of title 5;
> (C) are determined by the Secretary to be providing either direct patient care services or services incident to direct patient-care services; and
> (D) would not otherwise be available to provide medical care and treatment for veterans;
> (E) as the Secretary considers necessary for the recruitment and retention needs of the Department.
> (2) Notwithstanding chapter 71 of title 5, United States Code, the Secretary's authority provided in paragraph (1) is 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, the Office of Personnel Management, 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."

Probationary Periods for Part-Time Nurses

Subsection (b) provides for probationary periods for part-time (PT) Registered Nurses (RN) and revises the probationary period for RNs, both fulltime (FT) and PT, from 2 years to a maximum

of its equivalency in hours, 4180. It also provides that a PT appointee who previously served on a FT basis in a "pure" title 38 position (7401(1)), and completed a probationary period in the FT position, would not have to serve a probationary period in the PT "pure" title 38 position. VA opposes this provision. We believe this provision is technically flawed and would not be helpful.

Part-time title 38 employees, including RNs, do not serve probationary periods. Probationary periods apply to full-time, permanent employees. We see no benefit to creating a probationary period for part-time nurses as these positions are temporary.

Prohibition on Temporary Part-Time Nurse Appointments In Excess of 4,180 Hours

Subsection (c) would add a new section 7405(g) that would provide that part-time appointments of RNs are no longer temporary after no more than 4180 hours. After completion of the 4180 hours, the RN in essence would be converted to a permanent employee under section 7403(a) who has completed the probationary period. VA opposes this provision because it would impair our ability to adapt to changing demands in patient need and resource allocations. VA currently has the authority to create temporary appointments for up to three years. If this proposal is enacted, VA would lose this valuable flexibility. VA uses this flexibility to manage positions during periods of changing patient care needs and budgets. Without this current flexibility, VA's ability to make adjustments in the size of our temporary workforce would be limited. VA and its employees would be put into an untenable dilemma of either preemptively dismissing employees just prior to the expiration of the their probationary periods when patient demand justifies their continued employment or allowing a nurse to convert and retain employment, even if patient demand no longer justifies that position. In either scenario, patient care would be placed in competition with organizational flexibility, while the current system allows VA to achieve and maintain both.

Reemployed Annuitant Offset Waiver

Subsection (d) generally provides that annuitants may be temporarily reemployed in a title 38 position without being subject to having their salary offset by the amount of their annuity. VA opposes this provision as 5 U.S.C. 8344 and 8468 provide the agency access to retired title 38 health care providers.

Rate of Basic Pay for Section 7306 Appointees Set to Rate of Basic Pay for SES

Subsection (e) would amend section 7404(a) to add a provision setting the basic pay of non-physician/dentist section 7306 employees in accordance with the rate of basic pay for the Senior Executive Service (SES). This amendment would be effective the first pay period that is 180 days after enactment.

VA supports the principle of pay equity with SES rates for its section 7306 nonphysician/dentist executives as a tool needed to meet the challenge of recruitment and retention. Equity in pay for executive level managers and consultants is essential to attracting and retaining candidates for key positions. The pay schedule for 38

U.S.C. § 7306 appointees is capped at the pay rate for Level V of the Executive Schedule (currently $143,500). Locality pay is paid up to the rate for Level III (currently $162,900).

Individuals appointed under 38 U.S.C. § 7306 serve in executive level positions that are equivalent in scope and responsibility to positions in the SES. By comparison, employees in the SES receive a significantly higher rate of basic pay. The maximum SES pay limitation is the rate for Level II (currently $177,200) pending OPM certification that the agency meets all regulatory criteria for certified performance appraisal systems, including that the employing agency makes meaningful distinctions based on performance. We estimate the costs of this provision to be $343,917 in FY 2010 and $3,765,786 over a 10-year period.

As noted, the SES pay system conditions pay up to EX Level II on OPM certification that an agency's SES rating system meets all regulatory criteria for certified performance appraisal systems. In this regard we note that VHA uses the same rating system for its section 7306 executives as it uses for its SES members. OPM has certified this system in the past, and just last year recertified VA through July 2010. For consistency, we recommend that the bill be modified to require that the Secretary make the same certification for the rating system covering section 7306 employees. Thus, we suggest that section 101(e)(3) be modified to read as follows:

> (3) Positions to which an Executive order applies under paragraph (1) and are not described by paragraph (2) shall be paid basic rates of pay in accordance with section 5382 of title 5 for Senior Executive Service positions and not greater than the rate of basic pay payable for level III of the Executive Schedule; or if the Secretary certifies that the employees are covered by a performance appraisal system meeting the certification criteria established by regulation under section 5307(d), level II of the Executive Schedule.

Comparability Pay Program for Section 7306 and SES Appointees

Subsection (f) would amend section 7410 to add a new subsection to establish "comparability pay" for VHA non-physician/dentist section 7306 employees and SES employees of not more than $100,000 per employee in order to achieve annual pay levels comparable to the private sector. Similar to provisions for RN Executive Pay in section 7452(g), it would provide that "comparability pay" would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

VA supports the concept of comparability pay for its non-physician/dentist executives. However, we recommend that the new administration be given an opportunity to review this matter. Public sector executive pay is dramatically below the private sector for comparable positions, particularly in the health care sector. This proposal would allow VA executives to receive salaries far exceeding executives in other agencies which also must compete with the private sector. It would be a potentially precedent-setting departure from the unitary approach to governmentwide SES pay.

Special Incentive Pay for Department Pharmacist Executives

Subsection (g) would further amend section 7410 to authorize recruitment and retention special incentive pay for pharmacist executives of up to $40,000. VA's determination of whether to provide and the amount of such incentive pay would be based on: grade and 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 RN Executive Pay and comparability pay proposed by subsection (f), this subsection would provide that "comparability pay" would be in addition to other pay, awards and bonuses; would be considered base pay for retirement purposes; would not be base pay for adverse action purposes; and could not result in aggregate pay exceeding the annual pay of the President.

This provision will provide a retention incentive to about 40 positions: pharmacy benefit managers (PBM), consolidated mail outpatient pharmacy (CMOP) directors and VISN formulary leaders (VFL). VA supports this provision. Long-standing, severe and worsening pay compression exists within the ranks of senior pharmacy program managers in VHA. A national survey performed yearly by the American Society of Health System Pharmacists provides evidence that a similar trend exists in the private sector. Currently VHA has had extreme difficulty in recruiting pharmacists for leadership positions. Some examples include: the VA Medical Center in Bay Pines has not had a permanent Pharmacy Manager for two years; the VA Medical Center, Portland, Oregon position has been vacant for one year; the VA Medical Center, Asheville, NC has been vacant over one year; and numerous other facilities are experiencing the same recruiting difficulties. Several other facilities with extended vacancies that were recently been filled include: the VA Medical Center, Omaha, NE for two years; VA Medical Center Dayton, OH for two years; and VA Medical Center, Las Vegas, NV vacant for one year. The current pay rate that we are able to pay executives varies minimally from staff pharmacist positions and therefore is not an incentive to recruit pharmacy executive/those in leadership roles to VA. This provision will provide a mechanism to alleviate this compression. VA is still developing costs for this proposal and will submit them for the record when they are available.

