

PROMOTING RESPONSIBLE OPIOID MANAGEMENT AND
 INCORPORATING SCIENTIFIC EXPERTISE ACT

MAY 10, 2016.—Committed to the Committee of the Whole House on the state of
 the Union and ordered to be printed

Mr. MILLER of Florida, from the Committee on Veterans' Affairs,
 submitted the following

R E P O R T

[To accompany H.R. 4063]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans' Affairs, to whom was referred the bill (H.R. 4063) to improve the use by the Secretary of Veterans Affairs of opioids in treating veterans, to improve patient advocacy by the Secretary, and to expand the availability of complementary and integrative health, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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AMENDMENT

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) **SHORT TITLE.**—This Act may be cited as the “Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act” or the “Jason Simcakoski PROMISE Act”.

(b) **TABLE OF CONTENTS.**—The table of contents for this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—OPIOID THERAPY AND PAIN MANAGEMENT

- Sec. 101. Establishment of Advisory Committee to review guidelines on management of opioid therapy by Department of Veterans Affairs and Department of Defense.
 Sec. 102. Improvement of opioid safety measures by Department of Veterans Affairs.
 Sec. 103. Strengthening of joint working group on pain management of the Department of Veterans Affairs and the Department of Defense.
 Sec. 104. Review, investigation, and report on use of opioids in treatment by Department of Veterans Affairs.
 Sec. 105. Mandatory disclosure of certain veteran information to State controlled substance monitoring programs.

TITLE II—PATIENT ADVOCACY

- Sec. 201. Community meetings on improving care furnished by Department of Veterans Affairs.
 Sec. 202. Improvement of awareness of patient advocacy program and patient bill of rights of Department of Veterans Affairs.
 Sec. 203. Comptroller general report on patient advocacy program of Department of Veterans Affairs.

TITLE III—COMPLEMENTARY AND INTEGRATIVE HEALTH

- Sec. 301. Expansion of research and education on and delivery of complementary and integrative health to veterans.
 Sec. 302. Pilot program on integration of complementary alternative medicines and related issues for veterans and family members of veterans.

TITLE IV—FITNESS OF HEALTH CARE PROVIDERS

- Sec. 401. Additional requirements for hiring of health care providers by Department of Veterans Affairs.
 Sec. 402. Provision of information on health care providers of Department of Veterans Affairs to State Medical Boards.
 Sec. 403. Report on compliance by Department of Veterans Affairs with reviews of health care providers leaving the Department or transferring to other facilities.

TITLE V—OTHER VETERANS MATTERS

- Sec. 501. Audit of Veterans Health Administration programs of Department of Veterans Affairs.

TITLE I—OPIOID THERAPY AND PAIN MANAGEMENT

SEC. 101. ESTABLISHMENT OF ADVISORY COMMITTEE TO REVIEW GUIDELINES ON MANAGEMENT OF OPIOID THERAPY BY DEPARTMENT OF VETERANS AFFAIRS AND DEPARTMENT OF DEFENSE.

(a) **ADVISORY COMMITTEE.**—Not later than 120 days after the date of the enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall jointly convene an advisory committee to—

- (1) conduct a thorough review of the most recent VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; and
- (2) make recommendations to the Secretaries with respect to updating the Clinical Practice Guideline.

(b) **MATTERS INCLUDED.**—In conducting the review under subsection (a)(1), the Advisory Committee shall examine whether the Clinical Practical Guideline should include the following:

- (1) Enhanced guidance with respect to—
 - (A) the coadministration of an opioid and other drugs, including benzodiazepines, that may result in life-limiting drug interactions;
 - (B) the treatment of patients with current acute psychiatric instability or substance use disorder or patients at risk of suicide; and
 - (C) the use of opioid therapy to treat mental health disorders other than opioid use disorder.
- (2) Enhanced guidance with respect to the treatment of patients with behaviors or comorbidities, such as post-traumatic stress disorder or other psychiatric disorders, or a history of substance abuse or addiction, that requires a consulta-

tion or comanagement of opioid therapy with one or more specialists in pain management, mental health, or addictions.

(3) Enhanced guidance with respect to health care providers—

(A) conducting an effective assessment for patients beginning or continuing opioid therapy, including understanding and setting realistic goals with respect to achieving and maintaining an expected level of pain relief, improved function, or a clinically appropriate combination of both; and

(B) effectively assessing whether opioid therapy is achieving or maintaining the established treatment goals of the patient or whether the patient and health care provider should discuss adjusting, augmenting, or discontinuing the opioid therapy.

(4) Guidance that each health care provider of the Department of Veterans Affairs and the Department of Defense, before initiating opioid therapy to treat a patient as part of the comprehensive assessment conducted by the health care provider, use the Opioid Therapy Risk Report tool of the Department of Veterans Affairs (or similar monitoring tool), which shall include information from the prescription drug monitoring program of each State that includes the most recent information to date relating to the patient that accessed such program to assess the risk for adverse outcomes of opioid therapy for the patient, including the concurrent use of controlled substances such as benzodiazepines, as part of the comprehensive assessment conducted by the health care provider.

(5) Guidelines to govern the methodologies used by health care providers of the Department of Veterans Affairs and the Department of Defense to taper opioid therapy when adjusting or discontinuing the use of opioid therapy.

(6) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition between inpatient and outpatient health care settings, which may include the use of care transition plans.

(7) Guidelines with respect to appropriate case management for patients receiving opioid therapy who transition from receiving care during active duty to post-military health care networks.

(8) Enhanced standards with respect to the use of routine and random urine drug tests for all patients before and during opioid therapy to help prevent substance abuse, dependence, and diversion, including—

(A) that such tests occur not less frequently than once each year; and

(B) that health care providers appropriately order, interpret and respond to the results from such tests to tailor pain therapy, safeguards, and risk management strategies to each patient.

(9) Guidance that health care providers discuss with patients, before initiating opioid therapy, options for pain management therapies without the use of opioids and options to augment opioid therapy with other clinical and complementary and integrative health services to minimize opioid dependence.

(10) Guidance for health care providers with respect to evidence-based non-opioid treatments within the Department of Veterans Affairs and the Department of Defense, including medical devices and other therapies approved or cleared by the Food and Drug Administration for the treatment of chronic pain as an alternative to or to augment opioid therapy.

(c) CONSULTATION.—In carrying out the review under paragraph (1) of subsection (a), and before making the recommendations under paragraph (2) of such subsection, the Advisory Committee shall consult with the VA/DOD Management of Opioid Therapy for Chronic Pain Working Group.

(d) SUBMISSION.—Not later than one year after the date of the enactment of this Act, the Advisory Committee shall submit to the Secretaries the review and recommendations described in subsection (a)(1).

(e) APPLICATION OF FEDERAL ADVISORY COMMITTEE ACT.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall apply to the Advisory Committee.

(f) DEFINITIONS.—In this section:

(1) The term “Advisory Committee” means the advisory committee established under subsection (a).

(2) The term “Clinical Practice Guideline” means the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(3) The term “controlled substance” has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).

(4) The term “State” means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 102. IMPROVEMENT OF OPIOID SAFETY MEASURES BY DEPARTMENT OF VETERANS AFFAIRS.

(a) **EXPANSION OF OPIOID SAFETY INITIATIVE.**—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall expand the Opioid Safety Initiative of the Department of Veterans Affairs to include all medical facilities of the Department.

(b) **PAIN MANAGEMENT EDUCATION AND TRAINING.**—

(1) **IN GENERAL.**—In carrying out the Opioid Safety Initiative of the Department, the Secretary shall require all employees of the Department responsible for prescribing opioids to receive education and training described in paragraph (2).

(2) **EDUCATION AND TRAINING.**—Education and training described in this paragraph is education and training on pain management and safe opioid prescribing practices for purposes of safely and effectively managing patients with chronic pain, including education and training on the following:

(A) The implementation of and full compliance with the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, including any update to such guideline.

(B) The use of evidence-based pain management therapies, including cognitive-behavioral therapy, non-opioid alternatives, and non-drug methods and procedures to managing pain and related health conditions including medical devices approved or cleared by the Food and Drug Administration for the treatment of patients with chronic pain and complementary alternative medicines.

(C) Screening and identification of patients with substance use disorder, including drug-seeking behavior, before prescribing opioids, assessment of risk potential for patients developing an addiction, and referral of patients to appropriate addiction treatment professionals if addiction is identified or strongly suspected.

(D) Communication with patients on the potential harm associated with the use of opioids and other controlled substances, including the need to safely store and dispose of supplies relating to the use of opioids and other controlled substances.

(E) Such other education and training as the Secretary considers appropriate to ensure that veterans receive safe and high-quality pain management care from the Department.

(3) **USE OF EXISTING PROGRAM.**—In providing education and training described in paragraph (2), the Secretary shall use the Interdisciplinary Chronic Pain Management Training Team Program of the Department (or success program).

(c) **PAIN MANAGEMENT TEAMS.**—

(1) **IN GENERAL.**—In carrying out the Opioid Safety Initiative of the Department, the director of each medical facility of the Department shall identify and designate a pain management team of health care professionals, which may include board certified pain medicine specialists, responsible for coordinating and overseeing pain management therapy at such facility for patients experiencing acute and chronic pain that is non-cancer related.

(2) **ESTABLISHMENT OF PROTOCOLS.**—

(A) **IN GENERAL.**—In consultation with the Directors of each Veterans Integrated Service Network, the Secretary shall establish standard protocols for the designation of pain management teams at each medical facility within the Department.

(B) **CONSULTATION ON PRESCRIPTION OF OPIOIDS.**—Each protocol established under subparagraph (A) shall ensure that any health care provider without expertise in prescribing analgesics or who has not completed the education and training under subsection (b), including a mental health care provider, does not prescribe opioids to a patient unless that health care provider—

(i) consults with a health care provider with pain management expertise or who is on the pain management team of the medical facility; and

(ii) refers the patient to the pain management team for any subsequent prescriptions and related therapy.

(3) **REPORT.**—

(A) **IN GENERAL.**—Not later than one year after the date of enactment of this Act, the director of each medical facility of the Department shall submit to the Under Secretary for Health and the director of the Veterans Integrated Service Network in which the medical facility is located a report identifying the health care professionals that have been designated as members of the pain management team at the medical facility pursuant to paragraph (1).

- (B) ELEMENTS.—Each report submitted under subparagraph (A) with respect to a medical facility of the Department shall include—
- (i) a certification as to whether all members of the pain management team at the medical facility have completed the education and training required under subsection (b);
 - (ii) a plan for the management and referral of patients to such pain management team if health care providers without expertise in prescribing analgesics prescribe opioid medications to treat acute and chronic pain that is non-cancer related; and
 - (iii) a certification as to whether the medical facility—
 - (I) fully complies with the stepped-care model of pain management and other pain management policies contained in Directive 2009-053 of the Veterans Health Administration, or successor directive; or
 - (II) does not fully comply with such stepped-care model of pain management and other pain management policies but is carrying out a corrective plan of action to ensure such full compliance.
- (d) TRACKING AND MONITORING OF OPIOID USE.—
- (1) PRESCRIPTION DRUG MONITORING PROGRAMS OF STATES.—In carrying out the Opioid Safety Initiative and the Opioid Therapy Risk Report tool of the Department, the Secretary shall—
- (A) ensure access by health care providers of the Department to information on controlled substances, including opioids and benzodiazepines, prescribed to veterans who receive care outside the Department through the prescription drug monitoring program of each State with such a program, including by seeking to enter into memoranda of understanding with States to allow shared access of such information between States and the Department;
 - (B) include such information in the Opioid Therapy Risk Report; and
 - (C) require health care providers of the Department to submit to the prescription drug monitoring program of each State information on prescriptions of controlled substances received by veterans in that State under the laws administered by the Secretary.
- (2) REPORT ON TRACKING OF DATA ON OPIOID USE.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the feasibility and advisability of improving the Opioid Therapy Risk Report tool of the Department to allow for more advanced real-time tracking of and access to data on—
- (A) the key clinical indicators with respect to the totality of opioid use by veterans;
 - (B) concurrent prescribing by health care providers of the Department of opioids in different health care settings, including data on concurrent prescribing of opioids to treat mental health disorders other than opioid use disorder; and
 - (C) mail-order prescriptions of opioid prescribed to veterans under the laws administered by the Secretary.
- (e) AVAILABILITY OF OPIOID RECEPTOR ANTAGONISTS.—
- (1) INCREASED AVAILABILITY AND USE.—
- (A) IN GENERAL.—The Secretary shall maximize the availability of opioid receptor antagonists approved by the Food and Drug Administration, including naloxone, to veterans.
 - (B) AVAILABILITY, TRAINING, AND DISTRIBUTING.—In carrying out subparagraph (A), not later than 90 days after the date of the enactment of this Act, the Secretary shall—
 - (i) equip each pharmacy of the Department with opioid receptor antagonists approved by the Food and Drug Administration to be dispensed to outpatients as needed; and
 - (ii) expand the Overdose Education and Naloxone Distribution program of the Department to ensure that all veterans in receipt of health care under laws administered by the Secretary who are at risk of opioid overdose may access such opioid receptor antagonists and training on the proper administration of such opioid receptor antagonists.
 - (C) VETERANS WHO ARE AT RISK.—For purposes of subparagraph (B), veterans who are at risk of opioid overdose include—
 - (i) veterans receiving long-term opioid therapy;
 - (ii) veterans receiving opioid therapy who have a history of substance use disorder or prior instances of overdose; and

- (iii) veterans who are at risk as determined by a health care provider who is treating the veteran.
- (2) REPORT.—Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on carrying out paragraph (1), including an assessment of any remaining steps to be carried out by the Secretary to carry out such paragraph.
- (f) INCLUSION OF CERTAIN INFORMATION AND CAPABILITIES IN OPIOID THERAPY RISK REPORT TOOL OF THE DEPARTMENT.—
 - (1) INFORMATION.—The Secretary shall include in the Opioid Therapy Risk Report tool of the Department—
 - (A) information on the most recent time the tool was accessed by a health care provider of the Department with respect to each veteran; and
 - (B) information on the results of the most recent urine drug test for each veteran.
 - (2) CAPABILITIES.—The Secretary shall include in the Opioid Therapy Risk Report tool the ability of the health care providers of the Department to determine whether a health care provider of the Department prescribed opioids to a veteran without checking the information in the tool with respect to the veteran.
- (g) NOTIFICATIONS OF RISK IN COMPUTERIZED HEALTH RECORD.—The Secretary shall modify the computerized patient record system of the Department to ensure that any health care provider that accesses the record of a veteran, regardless of the reason the veteran seeks care from the health care provider, will be immediately notified whether the veteran—
 - (1) is receiving opioid therapy and has a history of substance use disorder or prior instances of overdose;
 - (2) has a history of opioid abuse; or
 - (3) is at risk of becoming an opioid abuser as determined by a health care provider who is treating the veteran.
- (h) DEFINITIONS.—In this section:
 - (1) The term “controlled substance” has the meaning given that term in section 102 of the Controlled Substances Act (21 U.S.C. 802).
 - (2) The term “State” means each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

SEC. 103. STRENGTHENING OF JOINT WORKING GROUP ON PAIN MANAGEMENT OF THE DEPARTMENT OF VETERANS AFFAIRS AND THE DEPARTMENT OF DEFENSE.

