S. HRG. 118–217

HEARING TO CONSIDER PENDING LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
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FIRST SESSION

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HEARING TO CONSIDER PENDING LEGISLATION

WEDNESDAY, JULY 12, 2023

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

The Committee met, pursuant to notice, at 3 p.m., in Room SR–418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Senators Tester, Murray, Brown, Blumenthal, Sinema, Hassan, King, Moran, Boozman, Cassidy, and Tuberville.

SENATOR MARGARET WOOD HASSAN

Senator HASSAN [presiding]. This hearing will now come to order, and I will now turn the hearing over to Ranking Member Moran for his opening remarks, and then we will proceed with introduction of witnesses.

Senator MORAN. Already this is moving more smoothly than when Senator Tester is here.

Senator HASSAN. This is true.

OPENING STATEMENT OF SENATOR JERRY MORAN

Senator MORAN. Thank you very much, Senator Hassan, and thank you to our panelists, and thank you to Senator Tester for calling this meeting. Good afternoon to all of you.

We have a full list of bills to consider this afternoon, and I look forward to hearing about each of them and how they will improve the care that veterans receive. I continue to hear from veterans in Kansas and across the country who face what are unacceptable barriers to accessing timely, quality health care that they need.

For example, we heard from one veteran who called the Veteran Crisis Line in 2021, and is still waiting for the VA to call him to schedule a follow-up mental health care. We heard from another veteran who paid several thousand dollars for dental care outside of the VA because the VA dental exam room could not accommodate her wheelchair. The VA has refused to issue her a Community Care referral. We heard from yet another veteran who asked for a referral to a rehab program at a non-VA facility in his rural community that had an opening for him but was told to wait several weeks for a bed at a VA facility in another state, hours away.

These are just three stories, but they are alarmingly common. I have always told people that what I know about what is going on at the VA and what is going on in veterans' lives is by the con-

versations I have with Kansas veterans, and these are stories that they bring to me.

I have introduced a couple of bills that are on today's agenda as a result of those kind of circumstances. S. 1315, the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH Act) would codify the current Community Care access standards, educate veterans on their rights to seek community care, hold the VA accountable for providing timely access to care, and help the VA keep pace with the best practices for modern medical care in DoD, CMS, and the private sector.

The Veterans HEALTH Act is bipartisan, and I appreciate my colleague, Senator Sinema, for working with me on this legislation. This bill is also widely supported by veterans' organizations including the American Warrior Partnership, and I am grateful to Jim Lorraine, who we will hear from on the second panel. He is the President and Chief Executive Officer of AWP and will testify shortly.

And because no health care system in the 21st century can provide world-class services without a safe top-notch IT system, S. 1037, my VA Electronic Health Record Modernization Standardization and Accountability Act would establish a clear and consistent set of safeguards that must be met before VA can move forward with implementing the new Oracle Cerner electronic health record. Ultimately, this bill facilitates a more thoughtful and evidence-based implementation, increasing the likelihood of success, and improve patient outcomes in the long run.

Chairman Tester has bills on today's agenda that are similar in certain ways to both of these, the Veteran Health Act and the VA Electronic Health Record Modernization Act, which suggests to me that we can find a path forward working together. I look forward to working together with all my colleagues on this Committee and the Senate as we work to negotiate a strong bipartisan and fiscally responsible legislative package that contains the best of our bills and the many others that we will discuss this afternoon.

And I thank you all for being here, and I yield back.

[The pending bills referred to by Senator Moran appear on page 31 of the Appendix.]

Senator HASSAN. Thank you, Ranking Member Moran, and I will note, too, that there is obviously a lot of bipartisanship on this Committee, and as we hear about pending legislation today I look forward to finding ways we can all work together.

With that I want to welcome the first panel to today's hearing. Dr. Miguel LaPuz, Assistant Under Secretary for Health for Integrated Veteran Care, will be VA's lead witness today. He is accompanied by Dr. Matthew Miller, Director of Suicide Prevention Program, Office of Mental Health and Suicide Prevention; Dr. Cynthia Gantt, Deputy Director of the Office of Patient Centered Care and Cultural Transformation within Patient Care Services; and Dr. Leslie Sofocleous, who is Executive Director for the Program Management Office of the EHRM–Integration Office.

Dr. LaPuz, please begin.

PANEL I

STATEMENT OF MIGUEL LAPUZ ACCOMPANIED BY MATTHEW MILLER; CYNTHIA GANTT; AND LESLIE SOFOCLEOUS

Dr. LAPUZ. Good afternoon, Senator Hassan, Ranking Member Moran, and members of the Committee. I appreciate the opportunity to discuss VA's views on pending legislation regarding health care benefits. I am accompanied today by Dr. Matthew Miller, Executive Director of VA Suicide Prevention, Office of Mental Health and Suicide Prevention; Dr. Cynthia Gantt, Deputy Director of Patient Centered Care and Cultural Transformation, Office of Patient Care Services; and Dr. Leslie Sofocleous, Executive Director, Program Management Office, Electronic Health Record Modernization Integration Office.

There are 19 bills on the agenda today, covering a range of issues and programs. My written statement provides more detailed information on nearly all of these bills, but I would like to take a few moments to raise some issues of general applicability to these bills, and particularly for the Veterans HEALTH Act and the Making Community Care Work for Veterans Act.

While we agree with the spirit of improving access and delivery of care to all veterans, there are several provisions in the aforementioned bills that VA does not support because statutorily mandating these efforts would impede VA's ability to furnish clinically appropriate and timely care to veterans.

Nearly 6 years ago, a predecessor of mine sat before this Committee and articulated a few principles that VA believed should be reflected in legislation that would ultimately become the VA MISSION Act of 2018. One of these principles was the idea that VA needs to retain flexibility to adjust and adapt to an evolving health care landscape. Legislation that is too prescriptive in terms of rules, responsibilities, or processes can only limit our options in the future, which would lead to frustration from our veterans, our community providers, and VA employees. We believe that the best legislation would provide broad, general authority that VA could define and implement through regulations, policies, and contracts.

These themes still ring true today. The Secretary and Under Secretary of Health have made ensuring veterans receive timely, appropriate, and accessible care a top priority. Each veteran's needs are different, and to best serve veterans we need the flexibility to respond to those needs.

Regarding the two electronic health record modernization bills, VA is committed to continued improvement of this program, and we are keeping you and your staff and key stakeholders informed of these efforts. Health care, and particularly health care information technology, is dynamic and needs to be responsive to veterans' and clinicians' needs. We strongly caution against enacting requirements that may address today's situation but could create unintended outcomes in the future.

VA appreciate this Committee's willingness to engage on these bills. There are many examples of where these efforts have borne fruit, including the Expanding Veterans' Options for Long Term Care Act.

We look forward to discussing VA's perspectives concerning the bills on the agenda, and we would welcome the opportunity to continue collaborating on how we can improve delivery of care and services to our Nation's veterans and their families.

We thank the Committee for its continued support, and this concludes my statement.

[The prepared statement of Dr. LaPuz appears on page 35 of the Appendix.]

Senator HASSAN. Well, thank you very much. I think we can proceed to questions from here, and I will go ahead and start and then, Senator Moran, you can follow. And I want to again thank all of our witnesses not only for being here but for your work and for the teams that you lead on behalf of our country's veterans.

Dr. LaPuz, I want to start with a question that highlights a Granite State veteran and his service dog, Duchess. Tim Carignan of Lyman, New Hampshire, reached out to my office last year because he was having difficulty obtaining insurance coverage for Duchess, his service dog, through the VA, something that the VA does for veterans. My office was able to coordinate with local and regional VA representatives to fix the problem. The insurance coverage was made possible through the Puppies Assisting Wounded Servicemembers for Veterans Therapy Act, known as the PAWS Act, a bipartisan bill that I co-sponsored and Senator Tillis introduced, that passed into law in 2021.

Now I am joining Senator Tillis and colleagues to support a follow-up bill that would further expand access to trained service dogs for veterans. Can you talk about how the VA coordinates between health care providers and nonprofit organizations that train service dogs to ensure that veterans who need them can receive service dogs as soon as possible?

Dr. LAPUZ. Ma'am, in reference to the service dogs, we are in the process of developing, in VA, the opinion on how we are going to proceed with that, so I apologize for not being ready to discuss that at this point.

Senator HASSAN. Well, I appreciate that. Let's follow up with a conversation because obviously this was passed in 2021. We know how useful service dogs can be for our veterans, and something like this barrier that prevented requisite insurance for the dog made it hard for this particular veteran to get that kind of service. And we are seeing more and more training efforts to get the dogs to veterans, so I hope you will treat it with some urgency, and I would look forward to working with you on it.

Dr. LAPUZ. We understand, Senator, and we look forward to having a discussion with the Committee.

VHA Response: Have contacted the Senators office twice to schedule briefing. Will continue to work this due-out with the Senators office (Melissa Reilly-Diakun).

Senator HASSAN. Okay. Thank you. Second question for you, Doctor. The VA provides veterans with numerous benefits and different types of care, but veterans seeking health care may not be aware of the other benefits and wraparound services that are available to them. These wraparound services could include things like

transportation, food or housing assistance, and various support groups.

Today I joined Senator Sullivan in introducing the bipartisan Leveraging Integrated Networks in Communities for Veterans Act, which aims to improve the VA's ability to coordinate across these different services. So how can Congress and the VA work to facilitate better coordination for getting veterans wraparound services?

Dr. LAPUZ. We appreciate your concern, Senator, regarding wraparound services, particularly those that will more or less address the socioeconomic determinants of health. And we have a program in the VA which is already assessing the requirements of our veterans in order to ensure that they have services that will customarily not be available, and we call that initiative ACORN.

We have already 5,000 veterans that have gone through that process, and we can have a conversation with the Committee regarding the progress of ACORN. But the reason why we feel that this is a redundant legislation, redundant in terms of what the VA is already doing, and we are hoping that we can share with the Committee the results of these before we actually have any legislation.

So we are looking forward to having a discussion regarding the existing programs that already are addressing the socioeconomic determinants of health.

Senator HASSAN. Well, I appreciate that, but again, this is about getting those full wraparound services that are already out there, and making sure that our veterans get them. So I would look forward to talking with you more about that, but in my experience sometimes until we pass legislation we do not get the full scale of services that we are looking for.

Let me just finish with one more question. Another example of the need for that coordination that we were just talking about is that often a veteran in New Hampshire, which, as you know, does not have a full-service VA hospital, will be seen at a local hospital for urgent health concerns, but that hospital may not have the experience needed to coordinate care through the VA.

As a result, the Manchester VA Medical Center in New Hampshire recently began embedding a VA care navigation team at one of the nearby hospitals. I believe this model could help other facilities connect veterans with wraparound services as well, and the LINC for Veterans Act, the one we just referenced, aims to do that.

How could care navigation teams like the one at Manchester help veterans across the country access wraparound services?

Dr. LAPUZ. We have learned from the experience in Manchester that you were referring to, Senator, and in fact we have several pilots that are mimicking what is happening in Manchester, and this is in our coordinating and optimizing emergency department care as part of that initiative, which is what we refer to as COED initiatives.

So we are hoping that we are going to learn from all of the pilots that are happening across the country because we do have several hospitals in Pennsylvania, for example, that are doing exactly similar initiatives that you have referred to in Manchester. So with that we will learn, in VHA, how to proceed to ensure that we do

have wraparound services, particularly for those who have been admitted to non-VA hospitals.

Senator HASSAN. Well, let's keep working on that together, and I appreciate very much the work that you all around doing.

Senator Moran.

Senator MORAN. Thank you, Senator Hassan. If Senator Tuberville would like, I would be happy to yield to him to ask questions.

SENATOR TOMMY TUBERVILLE

Senator TUBERVILLE. Let's do it. Thank you. Thank you to the witnesses for being here today to talk about this pending legislation. It is very important for veterans all across the country.

Dr. LaPuz, I co-sponsored Senator Blackburn's Veterans Health Care Freedom Act because I support veterans accessing the doctor of their choice, whether a doctor is at the VA or in their community. I understand frequently the veterans enrolled in the VA health care are not educated on access to care in the community. While the VA has taken the position to oppose this legislation, the fact remains that the MISSION Act gives eligible veterans the right to access community care.

Doctor, what trainings have the VA providers undergone to ensure they are open with the veterans on their eligibility for community care? Any training that has gone on?

Dr. LAPUZ. Yes, Senator. We have trained every one of our schedulers—it is a rather extensive training—to ensure that the schedulers have a good understanding of the eligibility for community care. So we have extensive training for that, Senator.

Senator TUBERVILLE. Are you getting good feedback from that, do you know?

Dr. LAPUZ. Generally. Our schedulers are able to perform quite well in their jobs. We do have a lot of dedicated employees that are performing to the best of their ability, and the majority of the time they are able to inform veterans regarding eligibility and community care appropriately.

Senator TUBERVILLE. Do you know of any post-appointment surveys that we do to get their feedback from the veterans after they have been to the VAs?

Dr. LAPUZ. Not to that question, Senator, but we have V-Signals, which is like a survey after a veteran has visited our clinic as well as after a veteran has visited community care clinics. So we do have the feedback regarding the care that they have received, whether that is in-house or in the community care.

Senator TUBERVILLE. Yes. And that is the best way to get better is find out what you did right and what you did wrong.

Dr. LAPUZ. Yes, sir.

Senator TUBERVILLE. Dr. Miller, as you know, Operation Deep Dive, conducted by Duke University and America's Warrior Partnership, requires information from the VA that is vital to their analysis on veteran suicide rates across the country. What information has the VA provided to America's Warrior Partnership so far, and what additional data does the VA plan to provide?

Dr. MILLER. Thanks for the question. There has been a rather extensive history of correspondence and dialogue with AWP and Op-

eration Deep Dive regarding this issue. I would be happy to present the full history, documentation to you, including present state and planned future state.

VHA Response: Briefing on Operation Deep Dive scheduled for August 29th 1-2 PM. (Riley Hambrick & Kaitlin Stoddard).

Senator TUBERVILLE. Do you think it is working, you know, getting that data? Is it helping? Are we learning from it, do you know of?

Dr. MILLER. I think what we are learning, and this gets to the More than Just the Number Act, I think that what we are learning is there is room for improvement in terms of data validity and speed coming from states and coming into the Federal network. And, therefore, you will see us supporting stipulations within the More than Just the Number Act.

Senator TUBERVILLE. Does the VA have concerns about sharing this data with other people? Are there concerns?

Dr. MILLER. By "this data" I would probably need more specifics, to answer that specifically. However, we do protect veteran data to the fullest extent possible for the benefit of veterans and for the mission. Now within that, then, we also seek to be as transparent as possible to promote the mission, which includes partnerships with other collaborators such as AWP.

Senator TUBERVILLE. Thank you. Dr. LaPuz, among many things, the HEALTH Act will allow veterans experiencing substance use disorder to access care in the community without first receiving a referral from the VA. Testimony states that the VA cannot support codification of residential treatment and rehabilitation services as proposed in this bill, and that the VA generally supports establishing a wait time standard of 10 or fewer days for the delivery of such treatment and services, although the VA opposes codifying this timeline into law.

Given that veterans experiencing substance use disorder require help immediately, why does the VA want to keep bureaucratic red tape in place before a veteran can get help?

Dr. LAPUZ. So, Senator, just like any other treatment modality there is a requirement to fully assess the veteran and have an idea of how you are going to meet the veteran's need, and this is just part of the clinical requirements. So we would like to make sure that we have a very good assessment of the veteran's needs before we actually have a remedy for that kind of condition, and that includes substance use disorder.

So in our minds, we would prefer for the VA to actually maintain that flexibility so then we can make sure that there is appropriate clinical determination of the veteran's needs.

Senator TUBERVILLE. Why is the VA opposed to codifying a wait time standard for rehabilitation services? Why are we opposed to that?

Dr. LAPUZ. Codifying the standards really limits the authority of the Secretary to determine what is required for veterans' care. And we all know that the health care landscape changes, and it is important to the VA for the Secretary to maintain that authority, to

make a determination on what will be needed in order to take care of veterans' needs at that particular point in time.

Senator TUBERVILLE. Thank you. I apologize, Madam Chair, for going a little long. Thank you.

Senator HASSAN. Thank you. Senator King.

SENATOR ANGUS S. KING, JR.

Senator KING. Thank you, Madam Chair.

One of the bills before the Committee today involves reimbursement for domiciliary care for veterans with dementia, and this is something that Maine veterans' homes undertook. On January 5, 2021, the President signed the Johnny Isakson and David P. Rowe Veterans Health Care Act. It had, in Section 3007, "the VA to allow a waiver for eligible veterans to receive per diem payments for domiciliary care." So far, so good. January 5, 2021.

As of today, no rules have been issued by the Veterans Administration to implement this law. This was not a suggestion from the United States Congress. This was a law, and we are still waiting.

So I have a bill in before this Committee that would mandate that the rules be issued. The Veterans Administration, for reasons that escape me, are opposing this rule. That takes a lot of nerve. Just issue the damn rule. And if you are going to issue the rule, do it. Otherwise, we are going to pass this bill. But it is a damn shame that we have to pass a second bill to implement a bill that we already passed. So what is the problem here?

Dr. GANTT. Senator, VA is not supporting this bill because we are actively, as you mentioned, working on regulations——

Senator KING. Define "active." It was 2021. Let's see. We are 2 ½ years later. That is not very active.

Dr. GANTT. And——

Senator KING. Eisenhower retook Europe in 11 months.

Dr. GANTT. Yes, sir.

Senator KING. So active? Are you active? Give me a date.

Dr. GANTT. I cannot——

Senator KING. August 1st?

Dr. GANTT. I cannot give you a date today.

Senator KING. September 1st? Well, I guess we are going to have to pass the bill.

Dr. GANTT. I will say, Senator, we are continuing to coordinate with this, as you know, the state veterans' homes also, to make sure that piece—and we absolutely do support this type of care, making sure that we have this, and we have the coordination that is required with the state veterans' homes.

Senator KING. Well, I am delighted to hear that, and I am delighted to hear about the coordination, but the veterans' homes, the DAV, the VFW, all support the bill that I am talking about, in order to move your agency to issue the rules so that we can give the veterans the care that they deserve. So as you can tell, this is not acceptable. So you said "actively," I will take you at your word and consider that a commitment to move on this matter in the immediate future, and that means in the next several months.

Dr. GANTT. Yes, sir.

Senator KING. Agreed?

Dr. GANTT. Yes, sir.

Senator KING. Thank you. Thank you, Madam Chair.

Senator HASSAN. Thank you, Senator King.

Senator Moran.

Senator MORAN. Thank you, Senator Hassan. Thank you, Senator King, for highlighting the challenge that we have, even when we do pass laws. And Dr. LaPuz, I had not planned on speaking about anybody else's legislation, but the suggestion that we do not want law because it changes so quickly, you could say the same thing. You do not want rules because tomorrow may be different.

Congress has a responsibility to give direction to the VA. We do it based upon our best abilities and the information that we have. And I find it—"offensive" is not the right word, but it saddens me that a bill that, even if you support it you do not want the Congress to be giving you directions. It is a significant part of our responsibility on behalf of those we serve.

Let me ask you, Doctor, I heard a lot recently from the VA about the need for timely medical documentation from community care providers. I could not agree more about the importance of that, and there are challenges with how we communicate between a community care provider and the VA.

I want to highlight an issue that just arose yesterday. My staff spoke to a longtime VA community care partner in Pennsylvania who has repeatedly been advised by the VA to send medical records information to a fax machine. It turns out that that fax machine is not monitored. This provider at the VA's instruction is sending medical documentation containing personal health information over and over again because there is no one else on the other end of the line. And, in addition, those documentations—let me just first say I would like for you to commit that you will work with my staff to solve this issue.

Dr. LAPUZ. Yes, sir, absolutely.

Senator MORAN. Thank you. This provider is also being told that the VA will not send subsequent referrals to them because they are not returning medical documentation in time, and the VA is actually calling veterans who are actively receiving care from this provider to advise them to stop going, to stop obtaining their ongoing treatment and to use VA telehealth services instead.

More concerning, the same provider shared documentation of a VA employee sending personally identifiable information, including dates of birth and full Social Security numbers, for veterans via unencrypted mail without taking even the basic steps to protect that information from disclosure. If a community provider had done this it would have been grounds to remove that community provider from the network, and lots of other serious repercussions.

Again, the Veterans HEALTH Act that I described in my opening remarks is trying to put a stop to this kind of conduct by improving how community care programs are administered. Will you assure me that the behavior that I described does not align with the standard of practice, and work with my staff to look into these allegations and see if we cannot put an end to them?

Dr. LAPUZ. Yes, sir. We will work with your staff in order to look into this circumstance.

Senator MORAN. Thank you very much. I yield.

Senator HASSAN. Senator Boozman.

SENATOR JOHN BOOZMAN

Senator BOOZMAN. Thank you, Madam Chair.

Dr. Miller, veteran suicide prevention continues to be my number one priority, and I think that is true of a lot of people on this Committee. I believe that the issue is more complex than just viewing it from a clinical perspective. There are other root causes of suicide we need to be looking at, such as food insecurity, lack of housing, and financial strain.

That is why Senator Tester and I teamed up to introduce the Not Just a Number Act, which would allow us to study this issue from a holistic standpoint in order to better understand why veterans are taking their lives.

Dr. Miller, do you think that it would be helpful to move the Suicide Prevention Office from VHA to the enterprise level at VA to allow for better communication and data-sharing between VHA and VBA?

Dr. MILLER. Thank you, and I am happy to answer this question and also I want to express appreciation from the perspective of the suicide prevention team for your advocacy for veteran suicide prevention.

What I think that you have done through this bill is you have demonstrated the importance, as you stated, of including important information and data within the analysis of veteran suicide. You have also further, I think, highlighted that that is going to require a deeper and broader level of cooperation and collaboration between VBA, VHA, NCA, and other Federal agencies, as well as states. I 100 percent agree with you on that level.

You then bring that into a conclusion, in Section 5, saying is suicide prevention organizationally placed well to implement Sections 2 and 3 in the manner that we are outlining here, and we believe need to move. We think it is a fair question, we think it is a good question, and therefore we 100 percent support the feasibility and advisability analysis that you have requested.

Senator BOOZMAN. Very good. Dr. LaPuz, you mentioned in your testimony that suicide is rare event with no single cause, which leads me to believe that you would agree that there is no single cause to suicide. I am sorry. What I am saying is, you know, is that there is no single cause to suicide, and there is no single solution as well. You go on to state in your testimony that the analysis required by this bill would only identify correlations and not causations.

Would you not agree that understanding the correlation between the VBA programs that prevent veterans from taking their lives is a good thing to know?

Dr. LAPUZ. Senator, I will defer to our expert, Dr. Miller, to respond to that question.

Dr. MILLER. Thanks. I appreciate the question, and the answer to the question is yes, it is important to study VBA-based efforts as well as VHA efforts, and efforts that go into our community-based interventions program, do what we can to validly study relationships between them, and move the field and the VA closer to understanding what works, what does not work, as well, and what is worth investing in, from a program perspective.

Senator BOOZMAN. So again, that is exactly what we would like to do. In this bill with Senator Tester our intent is to identify the programs that are working in order to better resource them, and identify the programs that do not work, so that we can modify them and be more supportive of veterans in need. So are we on the same page?

Dr. MILLER. We are 100 percent on the same page, sir. I think the spirit of that particular feedback was not to indicate we are on a different page with you on this. It was more to indicate there are some complexities with relationships, and we will move together with you to explore those.

Senator BOOZMAN. Good. Thank you. Thank you all for all of your hard work. We appreciate you.

Senator HASSAN. Well, thank you very much. Seeing no other questions for this panel, thank you all very much for your testimony and for your work. And I will welcome the second panel to the witness table.

[Pause.]

Senator HASSAN. Well, good afternoon to our second panel. It is good to see you all. We have Jon Retzer, Assistant National Legislative Director for the Disabled American Veterans; Meggan Thomas, Associate Director, National Legislative Service, Veterans of Foreign Wars; and Jim Lorraine, President and CEO of the America's Warrior Partnership. We are very grateful that you are all here today, and we look forward to your testimony on this pending legislation.

Mr. Retzer, why don't we start with you.

PANEL II

STATEMENT OF JON RETZER

Mr. RETZER. Madam Chair Hassan, Ranking Member Moran, and other members of the Committee, thank you for inviting DAV to testify at this legislative hearing. We appreciate the many beneficial pieces of proposed legislation on agenda today to improve services for our Nation's veterans, in particular, our service-disabled veterans. My oral remarks will focus on the community care bills under consideration by the Committee.

Both S. 1315 and the HEALTH Act, the draft bill, Making Community Care Work for Veterans Act make enormous changes to VA's current community care program. DAV supported the VA MISSION Act after working with the Committee and others to carefully craft a compromise to improve access, quality, and veteran-centric care, particularly those living in rural and remote areas, focusing on key principles, first ensuring VA would continue to be the primary provider and coordinator of veterans' care; increasing VA's internal capacity through investments in staffing, infrastructure, and IT to meet the rising demand for care; establishing access and quality standards, taking into account wait time and travel distance to care; and finally, requiring community care providers meet the same access and quality standards as well as training and certification requirements as VA clinicians.

Both bills would codify the existing VA access standards for wait and travel times and would limit VA's ability to modify those access standards in response to changing conditions. DAV supports responsible efforts to lower wait and travel times for care. However, codifying access standards by itself will not improve veterans' access to care, lower wait time, improve quality, or produce better health outcomes. We believe investing in the VA health care infrastructure, staffing, and IT would achieve these important goals.

Furthermore, studies continue to confirm that VA health care is equal to or better than private sector care, on average, and a robust VA health care system provides vital research, training, and emergency preparedness for veterans and the Nation, furthermore justifying such investments.

We have questions and concerns about the provision in both bills that would restrict the ability of the Secretary to review the "best medical interest" decisions between veterans and their referring physicians, which would limit VA's role in overseeing and meeting VA's quality care guidelines versus veterans' preference.

DAV supports provisions in Making Community Care Work for Veterans Act, which seeks to expand VA capacity by increasing recruitment and retention programs for critical health care provisions. We support provisions seeking to increase training and compliance by community care providers. However, we strongly believe they should be required to meet all the same training requirements as VA providers. We also support the provisions to expand reporting of quality matrix by community care providers. However, the Secretary should set those standards. Further, we support the provisions to ensure community care appointments are scheduled more timely.

DAV has questions with the provision in S. 1315, to mandate the conversation of VA health care into a value-based care model. Given the medical complexity and the needs of the VA patient population, we recommend further studies, including eliciting an opinion from the Secretary's Special Medical Advisory Group regarding the use of a value-based care model in the VA health care system. DAV welcomes the opportunity to work with the Committee to address concerns raised in these two bills and to develop a balanced, bipartisan package to improve access and quality health care for all enrolled veterans.

Our final comments are on S. 1545, the Veterans Health Care Freedom Act. DAV opposes this legislation, as it would unravel the MISSION Act by completely eliminating access standards for community care eligibility. Although similar bills in recent years have been scored by CBO to cost billions of dollars, this legislation would provide no additional funding and would weaken the VA's internal capacity to care for enrolled veterans. Ultimately, it would threaten the viability of VA health care, and more importantly, severely limit options of millions of veterans who have chosen and rely upon VA for care.

VA is unique health care system serving millions of ill, injured, and disabled veterans every year. We must ensure we continue to fulfill the mission in the years ahead, and we look forward to working with the Committee to find solutions that will improve access, particularly for rural veterans, while maintaining quality. We also

believe the community care framework establish by the MISSION Act is the optimal path forward to achieve those goals.

And now that Chairman Tester is here, Chairman Tester, this concludes my statement, and I am happy to address questions you or members of the Committee may have.

[The prepared statement of Mr. Retzer appears on page 100 of the Appendix.]

CHAIRMAN JON TESTER

Chairman TESTER [presiding]. And there will be questions, and thank you for your testimony, Jon, on behalf of the Disabled American Veterans. We appreciate always what you have to add to this Committee.

Next is Meggan Thomas, who is Associate Director of National Legislative Service of the Veterans of Foreign Wars, otherwise known as VFW. The floor is yours, Meggan.

STATEMENT OF MEGGAN THOMAS

Ms. THOMAS. Thank you, sir. Good afternoon, Chairman Tester, Ranking Member Moran, and members of the Senate Committee on Veterans' Affairs. On behalf of the VFW and its auxiliary, thank you for the opportunity to provide our insights on this proposed legislation.

The VFW strongly supports S. 928, that incorporates VBA data into its suicide prevention efforts. It is one of our top legislative priorities for this Congress. VA's suicide prevention efforts should include full information on disability compensation, use of education, employment, and home loan benefits; foreclosure assistance; and participation in housing and food insecurity programs.

VA has recently begun reporting on the convergence of VA benefits and veteran suicide, but not in any substantial manner. We must identify, study, and utilize information regarding economic opportunity benefits, and leverage that information to successfully prevent suicide among veterans.

All veteran economic programs are administered by VBA, but the Office of Suicide Prevention is operated out of the VHA. We strongly support this proposal to begin actively incorporating data and benefit usage into overall suicide prevention efforts within VA. We also believe this should be a program under the Office of Secretary, that would elevate suicide prevention as a top priority across the entire Department and not only within VHA.

VA's focus should remain on how veterans can receive the care they need, whether it is inside or outside of its facilities, which is why we support both Senator Tester' and Senator Moran's community care proposals presented here today. The VFW sees many important provisions in both the Veterans HEALTH Act and Making Community Care Work for Veterans Act, that would both benefit the Community Care Network. We encourage the Committee to work in a bipartisan manner to take the best parts of both bills and combine them into a comprehensive community care bill that provides improvements that will help VA and the veterans that it serves.

That said, there is one part of S. 1315 we believe should be clarified. Section 103 may provide contradictory guidance to patients or

clinicians regarding a veteran's preference for care. Currently, if a patient and the referring clinician agree that receiving care and services through a non-VA entity or provider would be in the best interest of the veteran, then they are referred to community care. We are concerned this proposed section has the potential to allow contradictory guidance with the veteran's preference and the best medical interests.

And there are certain sections of the Making Community Care Work for Veterans Act of 2023 we would like to see highlight as critical improvements and other sections we believe could benefit from additional improvements. In Section 107, the VFW understands the need for self-referrals for services that going to remain constant for the veteran. We would like to see additional services added to this list to include podiatry, prosthetics, laboratory services, dermatology, and the diabetes clinic. Services that are part of a veteran's treatment plan should not have to be reauthorized if it is for chronic care and often utilized.

In Section 112, the VFW supports a feasibility study to consider if Community Care Network is a viable option for care in the Philippines. However, veterans in that area currently utilize the Foreign Medical Program, which is in dire need of improvement. The FMP has no formal means through which either veterans or providers can receive consistent reimbursement. We recommend providing structure to the FMP, like VBA's Compensation and Pension overseas examination contracts and TRICARE Overseas, to include electronic reimbursement for care.

Finally, an issue we would like to see addressed is veterans who are referred to residential treatment via Community Care Network are mostly only able to access programs that are physically located within their respective jurisdictions, each of which is managed by either Optum Serve or TriWest. Arbitrarily restricting the program access based on administrative network boundaries limit's VA's ability to coordinate timely and appropriate residential mental health and substance abuse care for veterans.

Chairman Tester, Ranking Member Moran, this concludes my testimony, and I am prepared to answer any questions you may have. Thank you.

[The prepared statement of Ms. Thomas appears on page 116 of the Appendix.]

Chairman TESTER. Thank you for your testimony, Meggan. I appreciate it. It is always good to have VFW's perspective here.

Next we have Jim Lorraine, who is the President and CEO of America's Warrior Partnership. The floor is yours, Jim.

STATEMENT OF JIM LORRAINE

Mr. LORRAINE. Chairman Tester, Ranking Member Moran, and members of the Committee, thank you for the opportunity to testify before you today.

For nearly a decade, community care has grown in veteran preference and size. Its positive impact for the veteran community has been extraordinarily important and lifesaving. Access to community care is critical to America's Warrior Partnership and our rural com-

munity programs, where we advocate for veterans and their families.

The VA Secretary testified last year that the community care had grown so successfully that the cost may require limiting its growth. It is troubling that when the VA has a successful community care program that is working the instinct is to trim it back. A small number of individuals and organizations believe that if veterans are given the choice or allowed to manage their own care, the VA will cease to function. In fact, it is the contrary. Ensuring the VA has strong, effective community partnerships helps safeguard the VA's health care system and keeps it strong for future generations of veterans. We have seen veteran enrollees increase as the door to community care opens, as veterans return to the VA to get care.

But important elements of community care must be made permanent, including access standards. Mission Roll Call conducted a series of poll questions on these issues, with over 6,300 veteran responses across the United States. Over 81 percent said Congress should codify the community access standards. Seventy-one percent said they were not referred to a community care after a delay in mental health or other specialty care at a VA facility. This clearly indicates a problem.

The VA must not only provide community care but actively educate veterans that they have a choice. Accordingly, AWP was proud to support the access standards 2 years ago when introduced by Ranking Member Moran, and again proud to support the HEALTH Act, introduced by Ranking Member Moran and Senator Sinema. The HEALTH Act codifies the access standards and applies them to nearly all types of care. It also addresses the unacceptable practice of restarting the wait clock when the VA cancels or reschedules an appointment or refers to a telemedicine appointment instead.