Physician/Dentist Pay

Subsection (h) concerns physician/dentist pay. VA supports this provision. Paragraph (1) would provide that the title 5 non-foreign cost of living adjustment allowance for physicians and dentists would be determined as a percentage of base pay only. This would clarify the application of the title 5 non-foreign cost of living adjustment allowance to VHA physicians and dentists. The VA physician/dentist pay statute, 38 U.S.C. § 7431, does not address how the allowance is determined for physicians and dentists. We recommend that this provision be amended to clarify that it is applicable only to these physicians and dentists employed at Department facilities in Alaska, Guam, Hawaii, and Puerto Rico. These are the only Department facilities to which the title 5 non-foreign cost of living adjustment allowance is applicable.

Paragraph (2) would amend section 7431 (c)(4)(B)(i) to exempt physicians and dentists in administrative or executive leadership provisions from the panel process in determining the amount of market pay and pay tiers for such physicians and dentists. In situations where physicians or dentists occupy these leadership positions as chief officers, network directors, and medical center directors, the consultation of a panel has some limitations. The small number of physicians and dentists who would qualify as peers for these leaders results in their serving on each other's compensation panels and, in some cases, on their supervisor's panel. Providing the Secretary with discretion to identify administrative or executive physician/dentist positions that may be excluded from the panel process would resolve these issues.

Paragraph (3) would provide an exception to the prohibition on the reduction of market pay for changes in board certification or reduction of privileges correcting an oversight in the recent revision of the physician/dentist pay statute. This modification would allow VA to address situations where there is a loss of board certification or an adverse reduction in clinical privileges. No costs are associated with this provision.

RN and CRNA Pay

Subsections (i) and (j) relate to RN and Certified Registered Nurse Anesthetist (CRNA) Pay. Subsection (i) would amend the current cap for registered nurse from EL V to EL IV. VA supports this provision. This would increase the cap from level V to level IV for both RNs and CRNAs, consistent with the pay cap that applies to the GS locality pay system. We note that subsection (i) would obviate the need for subsection (j) as the two pay scales affected are already tied to each other. We estimate the cost of this provision to be $6.16 million for FY 2010 and $72.31 million over a 10-year period.

Subsection (k) would make amendments to the RN locality pay system (LPS). These provisions are not helpful and are unnecessary. No costs are associated with this provision.

Paragraph (1) would require the Under Secretary for Health to provide education, training, and support to VAMC directors in the "conduct and use" of LPS surveys, including third party surveys. Paragraph (2) would require the annual report VAMCs must provide to VA Central Office to include the methodology for every schedule adjustment. These reports form the basis for the annual VA report to Congress. We are concerned that this provision, especially in conjunction with proposed paragraph 3, could result in the inappropriate disclosure of confidential salary survey data, contrary to current section 7451 (d)(5). It also would impose an onerous burden inasmuch as VHA has nearly 800 nurse locality pay schedules. We do note that VA policy does provide for how these surveys are to be obtained or conducted. Paragraph (3) would require the most recent VAMC report on nurse staffing to be provided to any covered employee or employee's union representative upon request. This provision should be modified to specify at what point the report must be provided. It would not be appropriate to provide an individual a copy of the VAMC report before Congress receives the VA report.

Subsection (I) would increase the maximum payable for nurse executive special pay to $100,000. This provision would make the amount of nurse executive pay consistent with the Executive Comparability Pay proposed in section 2(f) of this bill. However, special pay of this amount would allow VA nurse executives to receive salaries far exceeding executives in other agencies that also must compete with the private section and there is no evidence that such levels of pay are necessary. Thus, VA opposes this provision.

The caption for subsection (m) suggests it provides for eligibility of part-time nurses for certain nurse premium pay. However, many of the substantive amendments are not limited to part-time nurses, or to all registered nurses.

VA opposes subsection (m) as it has serious technical flaws, is unnecessary, and is costly.

Subparagraph (1)(A) would amend section 7453 (a) to make part-time nurses eligible for premium pay under that section. However, part-time nurses already are eligible for section 7453 premium pay where they meet the criteria for such pay.

Subparagraphs (1)(B) and (1)(C) would require evening tour differential to be paid to all nurses performing any service between 6 pm and 6 am, and any service on a weekend, instead of just those performing service on a tour of duty established for those times to meet on-going patient care needs. Under current law, these differentials are limited to the RN's normal tour of duty and any additional time worked on an established tour.

The "tour of duty" requirement in the current law is intended to ensure adequate professional care and treatment to patients during off and undesirable tours. The limitation of tour differential and weekend pay only for service on a "tour of duty" rewards those employees who are subject to regular and recurring night and weekend work requirements. If that is changed to "period of service", any employees performing night or weekend work on an occasional or ad-hoc basis would also be entitled to this premium pay in addition to overtime pay, providing an inappropriate windfall for performing occasional work.

Subparagraph (2) would authorize title 5 VHA employees to receive 25 percent premium pay for performing weekend work on Saturday and Sunday. We understand the purpose of this provision is to limit the expansion of weekend premium pay to non-tour hours to registered nurses. However, it does not fully achieve that purpose. Pursuant to section 7454(a) and (b)(2), physician assistants, expanded-function dental auxiliaries, and hybrids are also entitled to weekend pay under section 7453. The expansion of weekend pay proposed in this subparagraph would apply to them as well. In addition, because physician assistants and expanded-function dental auxiliaries are entitled to all forms of registered nurse premium pay under section 7453, the expansion of the night differential premium pay also would apply to them. Furthermore, where VA has authorized section 7453 night differential for hybrids, the expansion of the night differential premium pay would apply to them as well.

Subsection (n) would add additional occupations to the exemption to the 28th step cap on title 38 special salary rates: LPNs, LVNs, and unspecified "other nursing positions otherwise covered by title

5". Notwithstanding the exemption, under current statute, title 38 special salary rates cannot exceed the rate for EL V. It is not clear what positions "nursing positions otherwise covered by title 5" would include. RNs are appointed under title 38, LPNs/LVNs are hybrids, and section 101(a)(2) of the bill would convert nursing assistants to hybrid. Moreover, it is not apparent why only these positions and not all positions authorized title 38 special rates would be exempted. Using the same formula for the cap on title 5 special rates would afford VA the most flexibility in establishing maximum rates for title 38 special rates. We also note that adopting the title 5 fixed-percentage formula would render unnecessary the section 7455(c)(2) report for exceeding 94 percent of the grade maximum and, so, propose deleting it.