- (a) IN GENERAL.—Not later than 90 days after the date of enactment of this Act, the Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the Pain Management Working Group of the Health Executive Committee of the Department of Veterans Affairs–Department of Defense Joint Executive Committee established under section 320 of title 38, United States Code, includes a focus on the following:
 - (1) The opioid prescribing practices of health care providers of each Department.
 - (2) The ability of each Department to manage acute and chronic pain among individuals receiving health care from the Department, including training health care providers with respect to pain management.
 - (3) The use by each Department of complementary and integrative health and complementary alternative medicines in treating such individuals.
 - (4) The concurrent use by health care providers of each Department of opioids and prescription drugs to treat mental health disorders, including benzodiazepines.
 - (5) The practice by health care providers of each Department of prescribing opioids to treat mental health disorders.
 - (6) The coordination in coverage of and consistent access to medications prescribed for patients transitioning from receiving health care from the Department of Defense to receiving health care from the Department of Veterans Affairs.
 - (7) The ability of each Department to identify and treat substance use disorders among individuals receiving health care from that Department.
- (b) COORDINATION AND CONSULTATION.—The Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the working group described in subsection (a)—
 - (1) coordinates the activities of the working group with other relevant working groups established under section 320 of title 38, United States Code, including the working groups on evidence-based practice, patient safety, pharmacy, psychological health, and psychological health;

(2) consults with other relevant Federal agencies, including the Centers for Disease Control and Prevention, with respect to the activities of the working group; and

(3) consults with the Department of Veterans Affairs and the Department of Defense with respect to, reviews, and comments on the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain, or any successor guideline, before any update to the guideline is released.

(c) CONSULTATIONS.—The Secretary of Veterans Affairs and the Secretary of Defense shall ensure that the working group described in subsection (a) is able to meaningfully consult with respect to the updated guideline required under subsection (a) of section 101, as required by subsection (b) of such section, not later than 1 year after the date of enactment of this Act.

SEC. 104. REVIEW, INVESTIGATION, AND REPORT ON USE OF OPIOIDS IN TREATMENT BY DEPARTMENT OF VETERANS AFFAIRS.

(a) **COMPTROLLER GENERAL REPORT.**—

(1) **IN GENERAL.**—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Opioid Safety Initiative of the Department of Veterans Affairs and the opioid prescribing practices of health care providers of the Department.

(2) **ELEMENTS.**—The report submitted under paragraph (1) shall include the following:

(A) Recommendations on such improvements to the Opioid Safety Initiative of the Department as the Comptroller General considers appropriate.

(B) Information with respect to—

(i) deaths resulting from sentinel events involving veterans prescribed opioids by a health care provider of the Department;

(ii) overall prescription rates and prescriptions indications of opioids to treat non-cancer, non-palliative, and non-hospice care patients;

(iii) the prescription rates and prescriptions indications of benzodiazepines and opioids concomitantly by health care providers of the Department;

(iv) the practice by health care providers of the Department of prescribing opioids to treat patients without any pain, including to treat patients with mental health disorders other than opioid use disorder; and

(v) the effectiveness of opioid therapy for patients receiving such therapy, including the effectiveness of long-term opioid therapy.

(C) An evaluation of processes of the Department in place to oversee opioid use among veterans, including procedures to identify and remedy potential over-prescribing of opioids by health care providers of the Department.

(D) An assessment of the implementation by the Secretary of the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

(b) **QUARTERLY PROGRESS REPORT ON IMPLEMENTATION OF COMPTROLLER GENERAL RECOMMENDATIONS.**—Not later than two years after the date of the enactment of this Act, and not later than 30 days after the end of each quarter thereafter, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a progress report detailing the actions by the Secretary during the period covered by the report to address any outstanding findings and recommendations by the Comptroller General of the United States under subsection (a) with respect to the Veterans Health Administration.

(c) **ANNUAL REVIEW OF PRESCRIPTION RATES.**—Not later than one year after the date of the enactment of this Act, and not less frequently than annually for the following five years, the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report, with respect to each medical facility of the Department of Veterans Affairs, to collect and review information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients that contains, for the one-year period preceding the submission of the report, the following:

(1) The number of patients and the percentage of the patient population of the Department who were prescribed benzodiazepines and opioids concurrently by a health care provider of the Department.

(2) The number of patients and the percentage of the patient population of the Department without any pain who were prescribed opioids by a health care

provider of the Department, including those who were prescribed benzodiazepines and opioids concurrently.

(3) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were treated with opioids by a health care provider of the Department on an inpatient-basis and who also received prescription opioids by mail from the Department while being treated on an inpatient-basis.

(4) The number of non-cancer, non-palliative, and non-hospice care patients and the percentage of such patients who were prescribed opioids concurrently by a health care provider of the Department and a health care provider that is not health care provider of the Department.

(5) With respect to each medical facility of the Department, information on opioids prescribed by health care providers at the facility to treat non-cancer, non-palliative, and non-hospice care patients, including information on—

(A) the prescription rate at which each health care provider at the facility prescribed benzodiazepines and opioids concurrently to such patients and the aggregate such prescription rate for all health care providers at the facility;

(B) the prescription rate at which each health care provider at the facility prescribed benzodiazepines or opioids to such patients to treat conditions for which benzodiazepines or opioids are not approved treatment and the aggregate such prescription rate for all health care providers at the facility;

(C) the prescription rate at which each health care provider at the facility prescribed or dispensed mail-order prescriptions of opioids to such patients while such patients were being treated with opioids on an inpatient-basis and the aggregate of such prescription rate for all health care providers at the facility; and

(D) the prescription rate at which each health care provider at the facility prescribed opioids to such patients who were also concurrently prescribed opioids by a health care provider that is not a health care provider of the Department and the aggregate of such prescription rates for all health care providers at the facility.

(6) With respect to each medical facility of the Department, the number of times a pharmacist at the facility overrode a critical drug interaction warning with respect to an interaction between opioids and another medication before dispensing such medication to a veteran.

(d) INVESTIGATION OF PRESCRIPTION RATES.—If the Secretary determines that a prescription rate with respect to a health care provider or medical facility of the Department conflicts with or is otherwise inconsistent with the standards of appropriate and safe care, the Secretary shall—

(1) immediately notify the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives of such determination, including information relating to such determination, prescription rate, and health care provider or medical facility, as the case may be; and

(2) through the Office of the Medical Inspector of the Veterans Health Administration, conduct a full investigation of the health care provider or medical facility, as the case may be.

(e) PRESCRIPTION RATE DEFINED.—In this section, the term “prescription rate” means, with respect to a health care provider or medical facility of the Department, each of the following:

(1) The number of patients treated with opioids by the health care provider or at the medical facility, as the case may be, divided by the total number of pharmacy users of that health care provider or medical facility.

(2) The average number of morphine equivalents per day prescribed by the health care provider or at the medical facility, as the case may be, to patients being treated with opioids.

(3) Of the patients being treated with opioids by the health care provider or at the medical facility, as the case may be, the average number of prescriptions of opioids per patient.

SEC. 105. MANDATORY DISCLOSURE OF CERTAIN VETERAN INFORMATION TO STATE CONTROLLED SUBSTANCE MONITORING PROGRAMS.

Section 5701(l) of title 38, United States Code, is amended by striking “may” and inserting “shall”.

TITLE II—PATIENT ADVOCACY

SEC. 201. COMMUNITY MEETINGS ON IMPROVING CARE FURNISHED BY DEPARTMENT OF VETERANS AFFAIRS.

(a) COMMUNITY MEETINGS.—

(1) MEDICAL CENTERS.—Not later than 90 days after the date of the enactment of this Act, and not less frequently than once every 90 days thereafter, the Secretary shall ensure that each medical facility of the Department of Veterans Affairs hosts a community meeting open to the public on improving health care furnished by the Secretary.

(2) COMMUNITY BASED OUTPATIENT CLINICS.—Not later than one year after the date of the enactment of this Act, and not less frequently than annually thereafter, the Secretary shall ensure that each community based outpatient clinic of the Department hosts a community meeting open to the public on improving health care furnished by the Secretary.

(b) ATTENDANCE BY DIRECTOR OF VETERANS INTEGRATED SERVICE NETWORK OR DESIGNEE.—

(1) IN GENERAL.—Each community meeting hosted by a medical facility or community based outpatient clinic under subsection (a) shall be attended by the Director of the Veterans Integrated Service Network in which the medical facility or community based outpatient clinic, as the case may be, is located. Subject to paragraph (2), the Director may delegate such attendance only to an employee who works in the Office of the Director.

(2) ATTENDANCE BY DIRECTOR.—Each Director of a Veterans Integrated Service Network shall personally attend not less than one community meeting under subsection (a) hosted by each medical facility located in the Veterans Integrated Service Network each year.

(c) NOTICE.—The Secretary shall notify the Committee on Veterans' Affairs of the Senate, the Committee on Veterans' Affairs of the House of Representatives, and each Member of Congress (as defined in section 104) who represents the area in which the medical facility is located of a community meeting under subsection (a) by not later than 10 days before such community meeting occurs.

SEC. 202. IMPROVEMENT OF AWARENESS OF PATIENT ADVOCACY PROGRAM AND PATIENT BILL OF RIGHTS OF DEPARTMENT OF VETERANS AFFAIRS.

Not later than 90 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall, in as many prominent locations as the Secretary determines appropriate to be seen by the largest percentage of patients and family members of patients at each medical facility of the Department of Veterans Affairs—

(1) display the purposes of the Patient Advocacy Program of the Department and the contact information for the patient advocate at such medical facility; and

(2) display the rights and responsibilities of—

(A) patients and family members and patients at such medical facility; and

(B) with respect to community living centers and other residential facilities of the Department, residents and family members of residents at such medical facility.

SEC. 203. COMPTROLLER GENERAL REPORT ON PATIENT ADVOCACY PROGRAM OF DEPARTMENT OF VETERANS AFFAIRS.

(a) IN GENERAL.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the Patient Advocacy Program of the Department of Veterans Affairs (in this section referred to as the "Program").

(b) ELEMENTS.—The report required by subsection (a) shall include the following:

(1) A description of the Program, including—

(A) the purpose of the Program;

(B) the activities carried out under the Program; and

(C) the sufficiency of the Program in achieving the purpose of the Program.

(2) An assessment of the sufficiency of staffing of employees of the Department responsible for carrying out the Program.

(3) An assessment of the sufficiency of the training of such employees.

(4) An assessment of—

(A) the awareness of the Program among veterans and family members of veterans; and

(B) the use of the Program by veterans and family members of veterans.

(5) Such recommendations and proposals for improving or modifying the Program as the Comptroller General considers appropriate.

(6) Such other information with respect to the Program as the Comptroller General considers appropriate.

TITLE III—COMPLEMENTARY AND INTEGRATIVE HEALTH

SEC. 301. EXPANSION OF RESEARCH AND EDUCATION ON AND DELIVERY OF COMPLEMENTARY AND INTEGRATIVE HEALTH TO VETERANS.

(a) **ESTABLISHMENT.**—There is established a commission to be known as the “Creating Options for Veterans’ Expedited Recovery” or the “COVER Commission” (in this Act referred to as the “Commission”). The Commission shall examine the evidence-based therapy treatment model used by the Secretary of Veterans Affairs for treating mental health conditions of veterans and the potential benefits of incorporating complementary alternative treatments available in non-Department facilities (as defined in section 1701 of title 38, United States Code).

(b) **DUTIES.**—The Commission shall perform the following duties:

(1) Examine the efficacy of the evidence-based therapy model used by the Secretary for treating mental health illnesses of veterans and identify areas to improve wellness-based outcomes.

(2) Conduct a patient-centered survey within each of the Veterans Integrated Service Networks to examine—

(A) the experience of veterans with the Department of Veterans Affairs when seeking medical assistance for mental health issues through the health care system of the Department;

(B) the experience of veterans with non-Department facilities and health professionals for treating mental health issues;

(C) the preference of veterans regarding available treatment for mental health issues and which methods the veterans believe to be most effective;

(D) the experience, if any, of veterans with respect to the complementary alternative treatment therapies described in paragraph (3);

(E) the prevalence of prescribing prescription medication among veterans seeking treatment through the health care system of the Department as remedies for addressing mental health issues; and

(F) the outreach efforts of the Secretary regarding the availability of benefits and treatments for veterans for addressing mental health issues, including by identifying ways to reduce barriers to gaps in such benefits and treatments.

(3) Examine available research on complementary alternative treatment therapies for mental health issues and identify what benefits could be made with the inclusion of such treatments for veterans, including with respect to—

(A) music therapy;

(B) equine therapy;

(C) training and caring for service dogs;

(D) yoga therapy;

(E) acupuncture therapy;

(F) meditation therapy;

(G) outdoor sports therapy;

(H) hyperbaric oxygen therapy;

(I) accelerated resolution therapy;

(J) art therapy;

(K) magnetic resonance therapy; and

(L) other therapies the Commission determines appropriate.

(4) Study the sufficiency of the resources of the Department to ensure the delivery of quality health care for mental health issues among veterans seeking treatment within the Department.

(5) Study the current treatments and resources available within the Department and assess—

(A) the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans;

(B) the number of veterans who have been diagnosed with mental health issues;

(C) the percentage of veterans using the resources of the Department who have been diagnosed with mental health issues;

(D) the percentage of veterans who have completed counseling sessions offered by the Department; and

(E) the efforts of the Department to expand complementary alternative treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered with the Department.

(c) MEMBERSHIP.—

(1) IN GENERAL.—The Commission shall be composed of 10 members, appointed as follows:

(A) Two members appointed by the Speaker of the House of Representatives, at least one of whom shall be a veteran.

(B) Two members appointed by the Minority Leader of the House of Representatives, at least one of whom shall be a veteran.

(C) Two members appointed by the Majority Leader of the Senate, at least one of whom shall be a veteran.

(D) Two members appointed by the Minority Leader of the Senate, at least one of whom shall be a veteran.

(E) Two members appointed by the President, at least one of whom shall be a veteran.

(2) QUALIFICATIONS.—Members of the Commission shall be—

(A) individuals who are of recognized standing and distinction within the medical community with a background in treating mental health;

(B) individuals with experience working with the military and veteran population; and

(C) individuals who do not have a financial interest in any of the complementary alternative treatments reviewed by the Commission.

(3) CHAIRMAN.—The President shall designate a member of the Commission to be the Chairman.

(4) PERIOD OF APPOINTMENT.—Members of the Commission shall be appointed for the life of the Commission.

(5) VACANCY.—A vacancy in the Commission shall be filled in the manner in which the original appointment was made.

(6) APPOINTMENT DEADLINE.—The appointment of members of the Commission in this section shall be made not later than 90 days after the date of the enactment of this Act.

(d) POWERS OF COMMISSION.—

(1) MEETINGS.—

(A) INITIAL MEETING.—The Commission shall hold its first meeting not later than 30 days after a majority of members are appointed to the Commission.

(B) MEETING.—The Commission shall regularly meet at the call of the Chairman. Such meetings may be carried out through the use of telephonic or other appropriate telecommunication technology if the Commission determines that such technology will allow the members to communicate simultaneously.

(2) HEARINGS.—The Commission may hold such hearings, sit and act at such times and places, take such testimony, and receive evidence as the Commission considers advisable to carry out the responsibilities of the Commission.