Chairman Tester, AWP supports Making Community Care Work legislation, which is similar to the HEALTH Act in many ways. In fact, we support that this bill creates a program for veterans to begin self-referral for some services, such as vaccinations, vision, or other hearing services, but feels substance abuse and mental health should be added to the self-referral program, and I would argue that what the VFW said is much further, that that should be included also.

AWP recommends including provisions for value-based care already used by Medicare to advance the quadruple aim of providing better care to individuals, improving population health management strategies, improving the work quality of health care providers, and reducing health care costs. Along these lines, as a nurse and a leader, I strongly encourage the Committee to consider continuity of care, which has been repeatedly documented to improve outcomes as a measure of criteria equal to the time and distance of an appointment.

AWP hopes this Committee can compromise on the best of both of these proposals and pass the legislation quickly.

Chairman Tester and Senator Boozman, regarding the Not Just a Number Act, AWP is supportive of the intent of the legislation. However, the suicide and premature non-natural death is too complex from one perspective, and this Committee should request an

outside view related to VA reporting. We suggest this Committee request transparency, not necessarily additional data. In fact, the data requested in the legislation is exactly what is missing from Operation Deep Dive, and we look forward to working with the VA in the future to fill that gap.

We are very grateful for the inclusion of some of the Operation Deep Dive interim summary recommendations in this legislation. Providing a tool for coroners and state medical officials to help verify veteran status quickly and accurately, and evaluating the VA Suicide Prevention Office to the Secretary level is long overdue.

Again, thank you for the opportunity, sir.

[The prepared statement of Mr. Lorraine appears on page 123 of the Appendix.]

Chairman TESTER. Thank you for your testimony, Jim. I appreciate it. I am going to use my privilege as Chairman of this Committee to turn it over to the old-timer on this Committee, Senator Murray.

SENATOR PATTY MURRAY

Senator MURRAY. The youngest old-timer ever. Thank you so much, Mr. Chairman, and thank you to all the Committee members. I really appreciate you holding this hearing to look at some of the really important legislation coming before this Committee, including the EHR Program RESET Act, which we introduced earlier this year with Senator Brown.

I, as you know, have been raising concerns about VA's implementation of EHR from the start, and when I say "start" I mean before the ink was even dry on the contract between Oracle Cerner and the Trump administration was signed. And the criteria for success is pretty straightforward to me—Does it work for our providers? Does it work for our patients? Are we helping veterans get the care that they deserve?—Which is what I am focused on when I talk to our veterans back in Spokane and Walla Walla.

Unfortunately, it was pretty clear early on that this new system was missing that mark in a lot of ways, whether it is the providers in Spokane who are really burnt out just trying to navigate the broken interface or the patients who are unable to get the medicine they rely on because of the system malfunctions. And as we all know, a flawed system can be fatal, and I have previously discussed here about a constituent of mine who received a late cancer diagnosis because the system did not work the way it was supposed to. So it is painfully, devastatingly clear to me this system has been not working for our veterans or our providers and was broken.

So the reset VA announced this year was really badly needed, but we do need more than a reset. We need reforms that make sure the problems with EHR are not just fixed but do not ever happen again in the future. Many of those problems stem from the deeply flawed single-source contract the Trump administration agreed to back in 2018—I think we should all agree on that—and regardless, we should be doing everything we possibly can to make sure we have a VA where veterans can get the highest quality of care they deserve.

So I look forward to our witnesses and appreciate all of you being here. And let me just start, for the whole panel, and ask you what gaps do you see in VA's current contracting process, and what else can VA be doing to make sure that in the future it does not face the same issues that we had with this contract?

Chairman TESTER. You get to go first, Jon.

Mr. RETZER. Thank you, Senator. A great question and obviously the EHR, we also resonate your concern. DAV is quite concerned with the progress of where EHR was and the safety issues that were brought up.

With regards to the contract, DAV's position is that we feel very strongly that our veterans deserve a modernization to ensure that they have the resources that are there to apply quality health issues and needs. But at the same time, we want to ensure the providers have that infrastructure that works for them to provide safe care.

With regards to now the contract, DAV does not have a position where we care who has that contract as long as the contract and the VA's relationship of governance over that contract has the authority to ensure that they are doing it right and they are overseeing, with good, strong oversight, to ensure VA is held accountable and so is the contract being accountable to fulfilling the contract and its obligations to the veterans, taxpayers, and this Nation.

So that is where we are sitting at this time, is we just want to ensure that VA knows what they are doing and does it with the right partners say will get it done for them.

Senator MURRAY. Ms. Thomas, Mr. Lorraine, do you have any comments about the contracting process?

Ms. THOMAS. Good afternoon. At this time I do not have any comments in regard to the contracting.

Senator MURRAY. Mr. Lorraine?

Mr. LORRAINE. Yes, ma'am. In terms of the contracting I do not have comments, but I would echo what DAV is saying, that it is critical that we have to get it done. I served on a Senior Oversight Committee at the Department of Defense back in 2008, and this was an issue then. That was in 2008, and it needs to get done. I am a victim of it myself, and it needs to get fixed.

Senator MURRAY. Okay. Thank you.

And let me quickly ask about the Expanding Veterans' Options for Long Term Care Act. Our population of veterans is aging, and we have to make sure that there are long-term care options available for them. So that is exactly why I joined Chair Tester and Ranking Member Moran in introducing the bipartisan Expanding Veterans' Options for Long Term Care Act, creating a pilot program for our veterans to get assisted living care.

Just real quickly, any of you, can you talk a little bit about what some of our veterans are facing in our rural areas in terms of long-term care? Ms. Thomas?

Ms. THOMAS. Thank you for that question. So when we deal with long-term care options, especially in the rural areas, we already have limited access to care. We actually see this program, this pilot, as a good opportunity to provide the care—it is like that middle care. They are not sick enough for nursing home care, and they

are not able to be on their own. I believe this opportunity for assisted living in rural areas would actually allow for the veterans to get the care they need without having to worry about the financial burden, and I think that is one of the biggest factors to look at.

Senator MURRAY. Okay. The Chairman has been generous, allowing me to speak, and I am out of time. But if any of you could give me written comments back I would really appreciate it. Thank you.

Chairman TESTER. Thank you, Senator Murray. Senator Moran.

Senator MORAN. Chairman, thank you. Ms. Thomas, I am grateful to you for your support of the Veterans HEALTH Act, and I am glad to have VFW and a diverse group of growing VSOs and other veteran service nonprofits supporting this legislation.

Can you elaborate on why the VFW supports Veterans HEALTH Act and how enacting it would align, not compete, with the VA's efforts to focus on improving wait times, embracing whole health, and preventing suicide?

Ms. THOMAS. Thank you for that question. The VFW definitely supports improving community care. We understand that patients in our care should be a priority. Value-based care focuses on prevention, which reduces illness and suicide, which is a top priority for all of us.

I would have to say that one section that we were looking into was Section 103, to clarity the best interest in veteran's preference versus a veteran's preference. We want to ensure that we are not pushing all veterans to go outside the care of the VA, which VA provides better than most outside areas.

Senator MORAN. Mr. Lorraine and Ms. Thomas, the VA opposes Section 103, that was just mentioned, of the Veterans HEALTH Act, which would require VA's criteria on how a veteran and their provider can reach a mutual decision about a veteran's best medical interest to include the consideration of a veteran's preference. So what I am saying is that the VA opposes the consideration of what the veteran, what they want to see.

To be clear, this section does not stipulate that a veteran's preference is the outcome of the decision. This section would not stipulate that a veteran is entitled to care in the community just because they express a preference for it, nor would it alter the current statutory requirement, put in the MISSION Act, that best medical interest be determined between the veteran and their clinician.

As you know, health care is a highly personal issue. Why do you think it is important that decisions about a veteran's care take into account personal preference for when, where, and how they seek care? Mr. Lorraine?

Mr. LORRAINE. Thank you for the question. You know, I think when it comes to health care it is a personal choice, and I think because you are veteran you should not have your choices foregone. You should have a say in the health care that you receive and where you receive it, no matter where you live in the country. And I think your point, and the point between the physician and the patient has to be the decision. It cannot be a bureaucratic decision that breaks the 30 days, that breaks the distance, that breaks all

the continuity. It needs to be between the physician and the patient.

Senator MORAN. Thank you. And let me ask just a broader question about this topic. Mr. Retzer, I understand the DAV's concern about preserving the primary role that the VA plays in providing coordinated care for veterans who are enrolled in the VA health care system. To that end, as Senator Tester and I perhaps join forces to craft a compromise bill that draws on the best of both of our separate bills, would DAV support the inclusion of language reasserting that role for the VA, even as access is expanded under certain circumstances into the community?

Mr. RETZER. Thank you, Senator, for asking that question, and where DAV stands with this is we appreciate both the bills, and we have provisions that we appreciate and that we understand where they are coming from, especially as you are trying to address your constituents' needs in Kansas and Montana. You have very dynamic, in Kansas, dynamic populations that are very sparse and that VA does not have the infrastructure to support that population. Not only in Montana do we have that same situation but geographical constraints that hurt that situation, along with the individual veterans' preference issues that may cause them not to.

Now we definitely invite, just as we had said in our testimony and also in my oral statement, I would welcome the opportunity to work with you and your staff to draw a nice piece of legislation that is bipartisan, and I think we can get there. We do understand what your intent is, and we just do not want to take away the authority from the VA as the primary. Because one of the concerns that we have with the VA is that they provide so many significant wraparound services.

Like myself, I use the VA health care system 100 percent. I am very fortunate to be 25 miles from D.C. and 25 miles from Baltimore, but you also know that navigating Baltimore and D.C. is not always easy. There will be veterans who cannot do that, so that would be maybe a foreseeable reason that is realistic. But I have the fortunateness of having a CBOC, not like your constituents. They may not have either of them.

So we do understand, and we did support the MISSION Act, and we did support the community care program. We just want to ensure that when we look at legislation it is very well thought out, and we think there is a special need for our rural veterans that are in a very unique situation.

Senator MORAN. Jon, my intent of that question was to suggest to you that I might be willing to again reassert—I was fully engaged in the MISSION Act, so the language that is in there is language that I participated in creating, and language that I voted for and support. And my point in asking that question is that I may be willing to reassert that role for the VA, but there still may be instances in which, in my view, we need to expand access to community care. Does that trouble you?

Mr. RETZER. We understand that initially when the MISSION Act was looked at, and we were compromising and looking at crafting it, the terminology of a supplement versus a plan. And we want to continue to supplement the community care. We know it is needed, and the VA system is weakened and is struggling. And

that is why we want the investments, and both of you have provided legislation to strengthen the VA's infrastructure.

So we think that just putting everything together and working together and discussing the provisions that we have concerns and how to clean it up a little bit easier for our veteran community to make a seamless system so that they are not navigating a bureaucracy, or they are not navigating red tape, but it gives authority to the Secretary to do the right things when the time is needed.

We really do want that warm handoff for our veteran community because the fact is our veterans—typically, if I go to general care and community care I have more than five issues that the general physician has to deal with. That physician may only be able to identify one issue or address one issue. Then they want me to do a lab for some reference. Now there are more referrals. So that is why we want to ensure the best medical practices and the best medical interests are applied accordingly.

Senator MORAN. Jon, Meggan, and Jim, thank you.

Chairman TESTER. Senator Blumenthal.

SENATOR RICHARD BLUMENTHAL

Senator BLUMENTHAL. Thanks very much, Mr. Chairman. Thank you for being here today.

Ms. Thomas, you have had very extensive experience as a caregiver, as a medic, and also as a caseworker, so I would like to ask you about a problem which may not be reflected extensively in the legislation. There is one piece of legislation dealing with veteran suicide. But perhaps you could give us your assessment as to what more we can and should be doing, "we" meaning not only the VA but also Congress. Like others on the Committee, I have worked extensively for legislation for more resources. I have been critical of past VA administrations because of the failure to do more outreach, for example, using the resources that have been available. But maybe you could talk a little bit about veteran suicide and what we ought to be doing.

Ms. THOMAS. Thank you for that, sir. One of the things that the VFW looks at—and I want to just speak a little bit on Senator Tester's bill, but not just the Number Act. We understand that the data that is received from the VBA is important. We know it coincides because it is not one thing that causes suicide. Having food to eat, having a roof over your head, having money in your pocket, or having a job are factors, and if those needs are not met, that puts a person in a position to want to commit suicide.

This actually brings me back to prevention methods that could be used. We actually currently have one that we could actually be using right now, and I just wanted to highlight the TAP Program. The TAP Program is actually given for servicemembers who are exiting out of the service. We need accredited service representatives to actually assist those with filing claims. We need those services at the TAP Program to actually talk about educational benefits, talks about housing options, talks about things that they are going to need to be able to get out, so they will not be able to walk out of the military and have nothing to look at.

So I think really looking into the TAP Program and how we better enhance the TAP Program, and how we make sure that our

servicemembers are being able to utilize that program is going to be key for what we need to do going forward in the veteran realm.

Senator BLUMENTHAL. Would you recommend any particular legislative initiatives to that end?

Ms. THOMAS. I would recommend the Not Just a Number Act. I think the VBA data is essential to get a whole view on barriers that could lead to suicide.

Senator BLUMENTHAL. I noticed that in your testimony, S. 1040, prohibiting smoking on the premises of any veterans facility, VHA facility, you recommend against our approving. Could you explain a little bit more why you are against prohibiting smoking on VA facilities? I know that you say that having a specific area where smoking may be permitted is a middle ground, but it would seem to me that smoking is certainly a detriment to health and permitting it anywhere on a VA facility sends a message of acceptability that the VA ought to avoid. Do you differ?

Ms. THOMAS. So with that being said, sir, and thank you for that, the VFW understands that there are barriers out there. What we do not want to see is, we do not want to see smoking as a barrier for veterans not going to get the care that they need. Also, when you are looking at the staff that works at the facilities, if they cannot smoke they may not want to work there. The VA is already behind when it comes to employment. So we do not want to have any barriers, and that is the reason why we are choosing against the bill.

Senator BLUMENTHAL. Thank you. I do not know the answer to this question. Maybe some of you do. Does the VA have smoking cessation programs as part of what it offers? I am seeing some heads nodding. I have not asked this question before so forgive my ignorance. And how widely are they offered? To any member of the panel.

Mr. LORRAINE. I will. From personal experience, every time I go to the VA I am asked whether I smoke or whether I consume alcohol, and they always have a program that is available. It is literature in the pamphlets and whatnot. There are a number of programs in the facility in Augusta that I attend.

Senator BLUMENTHAL. I am wondering how strongly they urge or recommend these programs, beyond saying it is available.

Mr. LORRAINE. I could just speak to my experience, but additionally, Senator Blumenthal, with our Operation Deep Dive study, we have also seen not just non-natural deaths, but we see natural death and a differentiation amongst cancer-related, that would be lung cancer-related premature early deaths amongst veterans. It is not a bad thing to stop smoking.

Senator BLUMENTHAL. Thank you all for being here. Thanks, Mr. Chairman.

Chairman TESTER. Senator Sinema.

SENATOR KYRSTEN SINEMA

Senator SINEMA. Thank you, Chairman Tester, for holding this hearing, and thank you to our witnesses for being here today.

With over 500,000 veterans calling Arizona home, conversations around accessibility of veteran-specific health care are critical to ensuring the welfare of our state. Access to veteran health care

services in rural areas is often limited, and it is necessary to come up with ways to keep our veterans from going without services simply because they cannot reach the facilities that are able to provide them with care.

In circumstances where non-VA emergency medical care results in saving these veterans' lives, they should not have to jump through hoops to get reimbursed. And that is why I, with Senator Braun, introduced the RELIEVE Act to expand the eligibility for veterans to access emergency care from a provider outside the VA. I have also joined with Senator Moran, our Ranking Member, in introducing the HEALTH Act, to ensure Arizona veterans retain the ability to make their own decisions around their health care, while also making much needed improvements to the quality of care provided. And I look forward to working with both Senator Moran and Chairman Tester to continue to improve options for community care.

My first question is for you, Ms. Thomas. Nearly every day my staff helps Arizona veterans navigate an unexpected VA medical bill. What efforts should the VA implement to ensure that staff and community emergency departments are aware of the new eligibility criteria to prevent the veteran from experiencing issues or reimbursement delays, and do you believe legislation like the RELIEVE Act will help address the problem?

Ms. THOMAS. Thank you for the question. I do believe that the legislation, the RELIEVE Act legislation, will definitely impact those veterans, definitely understanding that when a veteran needs to receive emergency care they need to receive emergency care. They should not be burdened by the fact that they did not get their initial visit at the VA to get that care.

Senator SINEMA. Thank you.

Mr. Retzer, Arizona has many veterans living in geographically isolated areas, like Show Low or Pinetop, where it can be harder to access care due to the lack of community providers or outreach or communication. Have your organizations raised similar concerns with the VA to ensure that these veterans are informed of their eligibility and have access to the care that they have earned?

Mr. RETZER. Senator, thank you for that question. That is actually a question that is asked to our national service officers out in the field. That is one of the things that I spent 14 years advocating out there and spent 20 years with the DAV trying to navigate this issue and trying to influence VA to ensure that they are doing proper training of the patient advocates, their staff, and to ensure that they are sharing that education and knowledge to the veterans on what they are eligible for.

So when we look at VA's infrastructure, it is very difficult for them. So we continue to speak with the VA and collaborate with them, where their shortcomings are, where there are more improvements, to improve the veteran's experience in both the benefit side and the health side.

Senator SINEMA. And as a follow-up, what steps could the organizations here or our congressional offices take to ensure that veterans in Native American communities, for us particularly the Navajo Nation, receive the same or better outreach?

Mr. RETZER. Thank you for that question too, and I think one of the things that we are seeing in the legislation here, it is very thoughtful in the way that we are looking out for our rural veterans or veterans in remote areas, and it comes with collaborating with the VA to do outreach. For example, the direct health care system of having direct connect to our homeless veterans, for example, could be the same application to our Native Americans who are needing that assistance, who have those barriers, and who may also have some issues or cultural issues with working with the VA system.

So we need to be able to ensure that we open the doors and start to communicate and show the communities what they are entitled to and make a warm entrance into it by making sure we have partners on both sides that are being trained equally, the same way, and that understand the system.

Senator SINEMA. Thank you.

Mr. Lorraine, my office also hears from Arizona's veterans about the cumbersome community care referral process, which can negatively impact continuity of care. One issue my HEALTH Act bill is trying to address is to ensure that veterans who are seeking mental health care or treatment for substance abuse can self-refer to get the help they need when they need it.

What improvements to the referral process should be made to make it work better, and of course, without delay for patients and caregivers?

Mr. LORRAINE. Yes, I think especially those two areas that you just talked about, they are stigma ridden, and I think if the veteran can have the ability to directly seek out care, whether it is mental health or substance abuse, that is important.

America's Warrior Partnership, one of our programs is the Diné Naazbaa Partnership. It is Navajo women veterans that are employed by us that work up in Show Low. They are up in Chimney Rock or Window Rock, and Shiprock. We see it all the time. We hear from them. Their goal is to go find and develop a relationship with veterans. Their biggest issue is that there are facilities that are local that they could use, but there is no mechanism to go use those. They either have to go to Gallup, as you know, or go down to Phoenix, which is a pretty arduous trip.

So between the Alaska Warrior Partnership and our work in the Navajo Nation, we have extensive experience.

I would just also—and I know I am running over—I would also say that the thought that we are going to call these veterans when they barely have electricity, they barely have water, and a phone is something that is far beyond that. I think that it is a personal relationship, especially within the culture of the Navajo.

Senator SINEMA. Yes. Thank you. Thank you all for taking the time to be here today, and my team is going to continue working with all of you. Mr. Chairman, thank you for the hearing.

Chairman TESTER. You bet. Thank you.

Senator Murray brought up Expanding Veterans Option for Long Term Care Act, a bill that I have got, and she talked about the number of veterans who are over the age of 85, which I think is going to increase by over 500 percent in the next 20 years.

Right now the VA is prevented from paying veterans to receive assisted living services. This bill would help address that. For you, Mr. Retzer, can you explain how allowing the VA to pay for assisted living would help address the needs of this growing population?

Mr. RETZER. Thank you, Chairman Tester. Well, at DAV we actually support this piece of legislation. We really appreciate the thoughtfulness of expanding options, not just for our long-term care but our seriously injured veterans. As we see even our younger veterans who have serious injuries or illnesses, they do need care that extends beyond skilled nursing care. So we appreciate the fact that there is a piece of legislation here that would create a little bit of seamlessness for a veteran who needs that extra care, to be able to have VA provide that resource.

Chairman TESTER. I am going to stick with you, Jon. The CHARGE Act makes permanent essential programs that expired in May. It is also a bill that I have authored. These programs serve homeless veterans and caregivers who assist at state veteran homes dealing with staffing shortages. Does DAV support this legislation?

Mr. RETZER. Yes, we do, and this is a very thoughtful piece of legislation to address the safety and survival issues and needs of our homeless veterans. We definitely support the issue of having direct services with our homeless veterans to provide not only the survival items of food, shelter, and clothing, but to also extend that service to the transportation to medical appointments, and also then keeping them connected with technologies of like tablets or even mobile phones.

Chairman TESTER. You answered my second question.

Last year the VFW came to our Committee with the idea to make VA's annual Suicide Prevention Report go beyond just health care so we could better understand what we can do to help prevent veteran suicide. Senator Boozman and I have the Not Just a Number Act, to require the VA to make a more comprehensive look at veteran suicide including the use of VA benefits.

For Ms. Thomas, can you speak to the importance of this bill for VFW and how it would be useful in improving veteran suicide prevention efforts?

Ms. THOMAS. Thank you, sir. So this bill would allow, from VBA's data, to be used in regards identifying the barriers that cause suicide. The additional data going into the annual VBA report would actually provide some clarity and actually start conversations about what preventive methods can we use to actually help the veterans to limit their chances of wanting to commit suicide.

Chairman TESTER. Secretary Elnahal was in front of this Committee before the 4th of July break and talked about self-referral as a potential option that he is working on, which I see some real potential for. Dr. Senator Cassidy brought up the point of oversubscribing and how do you prevent that. Our community care went by a little over $5 billion, with a B, last year, as far as a budget line item.

Look, Senator Moran and myself come from places where health care is hard to find if you are in the VA, or if you are not in the VA it is hard to find. So giving these folks the ability to go out and

get health care is really important in the community. You do not want them driving 100 miles, and the nearest big hospital, to me—and I actually live in a place that is not the end of the earth—is 75 miles, so 150-mile round trip.

But oversubscription issue is not something that we have talked about a lot. How do we control that, assuming there is going to be some, and you can live with some, but how do we control that? Anybody can answer that question if you have a thought. Jim, go ahead. You have not spoken yet, at least not in my questioning.

Mr. LORRAINE. Yes, so as a health care provider I would tell you that oversubscription, you are going to get it, but I think that the point of sale or the point of dispensary is probably the best place to address oversubscription. The pharmacies are linked.

Chairman TESTER. Oversubscription—and maybe I used the wrong word——

Mr. LORRAINE. Yes, maybe.

Chairman TESTER [continuing]. From a health care standpoint. So if somebody has a sprained finger, it really does not need to be looked at but what the hell. It is free so I am going to go do it.

Mr. LORRAINE. Right. You know, I think in terms of, so like overuse of the——

Chairman TESTER. Yes, overuse of the system overall, not only prescriptions but overall use.

Mr. LORRAINE. Yes, no problem. You know, I think, as I said, I think in terms of reducing that oversubscription you are going to have it whether it is in the VA or whether it is in the civilian community. The civilian community, on the billing, you are going to see it, and I think it is something that you address on a case-by-case basis. You know, I always say that 90 percent of the rules are meant for 10 percent of the people.

Chairman TESTER. That is a fact.

Mr. LORRAINE. And there is probably a group of people that are going to overuse it. But I would rather address that than take it away from the 90 percent.

Chairman TESTER. Yes. I do not think it is the intent of anybody on this Committee, and I do not want to speak for everybody, that we are going to take away community care by any stretch of the imagination. But it is a pitfall that I never thought about. Cassidy is a doctor. He has probably seen it, and that is why he brought it up, and I appreciate it.

I want to thank you all for being here. I appreciate your perspective. I want to apologize to the first panel—hopefully they are still here—for missing theirs. I had a water compact in Indian Affairs that I have been working on for 12 years, actually longer than that, that I had to introduce, so that is my excuse. But thank you all for being here.

Look, we are going to continue to work together to figure out ways we can get health care to our veterans in the best way so that we keep them healthy forever because they have earned that. Thank you all very much.

[Whereupon, at 4:21 p.m., the hearing was adjourned.]

A P P E N D I X

Hearing Agenda

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

Hearing: Pending Legislation

July 12, 2023, 3:00 p.m.
Russell Senate Office Building, Room 418

1. S. 449 (Stabenow) Veterans Patient Advocacy Act
2. S. 495 (Tester) Expanding Veterans' Options for Long Term Care Act
3. S. 853 (Rosen) VA Zero Suicide Demonstration Project Act of 2023
4. S. 928 (Tester) Not Just a Number Act
5. S. 1037 (Moran) Department of Veterans Affairs EHRM Standardization and Accountability Act
6. S. 1040 (Durbin) A bill to amend title 38, United States Code, to prohibit smoking on the premises of any facility of the Veterans Health Administration, and for other purposes.
7. S. 1125 (Tester) EHR Program RESET Act of 2023
8. S. 1172 (Sinema) Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act
9. S. 1315 (Moran) Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023
10. S. 1436 (Tester) Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023
11. S. 1545 (Blackburn) Veterans Health Care Freedom Act
12. S. 1612 (King) Reimburse Veterans for Domiciliary Care Act
13. S. 1828 (Rubio) Veterans Homecare Choice Act of 2023
14. S. 1951 (Sanders) Department of Veterans Affairs Income Eligibility Standardization Act
15. S. 1954 (Sanders) Improving Whole Health for Veterans with Chronic Conditions Act
16. S. 2067 (Tillis) A bill to require the Secretary of Veterans Affairs to award grants to nonprofit organizations to assist such organizations in carrying out programs to provide service dogs to eligible veterans, and for other purposes.
17. S. ____ (Tester) Making Community Care Work for Veterans Act of 2023
18. S. ____ (Sullivan) Leveraging Integrated Networks in Communities for Veterans Act
19. S. ____ (Sullivan) Rural Vital Emergency Transportation Services (VETS) Act

Prepared Statements

STATEMENT OF DR. MIGUEL LAPUZ
ASSISTANT UNDER SECRETARY FOR HEALTH FOR INTEGRATED VETERAN CARE
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE

JULY 12, 2023

Good morning, Chairman Tester, Ranking Member Moran, and Members of the Committee. I appreciate the opportunity to discuss the Department of Veterans Affairs' (VA) views on pending legislation regarding health care benefits. I am accompanied today by Dr. Matthew Miller, Executive Director – VA Suicide Prevention, Office of Mental Health and Suicide Prevention, Dr. Cynthia Gantt, Deputy Director, Office of Patient Centered Care and Cultural Transformation, and Dr. Leslie Sofocleous, Executive Director, Program Management Office, Electronic Health Record Modernization – Integration Office. VA does not have views on S. 2067, the Service Dogs Assisting Veterans Act, but will provide them to the Committee for the record.

S. 449 Veterans Patient Advocacy Act

S. 449 would amend 38 United States Code (U.S.C). § 7309A to require VA, beginning no later than one year after enactment, to ensure that there is no fewer than one patient advocate for every 13,500 enrolled Veterans and that highly rural Veterans may access the services of patient advocates, including, to the extent practicable, with respect to assigning patient advocates to rural community-based outpatient clinics (CBOC). Within two years of enactment, the Comptroller General would have to submit to Congress a report evaluating the implementation by VA of these changes.

VA does not support this bill. VA agrees with the intent of the Veterans Patient Advocacy Act. Over the last few years, the role of the patient advocate has expanded because of the enactment of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114-198), the VA MISSION Act of 2018 (Public Law (P.L). 115-182), Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (the Isakson-Roe Act; Public Law 116-315), the Veterans COMPACT Act of 2020 (Public Law 116-214), and the Honoring our PACT Act of 2022 (Public Law 117-168).

VA has explored establishing a set ratio, as the bill would do, but believes that a focus on program outcomes would be a better model. VA is concerned that a specific staffing ratio for patient advocates could result in facilities having too many patient advocates and too few providers or other necessary support staff. Advances in technology or different staffing models may yield the same or even better outcomes for Veterans than a codified staffing ratio would do.

VA's goal is to ensure the Patient Advocacy Program is responsive to Veterans' needs based on evidence of what those needs are and strongly recommends continued examination of data analytics from VA facilities to determine how best to proceed in this area. Although the data collected provided insights to overall staffing levels, it is unclear to what extent across VA a patient advocate is designated specifically to rural or highly rural CBOCs. VA will analyze the data with this consideration in mind to advance and expand access to patient advocacy services across VA.

VA also expresses concern regarding the timeline for implementation that would be required; one year is not sufficient time to implement the changes the bill would institute. VA welcome the opportunity to brief the Committee on research and analysis outcomes to better inform the intent of this bill.

VA does not currently have a cost estimate for this bill.

S. 495 Expanding Veterans' Options for Long Term Care Act

This bill would require VA, beginning not later than 1 year after the date of enactment, to carry out a 3-year pilot program to assess the effectiveness of providing assisted living services to eligible Veterans (at their election) and the satisfaction with the pilot program of the Veterans participating in the program. VA could extend the duration of the pilot program for an additional three years if VA determined it was appropriate to do so based on the result of annual reports to Congress and a report by the IG on the pilot program. This bill could result in a shift of some payment from Medicaid to VA.

VA supports, if amended, and subject to the availability of appropriations.

VA appreciates that the current version of this bill has addressed a number of the technical concerns we identified with similar legislation in the prior Congress. VA generally agrees that specific authority, particularly in the form of a pilot program, to furnish assisted living services would be a helpful addition to VA's options for long-term care. VA has encountered difficulties within its current authorities in appropriately placing Veterans who may only require assisted living services because these Veterans do not qualify for nursing home care. Moreover, due to shifts in the industry to an assisted living model of care, particularly for patients with dementia, Alzheimer's, or other memory deficits, VA's lack of authority to furnish assisted living services means they have no appropriate option. The pilot authority would allow VA to determine how best to develop a program to support these Veterans' needs. VA supports the protections this bill would include to ensure that Veterans are protected and receiving safe and appropriate care.

While VA supports the intent of this bill, VA recommends several amendments. First, the implementation timeline of one year from bill enactment is untenable. VA would need to issue regulations, hire staff, draft and enter into new agreements, and

likely develop new systems or processes to support successful implementation. VA recommends a timeline providing two years from enactment and will require timely and sufficient resources to support the program.

Second, VA seeks clarification in the application of section 2(b)(2)(B). As written, it is unclear whether this section applies to the pilot program as a whole or to each participating Veterans Integrated Service Network (VISN). VA cautions that requiring each VISN to meet the provisions of section 2(b)(2)(B) would severely complicate implementation and increase costs as well.

Third, VA seeks clarification as to whether the requirements in in 38 U.S.C. §§ 1741-1745 and in VA regulations should apply if the payments to State homes are intended to be accomplished by a grant program. VA has been working to implement section 3007 of the Isakson-Roe Act related to per diem payments for Veterans who do not meet all the requirements for per diem payments for domiciliary care in 38 C.F.R. part 51; VA recommends the bill be amended to allow for, but not require participation of State homes to ensure that the existing efforts to comply with section 3007 are not delayed or interrupted by implementation of this new authority. We further note that selecting a State home for a location could present other issues, as VA does not manage or control State homes. Presumably, VA would need to establish standards and parameters for a program that a Sate home could then opt into or apply to furnish.

Fourth, VA recommends more specificity in section 2(d)(2)(B) in the definition and scope of benefits and participants under this program. As written, section 2(d)(2)(B) would require VA to "enroll" Veterans who no longer wish to participate in the pilot program in other extended care services based on their preference and best medical interest, but VA does not have an enrollment requirement for most VA extended care. It is unclear if the intent of this subparagraph is to require VA to enroll and pay for these Veterans' care in non-VA programs, to establish an enrollment requirement for VA extended care programs, or simply to provide VA care through other means.

Finally, VA seeks clarity of the definition of "eligible veteran" in section 2(i)(2)(B)(i). In this section, the term "eligible veteran" is defined to mean, in pertinent part, Veterans who are "eligible for assisted living services, as determined by the Secretary." The intent of this provision is unclear and could be interpreted various ways that could create significant and potentially costly implementation challenges. VA would appreciate the opportunity to discuss these technical issues in detail with the Committee.

VA estimates this bill would cost $60.309 million in fiscal year (FY) 2024, $62.551 million in FY 2025, $188.195 million over 5 years, and $188.195 million over 10 years. The costs are the same for the 5- and 10-year estimates because this is only a 3-year pilot.

S. 853 VA Zero Suicide Demonstration Project Act of 2023

Section 2 of S. 853 would require VA, not later than 180 days after the date of enactment, to establish a pilot program called the Zero Suicide Initiative (hereafter, the Program). The Program would have to implement the curriculum of the Zero Suicide Institute of the Education Development Center (the Institute) to improve safety and suicide care for Veterans. VA would develop the Program in consultation with the Secretary of the Department of Health and Human Services (HHS); the National Institutes of Health; public and private institutions of higher education; educators; experts in suicide assessment, treatment, and management; Veterans Service Organizations; and professional associations VA determines relevant to the purposes of the Program.