Thus we recommend amending section 7455 to read as follows:

> (a)(1) Subject to subsections (b), (c), and (d), when the Secretary determines it to be necessary in order to obtain or retain the services of persons described in paragraph (2), the Secretary may increase the minimum rates of basic pay authorized under applicable statutes and regulations, and may make corresponding increases in all rates of the pay range for each grade. Any increase in such rates of basic pay——
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> (c) The amount of any increase under subsection (a) in the minimum rate for any grade may not exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5 or similar provision of law) for the grade or level by more than 30 percent, and no rate may be established under this section in excess of the rate of basic pay payable for level IV of the Executive Schedule.

VA's concerns that pay setting authorized by this provision may be subject to collective bargaining are discussed in conjunction with S. 362.

Section 102(a)(1) would add new section 7459, imposing restrictions on nurse overtime. Section 7459 generally would prohibit mandatory overtime for nurses (RNs, LPNs, LVNs, nursing assistants, and any other nurse position designated by the Secretary). It would permit mandatory overtime by nurses under certain conditions: an emergency that could not have been reasonably anticipated; the emergency is non-recurring and not due to inattention or lack of reasonable contingency planning; VA exhausted all good faith, reasonable attempts to obtain voluntary workers; the affected nurses have critical skills and expertise; and the patient work requires continuity of care through completion of a case, treatment, or procedure. VA could not penalize nurses for refusing to work prohibited mandatory overtime. Section 7459 provides that nurses may work overtime hours on a voluntary basis.

VA favors this mandatory overtime restriction with the caveat that first and foremost, VA needs to be able to mandate overtime where issues of patient safety are identified by facility leadership. We note VAMCs currently have policies preventing RNs from work-

ing more than 12 consecutive hours and 60 hours in a 7-day period pursuant to section 4(b) of Pub. L. 108–445.

Section 102(b) would amend 38 U.S.C. 7456 (the "Baylor Plan"), which authorizes VA to allow nurses who perform two 12-hour regularly scheduled tours of duty on a weekend to be paid for 40 hours. This work-scheduling practice typically would be used when facilities encounter significant staffing difficulties caused by similar work scheduling practices in the local community. It would delete current section 7456(c), the current Baylor Plan requirement, which provides for a 5-hour leave charge for each 3 hours of absence that reflects the relative value of the truncated Baylor tour, in effect increasing the value of leave for affected employees. Currently, VA has only one employee working on the Baylor Plan. VA opposes this provision as providing an unwarranted windfall.

Section 102(c) would amend section 7456A to change the 36/40 alternate work schedule to a 72/80 alternate work schedule, so that under the schedule six 12-hour "periods of service" anytime in a pay period would substitute for three "12-hour tours of duty" in each week of the pay period. Similar changes would be made to section 7456A's overtime, premium pay and leave provisions.

VA is experiencing planning problems with the use of the current 36/40 schedule. The problem stems from the 36/40 language requiring three 12-hour tours in a work week and because VA defines "work week" as Sunday to Saturday. The problem occurs because the work week requirement prevents scheduling one of the 12-hour tours over two different weeks, e.g., 6PM Saturday to 6AM Sunday. Changing "work week" to "pay period" only makes the problem occur every 2 weeks instead of every week, so we do not view that as helpful. We do support changing the 36/40 alternate work schedule to a 72/80 alternate work schedule, so that the six 12-hour tours can occur anytime in a pay period, providing more work scheduling/planning flexibility. We would be glad to provide appropriate bill language.

Section 103 would make amendments to VA's Education Assistance Programs. VA supports these proposals. Section 103(a) would amend section 7618 to reinstate the Health Professionals Educational Assistance Scholarship Program through the end of 2014. The program expired in 1998. The Health Professional Scholarship Program would help reduce the nursing shortage in VA by obligating scholarship recipients to work for 2 years at a VA health care facility after graduation and licensure. This proposal would also expand eligibility for the scholarship program to all hybrid occupations. This would be helpful in recruiting and retaining employees in the several hard-to-fill hybrid occupations. We are still determining costs for this provision and will forward them to the Committee as soon as they are available.

Section 103(b) would make certain amendments to the Education Debt Reduction Program. It would amend section 7681(a)(2) to add retention as a purpose of the program and amend section 7682(a)(1) to make it available to "an" employee, in lieu of "recently appointed." It would also increase the authorized statutory amounts in section 7683 to $60,000 and $12,000, respectively.

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. In several instances, employees applying just missed the six-month deadline. In many cases it takes more than six months for employees to become aware of this very helpful recruitment and retention program. This proposal offers greater flexibility to VA in applying the program. VA also supports the increased amounts in light of increased education costs since the program was enacted. We note this program can be implemented in a cost-neutral fashion.

Section 103(c) would authorize VA researchers from "disadvantaged backgrounds" to participate in a loan repayment program that the VA may establish using the Public Health Service Act authorities for the NIH Loan Repayment Program. We agree that loan repayment incentives would be helpful to clinicians with medical specialization and research interests who might consider career clinical care or clinical research opportunities relating to the work of VHA.

Section 104 is nearly identical to S. 246, Section 2(a), which I have previously discussed.

Section 201 would eliminate two reporting requirements: the Nurse Pay Report and the Long-Term Planning Report. VA supports this provision. There would be no discernible cost savings associated with this provision. Similarly, VA supports Section 202 to amend the Persian Gulf War Veterans' Health Status Act to change the due date of the annual report to Congress from March 1 to July 1. This change would have no impact on cost.

VA also supports Section 203. Section 203 will provide clarification of the legal authority beyond the existing regulations that will prevent providers from collecting from the beneficiary any amounts in excess of the CHAMPVA determined allowable amount. VA favors this provision. There would be no significant cost to VA.

Section 204, relating to payer provisions for care furnished to certain children of Vietnam Veterans, has been made moot by the passage of Pub. L. 110–387, Section 408, "Spina Bifida Comprehensive Health Care."

VA strongly supports Section 205 of S. 252, which 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 decisionmakers who are authorized to make decisions on behalf of patients who lack decisionmaking capacity, but to whom the patient had not specifically authorized release of that legally protected information prior to losing decisionmaking capacity. This provision would only permit such a disclosure when the practitioner deems the 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.

Section 206 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 authorizes 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.