(3) INFORMATION FROM FEDERAL AGENCIES.—The Commission may secure directly from any department or agency of the Federal Government such information as the Commission considers necessary to carry out the duties of the Commission.

(4) INFORMATION FROM NONGOVERNMENTAL ORGANIZATIONS.—In carrying out its duties, the Commission may seek guidance through consultation with foundations, veteran service organizations, nonprofit groups, faith-based organizations, private and public institutions of higher education, and other organizations as the Commission determines appropriate.

(5) COMMISSION RECORDS.—The Commission shall keep an accurate and complete record of the actions and meeting of the Commission. Such record shall be made available for public inspection and the Comptroller General of the United States may audit and examine such record.

(6) PERSONNEL RECORDS.—The Commission shall keep an accurate and complete record of the actions and meetings of the Commission. Such record shall be made available for public inspection and the Comptroller General of the United States may audit and examine such records.

(7) COMPENSATION OF MEMBERS; TRAVEL EXPENSES.—Each member shall serve without pay but shall receive travel expenses to perform the duties of the Commission, including per diem in lieu of substances, at rates authorized under subchapter I of chapter 57 of title 5, United States Code.

(8) STAFF.—The Chairman, in accordance with rules agreed upon the Commission, may appoint fix the compensation of a staff director and such other

personnel as may be necessary to enable the Commission to carry out its functions, without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, without regard to the provision of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this paragraph may exceed the equivalent of that payable for a position at a level IV of the Executive Schedule under section 5316 of title 5, United States Code.

(9) PERSONNEL AS FEDERAL EMPLOYEES.—

(A) IN GENERAL.—The executive director and any personnel of the Commission are employees under section 2105 of title 5, United States Code, for purpose of chapters 63, 81, 83, 84, 85, 87, 89, and 90 of such title.

(B) MEMBERS OF THE COMMISSION.—Subparagraph (A) shall not be construed to apply to members of the Commission.

(10) CONTRACTING.—The Commission may, to such extent and in such amounts as are provided in appropriations Acts, enter into contracts to enable the Commission to discharge the duties of the Commission under this Act.

(11) EXPERT AND CONSULTANT SERVICE.—The Commission may procure the services of experts and consultants in accordance with section 3109 or title 5, United States Code, at rates not to exceed the daily rate paid to a person occupying a position at level IV of the Executive Schedule under section 3109 of title 5, United States Code.

(12) POSTAL SERVICE.—The Commission may use the United States mails in the same manner and under the same conditions as departments and agencies of the United States.

(13) PHYSICAL FACILITIES AND EQUIPMENT.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission, on a reimbursable basis, the administrative support services necessary for the Commission to carry out its responsibilities under this Act. These administrative services may include human resource management, budget, leasing accounting, and payroll services.

(e) REPORT.—

(1) INTERIM REPORTS.—

(A) IN GENERAL.—Not later than 60 days after the date on which the Commission first meets, and each 30-day period thereafter ending on the date on which the Commission submits the final report under paragraph (2), the Commission shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate and the President a report detailing the level of cooperation the Secretary of Veterans Affairs (and the heads of other departments or agencies of the Federal Government) has provided to the Commission.

(B) OTHER REPORTS.—In carrying out its duties, at times that the Commission determines appropriate, the Commission shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate and any other appropriate entities an interim report with respect to the findings identified by the Commission.

(2) FINAL REPORT.—Not later than 18 months after the first meeting of the Commission, the Commission shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate, the President, and the Secretary of Veterans Affairs a final report on the findings of the Commission. Such report shall include the following:

(A) Recommendations to implement in a feasible, timely, and cost efficient manner the solutions and remedies identified within the findings of the Commission pursuant to subsection (b).

(B) An analysis of the evidence-based therapy model used by the Secretary of Veterans Affairs for treating veterans with mental health care issues, and an examination of the prevalence and efficacy of prescription drugs as a means for treatment.

(C) The findings of the patient-centered survey conducted within each of the Veterans Integrated Service Networks pursuant to subsection (b)(2).

(D) An examination of complementary alternative treatments described in subsection (b)(3) and the potential benefits of incorporating such treatments in the therapy models used by the Secretary for treating veterans with mental health issues.

(3) PLAN.—Not later than 90 days after the date on which the Commission submits the final report under paragraph (2), the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the House of Representatives and the Senate a report on the following:

(A) An action plan for implementing the recommendations established by the Commission on such solutions and remedies for improving wellness-based outcomes for veterans with mental health care issues.

(B) A feasible timeframe on when the complementary alternative treatments described in subsection (b)(3) can be implemented Department-wide.

(C) With respect to each recommendation established by the Commission, including any complementary alternative treatment, that the Secretary determines is not appropriate or feasible to implement, a justification for such determination and an alternative solution to improve the efficacy of the therapy models used by the Secretary for treating veterans with mental health issues.

(f) **TERMINATION OF COMMISSION.**—The Commission shall terminate 30 days after the Commission submits the final report under subsection (e)(2).

SEC. 302. PILOT PROGRAM ON INTEGRATION OF COMPLEMENTARY ALTERNATIVE MEDICINES AND RELATED ISSUES FOR VETERANS AND FAMILY MEMBERS OF VETERANS.

(a) **PILOT PROGRAM.**—

(1) **IN GENERAL.**—Not later than 180 days after the date on which the Secretary of Veterans Affairs receives the final report under section 301(e), the Secretary shall commence a pilot program to assess the feasibility and advisability of using wellness-based programs (as defined by the Secretary) to complement the provision of pain management and related health care services, including mental health care services, to veterans.

(2) **MATTERS ADDRESSED.**—In carrying out the pilot program, the Secretary shall assess the following:

(A) Means of improving coordination between Federal, State, local, and community providers of health care in the provision of pain management and related health care services to veterans.

(B) Means of enhancing outreach, and coordination of outreach, by and among providers of health care referred to in subparagraph (A) on the pain management and related health care services available to veterans.

(C) Means of using wellness-based programs of providers of health care referred to in subparagraph (A) as complements to the provision by the Department of pain management and related health care services to veterans.

(D) Whether wellness-based programs described in subparagraph (C)—

- (i) are effective in enhancing the quality of life and well-being of veterans;
- (ii) are effective in increasing the adherence of veterans to the primary pain management and related health care services provided such veterans by the Department;
- (iii) have an effect on the sense of well-being of veterans who receive primary pain management and related health care services from the Department; and
- (iv) are effective in encouraging veterans receiving health care from the Department to adopt a more healthy lifestyle.

(b) **DURATION.**—The Secretary shall carry out the pilot program under subsection (a)(1) for a period of three years.

(c) **LOCATIONS.**—

(1) **FACILITIES.**—The Secretary shall carry out the pilot program under subsection (a)(1) at facilities of the Department providing pain management and related health care services, including mental health care services, to veterans. In selecting such facilities to carry out the pilot program, the Secretary shall select not fewer than 15 medical centers of the Department, of which not fewer than two shall be polytrauma rehabilitation centers of the Department.

(2) **MEDICAL CENTERS WITH PRESCRIPTION RATES OF OPIOIDS THAT CONFLICT WITH CARE STANDARDS.**—In selecting the medical centers under paragraph (1), the Secretary shall give priority to medical centers of the Department at which there is a prescription rate of opioids that conflicts with or is otherwise inconsistent with the standards of appropriate and safe care.

(d) **PROVISION OF SERVICES.**—Under the pilot program under subsection (a)(1), the Secretary shall provide covered services to covered veterans by integrating complementary and alternative medicines and integrative health services with other services provided by the Department at the medical centers selected under subsection (c).

(e) **COVERED VETERANS.**—For purposes of the pilot program under subsection (a)(1), a covered veteran is any veteran who—

- (1) has a mental health condition diagnosed by a clinician of the Department;
- (2) experiences chronic pain;
- (3) has a chronic condition being treated by a clinician of the Department; or

(4) is not described in paragraph (1), (2), or (3) and requests to participate in the pilot program or is referred by a clinician of the Department who is treating the veteran.

(f) COVERED SERVICES.—

(1) IN GENERAL.—For purposes of the pilot program, covered services are services consisting of complementary and integrative health services as selected by the Secretary.

(2) ADMINISTRATION OF SERVICES.—Covered services shall be administered under the pilot program as follows:

(A) Covered services shall be administered by professionals or other instructors with appropriate training and expertise in complementary and integrative health services who are employees of the Department or with whom the Department enters into an agreement to provide such services.

(B) Covered services shall be included as part of the Patient Aligned Care Teams initiative of the Office of Patient Care Services, Primary Care Program Office, in coordination with the Office of Patient Centered Care and Cultural Transformation.

(C) Covered services shall be made available to—

(i) covered veterans who have received conventional treatments from the Department for the conditions for which the covered veteran seeks complementary and integrative health services under the pilot program; and

(ii) covered veterans who have not received conventional treatments from the Department for such conditions.

(g) REPORTS.—

(1) IN GENERAL.—Not later than 30 months after the date on which the Secretary commences the pilot program under subsection (a)(1), the Secretary shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the pilot program.

(2) ELEMENTS.—The report under paragraph (1) shall include the following:

(A) The findings and conclusions of the Secretary with respect to the pilot program under subsection (a)(1), including with respect to—

(i) the use and efficacy of the complementary and integrative health services established under the pilot program;

(ii) the outreach conducted by the Secretary to inform veterans and community organizations about the pilot program; and

(iii) an assessment of the benefit of the pilot program to covered veterans in mental health diagnoses, pain management, and treatment of chronic illness.

(B) Identification of any unresolved barriers that impede the ability of the Secretary to incorporate complementary and integrative health services with other health care services provided by the Department.

(C) Such recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

(h) COMPLEMENTARY AND INTEGRATIVE HEALTH DEFINED.—In this section, the term “complementary and integrative health” shall have the meaning given that term by the National Institutes of Health.

TITLE IV—FITNESS OF HEALTH CARE PROVIDERS

SEC. 401. ADDITIONAL REQUIREMENTS FOR HIRING OF HEALTH CARE PROVIDERS BY DEPARTMENT OF VETERANS AFFAIRS.

As part of the hiring process for each health care provider considered for a position at the Department of Veterans Affairs after the date of the enactment of the Act, the Secretary of Veterans Affairs shall require from the medical board of each State in which the health care provider has a medical license—

(1) information on any violation of the requirements of the medical license of the health care provider during the 20-year period preceding the consideration of the health care provider by the Department; and

(2) information on whether the health care provider has entered into any settlement agreement for the disciplinary charge relating to the practice of medicine by the health care provider.

SEC. 402. PROVISION OF INFORMATION ON HEALTH CARE PROVIDERS OF DEPARTMENT OF VETERANS AFFAIRS TO STATE MEDICAL BOARDS.

Notwithstanding section 552a of title 5, United States Code, with respect to each health care provider of the Department of Veterans Affairs who has violated a requirement of the medical license of the health care provider, the Secretary of Veterans Affairs shall provide to the medical board of each State in which the health care provider is licensed detailed information with respect to such violation, regardless of whether such board has formally requested such information.

SEC. 403. REPORT ON COMPLIANCE BY DEPARTMENT OF VETERANS AFFAIRS WITH REVIEWS OF HEALTH CARE PROVIDERS LEAVING THE DEPARTMENT OR TRANSFERRING TO OTHER FACILITIES.

Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives a report on the compliance by the Department of Veterans Affairs with the policy of the Department—

- (1) to conduct a review of each health care provider of the Department who transfers to another medical facility of the Department, retires, or is terminated to determine whether there are any concerns, complaints, or allegations of violations relating to the medical practice of the health care provider; and
- (2) to take appropriate action with respect to any such concern, complaint, or allegation.

TITLE V—OTHER VETERANS MATTERS

SEC. 501. AUDIT OF VETERANS HEALTH ADMINISTRATION PROGRAMS OF DEPARTMENT OF VETERANS AFFAIRS.

(a) **AUDIT.**—The Secretary of Veterans Affairs shall seek to enter into a contract with a nongovernmental entity under which the entity shall conduct a audits of the programs of the Veterans Health Administration of the Department of Veterans Affairs to identify ways to improve the furnishing of benefits and health care administered by the Veterans Health Administration to veterans and families of veterans.

(b) **AUDIT REQUIREMENTS.**—In carrying out each audit under subsection (a), the entity shall perform the following:

- (1) Five-year risk assessments to identify the functions, staff organizations, and staff offices of the Veterans Health Administration that would lead towards the greatest improvement in furnishing of benefits and health care to veterans and families of veterans.
- (2) Development of plans that are informed by the risk assessment under paragraph (1) to conduct audits of the functions, staff organizations, and staff offices identified under paragraph (1).
- (3) Conduct audits in accordance with the plans developed pursuant to paragraph (2).

(c) **REPORTS.**—Not later than 90 days after the date on which each audit is completed under subsection (a), the Secretary shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report that includes—

- (1) a summary of the audit;
- (2) the findings of the entity that conducted the audit with respect to the audit; and
- (3) such recommendations as the Secretary determines appropriate for legislative or administrative action to improve the furnishing of benefits and health care to veterans and families of veterans..

PURPOSE AND SUMMARY

H.R. 4063, the “Jason Simcakoski Promoting Responsible Opioid Management and Incorporating Scientific Expertise (PROMISE) Act,” was introduced by Representative Gus Bilirakis of Florida, the Vice Chairman of the Committee on Veterans' Affairs, on November 18, 2015. H.R. 4063, as amended, was ordered to be favorably reported to the full House on February 25, 2016, by voice vote.

H.R. 4063, as amended would: (1) Require the Department of Veterans Affairs (VA) and the Department of Defense (DOD) to jointly establish an advisory committee to review and update the

VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; (2) require VA to expand the opioid safety initiative; (3) strengthen the VA/DOD Pain Management Working Group; (4) require the Government Accountability Office (GAO) to report on VA's opioid safety initiative and the opioid prescribing practices of VA healthcare providers; (5) require VA to disclose information to state controlled substance monitoring programs; (6) require VA to ensure that each VA medical facility hosts regular community meetings on improving the provision of VA health care; (7) require VA to display information on the patient advocacy program and the patient bill of rights; (8) require GAO to report on VA's patient advocacy program; (9) establish a Commission to examine VA's evidence-based therapy treatment model and the potential benefits of incorporating complementary and alternative medicine; (10) establish a pilot program to assess the feasibility and advisability of using wellness-based programs to complement the provision of pain management to veterans; (11) require VA to ensure that State medical boards receive information on violations of a provider's medical license; (12) require VA to provide State medical boards detailed information with respect to a violation of a requirement of a provider's medical license; (13) require VA to report on the Department's compliance with policies to conduct a review of each healthcare provider who transfers to another VA medical facility, retires, or is terminated to determine whether there are any concerns, complaints, or allegations of violations relating to the provider's medical practice and to take appropriate action; and, (14) require VA to conduct an audit of Veterans Health Administration (VHA) programs and identify ways to improve the provision of benefits and healthcare to veterans and their families.