The Program would generally terminate after five years, but VA could extend the Program for not more than two years if VA notified Congress.

VA does not support this bill as written.

VA does not support this current bill for clinical, fiscal, empirical, contractual, technical, and empirical reasons, which are elaborated in this following response.

Clinically, existing suicide prevention efforts and strategies are more robust than what would be required by this bill. VA's current efforts incorporate all foundations within the Institute's Program and offers surveillance, prevention and intervention strategies that exceed the Institute's Program. We welcome an opportunity to provide a briefing to the Committee comparing VA's comprehensive approach and programs within suicide prevention to that of the Institute's Program.

VA has made suicide prevention a top clinical priority, and VA is implementing a comprehensive public health approach with the goal of reaching all Veterans within and outside the health care system. This approach is in full alignment with the President's White House Strategy for Reducing Military and Veteran Suicide, advancing a comprehensive, cross-sector, evidence-informed public health approach with focal areas in lethal means safety, crisis care and care transition enhancements, increased access to effective care (consistent with the VA/Department of Defense (DoD) Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide), addressing upstream risk and protective factors and enhanced research coordination, data sharing and program evaluation efforts. The FY 2023 Budget and the FY 2024 Budget request sufficiently supports VA's system of comprehensive treatments and services to meet the needs of Veterans and family members involved in the Veteran's care.

In August 2020, VA funded and completed a pilot, through the execution of a one-year contract awarded to the Education Development Center, for the development and implementation of a 9-month Zero Suicide Initiative at the Manchester VA Medical Center. The Manchester VA Medical Center (VAMC), with the support of the New Hampshire State Suicide Prevention Council, engaged key community agencies across

the State in a 9-month online community of practice. They also engaged in facility level organizational culture and performance related suicide prevention improvement efforts. A technical review of the Manchester VAMC pilot found that the facility did report qualitative improvements. However, when comparing suicide prevention outcomes and suicide prevention key performance indicators, there were no measurable improvements that could be directly attributed to the Zero Suicide processes (and some key performance indicators worsened). Therefore, further resource allocation to advance Zero Suicide was not supported ta that time. This conclusion was drawn by both reviewing the performance across several suicide prevention domains and considering other performance improvement supports provided by the VHA's public health approach.

Fiscally, the bill's requirements would come at unknown and unaccounted for cost to VA, which would likely require VA to divert resources from other suicide prevention programs and initiatives demonstrating solid, empirical evidence of progress. We welcome a conversation on the Institute's total costs of the Program to comply with the requirements in the bill prior to further action by the Committee. VA would then need adequate time to review and calculate indirect and opportunity costs associated with all phases of program implementation and with costs and cost parameters or assumptions provided by the Institute.

Contractually, the bill would direct VA to form a legally binding monetary agreement with a specific entity, seemingly violating Federal acquisition and procurement principles of open and fair competition. This could result in a greater cost to the Department than we might otherwise incur through full and open competition.

VA is concerned about legislating a specific model using specific entities when defining clinical operations. Suicide prevention is a dynamic field informed by evidence, and VA believes the best approach is to allow VA to continue to adopt a public health model based on proven clinical interventions, established business practices and equitable and transparent exchange of relevant data, rather than prescribing a single approach which predominantly focuses implementation within health care settings.

VA has several technical concerns regarding the bill. First, the stated goal of the implementation of the Institute's curriculum is to "improve safety and suicide care" for Veterans, but it is not clear how this would be defined, measured and reported, and over what course of time. Second, the eight metrics VA would have to use to compare the suicide-related outcomes at program sites and other VA medical centers would not be a methodologically valid or statistically valid study design. There are numerous and complex correlated, moderating, mediating, and confounding variables to include or statistically control if valid and reliable comparisons are going to be made isolating the impact of the Program. We could see value in a comparative study of different programs, but the evaluation would need to be carefully reviewed, constructed and implemented by appropriate data analytics and research design subject matter experts.

Finally, as written, the bill would require development and consultation with various stakeholders. This activity may invoke the Federal Advisory Committee Act and require VA to form multiple new Federal Advisory groups. VA recommends amending the bill's language to clarify that consultation activities are exempt from the Federal Advisory Committee Act. In the alternative, the consultation requirements could be removed, which would also address this concern. However, we again emphasize that even with these changes, VA would not support this bill.

VA does not know what the Institute would charge in terms of access to its materials and training resources or the direct and indirect costs to VA associated with implementation and training.

S. 928 Not Just a Number Act

Section 2 of this bill would require VA, not later than 18 months after enactment and not later than September 30 of each year thereafter, to submit to Congress and publish online a report to be known as the National Veteran Suicide Prevention Annual Report.

VA supports section 2, if amended. Since 2016, VA has produced and published an annual report regarding Veteran suicide with the latest available data. VA's National Veteran Suicide Prevention Annual Report already includes most of the information that would be required by the bill.

In addition to other technical amendments regarding the scope of several of the data elements, VA recommends the following amendments. First, suicide data is reported by sex, not gender, so VA could not disaggregate rates based on gender. The bill would also require a comparison to "Veterans who have never received health care from the Veterans Health Administration", but VA generally only compares with Veterans who have not received care from VHA within the past five years.

Second, VA is unable to provide trend information about Veterans who "applied for [a guaranteed] loan" or "who were turned down for such a loan by a lender." Most lenders in VA's guaranteed loan program are authorized to close loans without prior VA approval, and VA does not have access to the data on the applications they receive, unless the loan is closed. Further, VA believes that the report should include comparison data for Veterans who are rated as eligible for a specially adapted housing (SAH) grant under chapter 21, title 38, United States Code, and those who use their SAH grant to adapt or purchase a home. This critical benefit helps severely disabled Veterans achieve and maintain independence in their homes and communities, which may in turn affect their mental health outcomes.

Finally, this section would establish a process under which VA could request an extension for submitting a report, but the bill section lacks clarity on whether one or both Committees would have to approve the extension for it to be granted, how the extension would be communicated to VA, and if the Committees' respective responses would be

subject to a timeline. Also, this section refers to “suicide deaths,” as well as “suicide rates or deaths,” which raises technical questions about the scope of the report (i.e., whether “suicide” modifies rates and deaths or if VA is expected to report on non-suicide deaths).

These additional requirements would necessitate further collaboration and resources, but VA could generally provide the information required by this report within existing funding.

Section 3 of the bill would require VA, not later than three years after enactment, to submit to Congress and publish online a report that analyzes which benefits and services from VA (including VBA) have the greatest impact on prevention of suicide among Veterans, including recommendations for potential expansion of services and benefits to reduce the number of Veteran suicides.

VA supports section 3, with amendment, subject to the availability of appropriations. The three-year timeline may prove challenging. Suicide is a rare event with no single cause. Because it is the result of a complex interaction of risk and protective factors, to determine which have the “greatest impact” on preventing a suicide event is extremely difficult. Implementing interventions and programs at individual, interpersonal, community and societal levels takes time and coordination, with ongoing quality improvement revising and improving programs over time for maximum benefit. These processes impact comparability of programs year to year, resulting in less than helpful conclusions and comparisons.

The term “benefits and services” is undefined, but VA assumes this to be intentional on the part of the drafter to be broadly inclusive. We do note that this analysis could only identify correlations and not causation. Particularly given that those who are eligible for more benefits are often at higher risk, this analysis may not be able to produce much meaningful conclusions. Presently, VA is engaged in evaluating community and clinical interventions aimed at reducing Veteran suicide.

VA welcomes the opportunity to discuss this bill section further with the Committee to ensure there is a clear scope and methodology for implementation. VA estimates this section would cost approximately $1.2 million in FY 2024; VA also estimates it would take approximately five years to complete this review, and the total cost over that time would be approximately $18.5 million.

Section 4 of the bill would require VA, in collaboration with CDC, to develop a toolkit for State and local coroners and medical examiners that contains best practices for accurately identifying and reporting suicide deaths of Veterans and reporting such deaths to the CDC and other applicable entities. Not later than two years from enactment, VA would have to make the toolkit available online.

VA does not support section 4. VA currently has an interagency agreement with the Substance Abuse and Mental Health Services Administration that supports

outreach and efforts, and VA collaborates with CDC to access data from its Violent Death Record. Additionally, the Governor's Challenge has developed a toolkit that is more broadly applicable (not limited to State and local agencies or coroners). VA is also working, under section 303 of the STRONG Veterans Act, to provide additional support in this area.VA believes these current efforts sufficiently meet the intent of this section; legislating in this area could negatively impact current efforts and duplicate costs.

While the toolkit in this bill would be hosted on the VA website, it appears that most of the expertise for developing the toolkit, as well as the strategy and recommendations piece of the initial report detailed in section 3, would likely need to come from the Centers for Disease Control and Prevention (CDC). Veteran-specific information (in particular, identifying Veteran status) would come from VA, but vitals statistics expertise generally and vitals expertise relative to coroners and medical examiners specifically is housed in the National Center for Health Statistics within CDC. It is not clear from the bill whether CDC would make the final determination on recommendations from the report because the report would be hosted on the VA website. The same applies to the toolkit. The bill also does not include an authorization of appropriations for HHS related to the development, management, or publication of the report required by section 2 or the toolkit in section 4; both of these efforts could require relatively significant staff time to develop, but maintenance and annual evaluation and revisions would be less costly.

Section 5 of the bill would require VA, after submittal by the Comptroller General to Congress of the management review required by section 403 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (the Hannon Act, Public Law 116-171), to review the findings and recommendations of the management review and conduct a study on the feasibility and advisability of creating a suicide prevention office at the level of the Office of the Secretary.

VA supports section 5. VA supports conducting a study on the feasibility and advisability of creating a suicide prevention office at the level of the Office of the Secretary. VA concurs with the plan to submit a report to Congress that summarizes any planned reorganization that would result from the leadership review of the study, including a strategy for leadership of this new office.

VA estimates the study required by this section would cost approximately $600,000 to complete. The Office of Mental Health and Suicide Prevention (OMHSP) has experience completing a similar related feasibility and advisability study that focused on a broad review of suicide prevention related organizational structure (with the assistance of a contractor) as part of the Hannon Act. We believe Section 5 is asking for a similar type of analysis, so those costs were utilized.

S. 1037 VA EHRM Standardization and Accountability Act

Section 2(a) would prohibit VA from commencing a program activity at a VHA facility where no program activity has commenced as of the date of enactment of the

Act until VA submits to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives written certification that the electronic health record (EHR) system has met the following improvement objectives: (A) minimum uptime and system-wide stability standard; and (B) submission of a report detailing the completion status of corrections to the customization and configuration of workflow designs related to the EHR system. The provisions of section 2 would sunset once VA has completed certifications consistent with this section for VHA facility complexity levels 1, 2, and 3.

VA does not support section 2(a). This would prohibit VA from carrying out certain activities under the Electronic Health Record Modernization Program (EHRM) until the completion of sections 2(a)(2)(A) and (B). VA does not support the prohibition against commencing program activities until the completion of these sections, which do not consider the current EHRM Program Reset and infrastructure activities that necessitate continued engagement given the implementation lead time. Continuing program activities provides VA the opportunity to effectively incorporate Reset results and, where feasible, to standardize the current EHR to support future deployments and thereby reduce potential configuration rework that could have significant cost impacts later.

Section 2(b) of this bill would require the Under Secretary for Health, in consultation with the VHA facility director, to submit to the Secretary, and the Secretary to transmit to the House and Senate Committees on Veterans' Affairs, written certification that the staff and infrastructure of the facility are adequately prepared to receive the EHR system. This section would also require VA to provide written certification for one VHA facility for each of the complexity levels 1, 2 and 3.

VA does not support section 2(b). The written certification outlined by the bill is duplicative of VA's existing concurrence processes.VA has already implemented a consistent go-live approval process for each deployment of the EHR system that would satisfy this requirement. Specifically, infrastructure readiness is assessed through the current state review (CSR) process and addressed before deployment operations begin. Deployment kickoff starts one to two years prior to go-live, and there are weekly working deployment meetings with the facility, change leadership team and change sponsor to walk through outstanding issues. Approximately 8 weeks before go-live, VHA, EHRM-Integration Office (IO), VISN and site leadership meet weekly to review the readiness checklist and areas of concern. VA has also introduced formal Go Live Readiness Assessments which address risk and assess both site and solution readiness in the pre-go-live period and include a formal deployment decision.

VA fully supports section 2(c) of this bill, which would exclude application of this section to any facility jointly operated by VA and DoD. We note the term "joint" is not defined, and there are 65 facilities in which DoD and VA have partially integrated facilities (e.g., labs, audiology, etc.), with embedded staff, enhanced sharing of medical services, equipment, and non-medical staff. At these locations, a single, common health care record is anticipated to increase efficiency in operations and patient care.

To date, 119 of 138 DoD worldwide medical facilities have adopted the single, common EHR; 109 of 109 Department of Homeland Security (DHS) Coast Guard shoreside medical sites have adopted the new EHR; and 7 Department of Commerce National Oceanic and Atmospheric Administration sites have implemented the new EHR.

Section 2(d) would require submission of initial (i.e., not more than 30 days after the Act's enactment) and quarterly reports to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives, consistent with the elements outlined in section 2(d).

VA does not support section 2(d). With the EHRM Program Reset underway and the need to collaborate with DoD on systems and networks within the Federal EHR environment, providing an initial report within 30 days of enactment is not feasible. VA currently provides quarterly reports to Congress in accordance with section 2 of Public Law 117-154 (VA Electronic Health Record Transparency Act of 2021) and section 503(b) of Public Law 115-407 (Veterans Benefits and Transition Act of 2018) on deployment activities, and information on the topics listed can be added to those existing reports.

Section 2(e) provides definitions of EHR system and program activity.

VA support section 2(e), with amendment. VA recommends updating section 2(e)(2) to read: "(2) The term 'program activity' means any local or national workshop and/or training activities under the Electronic Health Record Modernization Program before the certification of the electronic health record system."

S. 1040 Prohibiting Smoking in Facilities of the Veterans Health Administration

This bill would repeal section 526 of Public Law 102-585 and amend 38 U.S.C. § 1715 to prohibit any person (including Veterans, patients, residents, employees, contractors, or visitors) from smoking on the premises of any VHA facility. The bill would prohibit the use of cigarettes, cigars, pipes, and any other combustion or heating of tobacco, as well as the use of any electronic nicotine delivery system, including electronic or e-cigarettes, vape pens, and e-cigars. The prohibition would apply to any land or building that is under VA's jurisdiction, under the control of VHA, and not under the control of the General Services Administration.

VA strongly supports this bill. Legislation to prohibit smoking on the premises of any VHA facility will ensure that VA can provide a smoke-free health care environment. Currently, there are more than 4,000 local or State, territorial, or commonwealth hospitals, health care systems and clinics, and at least four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation) in the United States that have adopted 100 percent smoke-free policies

that extend to all their facilities, grounds, and office buildings. Absent this legislation, VHA patients, health care providers and visitors may not have the same level of enduring protection from the hazardous effects of second-hand smoke exposure as do patients and employees in these other systems. Currently, approximately 12.7 percent of Veterans enrolled in VA health care are smokers. Many of the non-smokers are also older Veterans who may be at higher risk for cardiac or other conditions that may make them even more vulnerable to the cardiovascular events associated with secondhand smoke.

As with other health care systems, VA believes its employees and Veteran patients have a right to be protected from secondhand smoke exposure when working or seeking health care at a VA facility. For Veteran smokers who are inpatients, nicotine replacement therapy is available. VA also offers tobacco cessation programs and resources for its employees. VA recommends including an effective date to facilitate implementation.

VA estimates that this bill would not result in any costs because it is consistent with current policy.

S. 1125 EHR Program RESET Act

S. 1125 includes 6 titles and 18 substantive sections. VA does not support the RESET Act as currently written. Although VA generally agrees with several provisions of the bill, VA finds that many of the bill's provisions reduce managerial flexibility and create a significant operational burden. Both outcomes would impede or slow VA's ability to successfully execute the EHR Modernization program and deliver value to Veterans, clinical staff and the Veterans Health Administration (VHA) system as a whole. VA believes there is room for discussions relative to many of the proposed requirements. VA welcomes the opportunity to work with the committees to provide technical assistance to meet congressional intent while resolving potential conflicts with organizational structure and existing legal requirements.

Section 101 of this bill would establish, within VHA, a program to modernize the EHR and other relevant health information technology systems of the Department; a Program Management Office, with specifically defined functions and duties; and a Deputy Chief Information Officer for Electronic Health Record and Health Information Technology.

VA cites concerns with section 101. VA acknowledges the intent of section 101 is to realign the existing EHRM-Integration Office under VHA, with a portion of the office realigning under the Office of Information and Technology. Additionally, while the Deputy Secretary would remain accountable for the program, both the Under Secretary for Health and the Chief Information Officer would have responsibilities associated with the programmatic, technical, and functional execution of the program.

VA can support this proposal though cites concerns that under current EHRM appropriations the account is to be 'administered' by the Office of the Deputy Secretary. Changes of the organizational structure would potentially require clarification or adjustments to current appropriation law.

Section 102 would establish a permanent advisory subcommittee of the Special Medical Advisory Group on electronic health record and health information technology modernization within 60 days of enactment of the Act.

VA supports section 102.

Section 201 would suspend new go-live deployments until certain healthcare performance baseline or national metrics for continuation of the Program are met or exceeded.

VA cites concerns with section 201. As demonstrated by the Program Reset and VA's proactive decision to halt further deployments of the EHR until critical issues are addressed and the system is optimized, VA concurs with pausing deployments until certain thresholds are met. However, VA believes that the timelines stipulated in section 201 are too short. This bill requires completion of a re-organization and establishment of national standards within 60 days; this is not feasible. Additionally, while VA agrees there is a need to establish metrics for the EHRM program, the trigger requirements and timelines for pursuing alternative or replacement solutions, as outlined are too rigid and will not allow for the risk-based decision making that is needed in the context of the massive change effort incumbent within VA's EHRM effort.

Section 202 would establish reporting pre-requisites prior to continued deployment of the new EHR system at additional locations and facilities.

VA does not support section 202. VA believes section 202 is unnecessary since many of the proposed actions in this section are already in progress as part of VA's self-initiated reset efforts with more improvements being implemented over the coming months. Moreover, VA cannot support the specified timeline of 30 days for the report on the metrics, readiness criteria, and governance process to be used to determine whether to proceed with deployment or a continued pause. Additionally, the requirement to determine whether the record is ready for continued deployment in June 2023 has been overcome by the program Reset announcement on April 21, 2023, thereby rendering this requirement unnecessary.

Section 203 speaks to Congress' sense that training and change management should be led by VA and specifically VA employees who understand the legacy VistA system of the Department, the existing and future standardized workflow of the Department, and the history, culture, and mission of the Department.

VA has no objections to section 203.

Section 301 of the bill would require that a report be submitted to the appropriate committees of Congress, summarizing the standard support services that the Department does or intends to provide to each facility in preparation for potential future deployment, and, at a minimum, include the items enumerated in section 301(b)(1)-(6). This report would be due no later than 90 days after enactment. Section 302 would amend section 503(b) of the Veterans Benefits and Transition Act of 2018 regarding quarterly report requirements.

VA supports sections 301 and 302 with amendments. VA already provides regular reports to Congress on deployment activities and information on the topics listed in sections 301 and 302, but elements of these sections can be added to existing report requirements without legislation. However, portions of the bill need further clarification, including the definitions of some terms, frequency of reporting, and establishment of realistic timelines for providing financial data. VA welcomes the opportunity to work with the Committee to provide technical assistance on this section.

Section 401 would require VA to terminate all contracts with Oracle Cerner for training and change management related to EHRM and prohibit VA from issuing task orders for training and change management activities with Oracle Cerner or subcontractors.

VA does not support section 401. A process is already underway to evaluate the timeline to transition Oracle Cerner's training and change management efforts to more of a support role. Given the magnitude of the task, VHA is not yet ready to assume management lead of all training and change management activities. As acknowledged in Section 401, VA will still require some level of contract support. VA has concerns about a 275-day timeline for successful procurement of alternative contract resources. VA also requires sufficient time to transition the responsibilities to a new contractor and to validate that the new VA-led and contractor-supported training has been successful. In addition, if there are areas where Oracle Cerner needs to support VA or a new training contractor regarding the VA and alternative contractor's training and change management efforts, VA needs to be able to issue necessary task order to Oracle Cerner to allow such support.

Section 402 would designate a lead negotiator for all current and future contracts relating to the new EHR.

VA does not support section 402. VA does not support the need for stronger contract negotiation and the designation of a new lead negotiator per section 402, as the negotiation objectives identified have been achieved, the contract negotiations are already complete and VA has awarded Option Period 1.

Section 403 would require VA to negotiate a contract for independent oversight and validation of functions described in section 403(c).

VA supports section 403, with amendments. Although VA supports the proposal in section 403 for independent verification and validation (IV&V) and has agreed to such a proposal during public hearings, it does not support the proposed timeline. VA welcomes the opportunity to work with the Committee to develop a more appropriate timeline for implementation of the elements described in this section.

Section 404 would require VA to submit a report to Congress on maintain the legacy Veterans Health Information System Technology Architecture (VistA) system no later than 60 days after enactment and not later than 90 days after the beginning of each Fiscal Year thereafter with a termination date of 15 years post enactment.

VA supports section 404.

Section 405 would require VA to submit to Congress a report on alternatives to current EHR technology and the Oracle Cerner product.

VA does not support section 405. VA believes it would be premature during the current Program Reset to provide a report on possible alternatives to the Oracle Cerner EHR and its current contract with VA. Based on the results of the Program Reset, VA will determine the next steps. If the results suggest the need to pursue a different solution, a new acquisition strategy will be developed, which will evaluate alternative competitive solutions. Furthermore, if the report currently required by section 405 were to be mandated nonetheless, VA submits that the proposed timeline of 60 days is not adequate for production of a quality product that encompasses an analysis of alternative technologies in the EHR space, market trends, reinvestment of expenditures, the impact of aligning and interoperating with DoD's MHS GENESIS, and other matters as required.

Section 406 would require VA to submit a report to Congress on leadership, engagement and management, strategic planning, contracting and contract oversight and program management in the implementation of the EHR between 20217 through the date of the report and any large acquisitions and major modernizations conducted, including those that are ongoing or planned by the Department after the date of the report no later than 180 days after enactment.

VA does not support section 406. VA already provides reports on leadership, acquisition and contracting oversight lessons learned as part of our existing reporting process. Therefore, VA believes section 406 is unnecessary. Information detailing steps to improve the composition of and management of task orders are not specifically included in Congressional reporting at this time but can be incorporated in existing reporting.

Section 407 would require VA to submit a report to Congress on contract savings, services provided at no cost to VA and contract costs incurred with respect to Oracle Cerner product no later than 90 days after enactment.

VA supports section 407, with amendments. VA already provides reports on contract costs and savings to Congress, and the elements in this section can be added to existing requirements. Section 407(3) ties back to reporting under Sections 301 and 302 and as noted, VA welcomes the opportunity to work with the Committee to provide technical assistance on that section, and by extension, this one as well.

Section 501 would require, not later than 90 days after the date of the enactment of the Act, and not less frequently than quarterly thereafter, VA to submit to Congress quarterly reports on system uptime, modernization and coordination activities for DoD IT systems that are relied upon by VA to deliver health care, compensation, memorial benefits, and other services. Section 502 would require coordination with DoD, with a report submitted to the appropriate committees of Congress, and the Committees on Armed Services of the Senate and House of Representatives detailing the additional support needed from DoD to make the current and future delivery of health, benefits, memorial affairs, and other services of the VA, stable and successful.

VA does not support sections 501 and 502. Sections 501 and 502 have potential conflicts with the National Defense Authorization Act (NDAA) for Fiscal Year 2020 (the FY 2020 NDAA, Public Law 116-92, section 715) relating to authority and responsibility of the Federal Electronic Health Record Modernization (FEHRM), which requires the FEHRM office to submit a report on its activities during the preceding calendar year. This includes information on progress implementing a single, comment Federal EHR. Additionally, given the inter-agency nature of these reports and their statutorily described role, VA believes the FEHRM may be best equipped as the lead. Finally, the requested timelines for initial delivery of the reports in sections 501 and 502 do not seem feasible. There already exists a statutorily-established body, the VA-DoD Joint Executive Committee, to address VA-DoD IT and data issues or concerns.

Section 601 of the bill would require, not later than 180 days following enactment, and periodically thereafter, submission of a report to the appropriate committees of Congress detailing any legislative action, including resources, required to carry out the Act of implement a modernized EHR.

VA supports section 601. Section 602 of the bill would require, not later than 180 days following enactment, a report on the current state and level of interoperability with the VA's legacy VistA EHR and legacy applications, including the Joint Longitudinal Viewer, as well as the Oracle-Cerner product in use at the five deployed sites within VA.

VA supports section 602, if amended, and subject to the availability of appropriations. VA notes that section 602 has significant overlap with the NDAA of 2020 (P.L. 116-92, section 715), which requires the FEHRM office to submit a report on its activities during the preceding calendar year. Additionally, the FEHRM Interoperability Progress Quarterly Report includes updates on interoperability modernization in response to House Report 117-388, page 261, accompanying H.R. 8236, the Department of Defense Appropriations Bill, 2023. In addition to concerns regarding duplication of existing FEHRM reports, the contents of the report described in

section 602(b)(1-7) and (c)(1-3), cannot be completed solely by VA. As the FEHRM is currently completing the 2020 NDAA-mandated assessment and report, VA requests the FEHRM remain lead as planned to deliver under section 715 of the FY 2020 NDAA or that this section be issued as an amendment to that law to identify additional reporting requirements and establish the FEHRM as responsible for reporting. This would alleviate redundant efforts and leverage existing contractual support already aligned to this effort.

If enacted, section 602 would have additional costs. However, given the complexity of FEHRM involvement and potential to leverage existing contractual support, VA does not have a cost estimate for section 602 of this bill.

S. 1172 RELIEVE Act

Section 2(a) of the bill would amend 38 U.S.C. § 1725(b)(2)(B) to create an exception to the requirement that an enrolled Veteran has received care under chapter 17 within the 24-month period preceding the furnishing of emergency treatment at a non-VA facility to receive reimbursement from VA. This exception would make eligible for potential reimbursement Veterans who have not yet received care under chapter 17 but who enrolled and received emergency treatment within the first 60 days of the Veteran's enrollment. Section 2(b) would provide that the amendment made by section 2(a) would apply with respect to emergency treatment furnished on or after the date that is one year after the date of enactment.

VA supports this bill, subject to the availability of appropriations. This bill aligns with VA's legislative proposal Waiver of 24-Month Requirement for Reimbursement of Emergency Treatment under 38 U.S.C. § 1725 for Recently Enrolled Veterans. While there are only a few Veterans who might qualify under this exception, VA has no other means for reimbursing these Veterans unless VA is notified that the care was provided by a network provider under the Veterans Community Care Program (VCCP). This bill would provide an important benefit to this population.

We would appreciate the opportunity to discuss further with the Committee current limitations related to this authority and other possible options that might help ensure Veterans who might not otherwise know about these limitations to be reimbursed for their emergency treatment.

VA cautions that if rulemaking is required to implement this new authority, the one-year implementation timeline may be difficult to achieve, and VA therefore recommends a two-year timeline to ensure compliance.

VA estimates this bill would cost $5.2 million in FY 2025, $28 million over 5 years, and $60 million over 10 years.

S. 1315 Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023

S. 1315 contains two titles and a total of 19 substantive sections.

Section 101 would amend 38 U.S.C. § 1703B regarding VA's access standards to expand and codify VA's existing access standards established in regulation at 38 C.F.R. § 17.4040. Specifically, it would create a new section 1703B(a) that would provide that covered Veterans would be eligible to elect to receive hospital care, medical services, or extended care services under section 1703(d)(1)(D) (the eligibility criterion for VCCP based on VA's designated access standards) if VA determined, with respect to primary care, mental health care, or extended care services (excluding nursing home care), VA could not schedule an in-person appointment for the covered Veteran with a VA health care provider at a facility that is located less than a 30-minute average drive time from the Veteran's residence or during the 20-day period after the date on which the Veteran requests such appointment. With respect to specialty care, covered Veterans could elect to receive community care if VA could not schedule an in-person appointment with a VA health care provider at a facility that is located less than a 60-minute average drive from the Veteran's residence or during the 28-day period after the date on which the Veteran requests such appointment. The availability of telehealth appointments would not be taken into consideration when determining VA's ability to furnish such care or services in a manner that complies with the access standards. VA could prescribe regulations that establish a shorter average drive or time period than those otherwise described above. Covered Veterans could consent to longer drive or time periods, but if they did, VA would have to document such consent in the Veteran's EHR and provide the Veteran a copy of that documentation in writing or electronically. If a Veteran had an appointment cancelled by VA for a reason other than the request of the Veteran, VA would have to calculate the wait time from the date of the request for the original, canceled appointment.

Proposed section 1703B(b) would require VA to ensure that these access standards apply to all care and services within the medical benefits package to which a covered Veteran is eligible under section 1703 (except nursing home care) and to all covered Veterans, regardless of whether they are new or established patients.

Proposed section 1703B(c) would require VA to review, at least once every three years, the access standards established under the revised section 1703B(a) with Federal entities VA determines appropriate, other entities that are not part of the Federal Government, and entities and individuals in the private sector (including Veterans who receive VA care, VSOs, and health care providers participating in the VCCP). Section 101 would also strike section 1703B(g), which allows VA to establish through regulation designated access standards for purposes of VCCP eligibility and would make other conforming amendments.

VA opposes section 101. VA is opposed to codification of access standards. Limiting the ability of the Secretary to develop and publish such standards for VA diminishes the Secretary's authority to ensure Veterans receive the right care, at the right time. This bill fails to consider other market forces that also impact access to care

outside of VA and would not allow VA to consider and incorporate those forces to meet Veterans' needs for timely, high-quality care. Moreover, VA cannot support codification of residential treatment and rehabilitative services as proposed in this bill. VA generally supports establishing a wait-time standard of 10 or fewer days for the delivery of such treatment and services, although we oppose codifying this in law.

VA also opposes the provision that, in making determinations about scheduling appointments, prohibits consideration of a telehealth appointment or the cancellation of an appointment unless such cancellation was at the request of the Veteran. VA is considering how best to consider telehealth with regard to its access standards, including considering how to best prioritize the Veteran's preference..

Finally, VA notes that section 2 would require VA to engage in consultation with various stakeholders; this could invoke the Federal Advisory Committee Act and require VA to form multiple new Federal Advisory committees. VA recommends amending the bill's language to clarify that consultation activities are exempt from the Federal Advisory Committee Act. In the alternative, the consultation requirements could be removed, which would also address this concern.

Section 102 of the bill would amend 38 U.S.C. § 1703(a) by adding a new paragraph (5) that would require VA to notify a covered Veteran in writing of the eligibility of the Veteran for care or services under this section as soon as possible, but not later than two business days, after the date on which VA is aware that the Veteran is seeking care or services and is eligible for such care or services under § 1703. VA would have to provide such Veterans periodic reminders, as it determines appropriate, of their ongoing eligibility under § 1703(d). VA could provide covered Veterans notice electronically.

VA does not support section 102. While VA agrees that timely eligibility notification is an integral component of VA's ability to provide Veterans quality care, a statutorily prescribed two-business day notification deadline would make universal implementation of this standard extremely challenging, especially in cases where notification by electronic communication is unavailable or in instances of walk-in emergency care. VA personnel would face operational and administrative burdens if they were responsible for making notifications, which would come at additional cost to VA.

It is also unclear what is anticipated as the penalty for non-compliance in any situation where VA was unable to meet this requirement. VA welcomes the opportunity to work with the Committee to modify the process for notifying eligible Veterans to meet the intent of this section more feasibly.

Section 103 of the bill would amend 38 U.S.C. § 1703(d)(2) by adding new subparagraphs (F) and (G). These amendments would require VA to ensure that criteria developed to determine whether it would be in the best medical interest of a covered Veteran to receive care in the community include the preference of the Veteran

regarding where, when, and how to seek care and services and whether the covered Veteran requests or requires the assistance of a caregiver or attendant when seeking care or services.

VA does not support section 103. The wording in this section creates ambiguity and may shift this decision-making regarding the best medical interest of the Veteran from a joint decision to a unilateral one by the Veteran. Specifically, it is unclear whether the "preference of the covered veteran regarding where, when, and how to seek hospital care, medical services, or extended care services" would allow a Veteran unilaterally to determine his or her eligibility for community care if the Veteran stated a preference for community care. If the Veteran can choose to be seen in the community based on this preference, even if the provider did not agree, then by definition, the Veteran would be choosing to receive care that was not in the Veteran's best medical interest (in the judgment of the clinician). If, on the other hand, the Veteran's referring clinician only needed to "consider" the Veteran's preference, but the preference was not determinative, it is not clear that this would have any effect on operations or eligibility, and thus would seem unnecessary. Determinations regarding a Veteran's best medical interest already considers the distance between a provider and the Veteran, the nature of the care or services required, the frequency of the care or services, the timeliness of available appointments, the potential for improved continuity of care, the quality of care, and whether the Veteran would face an unusual or excessive burden in accessing VA facilities.