Given the significant privacy concerns related to this provision, we defer views until further analysis can be made and the new administration is given an opportunity to review this matter.

Section 207 addresses quality management in VA facilities and establishes quality management officer positions at the national, VISN and facility level. Section 207 is similar to S. 246, Section 3, although the position established is termed "Quality Management Officer" (QMO), and there is no stipulation that the position be filled by a board-certified physician. Section 207 would require the QMO to be responsible for and undertake specific actions to carry out VHA's quality management program. Section 207 additionally would require the National QMO to assess quality of care by developing an aggregate quality metric from existing data sources, monitoring and analyzing existing measures of quality, and encouraging research and development in the area of quality metrics. Section 207 would authorize appropriations necessary to carry out the quality management program, including $25,000,000 for the quality metric provisions during the 2 fiscal year period following enactment. Mr. Chairman, we support the intent of these provisions, that is enhancing VA's quality management programs, and have already undertaken 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.

Section 208 requires submission of an annual report to Congress describing progress toward implementing provisions of Sections 104 and 207. VA has no objection to this requirement and, in fact, supports the concept of transparency in health care. We note that a comprehensive Hospital Quality Report was prepared by the Department in 2008 and is updated annually.

We estimate that the requirement that the VISN Director review all information needed for physician appointment would require an additional FTEE (GS 14) at the VISN level. We also estimate that the appointment of a board-certified physician to serve as QAO at the facility and network levels would require 162 physicians for 141 medical staffs and 21 networks. We estimate salary and benefits costs for each QAO to be approximately $200,000 (actual will vary according to specialty, time commitment, and local market

factors). We estimate total costs for a FTE MD QAO and FTE VISN coordinator to be $35.10 million in the first year, $188.05 million over five years, and approximately $413.22 million over 10 years. We estimate that salaries plus benefits for the new positions will include a 4% increase in costs for each subsequent year.

Section 209 would require the Secretary to conduct a pilot program, 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. The pilot program would be conducted at three VA medical centers and, if determined appropriate, at one DOD medical center. 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 for the costs of training family members of servicemembers. Family caregivers certified under this program would 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 209. 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. Moreover, it does not put VA in the position of having to tell family members how, at the risk of losing their caregiver compensation, they have to care for their loved ones. If enacted, we estimate the cost of the three-year pilot to be $178.4 million.

Section 210 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 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.

VA does not support section 210. Individuals providing respite care do not require advanced degrees, only appropriate training. Respite care does not require specialized skills, and its functions are not applicable to curricula objectives in the graduate degree programs related to mental health or rehabilitation that we are aware of. Further, section 210 would require VA to use graduate students in roles that are not permissible under academic affili-

ation 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. We also 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 conducting the pilot program to be $3.5 million in the first year and approximately $11.4 million over five years.

Section 211 would require the Secretary to carry out a two-year pilot grant program (at five locations selected by the Secretary) to assess the feasibility of using community-based organizations and local and State government entities 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. Grantees could use grant funds for purposes prescribed by the Secretary.

VA opposes section 211 because it is duplicative of the Department's on-going efforts. Vet Centers are already providing many of the services contemplated by this provision. 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. The duplicated efforts required by the bill would likely create significant confusion for the beneficiary.

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 and assure the quality of services provided. That approach also gives us an accurate way to project the cost of the services. This provision, 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.

Although the proposed pilot project is limited to five locations, the bill does not specify the number and amount of the grants to be awarded. We are unable to estimate the cost of this provision due to the lack of specificity.

Section 212 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 independ-

ently; this represents an extremely small subset of the OEF/OIF population. In fact, for FY 2010, VA estimates only 10 veterans would qualify and participate in this program. Age appropriate day health and other community programs, VA's home based primary care, and medical foster homes will be expanded to provide these Veterans with long-term specialized rehabilitation services. VA supports this legislation as it would enable us to provide these veterans 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 212 to be $923,000 for the first year, $12.2 million over five years, and $76.8 over ten years.

Section 213 would amend sections 5701 and 7332 of title 38, United States Code. The amendments would 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.

Given the significant privacy concerns related to this provision, we defer views on this section until further analysis can be made and the new administration is given an opportunity to review this matter.

Section 214 would require VA to enter into a contract with the Institute of Medicine of the National Academies to conduct an expanded study on the health impact of Project Shipboard Hazard and Defense (Project SHAD). VA opposes this proposal. The 2007 four-year, $3.8 million, VA-sponsored study by the National Academies of Sciences (NAS) "Long-Term Health Effects of Participation in Project SHAD" represented an exhaustive effort to locate and evaluate the health of every living or deceased SHAD veteran. That study found little or no long-term health effects linked to SHAD participation, and spending additional resources with the hope that possibly tracking down a small number of additional SHAD veterans might significantly change those results is unrealistic. We have been assured by the NAS group who conducted the original study that they have spared no effort in tracking down every SHAD participant as part of their study. We estimate that such a study would cost $2.5 million.

When VA is providing inpatient or outpatient care for a patient with Traumatic Brain Injury, VA is required to develop an individual plan for the veteran or servicemember. In implementing such plans, 38 U.S.C. § 1710E authorizes the Secretary to provide hospital care and medical services through cooperative agreements with appropriate public or private entities that have established long-term neurobehavioral rehabilitation and recovery programs. Section 215 would amend this authority by defining covered individuals as servicemembers or veterans receiving inpatient or outpatient rehabilitative hospital care or medical services for Traumatic Brain Injury to whom the Secretary is unable to provide

treatment or services at the frequency or for the duration described in the plan, or for whom the Secretary determines such care is optimal. This provision would also require that facilities participating in such cooperative agreements maintain standards for the provision of treatment or services that have been established by an independent, peer-reviewed organization that accredits specialized rehabilitation programs for adults with Traumatic Brain Injury.

VA supports this provision but recommends that the plan referenced in this provision be described as the VA Individualized Rehabilitation and Reintegration Plan developed in accordance with section 1710C. Further, the bill as currently drafted states that the Secretary may not provide treatment or services at the non-VA facility unless the 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."

Section 216 would include federally recognized tribal organizations in certain State home programs. Specifically, section 216(a) would authorize VA to treat a health facility or certain beds in a health facility of a tribal organization as a State nursing home for veterans. This would allow VA to pay per diem to the organization for the nursing home care of veterans in the home. The home would be required to meet the existing standards for State homes and such other standards as VA requires. In addition, the organization would have to demonstrate that, but for treatment in the home, a substantial number of veterans residing in the area would not have access to nursing home care, and the Secretary would have to determine that treatment of the facility or beds as a State home would best meet the needs of veterans for nursing home care in the area. Finally, tribal organizations would be subject to limitations on the number of beds that could receive per diem under this provision.