BACKGROUND AND NEED FOR LEGISLATION

TITLE I—OPIOID THERAPY AND PAIN MANAGEMENT SECTION

Section 101—Establishment of an Advisory Committee to review guidelines on management of opioid therapy by Department of Veterans Affairs and Department of Defense

The effective management of pain is an increasingly critical issue for the American health care system. Given that the veteran population experiences chronic pain at a much higher rate than the general adult population, it is also an increasingly critical issue for the VA health care system. Chronic pain, which is defined as pain that persists beyond expected healing time and generally persists longer than three to six months, affects veterans of all eras. It is the most frequent medical condition facing veterans of Iraq and Afghanistan and, as the incidence and severity of pain increase with age, it is also common among older generations of veterans. Chronic pain is a complex condition, involving cognitive, psychosocial, and substance use issues as well as a variety of medical and mental health co-morbidities.

DOD and VA have been increasingly reliant on the use of prescription painkillers—and, in particular, opioids—to treat servicemembers and veterans experiencing both acute and chronic pain. Opioids are a commonly abused medication derived from, or synthesized similar to, the opium poppy and used for pain relief. Examples of common opioids include: hydrocodone; oxycodone,

fantanyl, methadone, and codeine. According to a CBS News report based on VA data, the number of patients treated by VA increased 29%, while the number of opioid prescriptions written by VA providers increased 259%, from 2002 to 2013.¹ Additionally, the Center for Investigative Reporting found that VA prescriptions for certain opioids—hydrocodone, oxycodone, methadone and morphine—rose 270% from 2001 to 2013.²

To help manage the use of opioid medications for servicemembers and veterans experiencing chronic pain, VA and DOD published the Clinical Practice Guideline for the Management of Opioid Therapy (Guideline) in May 2010.³ The Guideline recommends opioid therapy for servicemembers and veterans with chronic pain that meet several eligibility criteria including moderate to severe pain that has failed to adequately respond to non-opioid and non-drug therapeutic interventions. However, the Guideline notes the existence of, “controversy . . . among pain practitioners concerning the use of opioids for the treatment of chronic pain” due, in part to, “. . . a paucity of data regarding long-term opioid efficacy.”

Research has also noted concerns about the use of opioid prescriptions to treat veteran patients. A study conducted by VA researchers and published in *The Journal of the American Medical Association* on March 7, 2012,⁴ found that veterans with a mental health diagnosis—in particular, post-traumatic stress disorder (PTSD)—were significantly more likely than their peers to receive prescription opioids for pain. These veterans also were “more likely to have comorbid drug and alcohol use disorders; receive higher-dose opioid regimens; continue taking opioids longer; receive concurrent prescriptions for opioids, sedative hypnotics, or both; and obtain early opioid refills,” which can be a sign of opioid abuse. Perhaps most troublingly, the study concluded that, “receiving prescription opioids was associated with increased risk of adverse clinical outcomes for all veterans returning from Iraq and Afghanistan, especially veterans with PTSD who were at highest-risk of alcohol-, drug-, and opioid-related accidents and overdose as well as self-inflicted injuries.”⁵

The Committee is supportive of the Guideline but believes that it should be updated to reflect the most current research and best practices regarding the use of opioid medications in pain care, particularly in light of ongoing concerns regarding opioid use among veteran patients. As such, Section 101 would require VA and DOD to jointly establish an advisory committee to conduct a review of and make recommendations with respect to updating the Guideline. The advisory committee would be required to report to VA and DOD not later than one year after the date of enactment of this

¹ CBS News, “Veterans Dying from Overmedication,” Sep. 19, 2013, <http://www.cbsnews.com/news/veterans-dying-from-overmedication/>.

² The Center for Investigative Reporting, “VA’s Opiate Overload Feeds Veterans’ Additions, Overdose Deaths,” Sep. 28, 2013, <http://cironline.org/reports/vas-opiate-overload-feeds-veterans-additions-overdose-deaths-5261>.

³ The Department of Veterans Affairs and Department of Defense, “Management of Opioid Therapy for Chronic Pain,” May 2010, http://www.va.gov/painmanagement/docs/cpg_opioidtherapy_fulltext.pdf.

⁴ The Journal of the American Medical Association, “Association of Mental Health Disorders With Prescription Opioids and High-Risk Opioid Use in US Veterans of Iraq and Afghanistan,” March 7, 2012, <http://jama.jamanetwork.com/article.aspx?articleid=1105046>.

⁵ The article also noted that “in a sample of veterans with multiple pain problems, those with the highest-risk medical and psychiatric comorbidity were the most likely to receive the highest-dose, highest-risk opioid therapy.”

Act and to examine whether the Guideline should include enhanced guidance on a number of metrics, including the coadministration of opioids and other medications and the treatment of patients with comorbidities. In conducting the review of the Guideline, the advisory committee would be also required to consult with the VA/DOD Management of Opioid Therapy for Chronic Pain Working Group.

Section 102—Improvement of opioid safety measures by the Department of Veterans Affairs

VA launched the Opioid Safety Initiative (OSI) in October 2013, to reduce the use of opioids among veterans using the VA health care system and to improve care for veterans with chronic pain. According to VA, OSI works by incorporating a team-based approach, increasing the use of non-prescription pain management treatments and CAM, and emphasizing patient education and monitoring. To aid in the effectiveness of OSI, VA's National Pain Management Program office convened a national task force of pain management experts across multiple disciplines to create an accompanying toolkit to help VA clinicians better manage pain among—and prescribe appropriate medications to—their veteran patients. OSI was first deployed in and around Minneapolis, Minnesota, and has since expanded to many other VA medical facilities, while the OSI toolkit is available on VA's website for both VA providers and the general public to access.

Given the prevalence of chronic pain in the veteran population and ongoing concerns about opioid use and pain care management throughout VA, the Committee wants to ensure that OSI and the OSI toolkit are used uniformly across all VA medical facilities, that VA clinicians are trained in appropriately managing pain and prescribing opioid medications, and that VA leaders are effectively overseeing the provision of pain care and opioid use among veteran patients. To accomplish these goals, section 102 of the bill would require VA to expand OSI to all VA medical facilities. It would also require VA to use the Interdisciplinary Chronic Pain Management Training Team Program to ensure that all VA employees who are responsible for prescribing opioids receive education and training on pain management and safe opioid prescribing practices to enable them to safely and effectively manage care for patients with chronic pain. Such education and training would be required to include the Guideline, the use of evidence-based pain management therapies, the screening and identification of patients with substance use disorder, communication with patients on the use of opioids and other controlled substances, and other training as the Secretary considers appropriate.

Section 102 of the bill would further require the Director of each VA medical facility to designate a pain management team to coordinate and oversee pain management therapy at the facility and to consult with the Director of each Veterans Integrated Service Network (VISN) to establish standard protocols for designating pain management teams. Such protocols would be required to include assurances that any health care provider without expertise in prescribing analgesics or who has not completed education and training on pain management and safe opioid prescribing practices does not prescribe opioids to a patient unless such provider consults with a provider with pain management expertise and re-

fers the patient to the pain management team for any subsequent prescriptions and related therapy. VA would also be required to regularly report, track, and monitor the pain management teams, the use of OSI and other tools, opioid use among VA patients, and the availability of opioid receptor antagonists.

Section 103—Strengthening of joint working group on pain management of the Department of Veterans Affairs and the Department of Defense

As explained in the descriptive portion of section 101 of the bill above, the use of opioid medications for managing chronic pain has been rapidly increasing in recent years. Data suggests that veterans are a particularly high-risk population for prescription misuse, substance use disorder, accidental overdose, accidents, and/or self-inflicted injury and some studies have shown that those veterans with the highest-risk conditions are also the most likely to receive the highest-dose, highest-risk opioid therapies. As a result, the Committee believes that, along with updating the Guideline, VA and DOD must focus their collaborative efforts on improving pain care for servicemembers and veterans. The Committee is particularly concerned about how VA and DOD manage patients' needs—and, in particular, their medication needs—during the transition from DOD care to VA care, which is an especially vulnerable time for many.

To assist the Departments in focusing on these specific areas of need, section 103 of the bill would require VA and DOD to ensure that the Pain Management Working Group of the Health Executive Committee of the VA/DOD Joint Executive Committee focuses on the following: opioid prescribing practices; the ability to manage acute and chronic pain; the use of CAM; the concurrent use of opioids and prescription drugs to treat mental health disorders; the practice of prescribing opioids to treat mental health disorders; access to medications for patients transitioning from DOD to VA; and, the ability to identify and treat substance use disorder. Section 103 of the bill would also require VA and DOD to ensure that the Working Group coordinates with other relevant working groups and Federal agencies and consults with and comments on the updated Guideline or any successor guideline.

Section 104—Review, investigation, and report on use of opioids in treatment by Department of Veterans Affairs

As explained in the descriptive portions of section 102 of the bill above, VA developed and deployed the OSI in October 2013 in Minneapolis, Minnesota. In February 2014—five months after it was first deployed—VA reported that the OSI had already demonstrated success in lowering dependency on opioid medications. According to VA, the eight sites of care where the OSI was deployed in and around Minneapolis decreased high-dose opioid prescriptions by more than half. While encouraged by those results, the Committee wants to ensure that the OSI is continuously updated and improved as research surrounding pain management and opioid use is advanced.

In accordance with that goal, section 104 of the bill would require GAO to submit a report to Congress on the OSI and the opioid prescribing practices of VA health care providers and issue

recommendations for improvement. VA would be required to report to Congress quarterly on the Department's progress implementing GAO's recommendations. VA would also be required to report to Congress annually—for five years—on opioid prescriptions for non-cancer, non-palliative, and non-hospice care patients at each VA medical facility. Section 104 of the bill would further require VA to notify Congress and conduct a full investigation through the Office of Medical Inspector if the Secretary determines that a prescription rate with respect to either a medical facility or individual provider conflicts with or is otherwise inconsistent with the standards of appropriate and safe care.

Section 105—Mandatory disclosure of certain veteran information to State controlled substances monitoring programs

State prescription drug monitoring programs—which are also referred to as state controlled substance monitoring programs—are tools used by State governments to collect, monitor, and analyze prescribing and dispensing data submitted by pharmacies and dispensing practitioners to support state efforts in education, research, law enforcement and substance abuse prevention. Data collected by state prescription drug monitoring programs is provided to authorized entities including healthcare providers, pharmacists, regulatory boards, and law enforcement agencies. According to the Prescription Drug Monitoring Program Training and Technical Assistance Center, 49 states, the District of Columbia, and Guam have legislation that authorizes a prescription drug monitoring program, and of those, 49 states and Guam have a prescription drug monitoring program that is operational.

In 2013, VA promulgated a regulation that allowed but did not require VA medical facilities to disclose information about a veteran or dependent of a veteran to a State controlled prescription drug monitoring program in order to prevent the misuse and diversion of prescription medicines. Some, but not all, VA medical facilities are now communicating with their local State prescription drug monitoring program. However, the Committee believes that all VA medical facilities should be disclosing relevant information to State prescription drug monitoring programs. As such, section 105 would require VA to disclose information to state controlled substance monitoring programs.

TITLE II—PATIENT ADVOCACY

Section 201—Community meetings on improving care furnished by Department of Veterans Affairs

In April 2014, the Committee uncovered the use of unauthorized waiting lists at the Phoenix VA Health Care System in Phoenix, Arizona. At that time, at least forty veteran patients had died while waiting on those lists to receive VA care. This finding—and the subsequent investigations that resulted from it—led to a widespread access and accountability scandal that plagued the entire VA health care system. During that scandal—the repercussions of which continue today—it became increasingly clear to the Committee that there was a disconnect between the leaders responsible for managing the VA health care system and the veteran patients and their families who relied on that system to meet their needs.

To correct this disconnect and increase communication between local and regional VA leaders, veterans, and other stakeholders, section 201 of the bill would require VA to ensure that each VA medical facility—to include community-based outpatient clinics—hosts a community meeting with members of the public on improving the provision of health care by VA. Each community meeting would be required to be noticed at least 10 days in advance to the public and Congress. In addition, either the Director of the relevant VISN or an employee the Director delegates must attend each meeting, with the stipulation that the Director must personally attend at least one community meeting each year.

Section 202—Improvement of awareness of patient advocacy program and patient bill of rights of Department of Veterans Affairs

VA operates a patient advocacy program to assist in the timely resolution of patient complaints and concerns. In accordance with the patient advocacy program, each VA medical facility employs one or more patient advocates. Patient advocates work directly with service-line chiefs and, per the Patient Advocacy Program Handbook, are responsible for facilitating resolution to problems beyond the scope of front-line staff and participating in the resolution of system problems by presenting the patient's perspective and desired resolution.⁶ The Handbook also requires that patient rights and responsibilities as well as information regarding the patient advocacy program be posted in VA medical facilities and provided to patients upon admission. Despite this requirement, the Committee is concerned that veteran patients are not aware of their rights and responsibilities with regard to their health care or of their ability to contact a patient advocate to assist them in resolving complaints and concerns related to their health care.

To remedy this, section 202 of the bill would require VA to display the following information in each VA medical facility: The purposes of the patient advocacy program; the contact information for the facility's patient advocate; and the rights and responsibilities of the patients and family members of the patient or—with respect to community living centers or other VA residential facilities—the rights and responsibilities of residents and family members of residents. Such information would be required to be displayed in as many prominent locations as the Secretary determines is appropriate in order to be seen by the largest percentage of patients or residents and family members of patients or residents in each facility.

Section 203—Comptroller general report on patient advocacy program of Department of Veterans Affairs

The Committee believes that a strong patient advocacy program is vital to patient satisfaction and to the success of the VA health care system. However, the Committee has heard numerous concerns from veterans and their families that VA patient advocates are not always responsive to a veteran's needs. In light of those concerns, section 203 of the bill would require GAO to perform an audit of VA's patient advocacy program. The report produced by

⁶VHA Handbook 1003.4, VHA Patient Advocacy Program.

that audit would be required to include the purpose and activities of the patient advocacy program, the sufficiency of the patient advocacy program in achieving its purpose, an assessment of the staffing of the patient advocacy program, an assessment of the training of VA patient advocates, an assessment of whether veterans and their families are aware of and use the patient advocacy program, and such recommendations and proposals for improving or modifying the patient advocacy program as GAO considers appropriate.

TITLE III—COMPLEMENTARY AND INTEGRATIVE HEALTH

Section 301—Expansion of research and education on and delivery of complementary and integrative health to veterans

The National Center for Complementary and Integrative Health of the National Institutes of Health (NIH) defines complementary and alternative medicine (CAM) as “a group of diverse medical and health care interventions, practices products, or disciplines that are not generally considered part of conventional medicine.”⁷ The term “complementary” refers to the use of CAM together with conventional medicine, such as using meditation in addition to traditional psychotherapy to treat PTSD. The term “alternative” refers to use of CAM in place of conventional medicine, such as using meditation in place of traditional psychotherapy to treat PTSD. According to the VA Office of Research and Development, VA most often uses CAM to help veterans manage stress, to promote general wellness, or to treat PTSD, depression, back pain, headache, arthritis, fibromyalgia, or substance abuse. While the use of CAM has grown significantly throughout VA over the past decade, the demand for CAM services among veterans accessing VA care is increasing, and the Committee would like to see CAM provided to veterans more uniformly across the VA health care system.