Including "whether the covered veteran requests or requires the assistance of a caregiver or attendant" as a factor for determining whether it is in the Veteran's best medical interest to receive community care, would create confusion in practice. VA agrees that a Veteran's need for an attendant or caregiver is relevant and already considers consistent with 38 C.F.R. § 17.4010(a)(5)(vii)(E)). However, a Veteran's "request" for a caregiver or attendant does not establish need, but this section would qualify a requesting Veteran for community care irrespective of need.

VA believes that the proposed changes could not be implemented as written without fundamentally altering the process for making determinations about Veterans' best medical interest.

Section 104 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (o) that would require VA, if a request for care or services under the VCCP is denied, to notify the Veteran in writing as soon as possible, but not later than two business days, after the denial is made of the reason for the denial and how to appeal such denial using VHA's clinical appeals process. If a denial were made because VA determined the access standards under section 1703B(a) were not met, the notice would have to include an explanation of the determination. Notice could be provided electronically.

VA does not support section 104. VA is concerned that a statutorily prescribed two-business day notification deadline would be operationally burdensome, especially in

cases where notification by electronic communication is unavailable. It is also unclear the penalty for non-compliance in a situation where VA was unable to meet this requirement. Section 104 is ambiguous, as it refers to a Veteran not meeting the eligibility access standards; however, VA must be able to schedule an appointment that meets the eligibility access standards, and if it cannot, then the Veteran is eligible. We believe this was intended to apply when VA has determined that the access standards are met, and when a covered Veteran is ineligible for community care. We further note that the language would only apply to eligibility determinations regarding the access standards and would not apply to determinations regarding any other eligibility criteria.

VA is working to modify the process for notifying Veterans that VA has determined they are not eligible for community care to ensure they are notified in the timeliest fashion possible while avoiding some of the barriers that would be created by this section as written. We do not believe legislation is needed in this regard.

Section 105 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (p) that would require VA to ensure that Veterans were informed that they could elect to seek care or services via telehealth, either through a VA medical facility or through the VCCP, if telehealth is available to the Veteran, is appropriate for the type of care or service the Veteran seeks, and is acceptable to the Veteran.

VA supports section 105, with amendments. While VA supports this section, it is unclear whether the bill is intended to establish that a Veteran's preference to not receive care via telehealth would also be binding on how they receive care through the VCCP. If that is the case, that could result in additional costs to VA and could create network adequacy issues, as VA currently allows Veterans who decline VA-administered telehealth to receive telehealth from a community provider. VA welcomes the opportunity to discuss recommended amendments and cost implications of this section.

Section 106 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (q) that would establish that an agreement by a covered Veteran and the referring provider under § 1703 regarding the best medical interest of the covered Veteran or regarding eligibility for care or services under this section is final and may not be changed by VA without the knowledge and consent, documented in writing, of the covered Veteran and the provider unless there is a statutory or regulatory barrier preventing VA from providing the care or services in question.

VA does not support section 106. Referring providers may not always have the specific information needed to know whether receiving community care is in the best medical interest of the Veteran. This section would prohibit reviews or corrections of erroneous use of the best medical interest criterion and would not be appropriate if there are clinical or other changes that might require changes to use of the best medical interest criterion. For example, a referring provider may be unaware of a Veteran's other conditions (such as when test results are pending or a referral with another is still pending) before agreeing that community care would be in the Veteran's best medical

interest; other conditions may also arise during the course of treatment that would affect the best medical interest determination for a Veteran. While the bill would provide an exception for cases when there is a statutory or regulatory barrier preventing VA from providing the care or services, it is not clear that this exception would address the types of scenarios described above. Moreover, this bill would prevent the reconsideration of a best medical interest determination once it has been made and could consequently negatively impact the course of treatment based on these other factors.

VA is concerned that this section could complicate determinations VA must make on whether the care is necessary and appropriate. This determination must occur prior to determining whether receiving care in the community would be in the Veteran's best medical interest. For example, VA currently requires that any Veteran that is potentially in need of a transplant be entered into the VA TRACER system for evaluation before a determination is made about the provision of the transplant. It is not clear whether this language would impact these determinations, but VA is concerned that it could be interpreted to prevent this type of clinical review.

Finally, the proposed § 1703(q) would refer both to an agreement regarding the best medical interest of the veteran and to agreements "regarding eligibility for care or services under this section". It is not clear what this phrase is intended to convey, as the only agreements made between Veterans and referring providers concern whether receiving care in the community is in the Veteran's best medical interest. We recommend clarifying this to ensure that this phrase does not apply more broadly than intended.

Section 107 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (r) that would require VA to conduct outreach to inform Veterans of the conditions for care or services under section 1703(d) and (e), how to request such care or services, and how to appeal a denial of a request for such care or services using VHA's clinical appeals process. VA would have to, as part of the VA Solid Start Program, proactively reach out to newly separated Veterans to inform them of their eligibility for programs of and benefits provided by VA, including how to enroll in the system of annual patient enrollment under section 1705 and the ability to seek care and services under sections 1703 and 1710.

VA does not support section 107. The provisions of section 107 are already common practice in the VA enrollment process as enrollment prompts automated communications with information about the benefits available to them.

Under the VA Solid Start (VASS) program, VA conducts individualized conversations tailored to the needs of recently separated Service members to increase awareness and utilization of VA benefits and services. VASS calls are not scripted and are driven solely by the needs of the individual at the time of each interaction. Employees supporting VASS have the necessary training and resources to provide information about how to enroll in health care and seek community care for interested Veterans.

As VASS contacts all recently separated Service members, regardless of their character of discharge, some VASS-eligible individuals may not be eligible for VHA benefits, including VCCP. Requiring VASS to discuss these benefits with all VASS-eligible individuals may create concern or frustration for those recently separated Service members who are not eligible for VHA benefits due to their character of discharge.

VBA must allocate resources to allow for the extended time it would take to discuss these services with each VASS-eligible individual, which may negatively impact the overall program's successful connection rate. VA would require additional funding to support implementation and maintenance of this section.

Section 108 would require VA, working with third party administrators (TPA) and acting through the Center for Innovation for Care and Payment (CICP), to develop and implement a plan with a TPA to provide monetary and non-monetary incentives to health care providers under section 1703(c) that furnish care or services under the VCCP pursuant to an agreement with a TPA and submit that plan not later than 180 days after the date of enactment. No health care provider or TPA could be penalized for not carrying out any part of the plan. This section could not be construed to be a pilot program subject to the requirements of 38 U.S.C. § 1703E.

VA does not support section 108. VA does not support section 108 for several reasons. First, we do not believe it is necessary to specify the organization that would carry out this effort. Second, VA already has the authority to engage in efforts to support patient scheduling with community providers; indeed, sections 131-134 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (Division U of Public Law 117-328, the Cleland-Dole Act) requires VA to commence a pilot program under which covered Veterans eligible for care through the VCCP may use a technology that has the capabilities specified in section 133(a) to schedule and confirm medical appointments with health care providers participating in the VCCP. Third, given the contractual requirements that would be necessary to implement this section, the timeline (submitting a plan within 180 days) would be unrealistic.

Fourth, we are concerned that the bill would prohibit VA from penalizing a health care provider or TPA for not carrying out any part of the plan; to the extent the plan is reflected in contract terms, this would seemingly preclude VA's ability to enforce contractual terms. Finally, VA is concerned with the way the specific parameters of this proposal could create contractual relationships between VA and VCCP providers who are part of a TPA's network. Currently, VA has contracts with TPAs, and the TPAs have contracts with individual providers. There is no privity of contract between VA and the TPA's providers, which means these providers are not subject to other requirements associated with Federal contractors. If the intent of the proposed changes is for VA to establish a direct contractual relationship with these providers, or if a relationship was imputed, this could change the obligations imposed upon these providers. There is also

the potential that any contractual or other obligations between the provider and VA could conflict with requirements in the contract between the provider and the TPA. We recommend against creating a situation where providers could have conflicting requirements.

Section 109 of the bill would amend 38 U.S.C. § 1703(i)(5) to require VA to incorporate, to the extent practicable, the use of value-based reimbursement models to promote the provision of high-quality care. It would further require VA to negotiate with TPAs to establish the use of value-based reimbursement models under the VCCP. It would also impose additional reporting requirements associated with these efforts.

VA supports section 109. VA currently has efforts underway to incorporate value-based care to improve outcomes and care coordination while lowering costs. However, generally speaking, any negotiations with TPAs or others who have existing contracts or agreements with VA would be subject to bilateral agreement on such terms. While VA may seek to incorporate such changes through negotiation, there is no guarantee that the non-VA party would agree to such terms. VA does not have a cost estimate at this time.

Section 110 of the bill would amend 38 U.S.C. § 1703D to extend from 180 days to one year the time period for health care entities and providers to submit claims to VA for payment for furnishing hospital care, medical services, or extended care services.

VA does not support section 110. VA's contracts for community care generally include a 180--day timely filing requirement. Providers are aware of the 180-day timely filing requirement when agreeing to their contracts with the TPAs. Additionally, section 142 of the recently enacted Cleland-Dole Act amended 38 U.S.C. § 1725 to require 180 days for timely filing, which is consistent with current section 1703D. VA believes the 180 -day time limit is appropriate and ensures predictability and more accurate claims processing.

We note, though, at present, claims for service-connected emergency care under 38 U.S.C. § 1728 must be filed within two years of the date of service (see 38 C.F.R. § 17.126), and claims under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) must be filed within one year of the date of service (see 38 C.F.R. § 17.276). CHAMPVA claims are generally processed separately, and claims under section 1728 represent a relatively smaller number of claims processed by VA. Further, because claims under section 1728 are claims for service-connected care, a longer filing period helps ensure more Veterans receive benefits under this authority, which seems justified based on their service-connected disabilities.

VA recommends a single, consistent filing timeline which would make administration easier and more accurate and is concerned about the inconsistency this bill would create between sections 1703D and 1725.

Section 111 of the bill would require VA's Office of Inspector General (OIG), as OIG determines appropriate, to assess the performance of each VAMC.

VA has no objection to section 111 and defers to OIG.

Section 201(a) would express the sense of Congress regarding the importance of value-based care. Section 201(b) would require VA, within 90 days of enactment, to establish a working group that would have to be composed of individuals within VA, other Federal agencies, and could include other individuals from the private sector. Section 201(c) would require that within one year of establishing the working group, that group would have to develop a strategic plan to shift VHA to a value-based care system; this plan would have to include at least a dozen specific elements. Under section 201(d), within 30 days of the completion of the strategic plan, VA would have to submit the strategic plan to Congress. Section 201(e) would require that within 180 days of submitting the strategic plan to Congress, VA would have to commence a five-year pilot program to implement the strategic plan, including implementation of the plan for the delivery by VHA of primary care, inpatient and outpatient mental health treatment, and inpatient and outpatient substance use treatment.

VA does not support section 201. Initially, it is unclear if the intent of this provision is to evaluate value-based payment of VA employees in shifting to a value-based care system. This could have significant effects on the VA workforce and would require significant changes to VA's statutory authority. Such changes would also create significant uncertainty for employees in terms of benefits and future effects. If Congress intends for VA to change its salary and benefits structure for employees, it should clearly state so. It is also unclear whether this is intended to ensure VA does not provide certain types of care or services, or at least does not do so in certain circumstances, in the interest of value-based care. Certain locations might be able to provide services at lower cost but at more distance for Veterans, and it is unclear whether this type of arrangement would be supported under this proposal. The term "value-based care" is fundamentally unclear, and VA would need further understanding before it could support this effort. VA generally supports producing better outcomes at lower costs, but the specific parameters of this proposal and how this works in particular cases is unclear in the abstract. We would appreciate the opportunity to discuss these ideas further with the Committee.

Additionally, this section would require VA to develop and implement a plan, including potentially nationwide, when VA would not yet have the results of its analysis to determine whether the plan is feasible or advisable. We recommend separating such a determination from any future requirements for action or implementation.

We note that several of the elements required to be included in the strategic plan are duplicative of, or only slightly different from, requirements in other statutes, including 38 U.S.C. § 7330C (the quadrennial VHA review) and the recently enacted 38 U.S.C. § 1704A, as added by section 194 of the Cleland-Dole Act. Particularly given the timing of when this strategic plan would be completed and the requirements to complete

reviews under these two other statutes, this could result in duplication of efforts and could delay implementation of one or all of these efforts if VA staff are required to work on all of these efforts simultaneously.

Additionally, it is not clear whether the pilot program referenced here would be carried out by the CICP or another entity. If the CICP is expected to be responsible, 38 U.S.C. § 1703E defines a specific process for carrying out pilot programs under that authority, and VA can only proceed with such a pilot with Congressional approval. Given the absence of any specific direction in this section that CICP implement the pilot (as opposed to sections 108(a) and 202(a) of this bill), we would not interpret this as requiring CICP to implement this authority.

As a technical matter, we note that some of the titles of positions in subsection (b)(2) are inaccurate; for example, the correct titles would be "the Under Secretary for Health" and "the Assistant Secretary for Information and Technology".

Section 202 would require VA, working with TPAs and acting through the CICP, to develop and implement a plan to establish an interactive, online self-service module: (A) that would allow Veterans to request appointments, track referrals for care, and receive appointment reminders; (B) to allow Veterans to appeal and track decisions relating to denials of requests for care and services under VCCP and denials of requests for care and services at VA facilities; and (C) implement such other matters as determined appropriate by VA in consultation with TPAs. Within 180 days of enactment, VA would have to submit to Congress this plan. Following submittal of the plan, VA would have to submit to Congress quarterly reports for two years containing any updates on the implementation of the plan. This section could not be construed to be a pilot program subject to the requirements of 38 U.S.C. § 1703E.

VA does not support section 202. VA objects to a statutory requirement to work with the TPAs, as this could narrow the Secretary's authority and flexibility to design systems and processes that are responsive to the needs of Veterans. VA is working to implement many of the functions described in this section, such as by allowing Veterans to request and schedule appointments on their own and by allowing Veterans to appeal and track decisions. However, a single, consolidated module that would perform all of these functions would likely be very difficult to build and operate. We also do not support requiring the CICP to implement this program as it is not clear that the Center would have the resources or expertise to manage an information technology platform like this. The Secretary should have the discretion to determine which offices would be best to implement this authority.

Section 203 would create a new 38 U.S.C. § 1703G that would require VA to publish online the average wait time for a Veteran to schedule an appointment at each VA medical center for the receipt of primary care, specialty care, and mental health care measured from the date of request for the appointment to the date on which the care was provided. VA would have to update these wait times not less frequently than monthly.

VA supports section 203 with amendments. VA currently provides this information pursuant to section 206 of the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act, 38 U.S.C. § 1701, note), but this section would not rescind that authority. We recommend repealing section 206 of the Choice Act if Congress intends to codify a permanent requirement like this. VA does not anticipate any additional costs would result from this section.

Section 204 would require VA, upon the enrollment of a Veteran in VA health care and at least annually thereafter, to solicit from Veterans their preferences for scheduling appointments for health care and related services furnished by VA, including through non-VA providers.

VA opposes section 204. This language is overly prescriptive and unnecessary, as many of these preferences are already captured by VA. Additionally, VA currently is developing updates to reflect scheduling preferences.

Section 205 would require VA, within one year of enactment, to develop, validate, and implement a staffing model for the Office of Integrated Veteran Care (IVC), VISNs, and VA medical centers that includes appropriate target staffing levels nationally, regionally, and locally to ensure timely access to care and effectively oversee the provision of care by VA.

VA does not support section 205. The requirements seem to conflate access to care and scheduling; while scheduling is necessary for access to care, it is not sufficient, as an appointment could be scheduled before it should occur (as in the case when tests or other procedures are needed before other care can be provided Ensuring timely access to care is a Departmental responsibility, not solely a responsibility of those who are scheduling appointments. We are concerned that including performance metrics that could influence performance ratings could create incentives that would not reflect the needs or interests of Veterans seeking care from VA.

Additionally, VA currently has an Office of Integrated Veteran Care (IVC) staffing tool to guide local facilities on their staffing needs. VA is also developing staffing models for all VA medical centers with a focus on the metric of timely access to care. This initial assessment, starting with primary care and select specialties, should be completed by the end of calendar year 2023. However, these models are complex and have not been attempted at VA or other Federal agencies in the past. Specialty care analysis will take additional time to complete and review with VA medical centers and VHA leadership.

Section 206(a) would amend the CICP's authority in 38 U.S.C. § 1703E in ten ways.

VA does not support section 206(a). VA has concerns with this section. First, moving the CICP to the Office of the Secretary could lead to operational disruptions, cause work output delays, and create confusion through this reorganization.

Additionally, the apparently expanded scope of the Center's authority would still be constrained by the current statutory focus on testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by VA. It seems unlikely that VA could test payment and service delivery models to determine whether these models (1) improve access, quality, timeliness, and satisfaction of care, (2) create cost savings for VA, and (3) increase productivity, efficiency, and modernization throughout VA. The broader scope would seemingly include authorities or programs relevant to VBA, construction, IT, and other programs, but the core requirement to test payment and service delivery models to reduce expenditures while preserving or enhancing care would still apply.

Further, the proposed amendments to CICP's waiver authority under § 1703E(f) create some ambiguity. The amendments to paragraph (1) would allow VA, subject to Congressional approval, to waive any requirements in title 38, U.S.C. (rather than only subchapters I-III of chapter 17), any requirement in title 38, C.F.R., and any handbooks, directives, or policy documents, but the amendments to paragraph (2) refer only to waiving "any provision of this title" (title 38, U.S.C.), leaving open the question of whether waivers of regulatory authority in title 38, C.F.R. or waivers of VA policies would not require a waiver approved by Congress. Given the importance and novelty of this authority, we recommend Congress be explicitly clear as to the limits of this authority.

Also, the bill would require VA to carry out a minimum of three pilot programs concurrently. VA has defined the term "pilot program" through regulation at 38 C.F.R. § 17.450(b) to mean pilot programs conducted under that section (and thus under § 1703E). These pilot programs are subject to Congressional approval, as noted earlier. To the extent Congress did not approve at least three pilot programs concurrently, VA would be in violation of this requirement (although the penalties for non-compliance are not clear). Additionally, the limitations imposed by § 1703E would still apply (such as the limitation on the total amount VA could expend in any FY), so the requirement to carry out at least three pilot programs could narrow the scope of programs the CICP could pursue given these other constraints. It is possible the drafters only intended the CICP to operate three programs concurrently, whether they were "pilot programs" that required Congressional approval or not; if that was the intent, we recommend revising the language to reflect that.

Finally, we note that if the CICP is moved to the Office of the Secretary, the specific line item the bill would require for the CICP would need to be funded by the same account as the Office of the Secretary, which would either require a proportional increase to the budget for the Office of the Secretary or would require significant cuts to the existing Office infrastructure. We are also unsure how the shift from the Medical Services account to the General Administration account would affect the Center's ability to support the delivery of health care. We would appreciate the opportunity to discuss this and other issues further with the Committee.

Section 206(b) would require the Comptroller General, within 18 months of enactment, to submit to Congress a report on the efforts of the CICP in fulfilling the

objectives and requirements under 38 U.S.C. § 1703E and containing such recommendations as the Comptroller General considers appropriate.

Section 206(c) would require the CICP, not later than one year from enactment, to establish a three-year pilot program in not fewer than five locations to allow enrolled Veterans to access outpatient mental health and substance use services through the VCCP without referral or preauthorization.

VA has no objections to section 206(b); VA opposes section 206(c). VA has no objections to section 206(b) and defers to the Comptroller General on this provision.

Concerning section 206(c), we know there are a number of Veterans being recruited to participate in treatment programs, but VA has no means to verify that the care being provided is high quality, economical, or appropriate. Treatment plans are designed to address the unique needs of Veterans, who may need a more structured environment and schedule to succeed in their path to recovery. This raises concerns about the delivery of care to Veterans, and whether participation in some such programs might deter Veterans from seeking other, evidence-based care. A recent study demonstrated the efficacy of VA's integrated system, particularly for patients with mental health needs, but this type of program would impede our ability to furnish this integrated care.

VA has significant concerns with section 206(c) for several reasons. First, section 206(c)would seemingly conflict with § 1703(a)(3), which requires that covered Veterans only receive care through the VCCP "upon the authorization of such care or services by the Secretary". If Veterans could self-refer for care, unless VA were to issue a blanket authorization (and it is not clear that doing so would satisfy the requirements of 38 C.F.R. § 17.38(b), that VA determines the care is necessary to promote, preserve, or restore the health of the Veteran), it would still need to authorize this care individually. Further, VA's contracts are structured to rely upon an authorization from VA for care (other than walk-in care under § 1725A) and would require contract modifications to effectuate this under the CCN contracts. If this section is intended to establish a program separate from the VCCP, the MISSION Act was enacted to consolidate and simplify community care eligibility; this proposal would be a step back toward what the MISSION Act was intended to fix.

Second, the bill would require VA to have a care coordination system in place, though it is not clear that such a system would be nearly as effective as VA's current efforts. Participating health information exchange providers can already obtain VA health information, but not all VCCP providers participate in health information exchanges. In these situations, it is not clear how VA could coordinate the care of such Veterans, or even if VA would know that such care was being sought until after it was received. It is similarly unclear whether this pilot program would be intended to cover the full range of services – walk-in, regularly scheduled, emergent care – and how the pilot program would interact with or supersede other statutory authorities in these areas. It seems very likely that in at least many cases, VA would only be able to monitor

patient safety and outcomes retroactively, which would make implementation of a value-based model even more difficult.

Third, VA has concerns with the required metrics, as it is unclear whether community providers could actually report the metrics VA would use for its own programs or other metrics adopted within the industry (such as standards developed by the Centers for Medicare & Medicaid Services (CMS)).

Finally, section 206(c) would require the CICP to carry out a pilot program under § 1703E, but it is not clear whether this supersedes the waiver process required by § 1703E(f) or not.

Section 207 would require VA, within one year of enactment, to establish an online health education portal that includes interactive online educational modules to ensure enrolled Veterans understand their basic health care eligibilities and entitlements under the laws administered by VA, including the VCCP.

VA does not support section 207. VA already has an existing portal that could meet the requirements of this section, so VA does not believe it is necessary to establish such a portal.

Section 208(a) would require VA, within one year of enactment and annually for the next three years, in consultation with VSOs, Veterans, caregivers of Veterans, employees, and other stakeholders, to submit to Congress a report containing recommendations for legislative or administrative action to improve the clinical appeals process of the Department with respect to timeliness, transparency, objectivity, consistency, and fairness.

VA does not support section 208. Section 208 is too prescriptive, specifically with the proposed reporting of appeal volume and outcomes. VA does not support requirements to consult with a variety of stakeholders. VA also notes that request for community care that are not approved do not amount to a denial of care – that care, so long as it is necessary, is still furnished by VA.

This section would require VA to create an advisory committee subject to FACA, the National Records Act, the Privacy Act, the Freedom of Information Act, and the Government in the Sunshine Act. However, this section does not provide sufficient guidance to VA to establish, manage, or terminate this committee. The section would need to include an official name for the committee, the mission authority of the committee, the substantive objectives and scope for the committee, the size of the committee, the official to whom the committee would report, the reporting requirements for the committee, the meeting frequency of the committee, the qualifications for committee members, the types of committee members and their term limits, whether the committee is authorized to have subcommittees, the funding for the committee, and the record keeping requirements of the committee. Alternatively, the section could strike the

requirement to establish an advisory committee, or specifically exempt the working group from FACA requirements, and avoid these issues altogether.

S. 1436 CHARGE Act of 2023

This bill contains three titles that include six substantive provisions.

Section 101(a) of this bill would amend 38 U.S.C. § 2011 by adding a new subsection (i) that would prohibit VA from making any grants or providing any per diem payments under 38 U.S.C. § 2012 for more than 12,000 transitional housing beds for homeless Veterans furnished by grant recipients or eligible entities under such sections on average each year. Section 101(b) of the bill would amend 38 U.S.C. § 2012 by adding a new subsection (f) that would require VA to submit to Congress a report on the rate for per diem payments under this section that includes, for each VISN, the average rate for such payments, a list of locations where the rate for such payments is within 10 percent of the maximum rate for such payments, and the average length of stay by Veterans participating in programs under 38 U.S.C. § 2011(a). Section 101(c) of the bill would provide that, during the three-year period beginning on the date of enactment, the maximum per diem payment rate would be 200 percent of the rate authorized for State homes for domiciliary care. It would not amend section 2012 to make this change. Section 101(d) would require VA, not later than 540 days after enactment, to submit to Congress a strategic plan for the provision of grants and per diem payments for services furnished to homeless Veterans under 38 U.S.C. §§ 2011 and 2012.

VA supports section 101, if amended, subject to the availability of appropriations. VA recommends several technical amendments to adjust the timeframe for the reporting requirements and for the maximum rate to align the timeframes with the timing of a new FY and in light of other considerations, such as the strategic plan required by subsection (d). The technical edits also would cite to 38 U.S.C. § 2012 instead of § 2011(a) and would include a rate change for all of the transitional housing grants under 38 U.S.C. § 2012(a)(2)(B) instead of only some of the grants. Finally, the technical amendments would increase the authorization of appropriations for the Grant and Per Diem (GPD) program (38 U.S.C. § 2016) to provide VA clear authority to provide necessary resources required to implement this legislation and existing programs to assist Veterans experiencing homelessness through the GPD program. These technical amendments align with one of VA's FY 2024 legislative proposals (#74, Increase the Maximum Per Diem Rate for Services to Homeless Veterans under the Grant and Per Diem (GPD) Program).

VA estimates this section would cost a total of approximately $296.0 million in FY 2024 and $913.1 million for the three-year term authorized by this section. VA's cost estimate assumes the continuation of the 200 percent rate until a new GPD rate is adopted in law following the submission of VA's strategic plan. If new legislation were not enacted, then to prevent a cliff effect, VA assumed the program would remain at the 200 percent rate and the estimated cost would be $1.56 billion over five years, and $3.31 billion over ten years. Compared to the authorized level of $257.7 million, this

would be an increase of $38 million for FY 2024 and $140 million over three years. If no new legislation were enacted, the increase would be approximately $272 million for the five-year period from FY 2024 through FY 2028 and approximately $737 million for the ten-year period from FY 2024 through FY 2033.

The projected costs estimated here are lower than the projected costs estimated in VA's FY 2024 legislative proposal because adjustments are made to align with the new transitional housing grants scheduled to start on October 1, 2023, when VA will be awarding fewer beds compared to previous projections. The decrease reflects actual needs in communities as expressed by applicants and accounts for the most recent State domiciliary rate change, effective April 2023.

Section 102 of the bill would create a new 38 U.S.C. § 2069(a) that would authorize VA to provide to homeless Veterans and Veterans participating in the Department of Housing and Urban Development (HUD)-VA Supportive Housing (VASH) program, as VA determines, necessary, the following: (1) assistance required for the safety and survival of the Veteran (such as food, shelter, clothing, blankets, and hygiene items); (2) transportation required to support the stability and health of the Veteran (such as transportation for appointments with service providers, the conduct of housing searches, and the obtainment of food and supplies); (3) communications equipment and services (such as tablets, smartphones, disposable phones, and related service plans) required to support the stability and health of the Veteran (such as through the maintenance of contact with service providers, prospective landlords, and family members); and (4) such other assistance as VA determines necessary. A new § 2069(b) would authorize VA to collaborate, to the extent practicable, with one or more organizations to manage the use of VA land for Veterans experiencing homelessness for living and sleeping. Collaboration that would be authorized by this provision could include the provision of food services and security, by either VA or the head of the organization concerned, for VA property, buildings, and other facilities. A new § 2069(c) would provide that these authorities would terminate on the date that is three years after the date of enactment.

VA supports section 102, subject to the availability of appropriations. This section is very similar to one of VA's FY 2024 legislative proposals related to flexibility in the provision of assistance to Homeless Veterans. This proposal would continue the authority VA was able to use during the COVID-19 public health emergency to provide additional assistance and support to Veterans experiencing homelessness and Veterans participating in HUD-VASH to great effect. VA recommends permanent authority be granted, rather than authority that is subject to termination after three years. We do not believe a statutory time limit would provide stability and assurance to Veterans experiencing homelessness and Veterans participating in HUD-VASH. A permanent authority would provide assurances for Veterans and likely would result in lower per capita costs to the Department, as VA could negotiate contracts that could cover multiple years (provided appropriations are available for such purposes). Operating with a shorter statutory authority would prevent VA from such long-term arrangements and would likely result in higher costs.

This section would afford VA the authority it had during the COVID-19 public health emergency to furnish critically essential resources and services for homeless Veterans, including assistance required for safety and survival; transportation required to support stability and health; communications equipment and services to connect with service providers, prospective landlords and employers; payments toward security deposits and resources to increase housing options; and other assistance as VA determines necessary.

During the public health emergency, having this authorization transformed VA's effectiveness and efficiency in service provision to homeless Veterans. Before this authorization, VA could not use funds to provide these essential services or goods and had to rely on donations or community organizations to fill the service gaps, which were not always readily available, and VA is in the same position again today. The inability to consistently meet these gaps in services is disruptive and causes delays in permanent housing placement. VA providers need the continued flexibility and access to critical resources provided by this authority to execute the mission of making Veteran homelessness a rare, brief, and non-recurring experience.

In recent years, VA providers have excelled at reducing Veteran homelessness; however, the Veterans who remained unhoused or at risk often present with complex needs and face unprecedented barriers, such as high cost of food, increased housing costs, and lack of public transportation.

To complete the mission of housing all homeless Veterans is complex and multifaceted, VA needs to broaden its scope of resources and services to homeless Veterans.

VA estimates section 102 would cost a total of approximately $20.5 million in FY 2024 and $64.1 million for the 3-year term of this section of the bill. Should Congress continue authorizing VA under this section after the initial three years, VA estimates the 5-year cost would be $111.5 million, and the 10-year cost would be $243.4 million.

Section 103 of the bill would create a new 38 U.S.C. § 2070 that would require VA, to the extent practicable, to ensure that Veterans participating in or receiving services from a program under chapter 20 of title 38, U.S.C., have access to telehealth services to which such Veterans are eligible under the laws administered by VA, including by ensuring that telehealth capabilities are available to such Veterans, VA case managers of programs for homeless Veterans authorized under chapter 20, and community-based service providers for homeless Veterans receiving funds from VA through grants or contracts.

VA does not support section 103. In accordance with current practice and previous interpretations, VA is authorized to provide telehealth equipment to Veterans as well as case managers and grantees or contractors.

The proposed bill would only require VA to "ensure that veterans participating in or receiving services from a program under this chapter have access to telehealth

services to which such veterans are eligible under the laws administered by the Secretary" (emphasis added). In other words, VA would have to ensure that Veterans who are eligible for telehealth services can receive telehealth services. In this context, telehealth services are simply a modality for delivering services for which the person is otherwise eligible. It is VA's longstanding interpretation that the agency has authority to provide internet-enabled devices as contemplated by this section. VA does not have a cost estimate for this section.

Section 201 of the bill would authorize VA, on or before September 30, 2023, to complete any home visit required under 38 U.S.C. § 1720G or 38 C.F.R. part 71 with respect to a Veteran and their caregiver through video conference or other available telehealth modality, if agreed to by the Veteran or caregiver.

VA supports section 201, if amended. VA has resumed providing in-person home visits for the Program of Comprehensive Assistance for Family Caregivers but appreciates the flexibility this section would provide to allow VA, on a case-by-case basis, to conduct virtual visits through video conference or other available telehealth modality until September 30, 2023. As a technical edit, we recommend the bill clarify that VA can complete any home visit required under "such section or part" with respect to Veterans caregivers, as the bill refers to visits under § 1720G or 38 C.F.R. part 71.

Section 301 of the bill would define the term "State home" for purposes of sections 302 and 303 of this bill to have the meaning given that term in 38 U.S.C. § 101(19).

VA has no objection to section 301.

Section 302 of the bill would provide that, during the period between the date of enactment and September 30, 2024, the occupancy rate requirements for State homes for purposes of receiving per diem payments under 38 C.F.R. § 51.40(c) would not apply.

VA supports section 302. This section would provide State homes with flexibility to adjust to changing situations as the public health emergency has ended. This bill would provide State homes an opportunity to continue to receive support through FY 2024 as many of them have had staffing limitations that have affected their ability to maintain the occupancy rate. VA estimates this section would cost a total of approximately $4 million in FY 2023 and $29.3 million through September 30, 2024, authorized by this section.

Section 303 of the bill would authorize VA to provide to State homes medicines, personal protective equipment (meaning any protective equipment required to prevent the wearer from contracting an infectious disease, including gloves, N-95 respirator masks, gowns, goggles, face shields, or other equipment required for safety), medical supplies, and any other equipment, supplies, and assistance available to VA.

VA supports section 303, if amended, subject to the availability of appropriations. State homes are generally responsible for ensuring they have the resources to furnish care to Veterans in their facilities, and VA supports their efforts through daily per diem payments for eligible Veterans. We are concerned that, as written, this authority could eventually expand to include support Congress has not otherwise authorized or intended VA to provide.

VA recommends that the legislation be amended to only apply during a declared public health emergency. This would ensure that VA could provide assistance during emergency situations (without the need for a subsequent Act of Congress) but not during times of normal business operations. VA does not have a cost estimate for this section.