VA opposes Section 216(a). It would be very difficult to maintain a critical mass of staff with expertise in the care of frail, elderly patients in such a setting. Moreover, this would duplicate the function of the existing Community Nursing Home Program under which VA can pay for the care of Veterans placed in nursing homes in the private sector. VA contracts with more than 4,500 community nursing homes nationally and can add more as needed to assure Veterans' access to care.

Section 216(b) would authorize VA to award grants to tribal organizations for the construction or acquisition of state homes in the same manner and under the same conditions as grants awarded to States subject to exceptions prescribed by VA to take into account the unique circumstances of tribal organizations. This provision would require VA to give priority to grant applications from tribal organizations that had not previously applied for a grant even if the State in which the tribal organization was located had previously applied for (or received) a grant.

VA also opposes Section 216(b). The proposal would disenfranchise the states for which the construction grant program was expressly established since priority for awarding of grants is prescribed in statute and regulation. The first priority is for renovations necessary to protect the lives and safety of Veterans residing

in the home. The second priority is for grants to states, or under this provision, tribal entities, that have never previously received a grant from this program. Since every state has received a grant and no tribal entity ever has, all construction and renovation applications from tribes would take precedence over all applications from states, except for life safety grants, until all tribal entities that wished to submit applications had done so. Since there are more 500 recognized tribal entities, it could be years before states are again able to receive grants other than life safety grants, and even then they would have to compete with more than 500 eligible applicants instead of the 50 states and a few territories now eligible for the grants. The radical change being proposed would be detrimental to the states for which this program was specifically established.

VA estimates the cost of Section 216 to be $2.6 million for the first year, $14.2 million over five years, and $31.5 million over ten years.

Section 217 would require the Secretary to carry out a pilot program to assess the feasibility and advisability of providing a dental insurance plan to veterans enrolled for VA health care pursuant to section 1705 of title 38 and survivors or dependants enrolled for care under section 1781 of title 38 (CHAMPVA). Under this plan, VA would manage and administer a group dental plan. VA opposes section 217 as this provision would establish an entirely new and dramatically different role for VA.

Section 301 of this bill corresponds to section 101 of S. 597, another bill on today's agenda. This section would require VA to contract with a qualified independent entity or organization to carry out a comprehensive assessment of the barriers encountered by women veterans seeking comprehensive health care from VA, building on the VA's own "National Survey of Women Veterans in Fiscal Year 2007–2008" (National Survey). Many requirements related to sample size and the scope of the survey would apply to the conduct of the assessment. Section 301 would also require the contractor-entity to conduct research on the effects of the following concerns on the study participants:

- The perceived stigma associated with seeking mental health care services.
- The effect of driving distance or availability of other forms of transportation to the nearest appropriate VA facility on access to care.
- The availability of child care.
- The acceptability of integrated primary care, or with women's health clinics, or both.
- The comprehension of eligibility requirements for, and the scope of services available under, such health care.
- The perception of personal safety and comfort of women veterans in inpatient, outpatient, and behavioral health facilities of the Department.
- The gender sensitivity of health care providers and staff to issues that particularly affect women.
- The effectiveness of outreach for health care services available to women veterans.

• The location and operating hours of health care facilities that provide services to women veterans.
• Such other significant barriers identified by the Secretary.

Additionally, section 301 would require the Secretary to ensure that the heads of the Center for Women Veterans and the Advisory Committee on Women Veterans review the results of the comprehensive assessment and submit their own findings with respect to it to the Under Secretary for Health and other VA offices that administer health care benefits to women veterans.

The results of our National Survey will not be available until later in the fiscal year. Consequently, we do not think it feasible to enter into a contract for the mandated assessment and research until we have first had a chance to complete and fully analyze the results of the National Survey. Only in this way can the assessment and research adequately build on the National Survey and reliably augment, rather than duplicate, VA's efforts in this area. We estimate the cost of section 101 to be $3.5 million.

The next section, section 302, corresponds to section 201 of S. 597 and requires VA to develop a plan to improve the provision of health care services to women veterans. VA fully supports the evaluation and enhancement of care to women veterans and initiated a planning and implementation program in September 2008. Consequently, this provision is unnecessary as the initiative is already underway.

Section 303 of S. 252 corresponds to section 102 of S. 597. This section would require VA to enter into a contract with an entity or organization to conduct a very detailed and comprehensive assessment of all VA health care services and programs provided to women veterans at each VA facility. The assessment would have to include VA's specialized programs for women with PTSD, homeless women, women requiring care for substance abuse or mental illnesses, and those requiring obstetric and gynecologic care. It would also need to address whether effective health care programs (including health promotion and disease prevention programs) are readily available to, and easily accessed by, women veterans based on a number of specified factors.

After the assessment is performed, the bill would require VA to develop an extremely detailed plan to improve the provision of health care services to women veterans, taking into account, among other things, projected health care needs of women veterans in the future and the types of services available for women veterans at each VA medical center. VA would then be required to report to Congress on the assessment and plan, including any administrative or legislative recommendations VA deems appropriate. What is unclear in the bill is whether the contractor-entity conducting the assessment would also be required to develop the follow-up "plan," as the terms of section 303 refer to the contractor's conduct of "studies and research" required by that section. VA supports section 303 only if the development of the mandated plan would be conducted by a contractor-entity. We estimate the total costs of this section to be $4,354,000 during the period of Fiscal Year 2010 through Fiscal Year 2012.

Section 304 corresponds to section 202 of S. 597. This provision 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 304 because they are duplicative of existing programs. In FY 2007, VA funded a Military Sexual Trauma Support Team, whose mission is, in part, to enhance and expand MST-related 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 webpage 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 section 304's 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 inefficient and ineffective way to manage a health care system that is dynamic and experiences continual changes in workload, utilization rates, etc.

Section 305 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.

We are unclear as to the purpose of and need for this provision. The term "group retreat setting" is not defined, but we assume it could not include VA medical facilities or Vet Centers, as we could not limit Vet Center access to any one group of veterans. Moreover, it is important to note that many Vet Centers are already well de-

signed to meet the individual and group needs of women veterans. We estimate that the cost of the pilot would be around $300,000.

Section 306 mandates a report to Congress to ensure that health care needs of women are met and to assess whether there is at least one full-time Women Veterans Program Manager employed at each VAMC. This section is substantially similar to section 103 of S. 597. The report shall include an assessment of whether there is at least one full-time employee at each VA medical center who is a full-time women veterans program manager. VA does not oppose this provision but we believe it is unnecessary. VA is already reporting regularly on the employment of Women Veteran Program Managers. To date, 137 of the 144 positions have been filled as full-time employees. No additional funds would be required to submit this report.

