

MILITARY SEXUAL ASSAULT VICTIMS EMPOWERMENT ACT

MAY 18, 2018.—Committed to the Committee of the Whole House on the State of the Union and ordered to be printed

Mr. ROE of Tennessee, from the Committee on Veterans’ Affairs,
submitted the following

R E P O R T

[To accompany H.R. 3642]

[Including cost estimate of the Congressional Budget Office]

The Committee on Veterans’ Affairs, to whom was referred the bill (H.R. 3642) to direct the Secretary of Veterans Affairs to carry out a pilot program to improve the access to private health care for veterans who are survivors of military sexual trauma, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

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The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the “Military Sexual Assault Victims Empowerment Act” or the “Military SAVE Act”.

SEC. 2. PILOT PROGRAM FOR PRIVATE HEALTH CARE FOR VETERANS WHO ARE SURVIVORS OF MILITARY SEXUAL TRAUMA.

(a) **ESTABLISHMENT.**—The Secretary of Veterans Affairs shall carry out a pilot program to furnish hospital care and medical services to eligible veterans through non-Department health care providers to treat injuries or illnesses which, in the judgment of a professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty, active duty for training, or inactive duty training.

(b) **DURATION.**—The Secretary shall carry out the pilot program under subsection (a) for a three-year period. If at the completion of the pilot program an eligible veteran is receiving hospital care and medical services from a non-Department health care provider under the pilot program, the Secretary may approve, on a case-by-case basis, the continuation of such hospital care and medical services from that non-Department health care provider until the completion of the episode of care.

(c) **ELIGIBLE VETERANS.**—A veteran is eligible to participate in the pilot program under subsection (a) if the veteran—

(1) is eligible to receive counseling and appropriate care and services under section 1720D of title 38, United States Code; and

(2) resides in a site selected under subsection (d).

(d) **SITES.**—

(1) **SELECTION.**—The Secretary shall select not more than five sites in which to carry out the pilot program under subsection (a). Each site shall meet each of the following criteria:

(A) Except as provided by paragraph (2), the site consists of a city with a population between 200,000 and 500,000, as determined by the Bureau of the Census as of the first day of the pilot program.

(B) The site is in a State in which the National Violence Against Women Prevention Research Center or the Centers for Disease Control and Prevention, or both, has determined the rate of sexual assault to be a substantial problem.

(C) The site is in a State that, as of the first day of the pilot program, has a weighted percentage of reported rape of not less than 20 percent but not more than 30 percent of sexual assault cases, in accordance with the finding of the Centers for Disease Control and Prevention contained in the “Lifetime Prevalence of Sexual Violence by any Perpetrator” (NISVS 2010).

(2) **RURAL SITE.**—Not fewer than one site selected under paragraph (1) shall be rural, as determined by the Secretary.

(e) **PARTICIPATION.**—

(1) **ELECTION.**—Subject to paragraph (2), an eligible veteran may elect to participate in the pilot program under subsection (a). Such election shall not affect the ability of the veteran to receive health care furnished by Department providers.

(2) **NUMBER.**—Not more than 75 veterans may participate in the pilot program under subsection (a) at each site selected under subsection (d).

(3) **CHOICE OF NON-DEPARTMENT HEALTH CARE PROVIDERS.**—An eligible veteran who participates in the pilot program under subsection (a) may freely choose from which non-Department health care provider the veteran receives hospital care or medical services under the pilot program, except that the Secretary shall—

(A) ensure that each such non-Department health care provider maintains at least the same or similar credentials and licenses as those credentials and licenses that are required of health care providers of the Department, as determined by the Secretary for the purposes of this section; and

(B) make a reasonable effort to ensure that such non-Department health care provider is familiar with the conditions and concerns that affect members of the Armed Forces and veterans and is trained in evidence-based psychotherapy

(4) **PROVISION OF INFORMATION.**—The Secretary shall—

(A) notify eligible veterans of the ability to make an election under paragraph (1); and

(B) provide to such veterans educational referral materials, including through pamphlets and internet websites, on the non-Department providers in the sites selected under subsection (d).

(f) AUTHORIZATION AND MONITORING OF CARE.—In accordance with subsection (e), the Secretary shall ensure that the Department of Veterans Affairs authorizes and monitors the hospital care and medical services furnished under the pilot program for appropriateness and necessity. In authorizing and monitoring such care, the Secretary shall—

(1) treat a non-Department health care provider that furnishes to such a veteran hospital care or medical services under the pilot program as an authorized recipient of records of such veteran for purposes of section 7332(b) of title 38, United States Code; and

(2) ensure that such non-Department health care provider transmits to the Department such records as the Secretary determines appropriate.