S. 1545 Veterans Health Care Freedom Act

This bill would require VA, through the Center for Innovation for Care and Payment (CICP), to carry out a pilot program in a minimum of four VISNs to improve the ability of eligible Veterans to access hospital care, medical services, and extended care services through the "covered care system" (defined as each VA medical facility, health care providers under VCCP and eligible entities or providers that have entered into a Veterans Care Agreement, VCA, under 38 U.S.C. § 1703A) by providing eligible Veterans (meaning those enrolled in VA health care) the ability to choose health care providers.

Section 2(h) would require VA to carry out the pilot program during a three-year period beginning on the date that is one year after the date of enactment. Section 2(h) also would amend 38 U.S.C. § 1703(d) to add a new paragraph that would provide that, beginning on the date that is four years after the date of enactment, Veteran eligibility for VCCP based on the existing five eligibility criteria. VA would furnish care and services to covered Veterans "with the same conditions on the ability of the veteran to choose health care providers" as provided for in this bill. The bill would also amend 38 U.S.C. § 1703A(a)(1) to add a new subparagraph (E) that would state that the requirements in law that care or services can only be furnished under this section when such care or services are not feasibly available from a VA facility or through a contract or sharing agreement would not apply with respect to furnishing care and services under this section beginning on the date that is four years after the date of enactment. Beginning on the date that is four years after the date of enactment, VA would have to furnish care and services to Veterans under chapter 17 of title 38, U.S.C., at VA medical facilities, regardless of whether the facility is in the same VISN as the VISN in which the Veteran resides.

Section 2(i) of the bill would require VA, on a quarterly basis for the first two years following enactment, to submit to Congress a report on the implementation of the pilot program, and one of the reports would have to include a description of the final design of the pilot program. On an annual basis beginning one year after enactment and ending on the date of the conclusion of the pilot program, VA would have to submit to Congress a report on the results of the pilot program.

Section 2(j) would authorize VA, in consultation with Congress, to prescribe regulations to carry out this section. Section 2(k) would state that no additional funds would be authorized to be appropriated to carry out this section, and the amendments made by this section.

VA opposes this bill. We note that this bill appears to misunderstand the authority provided to VA under 38 U.S.C. § 1703A. Section 1703A authorizes VA to enter into VCAs and use VCAs in limited circumstances. These limitations were established because VCAs are not subject to general contracting requirements under the Federal Acquisition Regulations and the VA Acquisition Regulations. Section 1703A is an authority for how VA purchases care, not how or when it authorizes care. The principal statute through which Veterans are authorized to receive community care is 38 U.S.C. § 1703, which established the VCCP. The proposed amendments to § 1703A would undo the careful limitations Congress established to ensure that VCAs are used on a limited basis when conventional procurement options are not available or practical. Further, this bill would radically expand the scope of § 1703A to now control both the authorization of care and the purchasing of care as well, obviating (or at least duplicating) the VCCP authority under section 1703. We strongly recommend against changes to § 1703A without careful consideration of the effects and consequences that would result.

The bill's efforts at modifying 38 U.S.C. § 1703, the VCCP authority, would create significant ambiguity that could have unpredictable effects on Veteran eligibility for community care. Specifically, the bill would reverse all existing criteria for community care eligibility except for permissive eligibility upon the determination by VA that a medical service line is not providing care that complies with VA's standards for quality (under 38 U.S.C. § 1703(e)). VA has strong empirical basis on which it can make future estimates regarding the resources needed for the VCCP. This bill would create a wholesale change in eligibility in ways that would likely make past models for future demand inapplicable, or at least subject to a significantly greater margin for error. Further, prohibiting additional appropriations to carry out the amendments made by this bill would create significant risk of a shortfall of funding if demand for community care increased. In such a situation, VA would be forced to delay care for Veterans when funds cease to be available.

The bill would amend § 1703(d) to require VA to furnish care and services to covered Veterans "with the same conditions on the ability of the veteran to choose health care providers" as provided for in this bill. However, those "conditions on the ability of the veteran to choose health care providers" are not well-defined. For example, section 2(c) would provide that eligible Veterans participating in the pilot program could elect to receive care "at any provider in the covered care system"; however, section 2(d)(2) would require the primary care provider of the eligible Veteran to coordinate with VA and other providers in the covered care system and refer Veterans to specialty care providers as clinically necessary. In this context, it is unclear whether the primary care provider issuing the referral determines which provider sees the patient

or whether the patient determines which provider sees the patient. Further, it seems very likely that designated primary care providers, particularly those who are not VA employees, are unlikely to know how to make referrals within the "covered care system", and our contracts are not structured in a way to permit them to do so (except in limited circumstances where a bundled set of services has been authorized). If a non-VA provider were selected as the primary care provider, this would make care coordination by VA extremely difficult, or perhaps impossible, which could jeopardize patient care and limit VA's ability to ensure proper care is being authorized and furnished. Moreover, § 1703(a) would remain unchanged, and paragraph (2) of that subsection requires VA to coordinate the furnishing of care, while paragraph (3) of that subsection states that care and services can only be provided upon VA's authorization. It is not clear that VA could structure the pilot program consistent with these requirements. This would significantly complicate care coordination efforts and could jeopardize patient care.

There are several elements of VA care that are subject to additional restrictions or eligibility criteria such as dental or domiciliary care. Therefore, allowing Veterans to select their own provider could produce significant complications in verifying that such care is statutorily authorized. If enacted, Veterans could choose certain providers for certain care, and receive a referral for that care, before VA could determine whether or not the Veteran was eligible for such care. This could produce confusion and frustration for Veterans and providers.

We also note that the language regarding the eligibility of Veterans to elect to receive care outside their home VISN, this currently happens today in many situations, particularly when Veterans are located along the border of two VISNs. Further, in the pilot program phase of this authority, it is unclear how this would affect a Veteran's ability to elect to receive care from a VISN that isn't participating. Similarly, it is unclear whether this is intended to authorize additional beneficiary travel payments when Veterans elect to receive care at a different location. We note the bill would not alter VA's authority to furnish beneficiary travel payments, which are generally limited only to the nearest VA facility.

To the extent that it is the drafter's intent to allow non-VA providers to authorize and approve care at VA expense, this would allow non-governmental employees to commit VA resources, which raises significant concerns regarding fiscal responsibility and accountability. This would further exacerbate the concerns noted previously regarding budget predictions and accuracy would seemingly increase the risk of a shortfall in funding that would lead to curtailing and delaying care for eligible Veterans. Additionally, VA's contracts with TPAs are not designed to facilitate the type of network that this bill would seemingly envision; VA is in the beginning stages of pursuing the second generation of Community Care Network (CCN) contracts, but if this bill were enacted, those efforts would need to be revised significantly to account for this future program. Assuming that VA could find vendors willing to bid on such a revised contract, this could delay VA's ability to operate with a full and complete network of providers. Further complicating this issue, VA does not just rely on its CCN TPAs to furnish care –

through VCAs and local contracts, VA supplements the TPAs' network of providers. It would be extremely difficult if not impossible to integrate these providers into the "covered care system" described in this bill.

We have additional concerns with other specific provisions in the bill. For example, the bill refers to carrying out a pilot program through CICP, but it is not clear if this is intended to mean that the pilot program would involve a waiver request submitted to Congress for approval and otherwise subject to the limitations set forth in 38 U.S.C. § 1703E. Section 1703E(g)(2) generally prohibits VA from expending more than $50 million in any FY in carrying out pilot programs, and this proposal would almost certainly exceed that amount. It also is not clear that this proposal would meet the requirements of § 1703E(a)(3)(B), which requires VA to test payment and service delivery models to determine whether such models create cost savings for the Department. The pilot program proposed in this bill seems unlikely to do so.

The bill's reporting and briefing requirements under section 2(i) would represent additional administrative expense for the Department. Section 2(j), which would authorize VA, in consultation with Congress, to prescribe regulations, is ambiguous as to its intended effect. VA would almost certainly need regulations to implement the pilot program, and it would need to promulgate regulations to reflect the changes that would be made to § 1703. However, this provision of the bill seems to condition VA's prescribing of regulations to only what is done in consultation with Congress. During the drafting and development phase of the rulemaking process, much of the work is considered pre-decisional and deliberative in nature. It is unclear what level of "consultation" is intended, and at some point, that level of involvement could present challenges in terms of fulfilling the Secretary's responsibility to execute and carry out the law. Section 2(g) would require VA to furnish to eligible Veterans information on cost sharing, but other than VA copayments, there are no cost shares associated with care for VA enrollees. It is unclear if this reference is intended to authorize VA to impose additional cost shares or not.

Regarding extended care services, VA generally requires Veterans receiving nursing home care (whether in a VA community living center, a State nursing home, or a community residential center) to receive their primary care from the institutional providers to ensure there is no duplication of services and to avoid fragmentation of care. By including extended care services within the scope of this bill, the language could create situations where such care cannot be coordinated effectively, increasing the risk of adverse outcomes for Veterans while increasing costs to VA.

There are several technical issues with the bill. First, the bill does not address when or how a Veteran could elect to change their designated primary care provider (who could be a specialty care provider). If Veterans could regularly change their provider, this would further complicate administration and would make it more likely that Veteran care would be fragmented.

VA notes that the VA MISSION Act of 2018 (the MISSION Act) was enacted just over five years ago and has been in effect for just over four years. This bill would, in large measure, represent an abandonment of the principles and rationale of the MISSION Act. We do not believe that is an appropriate course of action.

VA does not have a cost estimate for this bill but is concerned that this could have a significant and unpredictable effect on demand; when combined with the prohibition on the authorization of additional appropriations, this puts at peril VA's ability to carry out the VCCP and furnish Veterans community care.

S. 1612 Reimburse Veterans for Domiciliary Care Act

Section 2(a) of this bill would require VA, within 90 days of enactment, to prescribe and publish in the Federal Register a proposed rule implementing section 3007(a) of the Isakson-Roe Act (38 U.S.C. § 1741, note). Section 3007(a) of the Isakson-Roe Act required VA to modify 38 C.F.R. § 51.51(b) to provide VA the authority to waive the requirements under that provision for a Veteran to be eligible for per diem payments for domiciliary care at a State home if the Veteran has not met fewer than four of the requirements in such section or such waiver would be in the best interest of the Veteran. Section 2(b) of the bill would require VA, within 180 days of the publication of the initial rule (or 260 days from enactment, whichever occurs first) to prescribe and publish in the Federal Register a final rule implementing section 3007(a) of the Isakson-Roe Act. Section 2(c) of the bill would require that, in prescribing the proposed and final rules, VA would have to ensure that VA's authority to provide payments to State homes pursuant to these rules is retroactive to January 5, 2021.

VA does not support this bill. This bill is unnecessary because VA is actively working on this regulation, which proposes to amend its medical regulations and State Veterans Home (State home) regulations that govern the eligibility for domiciliary care.

S. 1828 Veterans Homecare Choice Act of 2023

Section 2 of this bill would amend 38 U.S.C. § 1703 in two ways. First, it would amend subsection (c), which defines eligible entities and providers for purposes of the VCCP, to include any nurse registry, including any registered nurse, licensed practical nurse, certified nursing assistant, home health aide, companion, or homemaker furnishing services through a nurse registry. Second, it would define the term "nurse registry" in a new subsection (o)(3) to mean a person that satisfies any applicable State licensure requirement and that procures, or attempts to procure, contracts or other agreements on behalf of registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers under which such individuals can provide health care-related or assistive services and receive compensation for such services.

VA does not support this bill. This bill's addition of nurse registries under § 1703(c) would likely have no significant effect on the VCCP because nurse registries

already are an eligible entity or provider. Any entity or provider that is potentially an eligible entity or provider must enter into an agreement with VA to furnish covered health care services and comply with the terms of that agreement and any applicable laws and regulations. Being an eligible entity or provider does not mean that such entity or provider is participating under the VCCP.

However, VA understands that some State laws (such as Florida) require providers in a nurse registry to be independent contractors that have agreements directly with the patient. It is unclear how VA would contract with the registry instead of the provider and still provide protections to Veterans with billing issues from independent contractors. This could present complications that would make the attempted inclusion of nurse registries, at least as described in this bill, more difficult.

The requirement that a nurse registry be a person that "satisfies any applicable State licensure requirement" could raise concerns that such persons would not meet the same standards required by other providers. Licensure requirements can vary greatly by State, and a State's requirement for nurse registry license alone may not provide enough oversight of these providers. Florida law, for example, appears to preclude any such oversight, where it states that "A nurse registry may not monitor, supervise, manage, or train a registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter." *See* 2022 Florida Statutes, § 400.506(19). In this case, VA contracts would need to provide additional requirements to ensure patient safety that may be uniquely applicable to these registries.

We also have several technical concerns with the bill, some of which raise substantive concerns about the possible effects of the bill if enacted. The term "companion", for example, is undefined, and the intended effect of its inclusion is unclear. Additionally, the term "nurse registry" is defined to mean a person, while we believe in most situations the registry would be an entity. Further, a person or entity that "procures, or attempts to procure, contracts or other agreements on behalf" of nurses or other providers could potentially include a much broader category of organizations than is intended—labor unions or employment companies, for example, would seem to fit this description. Finally, the term "health care-related or assistive services" is undefined, and these may include services that are not hospital care, medical services, or extended care services (which is all that can be provided under the VCCP pursuant to § 1703).

VA does not have a cost estimate for this bill.

S. 1954 Improving Whole Health for Veterans with Chronic Conditions Act

Section 2 of the draft bill would express the sense of Congress regarding VA care providing better outcomes at lower costs, the consequences of poor dental care on diabetes and heart disease, and the consequences of such conditions. Section 3 of the draft bill would define the term "covered care" to mean dental care that is comprehensive in nature and consistent with the dental services and treatment

furnished by VA pursuant to 38 U.S.C. § 1712(a)(1)(G). The term "covered veteran" would mean a Veteran who is enrolled in VA health care (or is not enrolled but is otherwise entitled to hospital care and medical services pursuant to § 1705(c)(2)), is not eligible for dental services and treatment and related dental appliances under the laws administered by VA as of the date of enactment, and has a diagnosis of type 1 or type 2 diabetes or ischemic heart disease.

VA defers to Congress regarding section 2 and cites concerns with section 3. VA cites concerns with section 3, specifically with the definition of a covered Veteran. Making eligible any Veteran who "has a diagnosis of—(i) type 1 or type 2 diabetes; or (ii) ischemic heart disease" would seemingly require that the Veteran have a current diagnosis of one of these conditions. If the Veteran's condition improved such that they no longer had the condition, they would no longer be a covered Veteran. In such a situation, their eligibility under this provision would end. We recommend that in such a scenario, there be a wind-down period to allow for current treatment to continue until the episode of care is complete. We further note concern that providing eligibility for dental benefits based on a diagnosis could unintentionally incentivize Veterans who might otherwise be on the borderline but managing their conditions to allow their condition to worsen to qualify for dental benefits. Additionally, VA is concerned that a focus on certain diagnoses could create health inequities for other Veterans.

Regarding the definition of covered care, the definition would use the term "comprehensive", but this term itself is not defined. Absent a specific definition, we would apply VA's existing definition of "comprehensive dental care" from VHA Handbook 1130.01(1) as this is what is available to Veterans pursuant to 38 U.S.C. § 1712(a)(1)(G), In the alternative, we recommend revising the definition of "covered care" to focus instead on providing cost-effective, evidence-based dental care based on community standards that improves their oral health.

Section 4 would require VA, not later than one year after enactment, to carry out a four-year pilot program under which VA would furnish covered care to covered Veterans for the duration of the pilot program. VA would have to carry out the pilot program at each VA medical center and community-based outpatient clinic with an established dental clinic.

VA does not support section 4. VA is currently at maximum operating capacity within its facilities in terms of the number of Veterans it can see, and the expansion of eligibility this bill would create would be far more than VA could accommodate. This additional care would need to be furnished by community providers, which would increase administrative expenses and would also demand more time of VA providers.

Regarding the provision that would require VA to test the efficacy of dental therapists, we note that dental therapists are currently only allowed to practice in various settings in 13 States. Only five schools in three States offer programs that are approved by the American Dental Association Commission on Dental Accreditation. Dental therapists work under the supervision of a dentist and can provide limited dental

treatments. Dental therapists do not receive the extensive training, and clinical experience dentists obtain. Many Veteran patients require the management of multiple physical and mental comorbidities and multiple prescription medications. The average VA dental patient is approximately 58 years old, taking over ten medications, and has a higher caries risk. Allowing Veterans to seek restorative oral health care from a dental therapist poses a potentially significant overall health risk. A licensed dentist's professional education and clinical expertise are essential for the thorough evaluation and comprehensive treatment of patients in VA.

Similar to our earlier concern regarding section 3 and the need for a wind-down period for Veterans who no longer qualify for care under the pilot program, a similar wind-down process may be needed for the end of the pilot program as well to avoid interruptions in care. Otherwise, VA would need to cease authorizing episodes of care that would extend beyond the period of the pilot program well in advance of the actual termination date to avoid losing authority to furnish services in the middle of an episode of care.

While the bill purports to authorize VA to collect copayments for covered care, it is unclear how exactly this would operate. Copayments generally apply for Veterans in Priority Group 7 or 8, while dental care is generally for Veterans seeking service-connected care, and VA's regulations at 38 C.F.R. § 17.108(e)(7) state that outpatient dental care provided under 38 U.S.C. § 1712 is not subject to copayment requirements. In this context, if the bill is intended to have VA collect copayments, we recommend a clearer statement of authority in this regard. Similarly, it is unclear whether the limitation in VA's current dental program on the value of care that can be authorized (an amount not to exceed $1,000) would apply in the context of this pilot program, but we would not read this to include that limit.

Finally, VA would be unable to set up and implement a pilot program of this size and complexity within only one year.

Section 5 would require VA, to ensure it has sufficient staff to provide covered care to covered Veterans, to implement a loan reimbursement program for qualified dentists, dental hygienists, and oral surgeons who agree to be appointed at VA and serve at a dental clinic for a period of not less than the duration of the pilot program under section 4. VA could not reimburse more than $100,000 for each dentist, $25,000 for each dental hygienist, and $40,000 for each credentialed Doctor of Medicine in dentistry serving as an oral surgeon and participating in the program. VA could reimburse an individual serving in multiple positions not more than $140,000.

VA does not support section 5. VA already has two education loan repayment programs that can be leveraged for recruitment and retention of dentists, dental hygienists, and doctors of medicine in dentistry serving as oral surgeons. VA believes that the current Education Debt Reduction Program (EDRP) would be a more effective means to offer incentives for recruitment than the proposed authority here. The Student Loan Repayment Program could also be used for hybrid Title 38 positions as well. The

Education Debt Reduction Program (EDRP) provides reimbursement of qualifying education loan debt up to $200,000 over a five-year service period for direct patient care providers (Title 38 and Hybrid Title 38 employees), and the Student Loan Repayment Program (SLRP) can be used to repay up to $100,000 in education loan debt (Hybrid Title 38 and Title 5 employees). A loan repayment program specifically for dentists, dental hygienists, and doctors of medicine serving as oral surgeons, as outlined in section 5, would create disparity in loan repayment amounts and additional administrative burden to manage a separate loan repayment program.

We note that the timing of section 5 may not align well with the timing for section 4. Specifically, section 4 would require VA to begin the pilot program within one year of enactment. If VA were to commence the pilot program within one year, it is unlikely that it would be able to make awards for loan reimbursement under section 5 to support the delivery of care under the pilot program.

Section 6 would authorize to be appropriated for FY 2024 such sums as may be necessary to carry out this Act. The amount authorized to be appropriated would be available for obligation for the eight-year period beginning on the date that is one year after the date of enactment.

VA has no objection to section 6.

S. XXXX Leveraging Integrated Networks in Communities for Veterans Act (LINC VA Act)

Section 2(a) of this draft bill would require, not later than one year after the date on which VA submits to Congress the report required by section 201(k)(1) of the Hannon Act (38 U.S.C. § 1720F, note), VA's Center for Innovation for Care and Payment to carry out a pilot program under which VA would establish community integration network infrastructure to provide services for Veterans.

Section 2(h)(1) would define the term "community integration network infrastructure" to mean infrastructure used to enable the coordination, alignment, and connection of covered entities for purposes of communication, service coordination, and referral management of services, with respect to services such as nutritional assistance, housing, health care (including preventive health intervention, chronic disease management, and behavioral health care), transportation, job training, child development or care, caregiving and respite care, disability assistance, and other services as determined by VA.

Section 2(h)(2) would define the term "covered entity to mean any community-based organization that accepts referrals from health care organizations and that provide various services (such as nutritional assistance, housing, health care (including preventive health intervention, chronic disease management, and behavioral health care), transportation, job training, child development or care, caregiving and respite care, and disability assistance); public or private health care provider organizations;

public or private funded payors of health care services (including home- or community-based services); State, local, territorial, or Tribal health and social services agencies; State public housing authorities or housing finance agencies; public health information exchanges or public health information networks as defined by VA; or other similar entities as determined by VA.

Section 2(b) would require VA, in carrying out the pilot program, to establish a new or enhance an existing interoperable technology network that includes certain defined functions.

Section 2(c) would require VA to carry out the pilot program at not fewer than one facility in each VISN.

Section 2(d) would require VA, in carrying out the pilot program, to coordinate with existing community networks.

Section 2(e) would require VA to track the accuracy of referrals of Veterans to community networks under the pilot program, the response time of providers to which such Veterans are referred, and the outcome of the initial meeting between a Veteran and a provider.

Section 2(f) would require VA, not later than three years after amounts are first appropriated to carry out the pilot program, to submit to Congress a report indicating the social service needs of Veterans reflected by the use of services under the community integration network infrastructure established under the pilot program.

Section 2(g) would require the Comptroller General to conduct an evaluation that measures the overall impact of the community integration network infrastructure with respect to changes in individual and population health outcomes among Veterans, changes in access to health care or social services among Veterans, and such other factors as the Comptroller General considers appropriate.

VA does not support section 2. We agree with the areas of focus identified in the bill, but there are several key undefined elements of this pilot program. The bill describes a wide range of potential entities that could participate; however, it is not clear if Congress intended VA to vet or review role prior to an entity's use of or access to the interoperable technology network. Similarly, if the intent is to ensure that only enrolled Veterans are participating in the pilot program, for example, we would have a clear means of ensuring VA can provide such support and services. If this is intended to allow any Veteran or former Service member to use these resources, it is unclear whether VA would need to evaluate and determine eligibility, and if so, how it would do so. It is unclear if the pilot program is meant to operate by VA referring Veterans to specific providers or if this is intended to be a self-referral model, and if the latter, the tracking requirements in subsection (e) would likely be very difficult to meet. Whether VA would be referring Veterans or not, it is unclear whether the bill assumes that VA would have a

role in vetting organizations or providers participating in the network, and if so, how VA would do so fairly and competently.

It is unclear if organizations would need to have a license or be approved through some type of accreditation process to ensure that Veterans are accessing safe, legitimate, and quality service providers; this would make sense, but would involve significant administrative expense in areas where VA has comparatively little experience. It is similarly unclear what level of participation or interest there would be among potential community organizations and providers; it may make more sense to conduct a market assessment or analysis before requiring VA to construct and operate a network if no entities or providers are interested in participating in the first place. Finally, the intended outcomes are not clear. Presumably, facilitating connections between Veterans and providers, and between different providers, is intended to provide a greater network of support for Veterans and their families, but it is not clear how VA would measure these outcomes. Again, given the societal nature of many of the issues addressed in the bill, defining discrete outcomes or metrics would likely be difficult and imprecise.

Beyond these general concerns, the bill presents implementation challenges for VA in several areas. First, the bill is unclear as to whether VA would be able to establish the type of network required by section 2(b) of the bill, particularly within one year of enactment. The type of interoperable technology network could be incredibly complex and expensive to develop, implement, and maintain, given the variability in terms of services, providers, and resources of those providers to meet the needs of Veterans participating in this program. Given the responsibilities of other Federal agencies, as well as local and State governments, integration and coordination are critical. The impact to IT development and sustainment resources would be significant and, if not fully funded in addition to existing priorities, would likely be devastating to other projects. The specificity of the bill in several areas—for example, identifying specific ICD-10 codes—would exacerbate the difficulty of implementation and increases cost.

VA notes that the bill would require compliance with applicable Federal and State privacy laws, but the bill is unclear as to whether this applies to VA or only to non-VA parties using the exchange.

We would appreciate the opportunity to discuss the intent of this proposal. VA built a process to screen Veterans for needs regarding social determinants of health through the Assessing Circumstances & Offering Resources for Needs (ACORN) Initiative, which is being piloted in over 20 VAMCs. This effort is currently in a pilot phase but has already completed more than 5,000 screens.

Section 3 would require VA to collect from Veterans enrolled in VA care, as part of routine screenings conducted under the laws administered by VA, information related to social determinants that may factor into the health of such Veterans. The information would have to include standardized definitions for identifying social determinants of health needs identified in the ICD-10 diagnostic codes Z55 through Z63, Z65, and Z75

(as in effect on the date of enactment). The definitions would have to incorporate measures for quantifying the relative severity of any such social determinant of health need identified in an individual.

VA does not support section 3. VA does not have the capacity to collect the data required by this section, as this would require Bidirectional Health Information Exchange (BHIE) capabilities with community facilities, which would likely come at significant expense. Also, as noted above, VA's efforts through the ACORN Initiative may already address some of the intended outcome of this section. VA believes it would be more prudent to wait for the results of this effort before imposing system-wide requirements that may present cost and implementation challenges without being more effective.

Section 4 would require VA, in implementing this Act, to consider data privacy and how to prevent data blocking and promote interoperability.

VA does not support section 4. Although VA supports the intent of section 4, VA does not support other sections of this bill to which section 4 would apply. VA supports the protection of Veterans' privacy and information security, however, because section 4 would apply to the program required by section 2, and VA has concerns with section 2, VA does not support this section. Additionally, VA notes several areas where section 4 is incomplete.

First, the pilot program required by section 2 would require the disclosure of personally identifiable information (PII) and protected health information (PHI) to community networks that are non-health care providers for purposes beyond treatment of the Veteran (e.g., job training). VHA, as a covered entity under the Health Insurance Portability and Accountability Act, is required to have legal authority to make such disclosures of PHI. This section, as drafted, does not provide such authority and would likely require VHA to obtain signed, written authorizations from the Veterans participating in the pilot program for disclosure to each entity or for each purpose; this could hinder the success or the ability of the pilot to determine its true effectiveness (beyond the reasons previously articulated). Second, the administrative overhead of obtaining signed, written authorizations and developing an electronic system for storing the authorization to allow an easy mechanism for checking the validity of those authorization before sharing any PHI with the community networks could be considerable.

S. XXXX Making Community Care Work for Veterans Act of 2023

The draft "Making Community Care Work for Veterans Act of 2023" consists of 3 titles and 22 substantive sections.

Section 101 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (m) regarding the scheduling of appointments. Specifically, this would require VA to ensure that an appointment for a covered Veteran for care or services under the VCCP is scheduled for non-urgent appointments within seven days of the

date on which a VA clinician determined the care was needed or the Veteran presents to VA requesting care, whichever is sooner. For urgent care, VA would have to ensure appointments are scheduled within 48 hours instead of seven days. VA would have to submit to Congress quarterly reports on the average time it takes each VA medical facility to schedule appointments for care or services, broken out by primary care, mental health care, and each type of specialty care. Any facility whose average time is more than seven days would have to submit to the USH an explanation for why the average time is more than seven days, a remediation plan to bring the average time down to at least seven days, and an explanation for how each issue identified as a factor for the delay in scheduling is being mitigated. If the USH determined an explanation was insufficient, the USH would have to consult with any TPAs responsible for administering the network on how network insufficiency can be overcome and examine whether the TPA is meeting contractual obligations. VA would have to comply with these requirements within 60 days of enactment.

VA does not support section 101. The scheduling standard of seven-days that would be required by this bill would create significant operational challenges for VA. Currently, only a small number of sites could meet the seven-day standard. The current average across the system is 28 days. The key reasons most facilities are unable to schedule community care consults within seven days are: (1) the consult forwarding timeline (as schedulers cannot create appointments they cannot see); (2) communications regarding community care appointments taking more than two or three days (even for self-scheduled consults) and (3) staffing shortages within community care teams. Consults forwarded from an internal service to community care are included in this measure, and this processing time needs to be considered as well. If the seven-day timeline only started once the consult was received by the community care team, VA could meet that requirement. VA does not support this section for several reasons.

First, VA would need to implement changes in systems and processes, and possibly in contracts, before sites could consistently meet the seven-day standard. VA could not complete the work required to implement these changes within 60 days of enactment. Second, it is unclear what the consequences are if VA is unable to ensure an appointment is scheduled within these timeframes.

Third, the scope of this section is unclear. Neither the term “urgent appointment” nor “non-urgent appointment” is defined, so VA would need to interpret these phrases, likely based on clinical determinations. However, what constitutes “urgent” care can vary across different specialties. When a Veteran presents to VA, additional clinical evaluations may be needed to determine in the first place whether the appointment is an urgent one or not, but this time does not appear to be contemplated within the prescribed timelines. We also note that the term “urgent” could create ambiguity given its use in other contexts (such as under 38 C.F.R. § 17.4600, implementing the walk-in care authority under 38 U.S.C. § 1725A). In VA’s electronic health records (EHR), in the Cerner system, “urgent” is used to refer to consults that need to be completed within 72 hours, and “STAT” consults need to be completed within 24 hours. There is no

similar “urgent” consult status in VA’s Computerized Patient Record System (CPRS), which would need to be updated to account for this.

Section 102 would amend 38 U.S.C. § 1703B to expand and codify VA’s existing access standards established in regulation at 38 C.F.R. § 17.4040. Specifically, section 102 would create a new section 1703B(a) that would provide that covered Veterans would be eligible to elect to receive non-VA hospital care, medical services, or extended care services if VA determined it was unable to schedule an appointment within its designated access standards. Section 102 would also amend the current requirement that VA meet the access standards when furnishing care and services through the VCCP by allowing health care providers who are not covered by a TPA to request a waiver to this requirement.

VA does not support section 102. VA generally opposes codification of access standards. Removing the ability of the Secretary to develop and publish such standards for VA diminishes the Secretary’s authority to ensure Veterans receive the right care, at the right time. This section fails to consider other market forces that also impact access to care outside of VA and would not allow VA to consider and incorporate those forces to meet Veterans’ needs for timely, high-quality care.

VA appreciates the provision that would grant an opportunity for providers who are not covered by a TPA to request an exemption from the access standards. This requirement was imposed through section 125 of the Cleland-Dole Act, and as VA has expressed to the Committee, this would prove extremely difficult, if not impossible, for such providers to meet. We have technical recommendations on how to ensure this language works appropriately to reduce the burden on such providers while ensuring Veterans are able to access timely, appropriate care close to home. This language, for example, would still require providers to request a waiver, versus allowing VA to waive requirements on behalf of providers for whom compliance with these standards (particularly the average drive time standards) would be difficult or impossible.

Section 103 would amend 38 U.S.C. § 1703(d) to add a new paragraph (4) that would require VA, in determining whether it could schedule an appointment within the access standards established under § 1703B, to only consider the availability of a telehealth appointment if the Veteran accepts the use of telehealth.

VA supports section 103. VA appreciates and fully supports the requirement that, in making determinations about scheduling appointments, VA must consider a telehealth appointment. This is consistent with VA’s interest in accommodating a Veteran’s interest in receiving a telehealth appointment.

Section 104 would amend 38 U.S.C. § 1703(d) to establish that an agreement by a covered Veteran and the referring provider under § 1703 regarding the best medical interest of the covered Veteran is final and not subject to review or approval by VA. Covered Veterans and their referring clinicians could correct any errors made with respect to an agreement.

VA does not support section 104. Referring providers may not always have the specific information needed to know whether receiving community care is in the best medical interest of the Veteran. This section would prohibit reviews or corrections of erroneous use of the best medical interest criterion and would not be appropriate if there are clinical or other changes that might require changes to use of the best medical interest criterion. For example, a referring provider may be unaware of a Veteran's other conditions (such as when test results are pending or a referral with another provider is still pending) before agreeing that community care would be in the Veteran's best medical interest; other conditions may also arise during the course of treatment that would affect the best medical interest determination for a Veteran.

Moreover, this section would prevent the reconsideration of a best medical interest determination once it has been made and could consequently negatively impact the course of treatment based on these other factors.

VA is concerned this section could complicate determinations VA must make on whether the care is necessary and appropriate. This determination must occur prior to determining whether receiving care in the community would be in the Veteran's best medical interest. For example, VA currently requires that any Veteran that is potentially in need of a transplant be entered into the VA TRACER system for evaluation before a determination is made about the provision of the transplant. It is not clear whether this language would impact these determinations, but VA is concerned that it could be interpreted to prevent this type of clinical review.

Section 105(a) would amend 38 U.S.C. § 1151(a) by adding a paragraph that would require VA to pay compensation if a Veteran's disability or death was caused by hospital care or medical services furnished under proposed section 1703 of title 38, United States Code, and the proximate cause of the disability or death was carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault by the provider or an event not reasonably foreseeable. Section 105(b) would create new 38 U.S.C. § 1151(d) that would provide the amount of any judgment awarded to an individual in a civil action brought by the individual against a non-VA provider in a court of competent jurisdiction for a disability or death caused by hospital care, medical services, or an extended care services furnished by a non-VA provider would be offset by the amount of any compensation awarded to the individual under such subsection for such disability or death.