Next, section 307 (and the corresponding provision in S. 597, section 204) 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 fully support section 307. These amendments would help both Committees to better identify and address the needs of their respective veteran-populations.

Section 308 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 childcare 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. The corresponding provision is in section 205 of S. 597.

VA is very cognizant of the veterans' needs for convenient access to health care; however, we oppose section 308 as this expansion would divert resources from direct medical care.

We support section 309, which would authorize VA to furnish health care services up to seven days after birth to a newborn child of a female veteran who is receiving maternity care furnished by VA if the veteran delivered the child in a VA facility or in another facility pursuant to contract for service related to such delivery. This provision corresponds to section 206 of S. 597. We estimate that the cost would be $55.3 million the first year, $293.6 million over five years, and approximately $589.4 over ten years.

VA supports Section 401, which would make members of the Armed Forces who serve in Operation Enduring Freedom or Operation Iraqi Freedom eligible for counseling and services through Readjustment Counseling Service, but we are concerned with the precedent that would be established by providing disparate eligibility to veterans of different conflicts. Under this provision active duty combat veterans of OEF/OIF would have access to Vet Centers for counseling and related mental health services and behavioral health services, including substance abuse assessment, coun-

seling, and referral. Active duty veterans of the Persian Gulf War or other prior or subsequent combat would not have access to those services. Providing these services to active duty OEF/OIF personnel would cost approximately $3.7 million in the first year, $19.8 over five years, and $44.1 million over ten years. DOD has reimbursed VA for services provided to active duty members; however, we have not yet discussed the funding of this provision or possible reimbursement rates with DOD for readjustment counseling services.

Until 1996, VA had specific statutory authority to refer ineligible veterans to non-VA resources and to advise such individuals of the right to apply for review of the individual's discharge or release. VA supports Section 402, which would reinstate these provisions. Reinstatement of these provisions would give the Vet Centers the latitude to help Veterans with problematic discharges with problems deemed by Vet Center staff to be related to war trauma, through referral to services outside the VA and/or referral for assistance with discharge upgrades when appropriate. The total number of Veterans this provision would affect is assumed to be small so the costs of this provision would be negligible.

VA opposes Section 403, requiring VA 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. VA opposes conducting the study because other information, more valuable in guiding VA's strategy for suicide prevention, is already available and is continually being refined through other research and data collection efforts. Moreover, we do not believe that the new requirement would yield any additional information of significant value.

Rates and counts of deaths from suicide are available from 2000 onward for Veterans who utilized the VHA Health Care System. In addition, they are available on specific cohorts of Veterans including those who served in OEF/OIF and in the first Persian Gulf War, whether or not they utilize VHA health care services. Finally, they are available on all individuals identified at the times of their deaths as Veterans by their families in the sixteen states that participate in the Centers for Disease Control and Prevention's National Violent Death Reporting System. VA estimates that the overall cost for conducting such a study would be $2,356,000 in FY 2010 and $7,224,000 over five years.

VA is opposed to Section 404, which would transfer $5 million from VA to the Department of Health and Human Services (HHS) by the end of FY 2010 for a graduate psychology education (GPE) program. This transfer of funds to the GPE Program would reduce funding available for VA programs or services without any clear benefit to VA in exchange for those services. VA much prefers to target these funds to increasing internship and post-doctoral training positions within VA facilities. VA already supports 435 Psychology internship positions in 90 different programs and 200 postdoctoral fellowship programs in 54 programs. Thus we already provide the "training of psychologists in the treatment of Veterans with Post Traumatic Stress Disorder, Traumatic Brain Injury, and other combat-related disorders" that this legislation aims to achieve. Assuming that this $5 million would become a recurring transfer of funds, the estimate over ten years is $50 million.

Sections 501 and 502 of S. 252 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 pilot programs would require the Secretary to promulgate regulations establishing criteria for receiving grants and the scope of supportive services covered by the grant program.

The 2005 Base Realignment and Closure process has been completed and local plans have already been developed. Therefore the new authority as proposed in section 501 would be ineffective. Further, the Veterans Mental Health and Other Care Improvement Act of 2008, Public Law 110–387, Title VI, Section 604 provided authorization for VA to facilitate the provision of supportive services for very low income veterans for veteran families in permanent housing. VA is in the process of writing regulations and hopes to offer funding later this year. Section 604 allows VA to effectively aid veterans better than either of the two pilots. We respectfully suggest that the two pilots are no longer needed and believe that the supportive services grants under Pub. L. 110–387 which this Committee approved last year to be a more effective way to assist veterans.

Section 503 of S. 252 would require that VA establish a pilot program for financial support of entities that provide outreach to inform certain veterans about pension benefits. To this end, the bill would provide VA with additional authority to make grants to public and non-profit organizations (including faith-based and community organizations) for purposes of providing outreach to inform low-income and elderly veterans and their spouses residing in rural areas about potential eligibility for VA pension. The bill authorized the expenditure of $1,275,000 from General Operating Expenses (GOE) in each of fiscal years 2010 through 2014. Although VA supports the intent of Section 503 of S. 252, we oppose the bill because it duplicates ongoing outreach efforts by VBA to conduct outreach to low income and elderly veterans and their spouses and dependents. If this legislation is enacted, VA would need additional GOE to administer the pilot program and to train the public and non-profit organizations to accurately discuss VA benefit programs.

VA's outreach efforts to elderly veterans and their survivors include several approaches. We have provided the Social Security Administration with our pamphlet "Federal Benefits for Veterans and Dependents." Additionally, we have participated and will continue to participate in the annual conference of the American Association of Retired Persons (AARP). This year VA will participate in the National Convention of the Association of Directors of Assisted Living Facilities. From January 2008 to January 2009 the number of vet-

erans receiving disability pension declined about two percent or less than 7,000 veterans. That decline can be almost entirely accounted for by the decline in the number of World War II veterans receiving pension. The decline in this population accounted for 85 percent of the decline. The Vietnam Era veteran population is only now reaching age 65 where entitlement exists based on age. We expect their participation in the pension program to rise. With respect to survivor pension, the number of widow(ers) on the rules has increased 5,924 or 7.2 percent over the same January to January period. In light of the significantly lower allowable income limits for survivors, this rise is primarily attributable to entitlement being established as a result of high medical expenses. The rise is reflective of our work with social security and AARP and soon with the assisted living organizations.