Accordingly, section 301 of the bill would establish the Creating Options for Veterans’ Expedited Recovery (or COVER) Commission to examine the evidence-based therapy treatment model used by VA to treat veterans and the potential benefits of incorporating CAM into that treatment model. The Commission would have the following duties: To examine the efficacy of VA’s evidence-based treatment model in treatment mental illness in veterans; to identify areas to improve wellness-based outcomes; to conduct patient centered surveys within each VISN on veterans’ experiences and preferences; to examine available research on CAM and what benefits could result from the inclusion of CAM treatments; to study whether VA’s resources are sufficient for ensuring the delivery of quality care for veterans with mental health issues who are seeking VA treatment; and to study and assess the current treatments and resources available within VA. The Commission’s membership would be composed of appointees from the Speaker and Minority Leader of the House of Representatives, the Majority Leader and Minority Leader of the Senate, and the President who have relevant qualifications. The Commission would be required to meet and report to Congress regularly. Following the Commission’s final

⁷National Center for Complementary and Integrative Health, “Exploring the Science of Complementary and Alternative Medicine, Third Strategic Plan: 2011–2015,” https://nccih.nih.gov/sites/nccam.nih.gov/files/NCCAM_SP_508.pdf.

report, VA would be required to submit an action plan for implementing the Commission's recommendations and a timeframe for implementing CAM. If VA elects not to implement a given recommendation, VA would be required to submit a justification for determining that such recommendation is not appropriate and an alternative solution to improve the efficacy of VA's therapy model.

Section 302—Pilot program on integration of complementary alternative medicines and related issues for veterans and family members

As explained in the descriptive portion of section 301 of the bill, the Committee is interested in increasing the use of CAM throughout the VA health care system generally. The Committee is also interested in exploring how CAM may benefit veterans seeking pain care, specifically. To further this goal, section 302 of the bill would establish a three-year pilot program in at least 15 VA medical centers to assess the feasibility and advisability of using wellness-based programs to complement the provision of pain and related care to veterans. The pilot program would be required to assess the following: the means of improving coordination between Federal, State, local, and community health care providers in providing pain and related care; the means of enhancing outreach and coordination of outreach by and among health care providers providing pain and related care; the means of using wellness-based programs to complement pain and related care; and whether wellness-based programs are effective for veterans receiving pain and related care. In selecting VA medical centers for the pilot program, VA would be required to prioritize facilities with the opioid prescription rates that conflict or are otherwise inconsistent with usual standards of appropriate and safe care. In order to be eligible to participate in the pilot, veterans would have to be diagnosed with a mental health condition and experience chronic pain that is being treated by a VA clinician. During the pilot, participating veterans would be provided with CAM as defined by NIH. VA would be required to report to Congress not later than 30 months after the beginning of the pilot program.

TITLE IV—FITNESS OF HEALTH CARE PROVIDERS

Section 401—Additional requirements for hiring of health care providers by Department of Veterans Affairs

In response to complaints made in 2011 and 2012, the VA Office of the Inspector General (IG) conducted a review of alleged inappropriate prescription of controlled substances and alleged abuse of authority at the Tomah VA Medical Center (VAMC) in Tomah, Wisconsin. According to the IG, a total of 32 specific allegations were made before and during the course of the IG's review. These allegations concerned the number of opioid prescriptions at the facility, in general, and the opioid prescribing practices of the facility's Chief of Staff, in particular. According to media reports, veterans commonly referred to the facility as "Candy Land" and to the Chief of Staff as the "Candy Man" because of the high number of

opioid prescriptions that were provided.⁸ While the IG did not substantiate allegations that opioids were prescribed inappropriately to specific individuals or in inappropriate doses, the IG did find that the amounts of opioids prescribed by the Chief of Staff and select other providers were “at considerable variance compared with most opioid prescribers in VISN 12.”⁹ The IG also substantiated that there were, “widely held beliefs and concerns among pharmacy staff and among some other staff,” of abuse of authority, intimidation, and retaliation on the part of the Chief of Staff when controlled substance prescription practices were questioned.¹⁰ In conclusion, the IG stated that, “our inspection raised potentially serious concerns that should be brought to the attention of VISN 12 management for further review.”¹¹

Following the public release of the IG’s findings in 2015, VA began a comprehensive review of medication prescription practices at the Tomah VAMC. VA’s review substantiated unsafe clinical practices in areas such as pain management and psychiatric care and found that Tomah VAMC patients were: (1) 2.5 times more likely than the national average to be prescribed opioids greater than 400 morphine equivalents per day; (2) more likely than the national average to be prescribed opioid doses between 200–300 morphine equivalents per day; and, (3) almost double the national average with respect to the use of benzodiazepines and opioids together. Higher morphine equivalents per day and the concurrent use of benzodiazepines and opioids increase the occurrence of complications and adverse events.

The IG’s and VA’s investigations into the Tomah VAMC, and the issues that subsequently came to light regarding the Tomah VAMC Chief of Staff, started a national conversation about the prevalence of opioid prescriptions in the VA health care system, how VA oversees facility’s and providers’ opioid prescribing practices, and whether and how VA communicates with State and local medical licensing bodies regarding patient care concerns with individual providers.

To ensure that VA has insight into a prospective provider’s history to include any findings of negligent patient care section 401 of the bill would require that, as part of the hiring process for incoming providers, VA solicit information from the medical board of each State in which an incoming provider is licensed. Information VA would be required to solicit from the State medical board would include information regarding any violations of such provider’s medical license and information regarding whether such provider has entered into any settlement agreements as a result of disciplinary charges relating to the practice of medicine.

⁸ Chicago Tribune, “Veterans: VA hospital nicknamed ‘Candy Land’ because painkillers given out freely,” January 9, 2015. <http://www.chicagotribune.com/news/ct-tomah-va-hospital-nw-20150109-story.html>

⁹ VA Office of the Inspector General, “Administrative Closure—Alleged Inappropriate Prescribing of Controlled Substances and Alleged Abuse of Authority, Tomah VA Medical Center, Tomah, WI,” page 7. <http://www.va.gov/oig/pubs/VAOIG-11-04212-127.pdf>.

¹⁰ *Id.*, at page 5.

¹¹ *Id.*, page 9. <http://www.va.gov/oig/pubs/VAOIG-11-04212-127.pdf>.

Section 402—Provision of information on health care providers of Department of Veterans Affairs to State Medical Boards

As stated above, the Committee has concerns regarding the need for VA to have information regarding allegations or findings made against a prospective provider's medical license. The Committee recognizes a similar need for VA to share information with State and local medical licensing bodies about allegations or findings that are made about providers during their tenure at VA. As such, section 402 of the bill would require VA to provide the medical board of each State in which a healthcare provider is licensed detailed information with respect to a violation of a requirement of such provider's medical license.

Section 403—Report on compliance by Department of Veterans Affairs with reviews of health care providers leaving the Department or transferring to other facilities

Following the issues described above regarding the Tomah VAMC, the Committee heard concerns from many veterans and VA employees regarding providers who have had complaints made about their medical practice leaving VA employment or transferring to another VA facility to avoid negative repercussions of such complaints. As such, the Committee has also recognized the need for a heightened level of oversight regarding VA's policies with respect to outgoing providers and providers transferring from one VA facility to another. In light of this, section 403 of the bill would require VA to submit to Congress a report on the Department's compliance with policies to conduct a review of each health care provider who transfers to another VA medical facility, retires, or is terminated to determine whether there are any concerns, complaints, or allegations of violations relating to the provider's medical practice and to take appropriate action with respect to any such concern, complaint, or allegation.

TITLE V—OTHER VETERANS MATTERS

Section 501—Audit of Veterans Health Administration programs of Department of Veterans Affairs

The Veterans Access, Choice, and Accountability Act of 2014 (Public Law 113–146; 128 Stat. 1770) required VA to contract with a private sector entity to conduct an Independent Assessment of the VHA. To complete the Independent Assessment, which is composed of twelve individual assessments, VA entered into a contract with the Centers for Medicare and Medicaid Services Alliance to Modernize Healthcare (CAMH), a private federally funded research and development center that is operated by the MITRE Corporation. CAMH, in turn, partnered with the RAND Corporation, McKinsey and Company, and Grant Thornton, to complete eleven of the individual assessments with the remaining individual assessment (pertaining to access standards) being completed by the Institute of Medicine. CAMH and its partners interviewed hundreds of VA, VHA, and private sector health care staff; visited 87 VA medical facilities across 30 states, Washington, DC, and Puerto Rico; and reviewed approximately 500 data sets, reports, and documents from VA. The Independent Assessment was delivered to VA and to

Congress on September 1, 2015, and released publicly on September 18, 2015.

Assessment L, which was conducted by McKinsey and Company, focused on the competency of leadership across VHA with respect to culture, accountability, reform readiness, leadership development, physician alignment, employee engagement, succession planning, and performance management. Assessment L concluded that an expanding scope of activities has led to confusion around leadership priorities and strategic direction of VHA, and that VHA's organization is unnecessarily complex. Assessment L further found that VHA's culture is characterized by risk-aversion and distrust, and that VHA leadership oversees a workforce that appears to be steadily losing motivation, and is consumed by addressing crises that have occurred in the past at the expense of preparing for the future. As a result, Assessment L concluded that VHA is unable to improve performance consistently and fully across the system, is unprepared for the future, and lacks a leadership pipeline robust enough to meet current and future needs.

In recognition of the need for further study and recommendations on how VHA can better service veterans, section 501 of the bill would require VA to enter into a contract with a non-governmental entity to conduct an audit of VHA's programs and identify ways to improve the furnishing of benefits and health care administered by VHA to veterans and their families. The audit would be required to include five-year risk assessments to identify the functions and staff organizations and offices that would lead to the greatest improvements in the furnishing of health care and benefits to veterans and their families through VHA; the development of plans that are informed by such assessments; and for audits to be conducted in accordance with such plans. VA would be required to submit a report to Congress 90 days after the audit is complete with a summary of the audit, the findings of the entity that conducted the audit, and recommendations as the Secretary determines appropriate for legislative and administrative action to improve the furnishing of benefits and health care to veterans and families of veterans.

HEARINGS

There were no full Committee hearings held on H.R. 4063, as amended. On November 17, 2015, the Subcommittee on Health conducted a legislative hearing on: H.R. 1319; H.R. 1603; H.R. 1904; H.R. 2639; H.R. 3234; H.R. 3471; H.R. 3549; draft legislation, the Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act; and a VA legislative proposal, the VA Purchased Health Care Streamlining and Modernization Act.

The following witnesses testified:

The Honorable Beto O'Rourke of Texas; the Honorable Andy Barr of Kentucky; the Honorable Matt Cartwright of Pennsylvania; the Honorable Scott Peters of California; the Honorable Martha Roby of Alabama; the Honorable Jackie Walorski of Indiana; the Honorable John Kline of Minnesota; the Honorable Gus Bilirakis of Florida; Adrian Atizado, the Deputy National Legislative Director for the Disabled American Veterans; LaRanda D. Holt, the Assistant Director for Women and Minority Veterans Outreach for the National Veterans Affairs and Rehabilitation Division of the American

Legion; Carlos Fuentes, the Senior Legislative Associate for the National Legislative Service of the Veterans of Foreign Wars of the United States; and Janet Murphy, Acting Deputy Under Secretary for Health for Operations and Management for the Veterans Health Administration of the U.S. Department of Veterans Affairs, who was accompanied by Elias Hernandez, Chief Officer for Workforce Management and Consulting for the Veterans Health Administration, Harold Kudler, Chief Consultant for Mental Health Services for the Veterans Health Administration, and Susan Blauert, Deputy Assistant General Counsel for the Veterans Health Administration.

Statements for the record were submitted by:

The American Counseling Association; the American Orthotic and Prosthetic Association; AMVETS; the Kentucky Department of Veterans Affairs; the National Mobility Equipment Dealers Association; the Paralyzed Veterans of America; Heather Simcakoski; and Martin Simcakoski.

SUBCOMMITTEE CONSIDERATION

There were no Subcommittee markups involving H.R. 4063, as amended.

COMMITTEE CONSIDERATION

On February 25, 2016, the Full Committee met in open markup session, a quorum being present, and ordered H.R. 4063, as amended, to be reported favorably to the House of Representatives by voice vote.

During consideration of H.R. 4063, as amended, the following amendments were considered and agreed to by voice vote:

An amendment in the nature of a substitute offered by Representative Gus Bilirakis of Florida;

An amendment to the amendment in the nature of a substitute offered by Representative Jackie Walorski of Indiana;

A second amendment to the amendment in the nature of a substitute offered by Representative Jackie Walorski of Indiana.

COMMITTEE VOTES

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, there were no recorded votes taken on amendments or in connection with ordering H.R. 4063, as amended, reported to the House. A motion by Ranking Member Corrine Brown of Florida to report H.R. 4063, as amended, favorably to the House of Representatives was agreed to by voice vote.

COMMITTEE OVERSIGHT FINDINGS

In compliance with clause 3(c)(1) of rule XIII and clause (2)(b)(1) of rule X of the Rules of the House of Representatives, the Committee's oversight findings and recommendations are reflected in the descriptive portions of this report.

STATEMENT OF GENERAL PERFORMANCE GOALS AND OBJECTIVES

In accordance with clause 3(c)(4) of rule XIII of the Rules of the House of Representatives, the Committee's performance goals and

objectives of this legislation are to improve pain care, patient advocacy, and the use of opioid therapy across the VA health care system and to increase complementary and integrative health techniques for veteran patients.

NEW BUDGET AUTHORITY, ENTITLEMENT AUTHORITY, AND TAX
EXPENDITURES

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, the Committee adopts as its own the estimate of new budget authority, entitlement authority, or tax expenditures or revenues contained in the cost estimate prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

EARMARKS AND TAX AND TARIFF BENEFITS

H.R. 4063, as amended, does not contain any Congressional earmarks, limited tax benefits, or limited tariff benefits as defined in clause 9 of rule XXI of the Rules of the House of Representatives.

COMMITTEE COST ESTIMATE

The Committee adopts as its own the cost estimate on H.R. 4063, as amended, prepared by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974.

CONGRESSIONAL BUDGET OFFICE COST ESTIMATE

Pursuant to clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, the following is the cost estimate for H.R. 4063, as amended, provided by the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 4, 2016.

Hon. JEFF MILLER,
*Chairman, Committee on Veterans' Affairs,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 4063, the Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Ann E. Futrell.

Sincerely,

KEITH HALL.

Enclosure.

H.R. 4063—Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act

Summary: H.R. 4063 would require the Department of Veterans Affairs (VA) to update safety measures for opioid therapy, expand the use of alternative medicine, and conduct audits of the VA health care system through a nongovernment entity. In total, CBO

estimates that implementing the bill would cost \$138 million over the 2017–2021 period, subject to appropriation of the necessary amounts.

Pay-as-you-go procedures do not apply because enacting the legislation would not affect direct spending or revenues. CBO estimates that enacting H.R. 4063 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

H.R. 4063 would impose an intergovernmental mandate by requiring state medical boards to report to the VA information about medical violations in the past 20 years committed by licensed physicians whom the VA is considering for employment. Information from state medical boards indicates that many boards already provide information that is similar to what the bill requires. Consequently, CBO estimates that the incremental costs of the mandate would be small and would fall below the annual threshold established in the Unfunded Mandates Reform Act (UMRA) for intergovernmental mandates (\$77 million, adjusted annually for inflation).