VA does not support section 105. Veterans and survivors injured by non-VA providers have remedies available through the common law torts system. Non-VA providers have financial liability protection available through malpractice or professional liability insurance coverage. By inserting the potential for recovery under the VA disability compensation program into cases where non-VA providers harm their patients or clients, this amendment may shield both those providers and their insurers from the consequences of their actions. Doing so may shift the economic burden of those consequences from the persons who cause harm and insurance companies to the

taxpayers. Insurers of community care providers could receive a windfall if Veterans or their survivors choose to pursue benefits under § 1151 in lieu of civil tort litigation. That potential is not remote: the evidentiary standard for establishing entitlement to VA benefits (claimants receive the benefit of the doubt when the evidence is at least approximately balanced or nearly equal on a material fact) is lower than the standard generally required in civil tort actions (where plaintiffs must establish elements by a preponderance of the evidence), and the VA disability claim adjudication system is paternalistic whereas civil litigation is adversarial in nature.

Second, by having VA assume a community care provider's liability, section 105 could change the nature of the VA-community care provider relationship such that the non-VA community care provider may be viewed by courts as an "employee." This could result in other unforeseen and potentially detrimental changes to the VA-community care provider relationship. Currently, VA has contracts with TPAs, and the TPAs have contracts with individual providers. There is no privity of contract between VA and the TPA's providers, which means these providers are not subject to other requirements associated with Federal contractors (or, as could be the case here, Federal employees). This proposal could change the obligations imposed upon these providers.

Third, VA benefits claims processors would have to develop evidence regarding alleged insufficient care furnished by non-VA parties. This would almost certainly increase VA's administrative demands and slow the processing of other Veterans' benefits claims. Moreover, non-VA providers may be reluctant or unwilling to provide evidence necessary to properly process claims under § 1151, particularly when the facts involved in civil tort litigation relate to the alleged harm at issue in the § 1151 claim.

Finally, this section would make VA liable for the negligence of a non-VA provider or an unforeseeable event while under a non-VA provider's care. That concept is in tension with the basic principle that negligent parties should be held responsible and bear the financial liability for the consequences of their conduct. That principle has evolved, at least in part, to ensure that parties are incentivized to exercise appropriate caution and skill in their endeavors. By effectively shifting financial liability from non-VA community care providers to VA, section 105 diminishes that principle and could detrimentally impact the level of diligence exercised by non-VA providers and negatively impact the nature of the care they provide to Veterans.

Section 106 would amend 38 U.S.C. § 1703D to extend from 180 days to one year the time period for health care entities and providers to submit claims to VA for payment for furnishing hospital care, medical services, or extended care services.

VA does not support section 106. VA's contracts for community care generally include a 180-day timely filing requirement. Providers are aware of the 180-day timely filing requirement when agreeing to their contracts with the TPAs. Additionally, section 142 of the recently- enacted- Cleland-Dole Act amended 38 U.S.C. § 1725 to require 180 days for timely filing, which is consistent with current section 1703D. VA

believes the 180-day time limit is appropriate and ensures predictability and more accurate claims processing.

We note, though, at present, claims for service-connected emergency care under 38 U.S.C. § 1728 must be filed within two years of the date of service (see 38 C.F.R. § 17.126), and claims under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) must be filed within one year of the date of service (see 38 C.F.R. § 17.276). CHAMPVA claims are generally processed separately, and claims under section 1728 represent a relatively smaller number of claims processed by VA. Further, because claims under section 1728 are claims for service-connected care, a longer filing period helps ensure more Veterans receive benefits under this authority, which seems justified based on their service-connected disabilities.

In general, VA believes that a single, consistent filing timeline would make administration easier and more accurate and is concerned about the inconsistency this bill would create between sections 1703D and 1725.

Section 107 would require VA to carry out a program under which VA could furnish outpatient services through a VCCP provider to a covered Veteran who is eligible for such services under criteria established by VA and chooses to self-refer for routine vaccinations and routine vision and hearing services.

VA does not support section 107. The-referral model creates a greater risk of Veterans visiting providers who are no longer participating in the VCCP, which would result in Veterans being billed directly for these services. When VA authorizes and schedules care, Veterans know that the provider they are visiting is in VA's network and will bill VA for the care provided (or at least that VA will be responsible for paying for the care provided). Every day, providers join and leave the network, so a provider that a Veteran had been seeing who was in VA's network may not be if the Veteran self-refers for another appointment. Additionally, the term "routine" is used to describe both vaccinations and vision and hearing services, but this could create some confusion as to the scope of benefits. Vaccines, for example, could be administered on a routine basis (e.g., preventative) or on a therapeutic basis (e.g., curative), such as when a tetanus shot is administered after a person steps on a rusted nail. The language of the bill would not seemingly cover this therapeutic treatment. We also note the scope of "vision and hearing services" is not defined; for example, it is unclear whether, for example, these are intended to include only examinations or if items such as eyeglasses or hearing aids are also intended to be included and furnished by non-VA providers. If the latter, this could significantly expand the parameters of this program and result in additional costs to VA.

Finally, the MISSION Act was enacted to consolidate and simplify community care eligibility, which became overly confusing and costly for Veterans and VA. In creating a parallel authority for the receipt of community care, this proposal would be a step back toward what the MISSION Act was intended to fix.

Section 108 would require VA, within 60 days from enactment and monthly thereafter, to submit to Congress a report containing information on the timeliness of referrals for non-VA care by calculating a number of specific steps in the process.

VA supports section 108, if amended. VA generally supports this section but is concerned that VA may not be able to produce data for the entirety of the previous month due to lags in collecting and validating some data. VA recommends a timeline of 180 days for the first report, as the 60-day timeline would be very challenging to meet., VA wants to ensure that data reported on a monthly basis reflect longitudinal trends, rather than simply point-in-time numbers. VA welcomes the opportunity to provide additional technical assistance on this section. VA does not estimate there would be any costs associated with this section.

Section 109 would require VA, within one year of enactment, to require that covered providers submit to VA data required to be collected and considered by VA pursuant to VA's standards for quality (under 38 U.S.C. § 1703C). If a covered provider did not provide these data to VA, VA could not permit the covered provider to participate in the VCCP. VA would have to encourage other, non-covered providers to submit such data on a voluntary basis. VA would have to publish and maintain online an up-to-date list of all health care providers that have provided such data and that are high-performing providers, as determined by VA.

VA does not support section 109. VA has several concerns with this section. First, VA would have to identify covered providers who would be required to provide such data as a condition for participation in the VCCP. VA's determination would be based on providers VA has determined have "sufficient resources to submit the data required". This would likely only be our largest providers, such as health care systems or hospital systems. However, these providers are also often among our busiest providers and those most integral to ensuring Veterans have timely, quality care close to home. Imposing additional requirements on these providers could result in abrasion or refusal to participate in the VCCP, which would result in fewer options for care for Veterans. Second, any requirements to exclude certain providers from the existing TPA contracts would require bilateral contract modifications, which would likely prove costly to VA and could jeopardize network adequacy if such large providers are unwilling to collect and report these data.

VA cannot provide a cost estimate for this section because it would require contract modifications that would have to be agreed to by VA and non-VA parties.

Section 110 would require VA to establish a program under which VA would provide a "High Compliance" rating for community providers who comply with three specified requirements VA could provide a financial incentive for community care providers with a "High Compliance" rating. VA would have to establish a plan to promote this program and to encourage the participation of community care providers in the program.

VA cites concerns with section 110. VA is concerned that this program could create provider abrasion, as it would require providers to complete additional training and submit a certain percentage of medical records within established time periods that are not generally consistent with industry standards. The percentage requirement could disadvantage smaller providers who see fewer patients, in which case a single late submission could prevent their qualifying as a High Compliance provider. The bill would permit VA to provide financial incentives for providers who achieve a "High Compliance" rating, and we believe this would likely be necessary given the additional effort involved; however, it is unclear the contractual mechanism by which these incentives would or could be applied to providers themselves (versus incentivizing the TPAs to incentivize certain providers' behavior).

We are unsure what such requirements would cost because this would need to be negotiated bilaterally. It also is not clear that many Veterans would value a provider who meets the requirements of being a "High Compliance" provider more than one who does not. It seems unlikely that most Veterans would care whether medical documentation is submitted back to VA within 15 or 20 days of completion of treatment, for example. Maintaining a list of these providers would also require additional administrative resources, which could detract from care delivery.

Section 111 would require VA, in consultation with HHS and the National Coordinator for Health Information Technology, to create an implementation plan for VA to adopt national interoperability standards for the electronic transfer of health information, including information used to inform quality metrics, between VA and community providers. Within 180 days of enactment, VA would have to submit to Congress a report on this plan, including a timeline for adopting interoperability standards and an indication of any resources VA may request from Congress to implement such standards.

VA supports section 111 with amendments. VA supports standards with all health information exchange participants however, VA does not believe 180 days would be a realistic timeline to develop a plan given the involvement of the TPAs. We recommend this be extended to at least a one-year period. We also note that the plan would likely need to include exceptions for small providers, particularly those in rural areas, who may not have adopted electronic health records. We recommend this provide flexibility for this plan to adopt standards, as practicable. Finally, we recommend an analysis of VA and provider participation in the Trusted Exchange Framework and Common Agreement instead of, or in addition to, the standards evaluation.

Section 112 would require VA, within one year of enactment, to complete an analysis of the feasibility and advisability of establishing a community care network for the provision of care to Veterans in the Republic of the Philippines. Within 180 days of the completion of this analysis, VA would have to submit to Congress a report on this analysis and including various assessments.

VA supports section 112. VA agrees that an analysis and report of the feasibility and advisability of such a network would be helpful. We do not estimate any

additional costs would be incurred for this analysis, as VA could complete this analysis within existing resources.

Section 113 would require VA, not later than 180 days after enactment, to carry out a two-year pilot program to test the efficacy of hiring general dentists at the facility level to manage approval by VA of treatment plans requested by dental providers in providing community care and hiring dental specialist at the VISN level to aid in approving treatment plans requested by community dental providers.

VA does not support section 113. This section is unnecessary, as several facilities have already hired general dentists to manage community care consults. At the VISN level, we are not sure about the intent, as there are multiple dental specialties, and this section could create confusion as to reporting. If instead the intent is to reduce burden on dentists in the clinical setting, VA could hire more general dentists and other dental allied health personnel (dental assistants and hygienists).

Section 114 would require VA to conduct a review of rate waivers for TPAs under the VCCP to identify whether those waivers are helping to alleviate community-specific challenges, including scarcity of medical services associated with access to care.

VA cites concerns section 114. VA does not track the data this report would require in an easily reportable format. This would result in additional costs to VA (including potentially the costs of contract modifications). Subject to the availability of appropriations, VA has no objection to providing additional information to Congress.

We note as a technical matter that subsection (a) only appears to require a single review, but subsection (c) would require annual reports on the results of the review. Either subsection (a) should be amended to require VA to conduct annual reviews or subsection (c) should be amended to only require a single report.

Section 115 would require the Comptroller General to submit to Congress a report on dental care furnished by VA under the VCCP.

VA defers to the Comptroller General on section 115.

Section 201 would create a new subchapter X in chapter 76 of title 38, U.S.C., called the Start and Stay at VA Program. Under a new § 7699C-1, as part of the Educational Assistance Program, VA would have to carry out a program to provide scholarships (consisting of the payment of reasonable educational expenses to VA employees serving as a medical support assistant (MSA), advanced MSA, lead MSA, or supervisory MSA who have been employed by VA in one or more of those positions for at least two years, who have been accepted for enrollment or are enrolled as a student in certain courses of education or training (such as those listed as a requirement for any hard-to-hire or hard-to-recruit positions, those the completion of which results in any other degree or certification that VA considers appropriate for purposes of the program, and those related to business, health care administration, or human resources), and who have a record of VA employment that demonstrates a high likelihood the individual

will be successful in completing the course of education or training and in gaining employment in a field related to such course of education or training.

Under a new § 7699C-2, VA could also provide lump-sum education debt reduction to eligible individuals to consist of payment of principal and interest under student loans. In exchange for a one-time lump sum payment, participants would agree to be employed for at least three years at VA, at least two of which would be served in the position of MSA, advanced MSA, lead MSA, or supervisory MSA (the remainder of the period could be served in a hard-to-hire or hard-to-recruit position). Participants would be liable for breach of their service agreements.

A new § 7699C-3 would require VA to develop an outreach program to Tribal Colleges and Universities, historically Black colleges and universities, high schools in rural areas, community colleges, transition assistance programs for members of the Armed Forces, and spouses of such members.

VA does not support section 201. Though VA has provided technical assistance on this section, we believe VA's current incentives (scholarship programs, debt reduction, other recruitment, retention, and relocation incentives) provide sufficient incentives for VA staff. More specifically, the Student Loan Repayment Program (SLRP) provides broader support than these sections would authorize, as the SLRP is currently utilized for a range of professions, including MSAs. Between 2020 and 2022, we have seen a significant increase (more than 400 percent) in use of this program for MSAs. Additionally, VA has given more than 200 Employee Incentive Scholarship Program (EISP) awards for MSAs since 2019.

Section 202 would amend 38 U.S.C. § 7673(c) to increase the number of allowable years under the Employee Incentive Scholarship Program (EISP) from six school years to eight school years and from the equivalent of three years of full-time coursework to four such years.

VA supports section 202, with amendments, subject to the availability of appropriations. VA supports this section, but there are additional amendments that would be needed to ensure this section has its intended effect (specifically 38 USC § 7672(e)(A) and (B), § 7673(b)(1) and (c)). VA recommends an amendment to ensure the amount authorized is in alignment with other authorities.

This has a 5-year cost of $48.9 million for both New & Current scholarship recipients.

Section 203 would authorize VA to establish a program to connect covered individuals with peer mentors to facilitate sharing of best practices and leadership experiences and to foster opportunities to develop knowledge and skills needed to lead VA medical facilities successfully. Within one year of enactment, and annually for three years, VA would have to submit to Congress a report on the mentorship program.

VA supports section 203, if amended. Section 203 would provide the opportunity to continually improve the VA medical center leadership workforce. Moreover, this section would afford the opportunity to spread best practices while using field-based evidence. This section would promote and build network opportunities between new and seasoned medical center directors while promoting High Reliability Organization principles across the VHA enterprise. VA recommends removing or clarifying the phrase “across the Department” in subsection (e)(5). VA estimates section 203 would cost approximately $537,600 in FY 2024, $3.3 million over five years, and $8.6 million over ten years.

Section 301 would add a new 38 U.S.C. § 1706B that would establish a requirement that VA ensure appointments scheduled at VA facilities are scheduled for non-urgent appointments within seven days of the date on which a VA clinician determined the care was needed or the Veteran presents to VA requesting care, whichever is sooner. For urgent care, VA would have to ensure appointments are scheduled within 48 hours instead of seven days. VA would have to comply with these requirements within 60 days of enactment.

VA does not support section 301. There are several issues with this section that create implementation challenges. First, VA would require significant clarification with regard to the definition of “urgent care”, and the application of varying time requirements associated with different types of urgent care. Second, it is unlikely VA would be able to develop this requirement into a functional application within 60 days, as development of an additional requirement would inevitably require software modifications and other administrative actions prior to being applied. Section 302 would amend 38 U.S.C. § 1703C in several ways.

First, it would require VA ensure that the standards for quality are comparable to industry standards to ensure there is adequate transference between care furnished by VA and non-VA providers. Second, it would require VA to collect and consider additional data for purposes of establishing the standards for quality, specifically datasets that include elements relating to equitable care, and measurements of standards for quality that include measurements of the following: the degree to which care is furnished uniquely to patient needs; workforce safety; employee engagement; safety culture; outcomes on patient quality of life; and such other matters as VA considers appropriate.

Third, VA would need to consult with the Indian Health Service in its consultation with all pertinent Federal entities (which currently includes DoD, HHS, and CMS). Fourth, when collecting, considering, and applying data related to patient care for purposes of establishing standards for quality, VA would have to ensure no metric is being over- or under-analyzed.

Fifth, in establishing standards for quality, VA would have to utilize the most current practices in extracting and analyzing relevant data, utilize all relevant data available to VA, ensure the most efficient use of time and resources related to the use of data scientists employed by VA, and collaborate, as appropriate, with all pertinent

Federal entities, entities in the private sector, and other non-governmental entities in establishing the standards for quality.

Sixth, within seven years of enactment, and not less frequently than once every five years thereafter, VA would have to update the standards for quality pursuant to the requirements for establishing such standards set forth in law, as amended. Within 30 days of any update of the standards for quality, VA would have to submit to Congress a report on such updated standards.

Finally, VA would have to publish the quality rating of VA medical facilities on the Hospital Compare website (through CMS) not less frequently once every three years, publish that rating pursuant to VA's standards for quality, and ensure that VA solicits public comment not later than two years after updating the standards for quality.

VA does not support section 302. VA has already taken many of the actions this section would require. VA has aligned its standards for quality with industry standards used by community counterparts, and this is an inherent part of the existing process. Where alignment is possible and appropriate for Veteran care, it has already been undertaken. VA already has existing data sources for most of the areas this section would require VA to include, but it is likely that finding appropriate, accurate, actionable, and comparable community benchmark data at a facility or provider level would be very challenging and untenable in some cases. VA also updates quality ratings for its facilities more often than once every three years.

Though VA has provided technical assistance to this section, VA cites several concerns with specific language in this section. For example, it would also likely be very difficult measure a safety culture for non-VA providers or entities because there is no way to determine if they measure a culture of safety within their organizations, if they subscribe to high-reliability organization principles, how they report patient safety concerns within their organizations, or otherwise exhibit a safety culture.

Section 303 would impose a number of requirements related to VA's Mental Health Residential Rehabilitation Treatment Program (MH RRTP); MH RRTP would be defined to mean the array of VA programs and services that comprise residential care for mental health and substance use disorders (SUD) and includes the programs designated as of the date of enactment as domiciliary residential rehabilitation treatment programs. In general, VA would have to fulfill all requirements under this section within one year of enactment, unless otherwise specified.

VA supports section 303, with amendments, subject to the availability of appropriations. VA agrees with many of the intended outcomes of this section and has already established such requirements through policy. Many of the timelines and procedural requirements are consistent with current practice and policy, and VA currently makes both actual and prospective wait time data available to facility and VISN leadership.

VA generally supports making transportation available to Veterans in need of MH RRTP, as this could address barriers to access for this type of care. VA acknowledges that residential rehabilitation treatment often involves extensive travel; current data indicate that Veterans receiving community residential treatment care are traveling 189 miles on average to access such care.

However, VA cites concerns with several provisions in this section. First, this section refers to Veterans self-referring for MH RRTP care. MH RRTP is a form of domiciliary care, and domiciliary care includes additional requirements that must be met to receive such care (see, e.g., 38 U.S.C. § 1710(b); 38 C.F.R. § 17.47). While Veterans can unofficially self-refer for MH RRTP, verification of their eligibility occurs during the screening process. If this language is not modified, VA would interpret this phrase in light of these requirements.

Second, the language regarding Veterans' preferences for where to receive care between VA and non-VA facilities is unclear—the bill would require VA to "provide the veteran an option to select the preference of the veteran" and would require VA to "incorporate the preference" of the Veteran, but none of this could be easily or clearly implemented as written. It is unclear whether this is intended to establish that the Veteran's preference controls or if VA is to be provided discretion to make a decision inconsistent with the Veteran's preference (and if so, on what basis VA could make such decisions).

Third, this section would require VA to provide Veterans with a list of locations that meet their care needs and the preferred start date for the Veteran to receive residential care, but it is unclear how this provision would interact with the admission options just described. If VA was able to place the Veteran in an MH RRTP bed within the established time period and at an accessible VA facility, it is unclear what value would be realized in providing information about other locations. This also could reduce current protections to ensure there is a clear admission date provided at the time a Veteran is assessed as appropriate for residential admission. Current policy allows referring providers to refer Veterans to a range of programs both within and outside of VA. The section would require VA, in making screening, admission, and placement decisions to consider family- or occupational-related preferences or circumstances. Given the variety of factors VA would have to consider, some of these could lead to conflicting conclusions, and it is not clear how the drafters would intend VA to resolve such dilemmas. In the absence of further legislative clarity, VA would have to address these matters through rulemaking or policy.

VA cites concerns with the reporting requirements in this section. First, VA would be required to include a review of wait times under MH RRTP disaggregated by wait times for both VA and non-VA facilities. VA does not have consistent data on community wait times, and there are many such community programs (some within VA's network and some outside). To gather this data for community wait times within VA's network, VA would need to renegotiate contract terms with at least the two TPAs and potentially others, which would result in additional administrative costs to VA.

Second, there is no current mechanism to determine participation in a treatment track as data are captured at the official program level only. Third, the requirement to include recommendations under this report could be duplicative or conflict with the recommendations VA provides under section 503 of the STRONG Veterans Act (Division V of P.L 117-328 Division V).

Fourth, VA notes the definition of MH RRTP in the bill would technically include the Compensated Work Therapy-Transitional Residence (CWT-TR) programs, but that does not appear to be the focus. VA recommends specifically excluding CWT-TR because of its distinct role. VA also recommend removing subsection (e), regarding appeals, as VA already has a clinical appeals process.

Finally, VA recommends that if these requirements will continue to govern MH RRTP care (as appears to be the case) that this be codified in title 38, U.S.C., to allow for easier reference and amendment in the future. VA welcomes the opportunity to discuss this section with the Committee. VA is working to assemble the necessary data, but VA does not have a cost estimate for this section at this time.

Section 304 would require VA, within 18 months of enactment, to publish an online portal allowing individuals applying for medical care under the Civilian Health And Medical Program of the Department of Veterans Affairs (CHAMPVA) to submit application materials electronically, view the status of their application online, and select their preferred method of communication regarding their application (which VA would have to use upon the first attempt to contact the individual if there are any issues with the application).

VA supports section 304, if amended, subject to availability of appropriations. Creating an online portal will provide an additional communication tool that will allow VA to provide real-time information to beneficiaries and providers. It is anticipated that the online portal will remove administrative barriers that may exist when requesting a status, of a claim submitted to the program for reimbursement as well as providing a venue for the submittal of critical documents to establish eligibility for health care under CHAMPVA. Furthermore, VA will have the ability to utilize the portal to support other family member programs such as the Spina Bifida Health Care Benefits, Children of Women Vietnam Veterans, Camp Lejeune Family Member, and the Foreign Medical programs. Providing an online portal will demonstrate VA's commitment to utilize technology to enhance customer service as well as offer a similar option that is available to beneficiaries utilizing insurers of health care in the community.

The 18-month period provided in this section would provide not enough time to establish the portal described in this section. This portal would require multiple interfaces between complex claims processing and financial management systems. VA would likely need to contract for the construction of this portal and would also need additional staffing to support development of this portal. VA believes it would be possible to complete construction of the portal within 18 months from the date a contract is awarded, and we expect a contract award would take at least 12 months. If this

section is amended to provide VA additional time and resources, VA would support this section.

VA offers several technical comments on this section. First, this section would require, as a necessary element of the portal, individuals receiving care through CHAMPVA the ability to reprocess a denied claim electronically, but CHAMPVA beneficiaries do not process or reprocess claims—VA does. We believe this should state that individuals could request that VA reprocess a claim. Second, the portal would only be required to allow CHAMPVA providers to submit medical claims documentation, but it seems like these providers should also be able to request VA reprocess a claim (or file an appeal). VA estimates that expenditures to create an online portal to be approximately $23.1 million in FY 2025, $24.8 million over 5- and 10-years.

Section 305 would require VA conduct a review of the workflows directly associated with processing referrals of patients between VA facilities to identify specific delays or bottlenecks in such referrals.

VA does not support section 305. VA has already conducted a review as described in this section as part of the audits required by section 3102 of the Isakson-Roe Act, and VA is already working to issue a new directive in this regard later this year. Further, there are ongoing efforts to review the current process maps, identify any bottlenecks, and mitigate any delays related to referral processing. Finally, VA has published inter-facility consult guidance in the Referral Coordination Initiative guidebook and this will be published in a standard operating procedure format with publication of the updated VHA consult directive referenced above.

S. XXXX Rural Vital Emergency Transportation Services (VETS) Act

Section 2 of this draft bill would require under regulations prescribed by VA, to pay or reimburse a highly rural Veteran ambulance, including air ambulance, to a VA or non-VA provider for care authorized under the laws administered by VA regardless of whether the Veteran qualifies for payments or allowances for beneficiary travel under 38 U.S.C. § 111. The term “highly rural veteran” would mean a Veteran who is located in an area rated as a 10 or higher under the rural-urban commuting areas coding system of the Department of Agriculture.

VA does not support this bill. VA agrees with the intended goal of this legislation, but VA has a number of concerns with the text as written. VA provided technical assistance on an earlier draft of the bill where we raised several concerns regarding the scope of the text. We would appreciate the opportunity to discuss this bill further, particularly in terms of how this bill would operate given other authorities beyond § 111 (such as § 1725) for VA to pay or reimburse for emergency transportation costs.

S. 1951 VA Income Eligibility Standardization Act

Section 2(a) of the draft bill would amend 38 U.S.C. § 1710(a)(3), which generally authorizes VA to furnish hospital care, medical services, and nursing home care, to the extent resources and facilities are available, to Veterans not otherwise eligible for VA care under paragraphs (1) or (2) of such subsection. The amendments would require VA to furnish hospital care and medical services, and would permit furnishing nursing home care, which VA determines to be needed for such Veterans. It would also amend § 1710(a)(4) to clarify that this requirement would only be effective in any FY only to the extent and in the amount provided in advance in appropriations Acts for such purposes. Section 2(b) would require VA to eliminate all subcategories of priority for enrollment established by VA for Veterans eligible under Priority Group 8 of the enrollment system and ensure that all Veterans eligible for enrollment could enroll in VA's patient enrollment system.

Section 3 of the bill would require VA to ensure that all Veterans, once enrolled in VA's enrollment system, remain enrolled in such system and may continue receiving health care furnished by VA if they choose, subject to such cost-sharing requirements as may apply to the Veteran under existing provisions of law.

VA does not support this bill. VA broadly agrees that expanding eligibility for VA health care is important. This bill would expand eligibility for enrollment to 4.7 million more Veterans who are currently ineligible based on their income level. Approximately 76 percent of Veterans ineligible based on income under the age of 65 have employer-sponsored health insurance, and approximately 93 percent of similar Veterans over the age of 65 have Medicare coverage.

However, even if Veterans who enroll in VA health care under this expansion use VA for only a small portion of their health care needs due to their other coverage options, this bill could have a significant impact on capacity as hundreds of thousands of new Veterans could seek care from VA, which would negatively affect access to care for current enrollees and users (including Veterans with service-connected disabilities). For the population under the age of 65, this bill would largely result in a cost shift from private insurance to the Government, and for those over the age of 65, this could result in some shift from Medicare to VA. We also note that granting access to this cohort could have unintended consequence for their eligibility for assistance under the Affordable Care Act or under State programs. We also note, particularly for the older population, that Veterans' demand for non-institutional long-term care services would likely result in significant additional demand for resources from VA. For example, homemaker and home health aide services are unavailable under the Medicare program and these Veterans are unlikely to qualify under State Medicaid programs due to their income levels. This could increase VA's demand for resources considerably. We do not expect there would be a significant shift in either hospice care or skilled nursing care for Veterans over the age of 65 because these services are provided without copayments through the Medicare program.

The bill provides no delayed effective date, so these changes would be effective upon enactment. VA simply does not have the capacity today to accommodate this additional population. VA would likely need time to adjust to a significant expansion of Veteran eligibility to ensure that resources are available to furnish care to these Veterans and those currently enrolled in and receiving care from the system. A sudden expansion of eligibility could result in delays in care for current and new enrollees.

VA cites additional concerns with the bill. First, it is unclear how section 2(b) of the bill would affect VA's authority under 38 U.S.C. § 1705(b)(1) to ensure that the system will be managed in a manner to ensure that the provision of care to enrollees is timely and acceptable in quality. It is also unclear how section 2(b) would affect VA's authority under 1705(b)(2) to establish additional priorities within other priority groups than Priority Group 8. Second, in section (3) of the bill, it is unclear what the phrase "if they choose" is intended to qualify – the receipt of care or the enrollment of the Veteran in VA health care. Currently, VA regulations (at 38 C.F.R. § 17.36(d)(5)) provide for a disenrollment process that can occur at the election of the Veteran. It is unclear if the bill's requirement that the Veteran "remain enrolled" is intended to foreclose this opportunity.

We note that there may be situations were disenrollment could be preferrable for the Veteran (for example, if the Veteran would qualify for a subsidy or other benefit based on not having other qualifying health insurance). Third, the provision stating that Veterans "may continue receiving health care furnished by the Department if they choose" is unclear as to whether this is also supposed to be subject to the availability of appropriations under § 1710(a)(4). Finally, the language in section 3 about "cost-sharing requirements as may apply to the veteran under existing provisions of law" would cement in place current copayment requirements. If future regulations or statutes changed copayment (for example, by granting waivers or changing amounts), those changes may not apply to current enrollees but could apply to future enrollees. This could create significant additional complexity. If the drafters simply intended for this to subject enrollees to any cost-sharing requirements as may apply, now or in the future, we recommend striking the phrase "under existing provisions of law".

VA estimates that, if enacted, this bill would result in additional costs of $544.6 million in FY 2024, $5.75 billion over five years, and $14.26 billion over 10 years.

Conclusion

This concludes my statement. We appreciate the Committee's continued support of programs that serve the Nation's Veterans and look forward to working together to further enhance the delivery of benefits and services to Veterans and their families.

Department of Veterans Affairs

Senior Executive Biography

Miguel H. LaPuz, MD, MBA

Assistant Under Secretary for Health

Office of Integrated Veteran Care

Veterans Health Administration

Effective May 22, 2022, Miguel H. LaPuz, M.D., was appointed as the Assistant Under Secretary for Health (AUSH) for Office of Integrated Veteran Care (IVC) and is charged in leading the VA's efforts to address access and community care for Veterans and beneficiaries.

Prior being in this role, he served as the Acting Deputy Under Secretary for Health and served as VISN 8 Network Director, where he oversaw healthcare delivery through a system of eight hospitals (two of which are integrated) and nearly 60 primary care and specialty outpatient clinics; eight nursing homes; and five domiciliaries. Serving a population of more than 1.5 million Veterans.

A highly respected leader with a wide breadth of experience, Dr. LaPuz served as the Medical Center Director of the Salem VA Medical Center (VAMC), Salem, Va., from 2011 to 2015. He was also the Chief of Staff at the Salisbury VAMC, in Salisbury, N.C from 2009 to 2011; in 2010, he also served there as the VAMC's interim Director. From 2005 to 2009, he was the Chief of Staff at the Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH, and from 2000 to 2005, he served as Chief of Medicine Service at the Dayton VAMC in Dayton, OH.

A native of the Philippines, Dr. LaPuz received a Bachelor of Arts degree in Psychology (Pre-Med focus) in 1978 from the University of the Philippines, Quezon City, R.P., and his medical degree in 1982 from the University of the Philippines College of Medicine in Manila. In 2000, he also earned a Master of Business Administration from Wright State University in Dayton.

Specializing in Nephrology, Dr. LaPuz did his residency in Internal Medicine at The Brooklyn Hospital Center, Brooklyn, N.Y., and completed a Fellowship in Nephrology at Long Island College Hospital, also in Brooklyn. He also completed a Fellowship in Molecular Biology Research at the University of Kentucky, Lexington, KY. Named Teacher of the Year at Wright State University's School of Medicine in 1998, Dr. LaPuz holds professional certifications by the American Board of Internal Medicine and the Healthcare Leadership Institute.

CAREER CHRONOLOGY:

2022 – Present	Assistant Under Secretary for Health for Integrated Veteran Care
2022 – 2022	Acting Deputy Under Secretary for Health
2016 – 2022	Director, Veterans Integrated Service Network 8, VA, St. Petersburg, FL
2017 – 2018	Acting Principal Deputy Under Secretary for Health, VA, Washington DC
2011 – 2015	Medical Center Director, Salem VA Medical Center, Salem, VA
2010	Interim Director, Salem VA Medical Center, Salem, VA
2009 – 2011	Chief of Staff, Salem VA Medical Center, Salem, VA

EDUCATION:

2000	Masters of Business Administration, Wright State University, Dayton, OH
1982	Doctor of Medicine, University of the Philippines College of Medicine, Manila, R.P.
1978	Bachelor of Arts, Psychology, University of the Philippines, Quezon City, R.P.

Matthew A. Miller, PhD, MPH
Executive Director, VA Suicide Prevention
Office of Mental Health and Suicide Prevention
U.S. Department of Veterans Affairs

Dr. Matthew Miller is the Executive Director for VA Suicide Prevention for the U.S. Department of Veterans Affairs (VA), where he leads a team dedicated to the implementation and reinforcement of evidence-based community and clinical interventions addressing suicide prevention, intervention, and postvention.

Dr. Miller previously served as the Director of the Veterans Crisis Line (VCL). Under his leadership, VCL became the world's largest and most efficient suicide crisis call center. He began his VA career as the Chief of Mental Health at Aleda E. Lutz VA Medical Center in Saginaw, MI, where he later became the Deputy Chief of Staff.

Dr. Miller received his PhD from Michigan State University and a Master of Public Health (MPH) from the University of Michigan.