Section 504 of the bill would authorize a 3-year pilot program to assess the feasibility of providing grants to public or nonprofit organizations as a means of providing expanded services to veterans participating in vocational rehabilitation programs under chapter 31 of title 38, United States Code. Under this program, VA would provide financial assistance through grants to public or nonprofit organizations that would then establish new programs or activities, or expand or modify existing programs or activities, to provide assistance to veterans participating in vocational rehabilitation programs under chapter 31. The type of assistance to be provided includes transportation, childcare, and clothing to facilitate participation in a vocational rehabilitation program or related activity. The pilot program would be used to assess the feasibility of providing such expanded services to veterans through these types of grants.

VA supports efforts to facilitate successful completion of vocational rehabilitation programs under chapter 31. However, VA does not support the use of grant programs to achieve this objective. The administrative burden associated with creating and administering such a grant program would be prohibitive, particularly since VA must continue to monitor grantee's activities to ensure alignment with VA program objectives and each program participant's individual rehabilitation plan. VA personnel already use existing systems to process direct reimbursements to veterans for authorized, necessary costs associated with participation in their specific vocational rehabilitation programs. VA believes that, subject to the availability of funding for the purpose, any incentive programs to facilitate completion of vocational rehabilitation programs should be built onto existing VA reimbursement authorities.

The Department would be authorized $5 million from the amounts available in VA's GOE account in each of fiscal years 2010 through 2012 to carry out section 504 of this bill.

Section 505 would require that not less than one year before the expiration of the authority to carry out the pilot programs established under section 501 through 504, VA would submit a report to Congress including the following: lessons learned, recommendations on whether to continue such pilot program, the number of veterans and dependents served by such pilot program, an assessment of the quality of service provided to veterans and dependents, the amount of funds provided to grant recipients, and the names of organizations that have received grants.

VA supports sections 601 to section 606 of Title VI, which would update and clarify provisions of Public Law 100–322 authorizing VA-affiliated Nonprofit Research Corporations (NPCs). Title VI promulgates revisions that will allow the NPCs to better serve VA research and education programs while maintaining the high degree of oversight applied to these nonprofits. There are no added costs associated with Title VI. VA supports Title VI.

Subsection (a)(1) of section 701 of the 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 701 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. VA will work with the Department Justice to formulate our views on this proposed legislation. We will submit our views at a later date.

Section 702 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.

VA supports these provisions. Under current section 903, uniformed Department of Veteran Affairs Police are paid $400 for an initial uniform allowance, and then $200 annually throughout their careers. This is a marginal amount and does not cover the actual costs of uniforms and equipment required by the Department for our officers. VA Police officer uniforms are required by the Department and purchased by the officers using the statutorily authorized allowance. These amounts were last updated in 1991. Our Police Officers generally have to reach into their own pockets to supplement both the initial purchases and annual upkeep.

The Office of Personnel Management (OPM) published new regulations in the Federal Register that increase the authorized uniform allowance amount up to $800 initially and $800 annually. Section 702 would allow the Department to occasionally review and increase initial allowances up to the OPM-authorized maximum, if that is necessary.

The Department requires that all VA police officers present an image of professionalism and authority. Authorizing an updated

uniform allowance will help to achieve that. We also note that uniform allowances are a recruiting tool. We estimate costs at $1.58 million for one year, $6.5 million for five years, and $16.82 million for ten years.

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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

* * * * * * *

Subchapter III. Advisory Committees

* * * * * * *

SEC. 542. ADVISORY COMMITTEE ON WOMEN VETERANS

(a)(1) * * *

(2)(A) * * *

(i) * * *

(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) * * *

(2)(A) * * *

(i) * * *

(ii) * * *

(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

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CHAPTER 17. HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

SUBCHAPTER I. GENERAL

Sec.

SUBCHAPTER VIII. HEALTH CARE OF PERSONS OTHER THAN VETERANS

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Subchapter I. General

* * * * * * *

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. 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.

(d) [(c)] The Under Secretary for Health may provide for such training of professional, paraprofessional, and lay personnel as is necessary to carry out this section effectively, and, in carrying out this section, may utilize the services of paraprofessionals, individuals who are volunteers working without compensation, and individuals who are veteran-students (as described in section 3485 of this title) in initial intake and screening activities.

(e) [(d)](1) In furnishing counseling and related mental health services under subsections (a) and (b) of this section, the Secretary shall have available the same authority to enter into contracts with private facilities that is available to the Secretary (under sections 1703(a)(2) and 1710(a)(1)(B) of this title) in furnishing medical services to veterans suffering from total service-connected disabilities.

* * * * * * *

(f) [(e)] The Secretary, in cooperation with the Secretary of Defense, shall take such action as the Secretary considers appropriate to notify veterans who may be eligible for assistance under this section of such potential eligibility.

(g) [(f)] For the purposes of this section:

(1) * * *

* * * * * * *

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.

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Subchapter VIII. Health Care of Persons Other Than Veterans

SEC. 1781. MEDICAL CARE FOR SURVIVORS AND DEPENDENTS OF CERTAIN VETERANS

(a) * * *

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(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.

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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.

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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.

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SUBCHAPTER IV. RESEARCH CORPORATIONS

* * * * * * *

7365. Coverage of employees under certain Federal tort claims laws.

[7364A. Coverage of employees under certain Federal tort claims laws.]

[7365. Applicable State law.]

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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 management 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 management 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 MANAGEMENT OFFICERS

(a) NATIONAL QUALITY MANAGEMENT OFFICER.—(1) The Under Secretary for Health shall designate an official of the Veterans Health Administration to act as the principal quality management officer for the quality management program required by section 7311 of this title. The official so designated may be known as the "National Quality Management Officer of the Veterans Health Administration" (in this section referred to as the "National Quality Management Officer").

(2) The National Quality Management 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 Management Officer shall be the official within the Veterans Health Administration who is principally responsible for the quality management program referred to in paragraph (1). In carrying out that responsibility, the Officer shall be responsible for the following:

(A) Establishing and enforcing the requirements of the program referred to in paragraph (1).

(B) Developing an aggregate quality metric from existing data sources, such as the Inpatient Evaluation Center of the Department, the National Surgical Quality Improvement Program, and the External Peer Review Program of the Veterans Health Administration, that could be used to assess reliably the quality of care provided at individual Department medical centers and associated community based outpatient clinics.

(C) Ensuring that existing measures of quality, including measures from the Inpatient Evaluation Center, the National Surgical Quality Improvement Program, System-Wide Ongoing

Assessment and Review reports of the Department, and Combined Assessment Program reviews of the Office of Inspector General of the Department, are monitored routinely and analyzed in a manner that ensures the timely detection of quality of care issues.

(D) Encouraging research and development in the area of quality metrics for the purposes of improving how the Department measures quality in individual facilities.

(E) Carrying out such other responsibilities and duties relating to quality management 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 management 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.