This bill contains no private-sector mandates as defined in UMRA.

Estimated Cost to the Federal Government: The estimated budgetary effect of H.R. 4063 is shown in the table below. The costs of this legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—					
	2017	2018	2019	2020	2021	2017–2021
SPENDING SUBJECT TO APPROPRIATION						
Opioid Safety Measures						
Estimated Authorization Level	18	20	20	21	22	101
Estimated Outlays	16	20	20	21	22	99
Complementary and Integrative Health						
Estimated Authorization Level	0	0	6	7	7	20
Estimated Outlays	0	0	5	7	7	19
Audits						
Estimated Authorization Level	2	2	2	2	2	10
Estimated Outlays	1	2	2	2	2	9
Community Meetings						
Estimated Authorization Level	*	1	1	1	1	4
Estimated Outlays	*	1	1	1	1	4
Commission on Complementary Health						
Estimated Authorization Level	1	2	1	0	0	4
Estimated Outlays	1	2	1	*	0	4
Reports						
Estimated Authorization Level	1	1	*	*	*	3
Estimated Outlays	1	1	*	*	*	3
Total changes to Spending Subject to Appropriation						
Estimated Authorization Level	22	26	30	31	32	142
Estimated Outlays	19	26	29	31	32	138

Note: * = less than \$500,000; details may not add to totals because of rounding.

Basis of estimate: For this estimate, CBO assumes that H.R. 4063 will be enacted near the start of fiscal year 2017, that the estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for affected programs.

Opioid safety measures

Section 102 would require VA to expand its safety measures by improving training on providing pain management and prescribing opioids, establishing pain management teams at each medical facility, and improving patient tracking through electronic reports.

This provision would create pain management teams throughout the VA health care system. According to VA, each medical facility currently has its own methods to manage and oversee pain therapy; however, they do not have designated pain management teams. Under this provision, VA would be required to implement a protocol for such teams. Based on information from VA, we expect that establishing and implementing such protocols at roughly 1,000 medical facilities would require very little additional work and would have an annual cost of roughly \$6,500 per facility. On that basis, CBO estimates that establishing the pain management teams nationwide would cost \$33 million over the 2017–2021 period.

Section 102 also would require VA to expand the nationwide availability of certain treatments such as Naloxone kits for opioid overdose. According to VA, it currently has roughly 55,000 patients with opioid-use disorder and roughly 28,000 Naloxone kits in its inventory. CBO estimates that it would cost roughly \$14 million each year to ensure the availability of kits (at a cost of about \$400 per kit) for those 55,000 patients who have the greatest potential risk of overdose. On that basis, CBO estimates it would cost \$66 million over the 2017–2021 period to expand the availability of such treatments.

This section also would require VA to enhance the ability of the electronic Opioid Therapy Risk Report (OTRR) to access information on prescribed drugs through the Prescription Drug Monitoring Programs. According to VA, such modifications to the OTRR would require minimal analyst and programming support. CBO estimates that implementing that requirement would cost less than \$500,000 over the 2017–2021 period.

In total, CBO estimates that implementing section 102 would cost \$99 million over the 2017–2021 period.

Complementary and integrative health

Section 302 would require VA to operate a three-year program at 15 VA Medical Centers to assess the feasibility of integrating complementary and alternative medicine with traditional care. That program would begin after the commission established under section 301 publishes their final report on complementary health. CBO expects that report would be issued near the end of fiscal year 2018 and that the three-year program would begin near the beginning of fiscal year 2019. On the basis of VA's implementation of other pilot programs of similar scope (such as using meditation for veterans with Post Traumatic Stress Disorder), CBO expects that developing and operating the program would require two additional medical practitioners at each of the 15 facilities to provide non-traditional care, as well as two additional employees at each facility to engage in research, training, and assessment of the program.

The use of complementary and alternative medicine also would partially displace the use of traditional care (emergency care, primary care, and physical therapy) but would lead to greater use of

medical services on balance, than under current law. Specifically, CBO estimates that the net cost to deliver medical services, after adjusting for the expected reduction in usage of traditional health care services would be roughly \$66,000 per medical provider, resulting in costs of roughly \$2 million annually during the three-year pilot program.

On the basis of information from VA, CBO further estimates that the annual cost per person for the research and training personnel would be \$127,000 in 2015. Thus, in total, implementing section 302 would cost \$19 million over the 2019–2021 period, CBO estimates.

Audits

Section 501 would require VA to enter into a contract with a private entity to conduct a series of audits of the VA health care system. The audits would include a risk assessment for the following five years and provide recommendations to improve the delivery of health care and plans for subsequent audits. On the basis of costs incurred for previous system-wide assessments of the VA by contracted entities, CBO estimates that implementing section 501 would cost about \$2 million each year. After factoring in the time to solicit and select a contractor, CBO estimates total costs of \$9 million over the 2017–2021 period.

Community meetings

Section 201 would require VA Medical Centers and Community Based Outpatient Clinics to host community meetings on an annual and quarterly basis, respectively. Those meetings would be open to the public. VA currently hosts town hall meetings to get feedback from veterans, their family members and other community stakeholders. On the basis of information from VA, CBO estimates that VA would need to hold an additional 500 such meetings a year to meet the requirements of this provision.

Based on costs in the private sector, we estimate VA would spend roughly \$1,500 per meeting for audio visual equipment, staff time, and supplies. In total, CBO estimates implementing this provision would cost \$4 million over the 2017–2021 period.

Commission on complementary health

Within 90 days of enactment, section 301 would establish the Creating Options for Veterans' Expedited Recovery Commission to:

- Examine treatment of mental health at the VA through evidence-based therapy;
- Conduct a nationwide survey; and,
- Determine the benefits of incorporating alternative treatments at nonVA facilities.

The commission would have 10 members plus a paid staff and would exist for about 18 months. The commission would be required to submit interim reports and a final report within 18 months of the commission's first meeting. Within 90 days of the final report, VA would be required to submit a plan to the Congress on implementing the commission's recommendations. Based on the costs of similar commissions, CBO estimates that implementing section 301 would cost about \$4 million over the 2017–2021 period.

Reports

The bill would require VA to produce about a dozen reports on matters such as opioid therapy, patient advocacy, and complementary medicine. Based on the costs of similar reports, CBO estimates that meeting those requirements would cost a total of \$3 million over the 2017–2021 period.

Pay-As-You-Go considerations: None.

Increase in long-term direct spending and deficits: CBO estimates that enacting H.R. 4063 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

Estimated impact on state, local, and tribal governments: H.R. 4063 would impose an intergovernmental mandate by requiring state medical boards to report to the VA information about medical violations in the past 20 years committed by licensed physicians whom the VA is considering for employment. Information from state medical boards indicates that many boards already provide information that is similar to what the bill requires. Consequently, CBO estimates that the incremental costs of the mandate would be small and would fall below the annual threshold established in UMRA for intergovernmental mandates (\$77 million, adjusted annually for inflation).

Estimated impact on the private sector: This bill contains no private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Ann E. Futrell; Impact on State, Local, and Tribal Governments: Jon Sperl; Impact on the Private Sector: Paige Piper/Bach.

Estimate approved by: H. Samuel Papenfuss, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 4063, as amended, prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

Section 101 of H.R. 4063, as amended, would create an advisory committee within the meaning of section 5(b) of the Federal Advisory Committee Act.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, H.R. 4063, as amended, is authorized by Congress' power to "provide for the common Defense and general Welfare of the United States."

APPLICABILITY TO LEGISLATIVE BRANCH

The Committee finds that H.R. 4063, as amended, does not relate to the terms and conditions of employment or access to public services or accommodations within the meaning of section 102(b)(3) of the Congressional Accountability Act.

EXCHANGE OF COMMITTEE CORRESPONDENCE

COMMITTEE ON ARMED SERVICES

U.S. House of Representatives

Washington, DC 20515-6035

ONE HUNDRED FOURTEENTH CONGRESS

May 9, 2016

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ROBERT L. SIMMONS, II, STAFF DIRECTOR

The Honorable Jeff Miller
 Chairman, Committee on Veterans' Affairs
 U.S. House of Representatives
 335 Cannon House Office Building
 Washington, D.C. 20515

Dear Mr. Chairman:

I am writing to you concerning the bill H.R. 4063, the Jason Simcakoski PROMISE Act. There are certain provisions in the legislation which fall within the Rule X jurisdiction of the Committee on Armed Services.

In the interest of permitting your committee to proceed expeditiously to full consideration of this important bill, I am willing to waive this committee's right to sequential referral. I do so with the understanding that by waiving consideration of the bill the Committee on Armed Services does not waive any future jurisdictional claim over the subject matters contained in the bill which fall within its Rule X jurisdiction. I request that you urge the Speaker to name members of this committee to any conference committee which is named to consider such provisions.

Please place this letter into the committee report on H.R. 4063 and into the Congressional Record during consideration of the measure on the House floor. Thank you for the cooperative spirit in which you have worked regarding this matter and others between our respective committees.

Sincerely,



William M. "Mac" Thornberry
 Chairman

REPUBLICANS
JEFF MILLER, FLORIDA, CHAIRMAN
 DOUG LAMBERT, COLORADO
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 DON PHILLIPS
 DEMOCRATIC STAFF DIRECTOR

May 10, 2016

The Honorable William M. "Mac" Thornberry
 Chairman, Committee on Armed Services
 House of Representatives
 2216 Rayburn House Office Building
 Washington, D.C. 20515

Dear Mr. Chairman,

Thank you for your letter regarding H.R. 4063, as amended, the Jason Simcakoski PROMISE Act.

I agree that the Committee on Armed Services has valid jurisdictional claims to certain provisions in this legislation and I appreciate your decision not to request a referral in the interest of expediting consideration of the bill.

I agree that by foregoing a sequential referral to H.R. 4063, as amended, the Committee on Armed Services is not waiving its jurisdiction.

This exchange of letters will be included in the Committee's report on H.R. 4063, as amended.

If you have any further questions or concerns, please contact Christine Hill, Staff Director for the Subcommittee on Health, at Christine.Hill@mail.house.gov or by calling (202) 225-9154.

Thank you for your commitment to the well-being of our nation's veterans.

With warm personal regards, I am,

Sincerely,

JEFF MILLER
 Chairman

JM/sg

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to section 3(g) of H. Res. 5, 114th Cong. (2015), the Committee finds that no provision of H.R. 4063, as amended, establishes or reauthorizes a program of the Federal Government known to be duplicative of another Federal program, a program that was included in any report from the Government Accountability Office to Congress pursuant to section 21 of Public Law 111–139, or a program related to a program identified in the most recent Catalog of Federal Domestic Assistance.

DISCLOSURE OF DIRECTED RULEMAKING

Pursuant to section 3(i) of H. Res. 5, 114th Cong. (2015), the Committee estimates that H.R. 4063, as amended, contains no directed rule making that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

TITLE I—OPIOID THERAPY AND PAIN MANAGEMENT

Section 1. Short title; Table of contents

Section 1(a) would provide the short title of H.R. 4063, as amended, as the “Promoting Responsible Opioid Management and Incorporating Scientific Expertise Act” or the “Jason Simcakoski PROMISE Act.”

Section 1(b) would provide a table of contents for the Act.

Section 101. Establishment of advisory committee to review guidelines on management of opioid therapy by Department of Veterans Affairs and Department of Defense

Section 101(a) would establish an advisory committee to: (1) conduct a review of the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; and (2) make recommendations to the Secretaries for updating the Guideline.

Section 101(b) would require that the review under subsection (a) include enhanced guidance in respect to: (1) opioid and other drug prescription practices; (2) treatment of patients with behaviors or comorbidities; (3) patient status assessments for providers; (4) the use of the Opioid Therapy Risk Report tool; (5) governance of the methodologies used by VA and DOD providers to taper opioid therapy; (6) appropriate case management for opioid patients transitioning from an inpatient setting to an outpatient setting; (7) appropriate case management for opioid patients transitioning from active duty to post-military health care networks; (8) use of routine and random urine drug tests to help prevent substance abuse; (9) how providers should discuss with patients options for pain management therapies before initiating opioid therapy; and (10) evidence-based non-opioid treatments within VA and DOD.

Section 101(c) would require the advisory committee to consult with the VA/DOD Management of Opioid Therapy for Chronic Pain Working Group during the committee’s review.

Section 101(d) would require the advisory committee to submit the review and accompanying recommendations to the VA and DOD Secretaries no later than one year after the enactment of this act.

Section 101(e) would require that the provisions of the Federal Advisory Committee Act (5 U.S.C. App.) apply to the Advisory Committee.

Section 101(f) would define: (1) the term “Advisory Committee” to mean the advisory committee established under subsection (a); (2) the term “Clinical Practice Guideline” to mean the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain; (3) the term “controlled substance” to have the meaning given in section 102 of the Controlled Substance Abuse Act (21 U.S.C. 802); and (4) the term “State” to mean each of the several states, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

Section 102. Improvement of opioid safety measures by Department of Veterans Affairs

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

Section 102(b)(1) would require that all VA employees who prescribe opioids receive education and training on pain management and safe opioid prescribing practices.

Section 102(b)(2) would require that this education and training include the following: (A) the implementation and full compliance with the VA/DOD Clinical Practice Guidelines for Management of Opioid Therapy for Chronic Pain; (B) the use of evidence-based pain management therapies for the treatment of patients with chronic pain; (C) screening and identification of patients with substance use disorder before prescribing opioids and referral of patients to appropriate addiction treatment professionals, if needed; (D) communication with patients on the risks of opioid and other controlled substance use; and (E) such other education and training as the Secretary considers appropriate.

Section 102(b)(3) would require the Secretary to use the Interdisciplinary Chronic Pain Management Training Team Program (or success program) in providing this training and education.

Section 102(c)(1) would require that the director of each medical facility designate a pain management team of health care professionals responsible for coordinating and overseeing pain management therapy at the facility to carry out the Opioid Safety Initiative.

Section 102(c)(2) would require the Secretary to establish protocols for designating pain management teams in consultation with the VISN directors. Each protocol established under this subsection must ensure that any provider without expertise in prescribing analgesics or who has not completed the education and training in subsection (b) does not prescribe opioids except under specified circumstances.

Section 102(c)(3) would require the director of each facility to submit a report within one year of the enactment of this act to the Under Secretary for Health and the appropriate VISN director identifying the members of the facility’s pain management team. Each report must include a certification as to whether all members of the pain management team at the facility have completed the education and training required under subsection (b); a plan for the management and referral of patients to such pain management

team if providers without expertise in analgesics prescribe opioid medications to treat pain; a certification as to whether the medical facility fully complies with the stepped-care model or other pain management policies, and if not, whether the facility is carrying out a corrective plan of action to ensure such full compliance.

Section 102(d)(1) would require that in carrying out the Opioid Safety Initiative and the Opioid Therapy Risk Report tool, the Secretary: (A) ensure that VA health care providers have access to information on controlled substances prescribed to veterans who receive care outside of VA through States' prescription drug monitoring program through measures including entering into memoranda of understanding with States to allow shared access of such information; (B) include the information in the Opioid Therapy Risk Report; and (C) require VA providers to submit controlled substance prescription information to the relevant State prescription drug monitoring program(s).