Dr. Miller is an Air Force Veteran. He completed his professional residency in Clinical Psychology at Wright-Patterson Air Force Base Medical Center and served as the Chief of Mental Health at a Joint Services Pilot Training Wing. Dr. Miller was responsible for overseeing outpatient mental health operations for all active duty Service members and dependents within the installation community. In addition, he was head of the installation's suicide prevention, alcohol and drug demand reduction, critical incident response and family advocacy programs.

Department of Veterans Affairs

Senior Executive Biography

Cynthia Gantt, RN, PhD, FNP-BC, FAANP

Dr. Cynthia Gantt was appointed as Deputy Director, Office of Patient Centered Care and Cultural Transformation, Veterans Health Administration in October 2019. She oversees operations, communications, outreach, strategic planning, system development and field implementation strategies in support of VA's transformation to a Whole Health System of care that empowers and equips Veterans, caregivers, survivors, and employees to take charge of their health and well-being and live their lives to the fullest.

Dr. Gantt served 29 years as a Navy Nurse Corps officer. She began her career as a primary care provider and transitioned to leading Population Health and Medical Management policy, implementation, as well as research roles in Navy Medicine and at the TRICARE Management Activity. Her career culminated in two command tours at the naval hospital at Naval Air Station Lemoore, CA and in 2018, she also served as the Commanding Officer at the NATO Role 3 Multinational Medical (combat) Unit in Kandahar, Afghanistan. She was the Chief of Staff at Navy Medicine East, which included oversight of 20 military treatment facilities and worldwide Navy public health activities.

Dr. Gantt is a Fellow of the American Association of Nurse Practitioners. She is a recipient of the American Hospital Association's Federal Healthcare Executive Award and the American Association of Nurse Practitioners State Award for Excellence (Pacific U.S. Territory). In 2018 she received the Association of Military Surgeons United States (AMSUS) Lifetime Achievement Award. Dr. Gantt's military decorations include two Legion of Merit, a Defense Meritorious Service, four Meritorious Service, NATO Resolute Support and Afghanistan Campaign Medals.

CAREER CHRONOLOGY:

2019 – Present: Deputy Director, Office of Patient Centered Care and Cultural Transformation, Washington, DC

1990 – 2019: US Navy Nurse Corps Officer

EDUCATION:

2002: Doctor of Philosophy (PhD, Nursing) University of San Diego, CA

1991: Master of Science (Family Nurse Practitioner), Sonoma State University, CA

1983: Bachelor of Science (BS, Nursing), Sonoma State University, CA

Department of Veterans Affairs

Senior Executive Biography

Dr. Leslie Sofocleous, PhD

Executive Director
Electronic Health Record Modernization Integration Office's Program Management Office

Dr. Sofocleous has over 25 years of military, industry and federal acquisition experience, including successful delivery of capabilities for both commercial and government agencies. She has led efforts to align industrial control systems under disciplined acquisition, cybersecurity management and streamlined acquisition processes, with a focus on application rationalization, expedited capability delivery and cost/benefit trade-offs.

Dr. Sofocleous joined VA in February 2022 after leaving DOD where she served as the Portfolio Manager for Enterprise Capabilities for the Defense Logistics Agency (DLA) Information Operations Program Executive Office. There, she was responsible for managing interdisciplinary teams of government and contractor personnel developing acquisition strategies to expedite capability deliveries associated with multiple program offices. Her portfolio included the delivery of capabilities such as Robotics Process Automation, DevSecOps, Single Sign-On and Operational Technology and information technology (IT) solutions to support fuel management, collaboration, and installation and facility management.

Prior to DLA, Dr. Sofocleous served as Product Director for Army Human Resources Systems for the Army Program Executive Office Enterprise Information Systems. In this role, she established and defined the technical and acquisition direction for delivered capabilities and served as an advisor to the Army's program executive officer for identifying and evaluating IT products, technologies and capabilities that support human resources management.

CAREER CHRONOLOGY:

2022 – Present	Executive Director Program Management Office, Electronic Health Records Modernization Integration Office, Washington, DC *(Acting February – October 2022 before assuming the position)*
2014 – 2022	Portfolio Manager, Enterprise Capabilities for the Defense Logistics Agency, Fort Belvoir, VA
2010 – 2014	Product Director, Army Human Resources Systems, Army Program Executive Office Enterprise Information Systems, Alexandria, VA

EDUCATION:

2009	DAU Level III, Program Management,
2009	DAU Level III, Information Technology,
2007	Doctorate, Applied Management Decision Science, Walden University, Minneapolis, MN
2001	Master's Management, concentration Information Systems, Rensselaer Polytechnic Institute, Troy NY
1995	Bachelor's Biology, University of Virginia, Charlottesville VA

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STATEMENT OF
JON RETZER
DAV ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
July 12, 2023

Chairman Tester, Ranking Member Moran and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's legislative hearing for the Senate Committee on Veterans' Affairs. DAV is a congressionally chartered non-profit veterans service organization (VSO) comprised of more than one million wartime service-disabled veterans dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration today by the Committee.

S. 449, the Veterans Patient Advocacy Act

This legislation is aimed at improving the assignment of patient advocates at the Department of Veterans Affairs (VA) medical facilities. Specifically, it would direct VA medical center (VAMC) directors to ensure there are no fewer than one patient advocate for every 13,500 veterans enrolled in the system. It would also address the need for highly rural veterans to have access to the services of patient advocates assigned to rural community-based outpatient clinics.

The Veterans Health Administration (VHA) has designated patient advocates at each VAMC to receive and document feedback from veterans or their representatives, including requests for information, compliments, complaints and assist with clinical appeals. However, VHA has only provided limited guidance to VAMCs on the governance of patient advocacy programs and its guidance, a program handbook, has been outdated since 2010. VAMCs are still expected to follow the outdated handbook, which does not provide needed details on governance, such as specifying the VAMC department to which patient advocates should report. Officials from most of the VA facilities that the Government Accounting Office (GAO Report 18-356) reviewed noted that the department to which patient advocates report can have a direct effect on the ability of staff to resolve veterans' complaints. The lack of updated and complete guidance may impede the patient advocacy program from meeting expectations, to receive and address complaints from veteran patients in a convenient and timely manner.

VHA has also only provided limited guidance to VAMCs on staffing levels for the patient advocacy program. VHA's handbook states that every VAMC should have at least one patient advocate and appropriate support staff; however, it did not provide guidance on how to determine the number and type of staff needed. Officials at all but one of the eight VAMCs in GAO's review stated that their patient advocacy program staff had more work to do than they could realistically accomplish. This limited guidance on staffing does not support good practices to ensure there are an appropriate number of patient advocates and support staff to address veterans' complaints in a timely manner.

DAV supports this legislation in accordance with DAV Resolution No. 056, which recognizes that staffing shortages and vacancies in the VA health care system including critical positions like patient advocates can hamper the ability of veterans, who rely on the VA, to overcome barriers to accessing the care they need and deserve.

Veterans want and need a proactive patient advocacy program. Patient advocacy offices should be staffed appropriately to provide timely assistance to veteran patients in accessing health care and clinical appeals. A consistent system-wide organizational structure for patient advocates will help to facilitate best practices and improve patient satisfaction. Therefore, we recommend that additional research be conducted to ensure that the ratio of patient advocates to veterans is adequate to meet demand.

S. 495, the Expanding Veterans' Options for Long Term Care Act

S.495, the Expanding Veterans' Options for Long Term Care Act, would require the VA Secretary to carry out a pilot program to provide assisted living services to a rapidly growing population of aging and/or disabled veterans who are not able to live safely at home, but who do not yet require skilled nursing care.

This legislation would require the VA Secretary to carry out a three-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans in not fewer than six VA Veterans Integrated Service Networks (VISN). Assisted living fills a gap in VA's continuum of care for veterans who require a higher level of support than offered by domiciliaries, but do not need the full complement of skilled nursing care services.

Over the next two decades, an aging veteran population, including a growing number of service-disabled veterans with specialized care needs, will require long-term care and supportive services (LTC). While the overall veteran population is decreasing, the number of veterans in the oldest age cohorts with the highest use of LTC services is increasing significantly. For example, the number of veterans with disability ratings of 70% or higher, which guarantees mandatory LTC eligibility, and who are at least 85 years old is expected to grow by almost 600%—therefore, costs for LTC services and supports will need to double by 2037 just to maintain current services.

In order to meet demand for LTC for veterans in the years ahead, Congress must provide VA the resources to significantly expand home- and community-based programs, while also modernizing and expanding facilities that provide institutional care. The VA must focus on addressing staffing and infrastructure gaps in order to maintain excellence in skilled nursing care.

DAV supports S. 495, in accordance with DAV Resolution No. 016, which calls for legislation to improve the VA's program of long-term services and supports for service-connected disabled veterans irrespective of their disability ratings, and urges the Department to ensure each VA medical facility is able to provide service-connected disabled veterans timely access to a full continuum of institutional and noninstitutional long-term services and supports.

S. 853, the VA Zero Suicide Demonstration Project Act of 2023

S. 853, the VA Zero Suicide Demonstration Project Act of 2023, aims to improve safety and care for suicidal veterans by launching the Zero Suicide Initiative Pilot Program at the VA.

In 2019, there was an average of more than 17 U.S. veterans dying from suicide per day at a rate 52.3% higher than non-veterans. Forty percent of veteran suicides were among active VA patients. For veterans who have served since September 11, 2001, the rate is even more alarming, with 30,117 active-duty service members and veterans dying by suicide, over four times the number of combat deaths over the past two decades. These statistics support the need to pilot alternative intervention methods at VA facilities to improve veteran care, diminish the risk of suicide, and help keep safe those who have sacrificed to serve our nation.

As a nation we have an obligation to ensure that our veterans have timely access to the mental health services they need. Congress and the VA have been working diligently to address the epidemic of veteran suicide and everyone agrees we must work collectively until we get that number down to zero.

This legislation would initiate a pilot program to implement the Zero Suicide Institute curriculum to improve veteran safety and suicide care that stems from the Henry Ford Health Care System—built on the belief that all suicides are preventable through proper care, patient safety, and system-wide efforts. Advocates of the model note it has delivered clear decreases in suicide rates through innovative care pathways to assess and diminish suicide risk for patients across care systems.

The bill would require, in consultation with experts and veteran service organizations, that the VA Secretary select five medical centers to receive special training and support under the pilot program. Provisions in the bill aim to bolster clinical training, assessments, and resources to test the effectiveness of implementing the Zero Suicide Model.

Losing one service member or veteran to suicide is one too many. In conjunction with the White House, the VA has adopted a public health model to decrease service member and veteran suicides. The VA has partnered with the community and offers a vast range of targeted clinical and community-based programs and services aimed at this goal. This legislation would provide an opportunity to test the effectiveness of this alternative care model in combatting veteran suicide; however, we value the opinion of VA mental health experts in this approach to ensure there is not a duplication of services already being offered.

DAV supports S. 853, the VA Zero Suicide Demonstration Project Act of 2023, in accordance with DAV Resolution No. 059, which calls for legislation to support program improvements, data collection and reporting on suicide rates among service members and veterans and enhanced resources for VA mental health programs.

S. 928, the Not Just a Number Act

This bill would expand the VA National Veterans Suicide Prevention Annual Report to examine how veterans' suicides correlate with the utilization of VA health care and benefits. Elements of the report would include the findings of the national analysis of veteran suicide rates for the latest year data and include trends and comparisons to previous years. The legislation requires the report's findings be publicly available and also calls for a study of the feasibility and advisability of creating a suicide prevention office separate from the VA's Office of Mental Health.

While the bill requires the VA to disclose important suicide data, it does not require the inclusion of data generated by recipients of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. The grant program was part of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, signed into law on October 17, 2020. This initiative includes non-profit, private, and government groups who are assisting VA in addressing veteran suicide in their local communities. Given the importance of having a comprehensive data set to determine effectiveness of various suicide prevention programs and efforts, we ask the Committee to consider amending the legislation by adding a provision to require the data from the Fox Grants be added to the report.

Additionally, we note the data from the Fox Grant recipients is reflected as information for the whole program and does not provide an opportunity to determine whether a particular organization's services are effective. Therefore, we also request that a provision be added to the bill requiring VA to separate and report information for each Fox grantee to include information on how scores on the five required measures improve for veterans who use the grantee's services. Having this information publicly available will help mental health experts and policymakers determine the effectiveness of all programs and make better decisions on where to focus resources to reduce suicide in the veteran population.

DAV is pleased to support S. 928—the Not Just a Number Act, in accordance with DAV Resolution No. 059 and request the Committee consider our recommendations for amending the bill.

S. 1037, the Department of Veterans Affairs EHRM Standardization and Accountability Act

This legislation would require the VA to show that the required improvements to the new electronic health record (EHR) system have been met before it can deploy the system to other VHA facilities. The required improvements include the achievement of a minimum up-time and system-wide stability for the EHR system and a report detailing the completion status of the corrections to the customization and configuration of workflow designs.

VA has engaged in a multibillion-dollar and decade-long rollout of an "off-the shelf" EHR that is interoperable with other health record systems; however, it has experienced significant challenges in the initial phases of the rollout, to include patient safety issues and complaints from staff regarding insufficient training.

A modern EHR is critical to delivering high quality and safe care to veterans and DAV shares Congress' disappointment with the delays, performance challenges, and patient safety issues with VA's EHRM effort.

In accordance with DAV Resolution No. 040, we support S. 1037, to ensure that VA is maintaining patient safety as a priority as the new EHR system is being installed and tested and will not proceed with the roll-out to other facilities until it is safe to do so.

S. 1040, a bill to prohibit smoking on the premises of any facility of the Veterans Health Administration

This bill would amend title 38, United States Code, Section 1715 for the purpose of prohibiting smoking on the premises of any facility of the VHA. This mandate would apply to veterans, patients, visitors, contractors and VA employees and include medical centers, community-based clinics, nursing homes and domiciliary facilities. Smoking is defined as the use of cigarettes, pipes, electronic nicotine devices, including e-cigarettes and vape pens.

Currently, tobacco use is allowed by veterans who are hospitalized or reside in a VA domiciliary. The Secretary is required to provide a suitable indoor area in which patients or residents may smoke or an area in a building that is detached from the facility and accessible to patients or residents of the facility.

While the intent of the bill appears to be focused on maintaining the good health of VA patients and employees, we have some concerns that certain veterans addicted to tobacco may forgo needed treatment due to a complete ban on smoking in VA health care facilities if this bill is enacted. However, DAV has no resolution from our members

calling for a complete prohibition of smoking in VA health care facilities and therefore takes no formal position on the bill.

S. 1125, the EHR Program RESET Act of 2023

S. 1125, the EHR RESET Act, would require VA to implement a series of Electronic Health Record Modernization (EHRM) reforms to better serve veterans, medical personnel, and taxpayers.

Specifically, the bill would restructure, enhance, and strengthen the entire EHRM program with a comprehensive and aggressive set of oversight provisions to ensure the VA can reset and course correct this important but challenged modernization program on behalf of veterans, VA's dedicated medical professionals, and taxpayers. It would provide a framework to fix the patient safety, provider efficiency and morale, technology, cost, management and contracting challenges that continue to plague the program and hopefully prevent any future VA modernization project from being initiated without proper planning and controls.

The bill would also mandate specific reporting requirements to Congress to increase oversight, accountability, and transparency following a series of challenges with the system and program, including those found in VA's recent EHRM Sprint Report and a review by the Government Accountability Office report (GAO 23-106685).

The VA's EHRM program has experienced a series of challenges and shortcomings since it was initiated as has been documented in more than four years of Congressional oversight hearings, reports from the VA Office of Inspector General (OIG), GAO, and independent assessments commissioned by VA, as well as VA's own March 2023 Sprint Report and 2021 Strategic Review.

VA and its contractor, Oracle Cerner, made a series of questionable decisions, ignoring clear warning signs and independent oversight reports, selecting to proceed forward without first helping the initial facility in Washington State to recover and stabilize the technology to prevent its frequent crashes and freezes, and resolve how the EHR was designed, which prevented and inhibited VA medical personnel from consistently delivering care safely and efficiently. GAO and independent industry analysts KLAS noted the following troubling results: ''KLAS has measured EHR experience in 280 organizations around the world. VHA Cerner currently has the lowest EHR experience score of any organization measured.''

While VA's leadership has taken aggressive actions since 2021 and recently established a more stable and engaged management team to overhaul this program, significant challenges remain.

Among its many provisions, this legislation would require VA to:

- Develop clear metrics to guide whether and how VA should go forward with the new EHR at additional VA facilities and require additional resources to support those facilities;
- Require VA and Oracle Cerner to fix the technology features connected to the health safety and delivery issues found in VA's March 2023 Sprint Report;
- Not move forward with the new EHR at other VA health facilities until the data at the existing five facilities shows an ability to deliver health care to veterans at standards that surpass metrics using VA's VistA system or that meet national health operations standards as determined by the Under Secretary for Health;
- Appoint a lead senior negotiator and leverage other federal agencies and independent outside experts to offer advice and strategies for managing aggressive EHR contract negotiations with Oracle Cerner to protect taxpayers and veterans;
- Develop an alternative "Plan B" strategy for a new EHR in the event Oracle Cerner will not agree to new contract terms that protect taxpayers and increase accountability and penalties for poor performance or when VA data shows it cannot get the technology to work to serve veterans efficiently and safely;
- Reform major acquisitions at VA to prevent future programs with poor contracting, oversight, management, and planning from occurring; and
- Require an existing VA Advisory Committee to add health care experts with proven experience implementing EHR deployments to advise VA leaders on potential strategies on how to improve VA EHRM's implementation based on prior lessons learned in the private and non-profit health sectors.

DAV shares Congress' disappointment with the delays, performance challenges, and patient safety issues with VA's EHRM effort. Because a modern EHR is critical to delivering high quality and safe care to veterans, VA must modernize its EHR. The new EHR system is concerning to veterans, medical personnel, and taxpayers, and we agree that more governance is needed along with change management and accountability to right this wrong. Veterans deserve nothing less. In VA's pursuit of a modern EHR system, the Department should look to the GAO report 23-106731 recommendations to address these issues.

DAV supports this legislation in accordance with DAV Resolution No. 040, which recognizes that VA must continue its IT modernization efforts in a manner that ensures that the new system architecture allows it to fulfill all of its core missions, including maintaining patient safety, which should be the foremost concern, along with ensuring personal data is secure but accessible to veterans to allow them to be a partner in their health care.

S. 1172, the Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act

The Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act would allow veterans entitlement to emergency medical treatment within the first 60 days of being enrolled in the VA health care system. Veterans would have up to one year to file claims for reimbursement for emergency treatment services after the enactment of this legislation.

The VA aims to provide enrolled veterans a uniform benefits package that includes access to and coverage for urgent and emergent care. An August 2019 VA Office of Inspector General report found a significant number of emergency care claims were inappropriately denied and many rejected claims were inappropriately processed. As a result, many veterans faced an undue financial hardship.

DAV supports the RELIEVE Act in accordance with Resolution No. 148, which urges the VA to provide a more liberal and consistent interpretation of the law governing payment for urgent and emergency care and reimbursement to veterans who have received emergency care.

S. 1315, the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023
and
Draft bill, the Making Community Care Work for Veterans Act of 2023

Both S. 1315, the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023 and the draft bill, Making Community Care Work for Veterans Act of 2023, would change the VA's current community care program, which was established by the VA MISSION Act (Public Law 115-182), to expand access to community care for more veterans, particularly those who live in rural and remote areas of the country. Both bills would also make a number of other changes to the VA health care system to improve access to care for enrolled veterans.

Like most veterans service organizations (VSOs), DAV strongly supported the VA MISSION Act after working for several years with this Committee, your counterparts in the House, VA leaders, and other stakeholders. The resulting legislation was a carefully crafted compromise to improve veterans' access to timely, high-quality, and veteran-focused care. Our support for the legislation, however, was predicated on maintaining a fundamental set of principles underlying the VA MISSION Act to ensure that veterans' health outcomes would be improved. Specifically:

- VA would continue to be the primary provider and coordinator of veterans' care;
- VA's internal capacity to provide care would be expanded through investments in staffing, infrastructure, and IT in order to meet the rising demand for care by enrolled veterans, particularly disabled veterans;

- Veterans who would otherwise have to wait too long or travel too far to get necessary care from VA should have swift and seamless access to high-quality community care options; and
- Community care providers would have to meet the same access *and* quality standards, as well as training and certification requirements, as VA clinicians.

In evaluating this proposed legislation that would make significant changes to VA's community care program, our primary focus is on whether it would improve access and result in better health outcomes for enrolled veterans, particularly service-disabled veterans. The above principles were designed to achieve that goal by balancing the need for greater access to care with the imperative of providing high-quality and veteran-focused care.

Both community care bills would codify existing VA access standards for wait times and travel times, and would limit VA's ability to modify those access standards in response to changing conditions. The VA MISSION Act specifically required VA to regularly review and modify access standards whenever feasible to improve access to high-quality care, however this was to be a clinical and health management decision, not a legislative one. While DAV supports responsible efforts to lower wait and travel times for care, including some provisions in these bills, codifying access standards will not achieve these goals.

Codifying access standards—by itself—will *not* improve veterans' access to care, lower wait times, improve quality, or produce better health outcomes. Investing in VA's health care infrastructure and staffing, however, would directly and measurably improve veterans' access to care. This is particularly true for veterans who live in rural and remote areas where VA is most likely to be a stable, long-term health care option for veterans since private sector medical facilities and practices tend to close more often and without notice, regardless of the needs of veterans who live in those areas.

Investing in VA is also most likely the best way to produce better health outcomes for veteran patients, since studies continue to confirm that VA health care is equal to or better than private sector care, on average. A robust VA health care system also provides vital research, training, and emergency preparedness for veterans and the nation, further justifying such investments.

For these reasons, we do support provisions in the draft Making Community Care Work for Veterans Act that seek to expand VA's capacity to provide care by expanding recruitment and retention programs for critical health care positions. We also support provisions in the draft bill that seek to increase training and compliance by community care providers, though we would like to see greater focus on requiring non-VA providers to meet all the same training requirements as VA providers. We also support the provision to expand reporting of quality metrics by community care providers, though we would also like to see that section strengthened. Further, we support the provision in the draft bill to ensure that community care appointments are more timely scheduled.

We have some questions and concerns about provisions in both bills that would restrict the ability of the Secretary, or his designees, to review "best medical interest" decisions agreed to by veterans and their referring physicians. Would this mean that VA could not review any referral by a non-VA physician, even if that referral went against VA's quality care guidelines? We are concerned that limiting VA's role in overseeing the care of some enrolled veterans could result in less effective care. VA's generous care package, coupled with its specialized veteran-focused treatment programs and wrap-around supportive services are rarely found within a single health system.

We also have questions about provisions in S. 1315 that would mandate the conversion of the VA health care system into a value-based care model. While there have been studies indicating that similar models tested by Medicare and Medicaid can reduce federal spending, there have also been alarming questions raised about whether this comes at the cost of lower quality and worse health outcomes. VA already provides holistic, integrated care for veterans and coordinates care and comprehensive support services for them—services that no other health care system provides. Given the unique nature of the VA system purpose-built for veterans, and recognizing the other missions VA performs, not just to veterans but to the nation at large, we recommend eliciting an opinion from the Secretary's Special Medical Advisory Group (SMAG) regarding the use of value-based care model in the VA health care system.

Mr. Chairman, we applaud you, Ranking Member Moran and other Senators for your continued interest and efforts to improve veterans' health care. We would welcome the opportunity to work with you and your staffs to address the concerns we and others have raised, and collaborate with you to develop a balanced package of legislation that would improve the quality of, and access to, health care for all enrolled veterans, particularly those who were wounded, injured, made ill and disabled from their service.

S. 1436, the Critical Health Access Resource and Grant Extensions (CHARGE) Act

This bill would restore essential programs and authorities for homeless veterans, caregivers and State Veterans Homes that expired May 11, 2023.

Specifically, it would increase VA reimbursement rates for transitional housing facilities furnished to homeless veterans from 115% to 200% for a three-year period. The bill would also extend for three years the current authority for the VA Secretary to provide homeless veterans direct assistance when other resources through the homeless program office grantees are not available. Specifically, VA could provide safety and survival items such as food, shelter, clothing and hygiene items and transportation to health care appointments and other service providers, for food and supplies, along with communication equipment such as tablets, smart phones and related service plans.

The bill would also authorize veterans and caregivers to elect virtual home visits under the VA's caregiver programs through September 30, 2023, or until VA finalizes its new regulations for its comprehensive caregiver program. In addition, it would extend a

waiver of bed hold occupancy rate requirements for receipt of per diem payments for State Veterans Homes that was implemented at the outset of the COVID pandemic and makes permanent the authority for VA to provide State Veterans Homes medicines, personal protective equipment, and various supplies in similar health emergencies.

DAV supports S. 1436 in accordance with DAV Resolution No. 060, which calls for sustained and sufficient funding to improve services for homeless veterans to include improved access to specialized health and benefits services and Resolution No. 330, which calls on Congress to support State Veterans Home programs through adequate per diem payments for skilled nursing care, domiciliary and adult day care.

S. 1545, the Veterans Health Care Freedom Act

This bill would require the Center for Innovation for Care and Payment to carry out a three-year pilot program in four VISNs to allow enrolled veterans in those VISNs to choose any VA or non-VA health care provider they prefer, using no access standards for eligibility for community care. Four years after enactment of the legislation, this pilot would automatically be rolled out to the entire country, all VA access standards would be eliminated, and all enrolled veterans could choose any primary, specialty, or mental health care provider in VA or in the community care network.

The legislation would require VA to develop systems to coordinate veterans' medical care with private providers. However, the bill includes a provision stating that no additional funding will be authorized for VA to implement and carry out any provisions of the legislation.

This legislation would unravel the carefully crafted VA MISSION Act, which created VA's current community care program, while simultaneously expanding access to care by increasing VA's internal capacity. Based on similar bills introduced and analyzed in prior Congresses, the additional cost of this legislation could run into the hundreds of billions of dollars. However, by specifically stating that no additional appropriations are authorized, enactment of this legislation would likely result in funding shortfalls for the VA health care system, threatening its viability, and severely limiting the options for veterans – particularly disabled veterans – who choose to get their care from VA.

For the above reasons, and in accordance with DAV Resolution 149, DAV opposes this legislation. DAV will oppose any recommendation or proposal that could lead to weakening, diminishing or dismantling of the VA health care system that millions of veterans have chosen and rely upon, or that would weaken VA research or medical education programs.

S. 1612, the Reimburse Veterans for Domiciliary Act

The Reimburse Veterans for Domiciliary Care Act would require VA to publish a proposed rule to implement the requirement under section 3007(a) of Public Law 116-

315, which authorizes the VA to waive existing eligibility requirements for a veteran to receive per diem payments for domiciliary care at a State Veterans Home if the veteran meets at least four of those requirements (e.g., can feed himself or herself), or the waiver is in the best interest of the veteran. The bill requires VA reimburse State Veterans Homes retroactively to January 5, 2021.

DAV supports S. 1612 in accordance with DAV resolution 330, which calls on Congress and the VA to provide sufficient funding to support State Veterans Homes, including adequate per diem payments for skilled nursing care, domiciliary care and adult day health care.

S. 1828, the Veterans Homecare Choice Act

S. 1828, the Veterans Homecare Choice Act, would direct the VA Secretary to recognize nurse registries for purposes of the veterans community care program and the ability to procure contracts or other agreements on behalf of registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, under which such individuals may provide health care-related or assistive services (including such services provided directly to veteran patients or in support of health care facilities) and receive compensation for such services; and satisfy any applicable State licensure requirements.

Veterans deserve to live independently in their own homes but sometimes need extra assistance to do so. Veterans need care options to include home care professionals for everything from occupational therapy to housekeeping. However, finding the right home care professional can be a challenge, and for some, a daunting task. Many veterans have to search on their own to seek appropriate caregivers. It appears this legislation would help connect them with caregiver support options.

However, we do have some questions with regard to the bill's intent and definition of the "nurse registry," being that it includes more than skilled nursing positions, i.e., companion and homemaker. Likewise, should the program fall under community care versus VA's care giver program. Therefore, we ask the Committee to work with the bill's author to clarify these questions.

S. 1951, the Department of Veterans Affairs Income Eligibility Standardization Act

This legislation would expand entitlement to health care for certain veterans and require the VA Secretary to eliminate all subcategories of priority for enrollment established by the VA under paragraph (8) of section 1705(a) of title 38, United States Code.

One hurdle in getting new veterans' access to care and services through the VA is the enrollment process. Veterans face complex eligibility requirements to determine whether they can receive VA health care.

Currently, veterans are placed in Priority Group 8 if they do not have a compensable service-connected disability, their gross household income is above the VA national income threshold ($43,834) (including geographically adjusted income threshold for their resident location) and they agree to pay copays for care. Because of budgetary constraints, VA ended the enrollment of veterans in priority group 8 in 2003. However, veterans who were enrolled at that time were allowed to remain in VA's health care system with access to care.

The Veterans Affairs Income Eligibility Standardization Act would reduce the complexity of eligibility requirements in Priority Group 8 and open the aperture for more veterans to access care regardless of income or service-connected status.

DAV does not have a resolution calling for the removal of Priority Group 8 subcategories and therefore takes no position on the bill. However, if Congress intends to expand eligibility to all veterans, it must be accompanied by sufficient funding to ensure the VA health care system is able to provide timely, high-quality, and veteran-focused care to all enrolled veterans.

S. 1954, the Improving Whole Health for Veterans with Chronic Conditions Act

S. 1954, the Improving Whole Health for Veterans with Chronic Conditions Act, would authorize dental care services to be provided by the VA to enrolled veterans diagnosed with diabetes and heart disease.

These chronic conditions are closely linked with poor dental health. Lack of dental care exacerbates these conditions, worsening their progression and increasing medical costs. However, only 15% of veterans are eligible for dental care through the VA system. Many of the remaining 85% of veterans who are not eligible for dental care struggle with access to affordable, quality dental care that meets their physical and oral health needs.

The regulations governing dental care eligibility for veterans using VA health care, outlined in title 38, Section 17 of the United States Code, have not been substantively updated since 1948—with nearly the same guidelines governing which veterans can access oral health care for the past 70 years. Expanding dental care to this group of veterans would help to improve the cost of managing chronic diseases.

In fiscal year 2021, the VHA reported 3.3 million enrollees were treated for diabetes and just over 640,000 were treated for ischemic heart disease. In 2020, the VHA reported spending $86,079 per veteran treating ischemic heart disease and $10,777 per veteran treating diabetes compared to $1,132 per veteran for comprehensive dental care.

Based on these projections, the VHA could save an estimated $3.4 billion dollars in medical costs—almost 1.5 times the annual VHA budget for dental care—by expanding access to dental care for veterans with heart disease and diabetes.

According to CareQuest Institute of Oral Health for every $1 spent on dental care, the VHA could save $1 in medical expenses for veterans with diabetes and $2 for veterans with heart disease.

Additionally, on average, veterans with heart disease and diabetes miss more workdays and lose 42% more income than nonveterans with these chronic disease conditions. Veterans who don't get dental care face increased health concerns and are also more likely to experience prolonged pain, resulting in missed workdays and less productivity. Veterans cannot maintain their overall health without good oral health. The inadequate dental care most veterans have experienced has created a costly and painful crisis for many veterans.

DAV supports this legislation in accordance with DAV Resolution No. 013, which recognizes the need for routine dental care to be afforded all enrolled service-connected disabled veterans to ensure their whole health needs are met.

S. 2067, the Service Dogs Assisting Veterans (SAVES) Act

The Service Dogs Assisting Veterans (SAVES) Act would require theVA Under Secretary for Health to establish a program to award grants, on a competitive basis, to nonprofit organizations to assist such organizations in carrying out programs to provide service dogs to eligible veterans.

Groups who are accredited to train and work with service dogs could apply for grants to cover the costs of training the service dogs, as well as providing ongoing support to both veteran and service animal after they are matched.

While we understand the value a service animal brings to many service-disabled veterans, DAV has no resolution calling for VA to provide grants to nonprofit organizations training service dogs. Therefore, we take no position on the bill, but noting the potential benefit for certain disabled veterans, would not object to its passage.

Draft bill, the Leveraging Networks in Communities for Veterans Act

This draft legislation, the Leveraging Integrated Networks in Communities for Veterans Act, would require the VA Secretary to create a pilot program for the purpose of establishing a community integration network infrastructure for services for veterans, and require the collection of information from veterans related to social determinants of health.

This legislation would establish a new or enhance an existing interoperable technology network that enables the coordination of public and private providers and payors of services for veterans, including services such as:

- nutritional assistance;
- housing;

- health care, including preventive health intervention, chronic disease management, and behavioral health care;
- transportation;
- job training;
- child development or care;
- caregiving and respite care;
- disability assistance; and
- other services, as determined by the Secretary.

The bill also, prioritizes connectivity with appropriate existing technology networks developed by public or private organizations that comply with, as applicable, standards adopted by the Secretary of Health and Human Services (HHS) under section 3004 of the Public Health Service Act (42 U.S.C. 300jj–14).

Further, it would require the collection of information from veterans served under the pilot program regarding social determinants of health using a standardized risk assessment or screening tool, which shall include standardized definitions for identifying social determinants of health needs identified in the International Classification of Disease that incorporate measures for quantifying the relative severity of any such social determinant of health need identified in a veteran; and incorporate screenings used to collect information into routine care provided to veterans under the laws administered by the Secretary.