(b) QUALITY MANAGEMENT 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 management officer of the Network.

(2) The quality management officer for a Veterans Integrated Services Network shall report to the Regional Director of the Veterans Integrated Services Network, and to the National Quality Management Officer, regarding the discharge of the responsibilities and duties of the officer under this section.

(3) The quality management officer for a Veterans Integrated Services Network shall—

(A) direct the quality management office in the Network; and

(B) coordinate, monitor, and oversee the quality management programs and activities of the Administration medical facilities in the Network in order to ensure the thorough and uniform discharge of quality management requirements under such programs and activities throughout such facilities.

(c) QUALITY MANAGEMENT OFFICERS FOR MEDICAL FACILITIES.—(1) The director of each Veterans Health Administration medical facility shall appoint a quality management officer for that facility.

(2) The quality management officer for a facility shall report directly to the director of the facility, and to the quality management officer of the Veterans Integrated Services Network in which the facility is located, regarding the discharge of the responsibilities and duties of the quality management officer under this section.

(3) The quality management officer for a facility shall be responsible for designing, disseminating, and implementing quality management programs and activities for the facility that meet the requirements established by the National Quality Management Officer under subsection (a).

(d) AUTHORIZATION OF APPROPRIATIONS.—(1) Except as provided in paragraph (2), there are authorized to be appropriated such sums as may be necessary to carry out this section.

(2) There are authorized to be appropriated to carry out the provisions of subparagraphs (B), (C), and (D) of subsection (a)(3),

$25,000,000 for the two-year period of fiscal years beginning after the date of the enactment of this section.

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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.

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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"⟧ *the term "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 includes 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) IN GENERAL.—(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 applicable 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 and shall remain available for such use without fiscal year limitation.

(b) TRANSFER AND ADMINISTRATION OF FUNDS.—(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.

(3) A Department medical center may retain and use funds provided to it by a corporation established under this subchapter. Such funds shall be credited to the applicable appropriation account of the Department and shall be available, without fiscal year limitation, for the purposes of that account.

(c) RESEARCH PROJECTS.—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) EDUCATION ACTIVITIES.—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) POLICIES AND PROCEDURES.—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 director*, officer,* 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.

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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) Such other classes of health care occupations—

(i) are not occupations relating to administrative, clerical, or physical plant maintenance and protective services;

(ii) that would otherwise receive basic pay in accordance with the General Schedule under section 5332 of title 5;

(iii) provide, as determined by the Secretary, direct patient care services or services incident to direct patient services; and

(iv) would not otherwise be available to provide medical care or treatment for veterans.

(B) 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.

(C) Before submitting notice under subparagraph (B), 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 Adminis-

tration 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.

(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) Provide the Secretary a written authorization that permits the State licensing board of each State in which the individual holds or has held a license to practice medicine to disclose to the Secretary 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).

(D) Any lawsuit, disciplinary action, or claim filed or undertaken after the date of the disclosures under 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 this section 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, unless the medical center director and credentialing and privileging manager of the facility hiring the physician certify in writing that—

(A) a full investigation was carried out in compliance with section 104 of this title; and

(B) an investigation did not disclose any actions described in subsections (b), (c), and (d) of such section.

(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 Practitioner Data Bank.

(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) With respect to the appointment of a registered nurse under this chapter, paragraph (1) shall apply with respect to such appointment regardless of whether such appointment is on a full-time basis or a part-time basis.

(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.

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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)(A) The rate of basic pay for a position to which an Executive order applies under paragraph (1) and is not described by paragraph (2) shall be set in accordance with section 5382 of title 5 as if such position were a Senior Executive Service position (as such term is defined in section 3132(a) of title 5).

(B) A rate of basic pay for a position may not be set under subparagraph (A) in excess of—

(i) in the case the position is not described in clause (ii), the rate of basic pay payable for level III of the Executive Schedule; or

(ii) in the case that the position is covered by a performance appraisal system that meets the certification criteria established by regulation under section 5307(d) of title 5, the rate of basic pay payable for level II of the Executive Schedule.

(C) Notwithstanding the provisions of subsection (d) of section 5307 of title 5, the Secretary may make any certification under that subsection instead of the Office of Personnel Management and without concurrence of the Office of Management and Budget.

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SEC. 7405. TEMPORARY FULL-TIME APPOINTMENTS, PART-TIME APPOINTMENTS, AND WITHOUT-COMPENSATION APPOINTMENTS

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(g)(1) Except as provided in paragraph (3), employment of a registered nurse on a temporary part-time basis under subsection (a)(1) shall be for a probationary period of two years.

(2) Except as provided in paragraph (3), 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).

(3) This subsection shall not apply to appointments made on a term limited basis of less than or equal to three years of—

(A) nurses with a part-time appointment resulting from an academic affiliation or teaching position in a nursing academy of the Department;

(B) nurses appointed as a result of a specific research proposal or grant; or

(C) nurses who are not citizens of the United States and appointed under section 7407(a) of this title.

(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.

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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) 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 in-

dividual 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) * * *

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(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

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(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 statement of the reasons why the director did not conduct such a survey.

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(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*.

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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.

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(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) * * *

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[(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.]

(3) Employees appointed under section 7408 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

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[(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, 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.

[(2) Whenever the amount of an increase under subsection (a) results in a rate of basic pay for a position being equal to or greater than the amount that is 94 percent of the maximum amount permitted under paragraph (1), the Secretary shall promptly notify the Committees on Veterans' Affairs of the Senate and House of Representatives of the increase and the amount thereof.]

(c)(1) Subject to paragraph (2), the amount of any increase under subsection (a) in the minimum rate for any grade may not exceed the maximum rate of basic pay (excluding any locality-based comparability payment under section 5304 of title 5 or similar provision of law) for the grade or level by more than 30 percent.

(2) No rate may be established under this section in excess of the rate of basic pay payable for level IV of the Executive Schedule.

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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 tours of duty within a 14-day 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 tour of duty 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 tour of duty 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 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 tour of duty 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.

(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 shall be charged for such leave at a rate of ten hours of leave for every nine hours of absence.

SEC. 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 *as an appointee under paragraph (1) or (3) of section 7401 of this title.* **[**(under section 7401 of this title) as any of the following:**]**

[(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, 2014*.

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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

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[(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.]

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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.]

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SUBCHAPTER III. STATE HOME FACILITIES FOR FURNISHING DOMICILIARY, NURSING HOME, AND HOSPITAL CARE

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8133A. Tribal organizations.

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Subchapter I. Acquisition and Operation of Medical Facilities

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[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 Depart-

ment'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 sub-

section 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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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, 2010, and July 1 of each of the five following 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.

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