Section 102(d)(2) would require that, no later than 18 months after the enactment of this act, the Secretary submit to the Committees on Veterans' Affairs of the House and the Senate a report on the feasibility and advisability of improving the VA Opioid Therapy Risk Report tool to allow for a more advanced real-time tracking of and access to data on: (A) the key clinical indicators with respect to the totality of opioid use by veterans; (B) concurrent prescribing by VA health care providers of opioids in different health care settings; and (C) mail-order prescriptions of opioids prescribed to veterans under laws administered by the Secretary.

Section 102(e)(1) would require the Secretary to maximize the availability of FDA approved opioid receptor antagonists to veterans. In doing so, not later than 90 days after the enactment of this act, the Secretary must equip each VA pharmacy with opioid receptor antagonists to be given to outpatients as needed, and expand the VA Overdose Education and Naloxone Distribution program to ensure that veterans at risk of opioid overdose have access to and training on opioid receptor antagonists.

Section 102(e)(2) would require that, no later than 120 days after the enactment of this act, the Secretary submit a report regarding VA's implementation of this subsection to the Committees on Veterans' Affairs of the House and of the Senate.

Section 102(f) would require the Secretary to include in the VA Opioid Therapy Risk Report tool: (1) information on when the tool was last accessed by a VA provider regarding each veteran and the results of each veteran's most recent urine drug test; and (2) the ability to determine whether a VA provider prescribed opioids to a veteran without checking the information in the tool with respect to that veteran.

Section 102(g) would require the Secretary to modify the VA computerized patient record system to ensure that any health care provider who accesses a veteran's record is notified immediately whether that veteran is: (1) receiving opioid therapy and has a history of substance abuse or has previously overdosed; (2) has a history of opioid abuse; or (3) is at risk for opioid abuse.

Section 102(h) would define the term "controlled substance" as having the meaning given to that term in section 102 of the Controlled Substances Act (21 U.S.C. 802) and the term "State" to mean each of the several States, territories, and possessions of the

United States, the District of Columbia, and the Commonwealth of Puerto Rico.

Section 103. Strengthening of Joint Working Group on Pain Management of the Department of Veterans Affairs and the Department of Defense

Sec 103(a) would require that, within 90 days after the enactment of this act, the Secretaries of VA and DOD ensure that the Pain Management Working Group of the Health Executive Committee of VA–DOD Joint Executive Committee focuses on: (1) opioid prescribing practices of health care providers of each Department; (2) the ability of each Department to manage pain of each Department’s patients (including employee training on pain management); (3) the use of each Department of complementary and integrative health and complementary alternative medicines in treating those patients; (4) the concurrent use by each Department’s providers of opioids and prescription drugs to treat mental health disorders; (5) the practice by each Department’s providers of prescribing opioids to treat mental health disorders; (6) the coordination in coverage of and access to medications as patients transition from DOD to VA care; and (7) the ability of each Department to identify and treat substance abuse disorders among patients.

Sec 103(b) would require the Secretaries of VA and DOD to ensure that the working group described in subsection (a): (1) coordinates its activities with other relevant working groups; (2) consults with other relevant Federal agencies with respect to its activities; (3) and consults with VA and DOD with respect to any proposed updates to the VA/DOD Clinical Practice Guideline for Management of Opioid Therapy for Chronic Pain.

Section 103(c) would require the Secretaries of VA and DOD to ensure that the working group described in subsection (a) is able to meaningfully consult regarding updates to the Guideline for Management of Opioid Therapy no later than one year after the enactment of this act.

Section 104. Review, investigation, and report on use of opioids in treatment by Department of Veterans Affairs

Section 104(a)(1) would require the Comptroller General within two years after the enactment of this act to submit to the Committees on Veterans’ Affairs of the House and of the Senate a report on the VA Opioid Safety Initiative and the opioid prescribing practices of VA providers.

Section 104(a)(2) would require that the report include: (A) recommendations on improvements to the Opioid Safety Initiative; (B) information regarding VA-prescribed opioid-related deaths, overall opioid prescription rates to treat non-cancer, non-palliative, and non-hospice care patients, concomitant opioid and benzodiazepine prescription rates, the prescription of opioids to patients without any pain, and the effectiveness of opioid therapy; (C) an evaluation of VA’s oversight processes regarding veterans’ opioid use; and (D) an assessment of the Secretary’s implementation of the VA/DOD Guideline for Management of Opioid Therapy.

Section 104(b) would require that, within two years of the enactment of this act, and no later than 30 days after the end of each quarter thereafter, the Secretary submit to the Committees on Vet-

erans' Affairs of the House and of the Senate a progress report on VA's implementation of GAO's recommendations under subsection (a).

Section 104(c) would require that, within one year of the enactment of this act, and at least once a year for the following five years, the Secretary submit to the Committees on Veterans' Affairs of the House and of the Senate a report regarding information about VA providers' prescription of opioids with respect to each VA facility to treat non-cancer, non-palliative, and non-hospice care patients, including the following pertaining to the one-year period preceding the submission of the report: (1) the number of patients and percentage of VA's patient population concurrently prescribed opioids; (2) the number of patients and the percentage of VA's patient population; (3) the number of patients and the percentage of VA's patient population treated with opioids by a VA provider on an in-patient basis who also received prescription opioids through VA's Consolidated Mail Order Pharmacy; (4) the number of patients and the percentage of VA's patient population who were prescribed opioids concurrently by a VA provider and a non-VA provider; (5) with respect to each VA facility, the concurrent and the aggregate opioid prescription rate for all providers; the rate at which each facility provider prescribed opioids by mail to patients who were being treated with opioids on an in-patient basis, and the aggregate of such rate; the number of times a facility pharmacist overrode a critical drug interaction warning before dispensing opioids to a veteran.

Section 104(d) would require the Secretary to immediately notify the Committees on Veterans' Affairs of the House and of the Senate and conduct an investigation through the Office of the Medical Inspector if the Secretary determines that an identified prescription rate is inconsistent with the standards of appropriate and safe care.

Section 104(e) would define the term "prescription rate" to mean, with respect to a VA provider or facility, each of the following: (1) the number of patients treated with opioids by a provider or at a facility, divided by the total number of pharmacy users of that provider or facility; (2) the average number of morphine equivalents per day prescribed by the provider or at the facility to patients being treated with opioids; (3) the average number of prescriptions per patient of the patients being treated with opioids.

Section 105. Mandatory disclosure of certain veteran information to state controlled substance monitoring programs

Section 105 would amend Section 5701(1) of title 38, United States Code, by striking "may" and inserting "shall."

TITLE II—PATIENT ADVOCACY

Section 201. Community meetings on improving care furnished by Department of Veterans Affairs

Section 201(a) would require that: (1) within 90 days of the enactment of this act, and at least once every 90 days thereafter, the Secretary ensure that each VA medical facility hosts a public community meeting on improving VA health care; and (2) within one year of the enactment of this act, and at least annually thereafter,

the Secretary will ensure that each community-based outpatient clinic (CBOC) hosts such a community meeting.

Section 201(b) would require that each community meeting hosted by a facility or CBOC under subsection (a) be attended by the VISN director in which the facility or CBOC is located. The director may delegate the requirement of attendance to an employee of the director, provided the VISN director attends at least one community meeting each year.

Section 201(c) would require that the Secretary notify the Committees on Veterans' Affairs of the House and of the Senate and the Members of Congress who represent the area in which the facility is located of any community meetings under subsection (a) at least ten days in advance.

Section 202. Improvement of awareness of Patient Advocacy Program and patient bill of rights of Department of Veterans Affairs

Section 202 would require that, within 90 days of the enactment of this act, the Secretary display in as many prominent locations as the Secretary determines appropriate to be seen by the largest percentage of patients at each VA medical facility: (1) the purposes of the VA Patient Advocacy Program and the contact information for the patient advocate at each medical facility; and (2) the rights and responsibilities of patients and family members and, with respect to community living centers and other VA residential facilities, residents and family members.

Section 203. Comptroller General report on Patient Advocacy Program of Department of Veterans Affairs

Section 203(a) would require that, within two years of the enactment of this act, the Comptroller General submit a report on the VA Patient Advocacy Program to the Committees on Veterans' Affairs of the House and of the Senate.

Section 203(b) would require that the report include: (1) a description of the Program, including the Program's purpose, activities, and sufficiency in achieving its purpose; (2) an assessment of the sufficiency of the Program's staffing; (3) an assessment of the Program's employee training; (4) an assessment of veterans' and family members' awareness of and utilization of the Program; (5) recommendations for improving the Program; and (6) any other information the Comptroller General considers appropriate.

TITLE III—COMPLEMENTARY AND INTEGRATIVE HEALTH

Section 301. Expansion of research and education on and delivery of complementary and integrative health to veterans

Section 301(a) would establish a commission known as the "Creating Options for Veterans' Expedited Recovery" or the "COVER Commission," which would be required to examine the evidence-based therapy treatment model used by VA for treating mental health conditions of veterans and the potential benefits of incorporating complementary alternative treatments available in non-VA facilities.

Section 301(b) would require that the Commission's duties are to: (1) examine the efficacy of the evidence-based therapy model used

by VA to treat mental health illnesses and identify areas of improvement; (2) conduct a patient-centered survey within each VISN to examine: (A) the experiences of veterans with VA facilities regarding mental health care, (B) the experiences of veterans with non-VA facilities regarding mental health care, (C) the preferences of veterans regarding available treatment for mental health issues and which methods the veterans believe to be most effective, (D) the experience, if any, of veterans with respect to the complementary alternative treatment therapies described in subsection (b)(3), (E) the prevalence of prescribing medication to veterans seeking treatment for mental health disorders through VA, and (F) the outreach efforts of VA regarding the availability of benefits and treatments for veterans for addressing mental health issues; (3) examine available research on complementary alternative treatment therapies for mental health disorders in areas of therapy including: music therapy, equine therapy, training and caring for service dogs, yoga therapy, acupuncture therapy, meditation therapy, outdoor sports therapy, hyperbaric oxygen therapy, accelerated resolution therapy, art therapy, magnetic resonance therapy, and others; (4) study the sufficiency of VA resources to deliver quality mental health care; and (5) study the current treatments and resources available within VA and assess: (A) the effectiveness of such treatments and resources in decreasing the number of suicides per day by veterans, (B) the number of veterans who have been diagnosed with mental health issues, (C) the number of veterans who have been diagnosed with mental health issues, (D) the percentage of veterans who have completed VA counseling sessions, and (E) the efforts of VA to expand complementary alternative treatments viable to the recovery of veterans with mental health issues as determined by the Secretary to improve the effectiveness of treatments offered by VA.

Section 301(c)(1) would require that the Commission consist of 10 members, with at least one of each of the following pairs being a veteran: (A) two appointed by the Speaker of the House; (B) two appointed by the House Minority Leader; (C) two appointed by the Senate Majority Leader; (D) two appointed by the Senate Minority Leader; and (E) two appointed by the President.

Section 301(c)(2) would require that members of the Commission be: (A) individuals who have standing and distinction within the field of mental health care; (B) individuals with experience working with military and former military populations; and (C) individuals who have no financial interest in any complementary alternative treatments to be reviewed by the Commission.

Section 301(c)(3) would require that the President choose the chairman.

Section 301(c)(4) would require that members be appointed for the life of the Commission.

Section 301(c)(5) would require that any vacancy be filled in the same manner as the original appointment.

Section 301(c)(6) would require that appointments be made within 90 days of the enactment of this act.

Section 301(d)(1) would require that the Commission hold its first meeting no later than thirty days after a majority of members are appointed and that the Commission meet regularly at the chairman's discretion.

Section 301(d)(2) would allow the Commission to hold hearings that it deems advisable to carry out its responsibilities.

Section 301(d)(3) would allow the Commission to secure any information it considers necessary to carry out its duties, and it may do so directly from any department or Federal agency.

Section 301(d)(4) would allow the Commission to seek guidance through consultation with foundations, veteran service organizations, nonprofit groups, faith-based organizations, private and public institutions of higher education, and other non-governmental organizations as the Commission determines appropriate.

Section 301(d)(5) would require the Commission to keep a record of its action and meetings, which would be required to be made available to the public for inspection and to the Comptroller General for audit.

Section 301(d)(6) would require the Commission to keep a record regarding personnel, which would be required to be made available to the public for inspection and to the Comptroller General for audit.

Section 301(d)(7) would require that members serve without pay, but allows members to be compensated for travel expenses to perform Commission duties at rates authorized under subchapter I of chapter 57 of title 5, U.S.C.

Section 301(d)(8) would allow the Commission to employ a staff director and other personnel as needed to perform the Commission's function without regard to the provisions of title 5, U.S.C., governing appointments in the competitive service, without regard to the provision of chapter 51 and subchapter III of chapter 53 of such title relating to classification and General Schedule pay rates, except that no rate of pay fixed under this paragraph may exceed the equivalent of that payable for a position at a level IV of the Executive Schedule under section 5316 of title 5, U.S.C.

Section 301(d)(9) would require that such personnel be employees under section 2105 of title 5, U.S.C., for purposes of chapters 63, 81, 83, 84, 85, 87, 89, and 90 of such title. This does not apply to the members of the Commission.

Section 301(d)(10) would allow the Commission to enter into contracts to enable it to discharge its duties.

Section 301(d)(11) would allow the Commission to utilize experts and consultants in accordance with section 3109 of title 5, U.S.C., at rates not to exceed the daily rate paid to a person occupying a position at level IV of the Executive Schedule under section 3109 of title 5, U.S.C.

Section 301(d)(12) would allow the Commission to use the postal service in the same manner as other Federal agencies and departments.

Section 301(d)(13) would allow the Commission to be provided, on a reimbursable basis, physical facilities, equipment, and administrative support services necessary to carry out its duties.

Section 301(e)(1) would require that, within 60 days of the Commission's first meeting and every 30 days thereafter until the Commission submits its final report under subsection (e)(2), the Commission submit to the Committees on Veterans' Affairs of the House and the Senate and the President a report describing the level of cooperation of the Secretary and the heads of other Federal agencies or departments. The Commission must also submit an in-

terim report regarding its findings to the Committees on Veterans' Affairs of the House and the Senate and any other appropriate entities at times it deems appropriate.

Section 301(e)(2) would require that the Commission, within 18 months of its first meeting, submit to the Committees on Veterans' Affairs of the House and the Senate, the President, and the Secretary its final report. The final report would be required to include: (A) recommendations on improving the areas for which it was tasked with exploring; (B) analysis of the evidence-based therapy model used by VA for treating mental illness; (C) findings of the survey conducted within each VISN pursuant to subsection (b)(2); and (D) an examination of complementary alternative treatments described in subsection (b)(3) and their potential benefits.

Section 301(e)(3) would require that, within 90 days of the submission of the Commission's final report, the Secretary submit a report to the Committees on Veterans' Affairs of the House and of the Senate containing: (A) an action plan for implementing the Commission's recommendations; (B) a feasible timeframe for implementation; and (C) justifications for any recommendations the Secretary believes are not feasible complete with alternative solutions.

Section 301(f) would require that the Commission be terminated within 30 days after the Commission submits its final report.

Section 302. Pilot program on integration of complementary alternative medicines and related issues for veterans and family members of veterans

Section 302(a)(1) would require that, within 180 days after the Secretary receives the Commission's final report under Section 301(e), the Secretary commence a pilot program to assess the feasibility and advisability of using wellness-based programs to complement pain management and related health care services.