(g) PAYMENTS.—

(1) CURRENT PROVIDERS.—If a non-Department health care provider has entered into a contract, agreement, or other arrangement with the Secretary pursuant to another provision of law to furnish hospital care or medical services to veterans, the Secretary shall pay the health care provider for hospital care or medical services furnished under this section using the same rates and payment schedules as provided for in such contract, agreement, or other arrangement.

(2) NEW PROVIDERS.—If a non-Department health care provider has not entered into a contract, agreement, or other arrangement with the Secretary pursuant to another provision of law to furnish hospital care or medical services to veterans, the Secretary shall pay the health care provider for hospital care or medical services furnished under this section using the same rates and payment schedule as if such care and services was furnished pursuant to section 1703 of title 38, United States Code.

(3) NEW CONTRACTS AND AGREEMENTS.—The Secretary shall take reasonable efforts to enter into a contract, agreement, or other arrangement with a non-Department health care provider described in subsection (a) to ensure that future care and services authorized by the Secretary and furnished by the provider are subject to such a contract, agreement, or other arrangement.

(h) SURVEYS.—The Secretary shall conduct a survey of a sample of eligible veterans to assess the hospital care and medical services furnished to such veterans either pursuant to this section or section 1720D of title 38, United States Code, as the case may be.

(i) REPORT.—Not later than 60 days before the completion of the pilot program under subsection (a), the Secretary shall submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report on the pilot program. The report shall include the following:

(1) The results of the pilot program, including, to the extent possible, an assessment of the health outcomes of veterans who participated in the pilot program.

(2) The recommendation of the Secretary with respect to extending or making permanent the pilot program.

(j) DEFINITIONS.—In this section:

(1) The term “non-Department health care provider” means an entity specified in section 101(a)(1)(B) of section 101 of the Veterans Access, Choice, and Accountability Act of 2015 (Public Law 113–146; 38 U.S.C. 1701) or any other health care provider that has entered into a contract, agreement, or other arrangement with the Secretary pursuant to another provision of law to furnish hospital care or medical services to veterans.

(2) The term “sexual harassment” has the meaning given that term in section 1720D of title 38, United States Code.

(3) The term “State” has the meaning given that term in section 101(20) of title 38, United States Code.

PURPOSE AND SUMMARY

H.R. 3642, as amended, the “Military Sexual Assault Victims Empowerment Act” or the “Military SAVE Act” would require the Department of Veterans Affairs (VA) to carry out a pilot program to furnish care in the community to veterans who have experienced military sexual trauma (MST). Representative Andy Barr of Kentucky introduced H.R. 3642 on August 4, 2017.

BACKGROUND AND NEED FOR LEGISLATION

Section 1720D of title 38 United States Code (U.S.C.) requires VA to provide counseling, care, and services to veterans who are experiencing “psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training.” Such trauma is commonly referred to as MST. Diagnoses that are commonly associated with MST include posttraumatic stress disorder, depression, other mood disorders, and substance use disorder.¹

In fiscal year (FY) 2017, the Veterans Health Administration (VHA)—which manages and oversees the VA healthcare system—provided MST-related outpatient care to 142,750 veterans.² In addition, the Readjustment Counseling Service—which manages and oversees VA’s Vet Center program—provided MST-related care to 11,892 veterans in FY 2017. According to VA, “[c]onsistent with previous years, the total number of veterans who received MST-related care and the total number of encounters provided [by VA for MST] has increased relative to FY 2016,” and, “[i]n fact, the total number of veterans who received MST-related care and the total number of encounters [provided by VA for MST] has increased every year since VA Office of Mental Health and Suicide Prevention’s National MST Support Team began monitoring them.”³

VHA Directive 2010–033 provides VA policy for MST programming and states that MST-related care must be provided in a setting that is therapeutically appropriate and takes into account the circumstances that resulted in the need for such care.⁴ It also states that care in the community is available for veterans who have experienced MST when it is clinically inadvisable to provide such care in a VA facility, when VA facilities are geographically inaccessible, or when VA facilities are unable to provide care in a timely manner.⁵ However, testimony before the Committee from MST survivors and other stakeholders in recent years has called into question VA’s ability to adequately meet veterans’ MST-related needs and to refer veterans to community providers for MST-related care when it is requested by the veteran.^{6 7} This testimony is particularly concerning given the growing need within VA’s patient population for MST-related care.

Section 2 of the bill would create a three-year pilot program to furnish care in the community to veterans who have experienced MST. VA would select up to five sites to participate in the pilot program. Up to 75 veterans per site would be eligible to participate in the pilot program and these veterans would be able to select a

¹*Military Sexual Trauma*. Veterans Health Administration Office of Mental Health Care. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. Accessed April 26, 2018.