Section 302(a)(2) would require that, in carrying out the pilot program, the Secretary assess: (A) means of improving pain management care coordination between Federal, State, and community providers; (B) means of enhancing outreach by and among such providers; (C) means of using wellness-based programs as complements to pain management services by and among such providers; and (D) the effectiveness of wellness-based programs.

Section 302(b) would require that the pilot program last for three years.

Section 302(c)(1) would require that the pilot program be carried out at no fewer than 15 VA facilities providing pain management, two of which must be polytrauma centers.

Section 302(c)(2) would require that the Secretary prioritize medical centers at which there is a prescription rate that is inconsistent with the standards of appropriate care when selecting medical centers under subsection(c)(1).

Section 302(d) would require the Secretary to provide covered veterans covered services by integrating complementary and alternative medicine under the pilot program those treatments into other services provided by VA.

Section 302(e) would define the term "covered veteran" to mean a veteran who: (1) has a mental health condition diagnosed by a VA provider; (2) experiences chronic pain; (3) has a chronic condition being treated by a VA provider; or (4) is not described in para-

graph (1), (2), or (3) and requests to participate in the pilot program or is referred by a VA provider treating that veteran.

Section 302(f)(1) would define the term “covered services” to mean services consisting of complementary and integrative health services as selected by the Secretary.

Section 302(f)(2) would require that covered services under the pilot program be: (A) administered by VA professionals or other instructors with appropriate training and expertise; (B) included as part of the Patient Aligned Care Teams initiative in coordination with the Offices of Patient Centered Care and Cultural Transformation; (C) made available to covered veterans who have and have not received conventional treatments from VA for the conditions for which the veteran seeks complementary and integrative health services.

Section 302(g)(1) would require that, within 30 months of the start of the pilot program, the Secretary submit to the Committees on Veterans’ Affairs of the House and of the Senate a report on the pilot program.

Section 302(g)(2) would require that the report include: (A) the Secretary’s findings and conclusions regarding the use and efficacy of complementary and alternative health services established under the pilot program, the outreach conducted by VA about the pilot, and an assessment of the benefit of the pilot program to covered veterans; (B) the identification of any unresolved barriers to VA’s use of complementary and integrative medicine; and (C) recommendations for the continuation or expansion of the pilot program as the Secretary considers appropriate.

Section 302(h) would define the term “complementary and integrative health” to have the meaning given to that term by the National Institutes of Health.

TITLE IV—FITNESS OF HEALTH CARE PROVIDERS

Section 401. Additional requirements for hiring of health care providers by Department of Veterans Affairs

Section 401 would require that, as part of the hiring process for all health care providers considered for a position after the date of the enactment of this act, the Secretary require from the medical board of the State in which the applicant is licensed: (1) information on any violations of the requirements of medical license over the previous 20 years; and (2) information on whether the provider has entered into any settlement agreements for disciplinary charges related to the practice of medicine.

Section 402. Provision of information on health care providers of Department of Veterans Affairs to state medical boards

Section 402 would require that VA provide to the medical board of each State in which the provider is licensed information regarding violations, regardless of whether the board has requested such information.

Section 403. Report on compliance by Department of Veterans Affairs with reviews of health care providers leaving the Department or transferring to other facilities

Section 403 would require that, within 180 days of the enactment of this act, the Secretary submit to the Committees on Veterans' Affairs of the House and of the Senate a report on VA's compliance with VA policy to conduct a review of each provider who transfers from another VA medical facility, retires, or is terminated and to take appropriate actions with respect to any concerns, complaints, or allegations against the provider.

TITLE V—OTHER VETERANS MATTERS

Section 501. Audit of Veterans Health Administration programs of Department of Veterans Affairs

Section 501(a) would require that the Secretary seek to enter into a contract with a nongovernmental entity under which the entity will conduct audits of VHA programs to identify ways to improve the administration of benefits and health care to veterans and their families.

Section 501(b) would require that the entity perform the following with regard to each such audit: (1) five-year risk assessments to identify the functions, staff organizations, and staff offices of the VHA that would lead to the greatest improvement in health care and benefits provided; (2) development of plans that are informed by those risk assessments to conduct audits of the functions, staff organizations, and staff offices; (3) conduct audits in accordance with the developed plans.

Section 501(c) would require that, within 90 days of the completion of each audit under subsection (a), the Secretary submit to the Committees on Veterans' Affairs of the House and of the Senate a report including: (1) a summary of the audit; (2) the entity's findings; and (3) recommendations as the Secretary determines appropriate.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the 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):

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, and existing law in which no change is proposed is shown in roman):

TITLE 38, UNITED STATES CODE

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**PART IV—GENERAL ADMINISTRATIVE
PROVISIONS**

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CHAPTER 57—RECORDS AND INVESTIGATIONS

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SUBCHAPTER I—RECORDS

§ 5701. Confidential nature of claims

(a) All files, records, reports, and other papers and documents pertaining to any claim under any of the laws administered by the Secretary and the names and addresses of present or former members of the Armed Forces, and their dependents, in the possession of the Department shall be confidential and privileged, and no disclosure thereof shall be made except as provided in this section.

(b) The Secretary shall make disclosure of such files, records, reports, and other papers and documents as are described in subsection (a) of this section as follows:

(1) To a claimant or duly authorized agent or representative of a claimant as to matters concerning the claimant alone when, in the judgment of the Secretary, such disclosure would not be injurious to the physical or mental health of the claimant and to an independent medical expert or experts for an advisory opinion pursuant to section 5109 or 7109 of this title.

(2) When required by process of a United States court to be produced in any suit or proceeding therein pending.

(3) When required by any department or other agency of the United States Government.

(4) In all proceedings in the nature of an inquest into the mental competency of a claimant.

(5) In any suit or other judicial proceeding when in the judgment of the Secretary such disclosure is deemed necessary and proper.

(6) In connection with any proceeding for the collection of an amount owed to the United States by virtue of a person's participation in any benefit program administered by the Secretary when in the judgment of the Secretary such disclosure is deemed necessary and proper.

(c)(1) The amount of any payment made by the Secretary to any person receiving benefits under a program administered by the Secretary shall be made known to any person who applies for such information.

(2) Any appraisal report or certificate of reasonable value submitted to or prepared by the Secretary in connection with any loan guaranteed, insured, or made under chapter 37 of this title shall be made available to any person who applies for such report or certificate.

(3) Subject to the approval of the President, the Secretary may publish at any time and in any manner any or all information of record pertaining to any claim filed with the Secretary if the Secretary determines that the public interest warrants or requires such publication.

(d) The Secretary as a matter of discretion may authorize an inspection of Department records by duly authorized representatives of recognized organizations.

(e) Except as otherwise specifically provided in this section with respect to certain information, the Secretary may release information, statistics, or reports to individuals or organizations when in the Secretary's judgment such release would serve a useful purpose.

(f) The Secretary may, pursuant to regulations the Secretary shall prescribe, release the name or address, or both, of any present or former member of the Armed Forces, or a dependent of a present or former member of the Armed Forces, (1) to any non-profit organization if the release is directly connected with the conduct of programs and the utilization of benefits under this title, or (2) to any criminal or civil law enforcement governmental agency or instrumentality charged under applicable law with the protection of the public health or safety if a qualified representative of such agency or instrumentality has made a written request that such name or address be provided for a purpose authorized by law. Any organization or member thereof or other person who, knowing that the use of any name or address released by the Secretary pursuant to the preceding sentence is limited to the purpose specified in such sentence, willfully uses such name or address for a purpose other than those so specified, shall be guilty of a misdemeanor and be fined not more than \$5,000 in the case of a first offense and not more than \$20,000 in the case of any subsequent offense.

(g)(1) Subject to the provisions of this subsection, and under regulations which the Secretary shall prescribe, the Secretary may release the name or address, or both, of any person who is a present or former member of the Armed Forces, or who is a dependent of a present or former member of the Armed Forces, to a consumer reporting agency if the release of such information is necessary for a purpose described in paragraph (2) of this subsection.

(2) A release of information under paragraph (1) of this subsection concerning a person described in such paragraph may be made for the purpose of—

(A) locating such a person—

(i) who has been administratively determined to be indebted to the United States by virtue of the person's participation in a benefits program administered by the Secretary; or

(ii) if the Secretary has determined under such regulations that (I) it is necessary to locate such person in order to conduct a study pursuant to section 527 of this title or a study required by any other provision of law, and (II) all reasonable steps have been taken to assure that the release of such information to such reporting agency will not have an adverse effect on such person; or

(B) Obtaining a consumer report in order to assess the ability of a person described in subparagraph (A)(i) of this paragraph to repay the indebtedness of such person to the United States, but the Secretary may release the name or address of such person for the purpose stated in this clause only if the Secretary determines under such regulations that such person

has failed to respond appropriately to administrative efforts to collect such indebtedness.

(3) The Secretary may also release to a consumer reporting agency, for the purposes specified in subparagraph (A) or (B) of paragraph (2) of this subsection, such other information as the Secretary determines under such regulations is reasonably necessary to identify a person described in such paragraph, except that the Secretary may not release to a consumer reporting agency any information which indicates any indebtedness on the part of such person to the United States or any information which reflects adversely on such person. Before releasing any information under this paragraph, the Secretary shall, under such regulations, take reasonable steps to provide for the protection of the personal privacy of persons about whom information is proposed to be released under this paragraph.

(4)(A) If the Secretary determines, under regulations which the Secretary shall prescribe, that a person described in paragraph (1) of this subsection has failed to respond appropriately to reasonable administrative efforts to collect an indebtedness of such person described in paragraph (2)(A)(i) of this subsection, the Secretary may release information concerning the indebtedness, including the name and address of such person, to a consumer reporting agency for the purpose of making such information available for inclusion in consumer reports regarding such person and, if necessary, for the purpose of locating such person, if—

(i) the Secretary has (I) made reasonable efforts to notify such person of such person's right to dispute through prescribed administrative processes the existence or amount of such indebtedness and of such person's right to request a waiver of such indebtedness under section 5302 of this title, (II) afforded such person a reasonable opportunity to exercise such rights, and (III) made a determination with respect to any such dispute or request; and

(ii) thirty calendar days have elapsed after the day on which the Secretary has made a determination that reasonable efforts have been made to notify such person (I) that the Secretary intends to release such information for such purpose or purposes, and (II) that, upon the request of such person, the Secretary shall inform such person of whether such information has been so released and of the name and address of each consumer reporting agency to which such information was released by the Secretary and of the specific information so released.

(B) After release of any information under subparagraph (A) of this paragraph concerning the indebtedness of any person, the Secretary shall promptly notify—

(i) each consumer reporting agency to which such information has been released by the Secretary; and

(ii) each consumer reporting agency described in subsection (i)(3)(B)(i) of this section to which such information has been transmitted by the Secretary through a consumer reporting agency described in subsection (i)(3)(B)(ii)(I) of this section,

of any substantial change in the status or amount of such indebtedness and, upon the request of any such consumer reporting agency for verification of any or all information so released, promptly verify or correct, as appropriate, such information. The Secretary

shall also, after the release of such information, inform such person, upon the request of such person, of the name and address of each consumer reporting agency described in clause (i) or (ii) of this subparagraph to which such information was released or transmitted by the Secretary and of the specific information so released or transmitted.

(h)(1) Under regulations which the Secretary shall prescribe, the Secretary may release the name or address, or both, of any person who is a present or former member of the Armed Forces, or who is a dependent of a present or former member of the Armed Forces (and other information relating to the identity of such person), to any person in a category of persons described in such regulations and specified in such regulations as a category of persons to whom such information may be released, if the release of such information is necessary for a purpose described in paragraph (2) of this subsection.

(2) A release of information under paragraph (1) of this subsection may be made for the purpose of—

(A) determining the creditworthiness, credit capacity, income, or financial resources of a person who has (i) applied for any benefit under chapter 37 of this title, or (ii) submitted an offer to the Secretary for the purchase of property acquired by the Secretary under section 3720(a)(5) of this title;

(B) verifying, either before or after the Secretary has approved a person's application for assistance in the form of a loan guaranty or loan insurance under chapter 37 of this title, information submitted by a lender to the Secretary regarding the creditworthiness, credit capacity, income, or financial resources of such person;

(C) offering for sale or other disposition by the Secretary, pursuant to section 3720 of this title, any loan or installment sale contract owned or held by the Secretary; or

(D) providing assistance to any applicant for benefits under chapter 37 of this title or administering such benefits if the Secretary promptly records the fact of such release in appropriate records pertaining to the person concerning whom such release was made.

(i)(1) No contract entered into for any of the purposes of subsection (g) or (h) of this section, and no action taken pursuant to any such contract or either such subsection, shall result in the application of section 552a of title 5 to any consumer reporting agency or any employee of a consumer reporting agency.

(2) The Secretary shall take reasonable steps to provide for the protection of the personal privacy of persons about whom information is disclosed under subsection (g) or (h) of this section.

(3) For the purposes of this subsection and of subsection (g) of this section—

(A) The term “consumer report” has the meaning provided such term in subsection (d) of section 603 of the Fair Credit Reporting Act (15 U.S.C. 1681a(d)).

(B) The term “consumer reporting agency” means—

(i) a consumer reporting agency as such term is defined in subsection (f) of section 603 of the Fair Credit Reporting Act (15 U.S.C. 1681a(f)), or

- (ii) any person who, for monetary fees, dues, or on a cooperative nonprofit basis, regularly engages in whole or in part in the practice of (I) obtaining credit or other information on consumers for the purpose of furnishing such information to consumer reporting agencies (as defined in clause (i) of this paragraph), or (II) serving as a marketing agent under arrangements enabling third parties to obtain such information from such reporting agencies.
- (j) Except as provided in subsection (i)(1) of this section, any disclosure made pursuant to this section shall be made in accordance with the provisions of section 552a of title 5.
- (k)(1)(A) Under regulations that the Secretary shall prescribe, the Secretary may disclose the name and address of any individual described in subparagraph (C) to an entity described in subparagraph (B) in order to facilitate the determination by such entity whether the individual is, or after death will be, a suitable organ, tissue, or eye donor if—
- (i) the individual is near death (as determined by the Secretary) or is deceased; and
- (ii) the disclosure is permitted under regulations promulgated pursuant to section 264 of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-2 note).
- (B) An entity described in this subparagraph is—
- (i) an organ procurement organization, including eye and tissue banks; or
- (ii) an entity that the Secretary has determined—
- (I) is substantially similar in function, professionalism, and reliability to an organ procurement organization; and
- (II) should be treated for purposes of this subsection in the same manner as an organ procurement organization.
- (C) An individual described in this subparagraph is—
- (i) a veteran; or
- (ii) a dependent of veteran.
- (2) In this subsection, the term “organ procurement organization” has the meaning given the term “qualified organ procurement organization” in section 371(b) of the Public Health Service Act (42 U.S.C. 273(b)).
- (1) Under regulations the Secretary shall prescribe, the Secretary **【may】** *shall* disclose information about a veteran or the dependent of a veteran to a State controlled substance monitoring program, including a program approved by the Secretary of Health and Human Services under section 3990 of the Public Health Service Act (42 U.S.C. 280g-3), to the extent necessary to prevent misuse and diversion of prescription medicines.

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