²“Department of Veterans Affairs Annual Report on Training and Certification for Health Care Providers on Care for Veterans and Active Duty Servicemembers who Experienced Military Sexual Trauma for Fiscal Year 2017,” January 17, 2018.

³*Ibid.*

⁴VHA Directive 2010-033, “Military Sexual Trauma (MST) Programming,” July 14, 2010.

⁵*Ibid.*

⁶United States Cong. House Committee on Veterans’ Affairs. “*Legislative Hearing*” October 24, 2017. 115th Cong. 1st sess. Washington: GPO, 2017 (statement of the Honorable Andy Barr, U.S. House of Representatives, 6th District, Kentucky).

⁷United States Cong. House Committee on Veterans’ Affairs Subcommittee on Health. “*Legislative Hearing*” November 17, 2015. 114th Cong. 1st sess. Washington: GPO, 2015 (statement of Susan Moseley).

community provider of their choice to receive MST-related care from. Community providers participating in the pilot program who have entered into a contract, agreement, or other arrangement with VA would be reimbursed pursuant to such contract, agreement, or other arrangement. However, community providers participating in the pilot program who have not entered into a contract, agreement, or other arrangement with VA would be reimbursed using the same rates or payment schedule as if such care were provided pursuant to VA's authority to provide care in the community in section 1703 of title 38 U.S.C. and VA would be required to make a reasonable effort to ensure that future care or services provided by that community provider is pursuant to a contract, agreement, or other arrangement. VA would further be responsible for: notifying eligible veterans of the pilot program and providing them with relevant educational materials; ensuring that community providers participating in the pilot program are appropriately licensed, credentialed, trained, and culturally competent; for authorizing and monitoring the care that veterans receive under the pilot program to include ensuring medical documentation return from community providers; and reporting to the Committees on Veterans' Affairs of the House of Representatives and the Senate with the results of the pilot program and a recommendation with respect to extending or making it permanent. In addition, VA would be required to conduct a survey of a sample of eligible veterans to assess the provision of MST-related counseling, care, or services through VA or pursuant to the pilot program.

HEARINGS

On October 24, 2017, the full Committee conducted a legislative hearing on a number of bills including H.R. 3642.

The following witnesses testified:

The Honorable Jim Banks, U.S. House of Representatives, 3rd District, Indiana; The Honorable Mike Gallagher, U.S. House of Representatives, 8th District, Wisconsin; The Honorable John R. Carter, U.S. House of Representatives, 31st District, Texas; The Honorable Glenn Thompson, U.S. House of Representatives, 5th District, Pennsylvania; The Honorable Neal P. Dunn, U.S. House of Representatives, 2nd District, Florida; The Honorable Andy Barr, U.S. House of Representatives, 6th District, Kentucky; The Honorable David J. Shulkin, M.D., Secretary, U.S. Department of Veterans Affairs, who was accompanied by Carolyn Clancy M.D., the Executive in Charge of the Veterans Health Administration, and Laurie Zephyrin M.D., MPH, MBA, the Acting Deputy Under Secretary for Health for Community Care for the Veterans Health Administration; Adrian M. Atizado, Deputy National Legislative Director, Disabled American Veterans; Roscoe G. Butler, Deputy Director for Health Care, Veterans Affairs and Rehabilitation Division, The American Legion; and, Kayda Keleher, Associate Director, National Legislative Service, Veterans of Foreign Wars of the United States.

Statements for the record were submitted by:

American Federation of Government Employees, AFL-CIO; American Health Care Association; American Medical Association; AMVETS; Concerned Veterans of America; Fleet Reserve

Association; Got Your 6; Health IT Now; Iraq and Afghanistan Veterans of America; Military Officers Association of America; Military Order of the Purple Heart; National Alliance on Mental Illness; National Guard Association of the United States; Nurses Organization of Veterans Affairs/Association of VA Psychologist Leaders/Association of VA Social Workers/Veterans Healthcare Action Campaign; Paralyzed Veterans of America; Reserve Officers Association; University of Pittsburgh; Vietnam Veterans of America; the Wounded Warrior Project; The American Congress of Obstetrics and Gynecologists; the University of California, Riverside School of Medicine; the American Society of Transplant Surgeons; and, the National Indian Health Board.

SUBCOMMITTEE CONSIDERATION

There was no Subcommittee consideration of H.R. 3642.

COMMITTEE CONSIDERATION

On May 8, 2018, the full Committee met in open markup session, a quorum being present, and ordered H.R. 3642, as amended, to be reported favorably to the House of Representatives by voice vote. During consideration of the bill, the following amendment was considered and agreed to by voice vote:

An amendment in the nature of a substitute offered by Representative Bruce Poliquin of Maine.

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. 3642, as amended, reported to the House. A motion by Representative Tim Walz of Minnesota, Ranking Member of the Committee on Veterans' Affairs, to report H.R. 3642, as amended, favorably to the House of Representatives was adopted 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 are to create a pilot program to provide MST-related care to veterans in the community.

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. 3642, 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. 3642, 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. 3642, as amended, provided by the Director of the Congressional Budget Office pursuant to section 402 of the Congressional Budget Act of 1974:

U.S. CONGRESS,
CONGRESSIONAL BUDGET OFFICE,
Washington, DC, May 9, 2018.

Hon. PHIL ROE, M.D.,
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. 3642, the Military Sexual Assault Victims Empowerment 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,
Director.

Enclosure.

H.R. 3642—Military Sexual Assault Victims Empowerment Act

Summary: H.R. 3642 would require the Department of Veterans Affairs (VA) to conduct a three-year pilot program to provide treatment at non-VA medical facilities to veterans who have experienced medical sexual trauma (MST). CBO estimates that implementing the bill would cost \$6 million over the 2019–2023 period, assuming appropriation of the necessary amounts.

Enacting the bill would not affect direct spending or revenues; therefore, pay-as-you-go procedures do not apply.

CBO estimates that enacting H.R. 3642 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

H.R. 3642 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA).

Estimated cost to the Federal Government: The estimated budgetary effect of H.R. 3642 is shown in the following table. The costs

of the legislation fall within budget function 700 (veterans benefits and services).

	By fiscal year, in millions of dollars—						
	2018	2019	2020	2021	2022	2023	2019— 2023
INCREASES IN SPENDING SUBJECT TO APPROPRIATION							
Estimated Authorization Level	0	1	1	2	1	1	6
Estimated Outlays	0	1	1	2	1	1	6

* = less than \$500,000.

Basis of estimate: For this estimate, CBO assumes that H.R. 3642 will be enacted at the beginning of fiscal year 2019 and that the estimated amounts will be appropriated each year. Estimated outlays are based on historical spending patterns for similar programs.

The bill would require VA to implement a three-year pilot program to treat MST patients at non-VA medical facilities. After completion of the pilot program, VA would be authorized to continue to provide such care to participants through the remainder of their treatment. The pilot program would operate in not more than five locations in the VA health care system and would include no more than 75 participants at each location, or a total of 375 participants.

On the basis of information from VA on the costs and duration of treatment for MST patients, CBO estimates an average annual cost of \$5,700 per patient over a three-year treatment period. CBO expects that VA would allow patients whose treatment was ongoing at the end of the pilot to complete that treatment in the private sector. Implementing this bill, therefore, would cost \$6 million over the 2019–2023 period, assuming appropriation of the necessary amounts, CBO estimates.

Pay-As-You-Go considerations: None.

Increase in long-term direct spending and deficits: CBO estimates that enacting H.R. 3642 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2029.

Mandates: H.R. 3642 contains no intergovernmental or private-sector mandates as defined in UMRA.

Estimate prepared by: Federal Costs: Ann E. Futrell; Mandates: Andrew Laughlin.

Estimate reviewed by: Sarah Jennings, Chief, Defense and International Affairs Cost Estimates Unit; Leo Lex, Deputy Assistant Director for Budget Analysis.

FEDERAL MANDATES STATEMENT

The Committee adopts as its own the estimate of Federal mandates regarding H.R. 3642, as amended, prepared by the Director of the Congressional Budget Office pursuant to section 423 of the Unfunded Mandates Reform Act.

ADVISORY COMMITTEE STATEMENT

No advisory committees within the meaning of section 5(b) of the Federal Advisory Committee Act would be created by H.R. 3642, as amended.

STATEMENT OF CONSTITUTIONAL AUTHORITY

Pursuant to Article I, section 8 of the United States Constitution, H.R. 3642, 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. 3642, 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.

STATEMENT ON DUPLICATION OF FEDERAL PROGRAMS

Pursuant to clause 3(c)(5) of rule XIII of the Rules of the House of Representatives, the Committee finds that no provision of H.R. 3642, 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, 115th Cong. (2017), the Committee estimates that H.R. 3642, as amended, contains no directed rulemaking that would require the Secretary to prescribe regulations.

SECTION-BY-SECTION ANALYSIS OF THE LEGISLATION

Section 1. Short title

Section 1 of the bill would provide the short title for H.R. 3642, as amended, as the "Military Sexual Assault Victims Empowerment Act" or the "Military SAVE Act".

Section 2. Pilot program for private health care for veterans who are survivors of military sexual trauma

Section 2(a) of the bill would require VA to carry out a pilot program to furnish hospital care and medical services to eligible veterans through community providers to treat injuries or illnesses which, in the judgement of a VA professional, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty, active duty for training, or inactive duty for training.

Section 2(b) of the bill would require VA to carry out the pilot program for a three year period and authorize VA, at the completion of the pilot program, to approve, on a case-by-case basis, the continuation of hospital care or medical services from a community provider until the completion of the episode of care.

Section 2(c) of the bill would define a veteran who is eligible to participate in the pilot program as a veteran who is eligible to receive counseling and appropriate care and services under section 1720D of title 38 U.S.C. and resides in a site selected under section 2(d) of the bill.

Section 2(d) of the bill would require VA to select not more than five pilot sites in which to carry out the pilot program under section 2(a) of the bill and require each site to: consist of a city with a population between 200,000 and 500,000 as determined by the Bureau of Census as of the first day of the pilot program (except that at least one pilot site would be required to be in a rural area as determined by VA); be a site within a State in which the National Violence Against Women Prevention Research Center or the Centers for Disease Control and Prevention, or both, has determined the rate of sexual assault to be a substantial problem; and be a site within a State that, as of the first day of the pilot program, has a weighted percentage of reported rape of not less than 20 percent but not more than 30 percent of sexual assault cases in accordance with the finding of the Centers for Disease Control and Prevention contained in the "Lifetime Prevalence of Sexual Violence by any Perpetrator (NISVS 2010).

Section 2(e) of the bill would authorize up to 75 eligible veterans per site to elect to participate in the pilot program under section 2(a) of the bill and require that such an election does not affect the ability of such veteran to receive health care from VA providers. Section 2(e) of the bill would also authorize an eligible veteran who participates in the pilot program under section 2(a) of the bill to freely choose which community provider the veteran receives hospital care or medical services from under the pilot program. Section 2(e) would further require VA: to ensure that each community provider who participates in the pilot program maintains at least the same or similar credentials and licenses as those required by VA providers, as determined by VA; to make a reasonable effort to ensure that such community provider is familiar with the conditions and concerns that affect members of the Armed Forces and veterans and is trained in evidence-based psychotherapy; to notify eligible veterans of their ability to elect to participate in the pilot program; and to provide eligible veterans with educational materials regarding community providers participating in the pilot program, including through pamphlets and internet websites.

Section 2(f) of the bill would require VA to authorize and monitor the hospital care and medical services furnished to eligible veterans under the pilot program for appropriateness and necessity and to treat each community provider participating in the pilot program as an authorized recipient of records for the purposes of section 7332(b) of title 38 U.S.C. and to ensure that such community providers transmit to VA such records as VA determines appropriate.

Section 2(g) of the bill would require VA to reimburse community providers participating in the pilot program at the same rates and payment schedules as provided for in such contract, agreement, or other arrangement. Section 2(g) of the bill would also require VA to reimburse community providers participating in the pilot program who VA has not entered into a contract, agreement, or other arrangement with using the same rates and payment schedules as if such care and services was furnished pursuant to section 1703 of title 38 U.S.C. and to take reasonable efforts to ensure that future care and services authorized by VA and furnished by such providers are subject to a contract, agreement, or other arrangement.

Section 2(h) of the bill would require VA to conduct a survey of a sample of eligible veterans to assess the hospital care and medical services furnished to veterans either pursuant to section 2 of the bill or to section 1720D of title 38 U.S.C.

Section 2(i) of the bill would require VA to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate not later than 60 days before the completion of the pilot program established under section 2(a) of the bill on the pilot program and to include the results of the pilot program—including, to the extent possible, an assessment of the health outcomes of veterans who participated in the pilot program—and VA's recommendation with respect to extending or making the pilot program permanent.

Section 2(j) of the bill would define: the term "non-Department health care provider" as an entity specified in section 101(a)(1)(B) of section 101 of the Veterans Access, Choice, and Accountability Act of 2015 (Public Law 113–146; 38 U.S.C. 1701) or any other health care provider that has entered into a contract, agreement, or other arrangement with VA pursuant to another provision of law to furnish hospital care or medical services to veterans; the term "sexual harassment" as the meaning given that term in section 1720D of title 38 U.S.C.; and the term "State" as the meaning given that term in section 101(20) of title 38 U.S.C.

CHANGES IN EXISTING LAW MADE BY THE BILL, AS REPORTED

If enacted, this bill would make no changes in existing law.