In carrying out the pilot program the Secretary of Health and Human Services, in consultation with the VA Secretary, shall issue guidance to states that includes options for State Medicaid programs to coordinate and integrate medical assistance provided under a state plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.) with services for veterans.

Adequate representation is an important social determinant of health, ensuring the special needs and preferences of a subgroup are voiced, understood, and addressed. Many veterans with service-connected disabilities using the VA belong to subpopulations, including racial or ethnic minorities; LBGTQ+ groups, women, or reside in geographically remote areas (rural, underserved or outlying areas) and these subgroups are gradually making up greater portions of the veterans' population.

DAV supports this legislation in accordance with DAV Resolution No. 433, which recognizes the need to advocate for holistic programming to address social and economic determinants (related to income, employment, education, and family and community support), health behaviors (substance use, sexual behavior, diet and exercise) and physical environment (access to nutritional food, housing and transit) in addition to culturally relevant and personalized clinical care necessary to address health disparities among service-connected veterans.

Draft bill, the Rural Vital Emergency Transportation Services (VETS) Act

The Rural Vital Emergency Transportation Services (VETS) Act would require the VA to reimburse highly rural veterans for the cost of ambulance service, to include air ambulance service to either VA or non-VA facilities for care regardless of whether the veteran qualifies for payment or allowances for beneficiary travel.

The VA aims to provide enrolled veterans a uniform benefits package that includes access to and coverage for urgent and emergent care, including veterans in rural and highly rural areas. Fifty-six percent of all rural veterans are enrolled in the VHA and rural veterans are older, poorer, sicker and less likely to have internet access. VA's Office of Rural Health has funded 450 projects in rural areas to improve access, care and services to this population, including transportation programs.

DAV supports the VETS Act, in accordance with Resolution No. 014, which supports rural and remote veterans' sufficient access to care and legislation to overcome barriers to care by assisting such veterans with transportation and travel needs.

This concludes my testimony on behalf of the DAV. Again, we appreciate the opportunity to comment on the bills before the Committee and I am happy to address any questions members of the Committee may have.

STATEMENT OF

MEGGAN THOMAS, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

Pending Legislation

WASHINGTON, D.C. July 12, 2023

Chairman Tester, Ranking Member Moran, and members of the committee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on this proposed legislation.

S. 449, Veterans Patient Advocacy Act

For the past nine years, the VFW has partnered with Student Veterans of America (SVA) to select student veterans from across the country to research and advocate for improving an issue that is important to veterans. VFW-SVA Fellow and Grand Valley State University graduate Cameron Zbikowski focused his semester-long research proposal on enhancing the patient advocate program of the Department of Veterans Affairs (VA). Cameron called for the improvement of the program by making sure there is an adequate amount of patient advocates at each facility. The VFW supports this bill that would ensure there is no less than one patient advocate for every thirteen thousand five hundred veterans enrolled in the local VA system. It would also provide highly rural veterans with better access to the services of patient advocates.

S. 495, Expanding Veterans' Options for Long-Term Care Act

The VFW supports this legislation that would require VA to carry out a three-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans. Assisted living facilities are needed when a veteran does not require nursing home care but cannot live alone. This program would allow veterans to receive needed services without being financially responsible for the cost, thereby reducing or eliminating the burden on family members who may not be able to provide round-the-clock care. This option for long-term care has great potential for veterans to still have some independence while being cared for at facilities that are authorized and inspected by VA.

S. 853, VA Zero Suicide Demonstration Project Act of 2023

The VFW supports this legislation that would establish the Zero Suicide Initiative pilot program of VA. Reducing the number of service members and veterans who die by suicide has been a priority for the VFW and will remain so until it is no longer needed. This multi-layered approach consists of continuous suicide screening at all health care touchpoints, creating a crisis plan, and maintaining consistent communication with veterans. Removing the stigma of discussing suicide and fostering healthy conversation will help in reaching the goal of zero suicides. The Veterans Health Administration has the opportunity to support all VA providers with the tools and knowledge to screen their patients for suicide at every appointment.

S. 928, Not Just a Number Act

The VFW has advocated for many years that VA must immediately incorporate Veterans Benefits Administration (VBA) usage into its suicide prevention efforts. This should include full information on disability compensation; use of education, employment, and home loan benefits; foreclosure assistance; and participation in housing and food insecurity programs. VA has only recently begun reporting on the convergence of VA benefits and veteran suicide, but not in any substantive manner. We must identify, study, and utilize information regarding economic opportunity benefits, and leverage that information to successfully prevent suicide among veterans.

A 2017 study in the *American Journal of Preventive Medicine* found individuals with a college degree were half as likely to die by suicide compared to those with a high school education. Moreover, a study of recently transitioned service members found those with fewer years of education had a higher hazard of suicide, with lack of education being a likely factor in difficulty finding post-military employment, potentially leading to financial instability.

Unemployment can be detrimental to mental health. It is even associated with an increased risk of suicide. However, the relationship between unemployment and suicide is a complex one. Providing benefits while veterans are unemployed and making sure they are swiftly reemployed can moderate mental health issues and potentially mitigate suicidal ideations.

Data from veterans who self-reported housing instability between 2012 and 2016 indicated over half of these veterans accessed homeless services and associated this use of services with a significant reduction in suicide risk. This demonstrates the ability of these programs to perform upstream intervention.

Veterans can feel hopeless, unheard, and retriggered by their trauma during the benefit claims process. They may also be facing financial hardship to pay medical expenses until they receive care from VA. A 2021 study showed that veterans with a service-connected disability designation who utilized services were less likely to attempt suicide.

All of these veteran economic programs are administered by VBA, but the VA Office of Suicide Prevention is operated out of the Veterans Health Administration (VHA). We strongly support this proposal to begin actively incorporating VBA data and benefit usage into the overall suicide

prevention efforts within VA. We also believe there should be a study on the feasibility and advisability of creating a suicide prevention office at the level of the Office of the Secretary that would elevate suicide prevention as a top priority across the entire Department, not only within VBA.

S. 1037 Department of Veterans Affairs EHRM Standardization and Accountability Act & S. 1125, EHR Program RESET Act of 2023

The VFW supports S. 1037 to prohibit the Secretary of VA from carrying out certain activities under the Electronic Health Record (EHR) Modernization program until certification of system stability improvements. The VFW also supports S. 1125 which we believe should work in conjunction with S. 1037 in order to deliver a modern, safe, and trusted EHR system for the patients and providers. S. 1125 would establish certain metrics for success, and S. 1037 would ensure no further deployments of the EHR would proceed until those metrics are satisfied.

S. 1040, A bill to amend title 38, United States Code, to prohibit smoking on the premises of any facility of the Veterans Health Administration, and for other purposes

The VFW does not support this proposal at this time. We encourage our individual VFW Posts to provide smoke-free environments, but we do not mandate it. We believe increasing the awareness of smoking cessation programs and encouraging healthy behavior at VA is the appropriate path. Providing designated smoking areas that are far enough away from entrances or areas where individuals congregate is enough of a middle-ground solution to allow people who smoke to do so without affecting patient safety and health.

S. 1172, Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act

The VFW supports legislation that would make certain improvements relating to the eligibility of veterans to receive reimbursement for emergency treatment furnished to veterans in non-VA facilities. This bill would allow veterans to receive emergency care from a non-VA facility and not be billed in the event they did not have an initial visit at a VA medical facility but have enrolled for VA care. This prevents a veteran from being financially penalized if immediate treatment is rendered by a non-VA facility for needed care.

S. 1315, Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023

The VFW supports this legislation that would improve the provision of care and services under the Veterans Community Care Program of VA. We understand this program is essential as it provides services for veterans who live too far from a VA facility or in the event a requested appointment is not available in an acceptable timeframe. VA's focus should remain on how veterans can receive the care they need, whether it is inside or outside of its facilities.

Adopting a value-based health care model allows for a patient-centered system that aligns with VA's whole health care approach. Value-based care programs focus on prevention efforts to

reduce illnesses and suicide, which is a top priority of VA. The VFW also supports the continuation of the EHR Modernization program as it is needed to work in conjunction with the value-based program.

The VFW agrees the ability to access the scheduling system would help improve the timeliness of appointments and/or allow veterans to obtain care at non-VA facilities. Medical record documentation needs a timely return to allow VA providers to access treatments received and determine if additional follow-up would be appropriate. The VFW understands the need for VA to explore a value-based reimbursement plan to determine and implement a more holistic system. There is one section of this proposal we believe should be clarified. Section 103 may provide contradictory guidance to patients or clinicians regarding a veteran's preference for care.

Currently, if a veteran and the veteran's referring clinician agree that receiving care and services through a non-VA entity or provider would be in the best medical interests of the veteran, then the veteran is referred to community care. We are concerned this proposed section has the potential to allow for conflicts with the veteran's preference and the best medical interest of the veteran. We would like to see this clarified.

S. 1436, Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023

The VFW supports this proposal to permanently authorize the use of certain funds to improve flexibility in the provision of assistance to homeless veterans. Combating veteran homelessness is more than just simply providing a roof over a person's head, and oftentimes is accompanied by other financial struggles. This proposal would allow for more flexibility in assisting veterans struggling to acquire food, clothing, hygiene materials, and other items needed for daily life. This holistic effort would hopefully provide additional help for veterans struggling with housing security.

The VFW also believes financial literacy training is important to assist veterans seeking supportive services for housing through VA. Too many veterans face housing instability because they are not as financially literate as they could be. We recommend that VA establishes a basic financial literacy tool and ensures every veteran who utilizes supportive services also completes a financial literacy course and undergoes credit counseling. This simple, educational tool can mitigate future dilemmas and the recurrent need for supportive programs.

S. 1545, Veterans Health Care Freedom Act

The VFW does not support this proposal at this time. We believe the Community Care Network (CCN) is an integral part and necessary supplement, but not a replacement for VA care. The *Journal of General Internal Medicine* and the *Journal of the American College of Surgeons* recently published articles based on a systematic review of studies about VA health care that concluded VA health care is consistently as good as, or better than, non-VA health care. We believe a veteran's preference should be a factor when determining where to receive care, but we cannot advocate for fully directing care outside of a measurably better system based solely on a veteran's preference.

S. 1612, Reimburse Veterans for Domiciliary Care Act

The VFW supports this proposal to require the Secretary of VA to publish a rule to implement the requirement that the Secretary be permitted to waive the limitation in law on reimbursement of veterans receiving domiciliary care in State homes.

S. 1828, Veterans Homecare Choice Act of 2023

The VFW supports this proposal to recognize nurse registries for purposes of the Veterans Community Care Program.

S. 1951 Department of Veterans Affairs Income Eligibility Standardization Act

The VFW supports this proposal to standardize eligibility for VA care.

S. 1954, Improving Whole Health for Veterans with Chronic Conditions Act

Preventive dental care can significantly impact veterans' health and quality of life, including job security. However, only veterans who are one hundred percent service-connected disabled, certain homeless veterans, and those who have a service-connected dental condition are eligible for VA dental care. The majority of veterans enrolled in VA health care are unable to access VA dental care. Instead, they are offered the ability to purchase dental insurance through the VA Dental Insurance Program, which is a discounted, plan-based coverage program.

Cardiovascular disease is the number one cause of death in the United States and is highly prevalent among the veteran population. Diabetes is also highly prevalent among veterans and is even a presumptive condition for exposure to Agent Orange. Proper oral health care can help mitigate these conditions or prevent them from developing. We believe this is a good first step to providing necessary health care for veterans with certain chronic health conditions.

S. 2067, A bill to require the Secretary of Veterans Affairs to award grants to nonprofit organizations to assist such organizations in carrying out programs to provide service dogs to eligible veterans, and for other purposes

The VFW supports this legislation. Service dogs can assist veterans with a variety of physical, auditory, and trauma-related disabilities. They can empower veterans to regain physical independence, pride, and hope. These dogs are free of charge to the veteran, but there is a cost for training and medical care for these service animals. This bill would allow veterans to receive support companions and not be placed on long waitlists.

S. ____Making Community Care Work for Veterans Act of 2023

The VFW supports this legislation that would improve community care provided by VA. There are certain sections of this proposal we would like to highlight as critical improvements to the community care program, and other sections we believe could benefit from additional improvements.

In Section 103, the VFW believes that telehealth is a critical tool for VA to deliver care. Veterans should not have telehealth appointments scheduled for them if that is not their request or preference. However, we do believe they should be an option if appropriate to patients' wants and needs. We look forward to working with the committee to ensure the best outcomes are available for veterans.

In Section 107, the VFW understands the need for self-referrals for services that are going to remain constant for the veteran. We would like to see additional services added to that list such as podiatry, prosthetics, laboratory services, dermatology, and the diabetes clinic. Often utilized care services that are part of a veteran's treatment plan for chronic conditions should not have to be reauthorized.

In Section 110, we believe it would be a positive step to begin identifying which community care providers are taking additional measures to ensure the best care for veterans. CCN providers are not mandated to be trained for cultural competency or proper billing procedures. However, identifying the CCN providers who actively choose to participate in these programs would reward those who take additional steps. We believe something like a bronze, silver, or gold level identifier would hopefully entice more providers to voluntarily agree to additional training and compliance efforts.

In section 112, the VFW applauds the efforts for the Philippines of a feasibility study to consider the CCN as a possible option for care. However, the Philippines currently has the Foreign Medical Program (FMP) that provides reimbursements for care of service-connected conditions. The VFW would like the FMP to be reviewed from the perspective of updating and monitoring. We are concerned that FMP has no formal means through which either veterans or providers can receive consistent reimbursement. The VFW recommends providing structure to FMP like VBA's Compensation and Pension overseas examination contracts and TRICARE Overseas, to include electronic reimbursement for care. Moreover, the VFW is concerned that FMP offers a lower standard of care for overseas veterans, many of whom support American military interests as civil servants, non-appropriated fund employees, or defense contractors.

The VFW is pleased to see language that would improve the policies and processes that govern veterans' access to VA's Mental Health Residential Rehabilitation Treatment Program (MHRRTP) as outlined in Section 303. Veterans in crisis must receive timely, quality, and consistent care that aligns with their needs while also accounting for their individual preferences where feasible. We feel the proposed seventy-two-hour deadline for residential treatment screening and admissions decisions has the potential to save lives and mitigate instances of veterans losing trust in VA's ability to provide or facilitate care when they need it most. As we collectively look to improve help-seeking behaviors among veterans, Congress and VA must ensure resources like the MHRRTP are equipped to meet veterans where they are without bureaucratic hurdles or inefficiencies undermining such efforts.

To that end, we would like this committee to consider including a provision that removes barriers to accessing the breadth of community-based residential treatment programs available for, and commonly tailored to, veterans. One VFW member recently sought but ultimately gave up on receiving residential mental health care through VA because the program the provider determined

would best meet the care needs was in the wrong network. Other available programs that met treatment needs and preferences like gender-specific programming were similarly out of network.

With rare exceptions, veterans referred to residential treatment via CCN are only able to access programs that are physically located within their respective jurisdictions, each of which is managed by either Optum Serve or TriWest. While this structure works relatively well for common needs like orthopedics and diabetes care, the same cannot be said for mental health and substance use disorder (SUD) programs that are limited in number, highly specialized, and variable in terms of medical expertise and treatment methods. Arbitrarily restricting program access based on administrator network boundaries limits VA's ability to coordinate timely and appropriate residential mental health and SUD care for veterans.

S. ____ Leveraging Integrated Networks in Communities for Veterans Act

The VFW supports this legislation that would require the Secretary of VA to carry out a pilot program to establish community integration network infrastructure for veteran services, and to require the collection of information from veterans related to social determinants of health. We believe a study of this data is vital to help treat veterans holistically. This proposal would establish a community network of information that looks at the whole veteran, not just the physical or mental health outcomes. This bill in combination with S. 928 would shift the way in which veteran care is approached. It is time we stop viewing veterans' care as simply the services provided by doctors and nurses, and begin viewing it as all the services affecting the veteran as a whole.

S. ____ Rural Vital Emergency Transportation Services (VETS) Act

The VFW supports this proposal to cover or reimburse the cost of ambulance services for highly rural veterans. Many veterans live in highly rural areas and the high costs of medical transportation could be a deterrent to seeking prompt care. This proposal could help eliminate that potential barrier for veterans in certain areas around the country.

Chairman Tester, Ranking Member Moran, this concludes my testimony. I am prepared to answer any questions you or the committee members may have. Thank you.

Written Testimony of
Lt Col James Lorraine, USAF (retired)
President & CEO
America's Warrior Partnership (AWP)
Augusta, GA

Before the
U.S. Senate Committee on Veterans Affairs

July 12, 2023
3pm, Russell Senate Office Bldg, Room 418

Legislative Hearing to Consider:

1. **S. 449 (Stabenow) Veterans Patient Advocacy Act**
2. **S. 495 (Tester) Expanding Veterans' Options for Long Term Care Act**
3. **S. 853 (Rosen) VA Zero Suicide Demonstration Project Act of 2023**
4. **S. 928 (Tester) Not Just a Number Act**
5. **S. 1037 (Moran) Department of Veterans Affairs EHRM Standardization and Accountability Act**
6. **S. 1040 (Durbin) A bill to amend title 38, United States Code, to prohibit smoking on the premises of any facility of the Veterans Health Administration, and for other purposes**
7. **S. 1125 (Tester) EHR Program RESET Act of 2023**
8. **S. 1172 (Sinema) Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act**
9. **S. 1315 (Moran) Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023**
10. **S. 1436 (Tester) Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023**
11. **S. 1545 (Blackburn) Veterans Health Care Freedom Act**

12. **S. 1612 (King) Reimburse Veterans for Domiciliary Act**
13. **S. 1828 (Rubio) Veterans Homecare Choice Act**
14. **S. 1951 (Sanders) Department of Veterans Affairs Income Eligibility Standardization Act**
15. **S. 1954 (Sanders) Improving Whole Health for Veterans with Chronic Conditions Act**
16. **S. 2067 (Tillis) A bill to require the Secretary of Veterans Affairs to award grants to nonprofit organizations to assist such organizations in carrying out programs to provide service dogs to eligible veterans, and for other purposes.**
17. **S. ____ (Tester) Making Community Care Work for Veterans Act of 2023**
18. **S. ____ (Sullivan) Leveraging Integrated Networks in Communities for Veterans Act**
19. **S. ____ (Sullivan) Rural Vital Emergency Transportation Services (VETS) Act**

Chairman Tester, Ranking Member Moran, and Members of the Committee – thank you for the invitation to testify before you today.

For nearly a decade, since the Congress developed the CHOICE Act, community care has grown in prominence and size. Its impact in the veteran's community has been extraordinarily important and impactful, and veterans across the nation have taken millions of medical appointments in their local communities, with their local doctors, instead of waiting for care at the VA or driving long distances.

The program has changed dramatically in that time. The MISSION Act refined and reformed the program and expanded access to millions of veterans. Despite 2021 reports that the VA was overruling doctors and patients to keep veteran care in the VA, veterans voted with their feet, and chose their community providers over the VA in large and growing numbers. In fact, it is important to remember that VA Secretary McDonough himself testified last year to this Committee, that community care was so successful that the costs may require limiting its successful growth.

Congress has generously funded the community care programs and ensured adequate funding of the Veterans Health Administration in record amounts. The fact that when the VA finally has an overwhelmingly successful community care program that is working, and the VA's first instinct was to trim it back – is troubling.

This speaks to a larger issue, one that some see as a paramount challenge to the VA model itself. A small number of individuals believe if veterans are given a choice, or allowed to manage their own care, the VA will cease to function. In fact, it is to the contrary. Ensuring the VA has strong and effective community partnerships helps safeguard the VA healthcare system and keeps it strong for future generations of veterans.

Importantly, the number of veterans is projected to decrease nationwide over the next several decades. And the younger generation of veterans have shown the greatest interest in community care and managing their own care themselves. Just as demographics and our nation's health care systems are changing and evolving – so must the VA. Accordingly, this means Congress will

need to direct appropriate changes and reforms required to bring VA forward, and still offer veterans the best service available.

However, this does not mean that the VA system will disappear, nor will the VA cease to exist. Not even close. We have all seen veteran enrollees increase as the door to community care opens, another strong signal of support that veterans need and want community care, and are coming to the VA to get it.

But first, important elements of community care must be made permanent, including the access standards. Mission Roll Call (MRC) conducted a poll question on the issue, and with over 6,300 veteran responses across America, over 81% said Congress should codify the community care access standards.

Further, MRC asked questions on the more general veteran experience accessing community care. With an average of 6,200 responses across 7 unique polls:

- 60% of veterans said their VA providers don't make them aware of this option after a delay in care;
- 37% said they had experienced a delay or postponement of any healthcare appointment at a VA facility;
- 71% of veterans said they were not referred to the community after a delay in mental health or other specialty care at a VA facility;
- 22% experienced problems scheduling the care once referred;
- 14% said their providers referred them to the community but the referral was later denied by the VA upon review;
- 21% said their providers scheduled them a telehealth to access their healthcare when they preferred in-person visits.

This clearly indicates a problem simmering under the surface on this issue, and there are good reasons why veterans are 'voting with their feet' and leaving VA in-house care at a growing rate.

At America's Warrior Partnership, we see veterans every day. Our approach to helping veterans is based on serving communities and utilizing a network of resources to assist. The VA has been a partner for many years, and AWP refers countless numbers of veterans to the VA.

However, we have also seen the growing demand for community care. And the positive outcomes it brings. The VA is not the answer to every issue. Every veteran is unique. And every veteran deserves to be treated individually and holistically.

One of the myriad of issues veterans face at the VA is being another nameless veteran at VHA. Even among those veterans who have received great care from their local VA, a common refrain is that they never see the same doctor twice. And not to mention the long waits for service that have been documented. The United States has a robust health care system. While it is not perfect, it services our communities throughout the nation, including areas without VA resources. And often, you have the same doctor or specialist for decades – and they will likely live in the same community.

The relationship and trust between a veteran and their doctor cannot be understated. It is invaluable in health care. And it is possible when community care is done smartly.

S. 1315 – The Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023 (Senator Moran)

Accordingly, America's Warrior Partnership is proud to support Senator Moran's HEALTH Act.

As I said when the bill was introduced, community care has proven to be efficient, effective, and popular among veterans, with very positive outcomes. Veterans continue to request referrals to see providers located nearby, in their communities, rather than wait for care at the VA. AWP applauds the bipartisan efforts of Ranking Member Moran and Senator Sinema to codify access standards and make common sense reforms to the program that will make it easier for veterans to access and utilize the community care.

The intent of Congress was very clear when community care reforms were recently made. Issues such as restarting the "wait time" clock when the VA cancels or reschedules an appointment, or offers a telehealth appointment instead, were clearly not part of this intent. Unfortunately, it will require a Congressional fix to ensure the VA accepts, understands, and implements this.

The HEALTH Act will codify the access standards for receiving community care, something that has long been necessary. And it applies to all types of care provided (except nursing home care) by the VA, not just access to mental health care. It also ensures that the clock starts when the veteran requests a referral and doesn't reset if the appointment is cancelled.

Far too often, we have heard from veterans who were pulled back into the VA system because they didn't meet the time/wait standards. This was because the VA would routinely schedule appointments and deny referrals, only to cancel appointments repeatedly. This is not only an unacceptable practice, but devastating for a veteran who is reaching out for help.

Perhaps just as important, the bill puts veterans back in control of their care. It requires VA to do a better job at educating veterans on their options and gives the veteran a chance to discuss their preferences. The legislation also has an important outreach push and doesn't let the VA administrators change the decision by doctors to refer to community care.

These are bipartisan, common-sense fixes to a program that is popular and working.

S. ___ - The Making Community Care Work for Veterans Act (MCCWFV) of 2023 (Senator Tester)

Over the past decade, only a few issues have been more popular and bipartisan than the VA reforms regarding community care. It is terrific to be here today and see such support for the program and our veterans.

Chairman Tester's MCCWFV legislation is similar to Ranking Moran's HEALTH Act in many ways that AWP strongly supports. For example, the MCCWFV and HEALTH Act both include access standard codification, which has long been necessary. Both bills also ensure that while telemedicine is an option for helping the veteran receive timely help, it is only helpful if the veteran agrees and accepts the telehealth appointment instead of an in-person visit. In addition, ensuring the VA cannot overrule a doctor's decision for a community care referral is also included in both bills.

In fact, AWP supports that the MCCWFV goes one step further and creates a program for veterans to begin self-referral for some services, such as vaccinations and vision/hearing services. Although it should be noticed that mental health should be added to this self-referral program, just as it does in a similar program in TRICARE. Allowing veterans to take ownership of their own care, schedule it in their own communities – at their convenience – is a terrific step.

AWP strongly hopes that the Committee can combine the best of both Chairman Tester's bill, the MCCWFV, and Ranking Member Moran's HEALTH Act, for a strong, bipartisan bill that would reform and improve the community care program. In addition to the similarities and self-referral program previously mentioned, AWP recommends including at least the three points below:

1. Value-based care – Some of the best specialists in America are in private practices. Our veterans deserve the best, and the VA should do everything it can to bring these providers into community care. By focusing on rewarding providers with incentives for quality, rather than quantity, top end providers can see veterans and provide top level services with fewer appointments and better outcomes.
2. Training for community care providers – Ensuring the community care provider network is continuing their professional education and maintaining the highest standards is something everyone agrees on. But the approach must be nuanced. Rather than discouraging care providers for their specific non-VA training modules, they should be incentivized. Many providers have made it clear that their own standards and issue-based training are much higher quality than that VA provided modules. Further, providers in rural areas are generally not as large and have less capacity to comply with the VA module training and would be punished disproportionally.
3. Rather than codifying access standards for certain care at the VA, it should be open to all types of care except nursing home care. This includes extended-care veterans. These veterans are generally high-risk, and community care providers have regularly stated that there are openings available. Rather than putting them on a waitlist for assistance at the VA, they should also be open to community care referrals.

AWP hopes this Committee will be able to find a compromise and pass this promising legislation as soon as possible to enable the President to sign it into law.

S. ____ The Leveraging Integrated Networks in Communities for Veterans Act (Senator Sullivan)

The intent of this legislation is terrific. Across the nation, our communities are always the first to be affected when major issues are happening. Whether it's flooding, layoffs, crime, drugs, suicides, etc. So, solving issues at the community level makes sense. However, not every community has the resources to handle these issues by themselves.

The community integration model is unique. While traditional agencies and organizations, like the VA and thousands of VSOs, utilize a collective impact model, community integration is about building relationships and focusing on individuals. Collective Impact focuses on how to organize departments or organizations together, in sync, to offer their services. Community integration focuses on the needs of the individual through outreach and relationship building and provides a unique solution that brings resources to the individual. Additionally, while collective impact is traditionally transactional, the relationships in community integration provide a better long-term outcome, as assistance can continue beyond the one issue that initiated interaction.

AWP is focused on communities. It's our model. And while we help veterans nationwide through our partners and networks, our casework success rate is over 90%. The community integration model works. And when done right, it can thrive and help communities.

In fact, one of AWP's branch programs is the Alaska Warrior Partnership (AKWP). It is a statewide program that connects veterans to resources at all levels. AKWP has a terrific relationship with the state government, especially Verdi Bowen, and has worked closely with the Tribal community. The partnership has grown, and all three groups work closely together and with the VA. In fact, great credit goes to Verdi for helping build the connection that enables veterans in Alaska to utilize the thriving Alaska Tribal Health System, which has provided much shorter travel times and terrific outcomes across the state. We look forward to continuing to work with Senator Sullivan, his staff, our friend and partners in Alaska, and the veterans across the state.

But our communities across the nation need help. Veterans are everywhere, and the issues reflect the American people. Services need to be coordinated, especially related to veterans.
The LINC Act proposes to bring these networks and resources together through technology, and develop a VA-run pilot project to assist in the effort.

This is a great idea, except that much of this work is already being done – separate of the VA. Every day, AWP is working with veterans in the community, and tying together local resources to help. And for those issues that can't be solved locally, AWP works with national partners to assist, rather than re-inventing the wheel and trying to solve every issue internally. The VA and VSO's often have programs and specializations that fit many needs of veterans. Let them be the specialists. However, any VA involvement directly in the administration of our community integration makes it a top-down approach. Whereas community integration – by its very nature- is a bottom-up approach. That is why rather than having this be an internal VA pilot program, it may be better suited as a grant program to integrate veteran resources in communities.

Further, AWP and many other organizations already use specialized casework software that puts caseworkers and resources together. Our proprietary WarriorServe platform is in use across the nation, including Alaska, and based on SalesForce to make it easy to understand and operate. And while this type of technology already exists, it is not the focus or intent of AWP. While this helps with our mission, everything is based on relationships and getting to know the veteran and their needs. Creating a list of resources, or an app, by itself is not helpful. Nor is linking together resources without the individuals behind them that make things happen. Thankfully, the LINC Act understands this and properly utilizes technology as a tool, not a solution.

As someone who has helped veterans and tried to integrate technology to make our efforts more successful, I am left to offer these lessons that were given to me by several friends and colleagues over the years: "If you think technology will solve all your problems, you don't know what your problems are, and you don't know technology." Community integration needs a human approach, not technology. Technology is not a program, it's a tool for a program.

AWP recommits to our continued work with the Senator and his staff on this legislation and others, and our mutual commitment to the veterans of Alaska.

S. 928 - The Not Just a Number Act (Senator Tester)

For many years, this Committee has closely tracked the annual VA suicide report. And the results were grim. Every member on this Committee has pledged to work to address the scourge of veteran suicide and put programs and resources behind the effort. AWP is grateful for focus and attention on our organization's top priority issue, and the focus of countless veterans across the nation. Yet more can and needs to be done, and it starts with fully understanding the scope of veteran suicide issue.

Nearly a decade ago, AWP started Operation Deep Dive. This program was solely focused on diving into the veteran suicide data and finding ways to get upstream of the issue to prevent these individuals from taking their life. As we worked with states, the Department of Defense, the CDC, the University of Alabama, and now Duke University, a lot of troubling information came to light. The first interim study was published in the fall of 2022, and some of the interim findings were contrary to the direction the VA annual suicide study was reporting.

Much of the interim report focused on the issues with data reporting. Operation Deep Dive (OpDD) found significant differences in the number of former servicemember deaths reported by states and coroners. In addition, the cause of death varied widely, and the number of preventable non-natural deaths were significantly higher than being reported, especially when it comes to drug overdoses.

While the Committee is very familiar with the interim study, and has written a multitude of letters to the VA regarding data sharing and annual suicide study methodology, very little useful information has been sent back from the VA to answer these queries.

This is why AWP is supportive of the intent of the legislation, but unsure how this will fix the issue or provide further clarification on the veracity and development of guides to track the issue more closely. When an issue such as veteran suicide gains enough attention that media and groups closely track a statistic, and use that statistic as a metric – it becomes political. There becomes an incentive to show progress and hide failure or things that don't work or make the VA look bad. It's exactly what happened in Phoenix in 2014.

The VA cannot continue to do this annual suicide study alone without outside participation, corroboration, or oversight. The VA is not being held accountable. It is my opinion that if this Committee would like to fulfill the intent of this legislation, including finding how to reduce the veteran suicide rate and track efficacy of programs to this outcome, then this Committee should request outside perspectives. Request transparency; not additional data.

As many here understand well, VA data has long been the missing piece at Operation Deep Dive. Though it has been requested on numerous occasions at different levels of the VA with different requestors, the VA has never shared data with Operation Deep Dive - including much of the data being requested and referenced in this pending legislation. And OpDD can point to each individual record for the statistics referenced. OpDD is merging service history, justice involvement, financial data – correlated to the details of natural and non-natural death. The only missing piece is the former servicemembers VA details. Instead of mandating the VA report on these issues, Congress should mandate the VA provide this data to organizations and academic institutions researching the issue. In fact – Congress already has! And stated it clearly to the VA on many occasions.

Chairman Tester, Senator Boozman, and Members of this Committee – with that being said, AWP is very grateful for the inclusion of some of the interim study recommendations in this legislation. Providing a tool for coroners and state medical officials will help verify veterans' status quickly and accurately. And elevating the Office of Suicide Prevention to the Secretary level at VA is long overdue, and something many of us at AWP have been requesting for many years. In sum, these are a touching and validating recognition of our work at AWP and our work together with Members and staff here today. Thank you.

S. 2067 - The Service Dogs Assisting Veterans (SAVES) Act of 2023 (Senator Tillis)

AWP is proud to be a supporter of the SAVES Act, and we would like to thank Senator Tillis for introducing this legislation. Many across the nation only see the end results: successful veterans with adorable service dogs. However, much effort goes into getting things to that point, and most of that effort is done privately through nonprofit groups. Organizations like K9's for Warriors and Southeast Guide Dogs have been great partners and helped thousands of veterans.

For many veterans, service dogs are an invaluable part of their lives. The role these dogs play in each veteran's life may vary, but the impact is the same. While the PAWS Act was focused on service dogs assisting veterans with PTSD, the SAVES Act is much broader in assisting those with recognized VA disabilities, including mobility and blindness. Anything the VA can do to help continue supporting the work these organizations are doing with service dogs is welcome and encouraged.

Again, thank you to everyone on the Committee for your invaluable work. We look forward to working with you all and stand by to assist. Thank you, and I look forward to your questions.

Questions for the Record

Senator Angus S. King Jr.
Questions for the Record
Senate Veterans' Affairs Committee
Pending Legislation Hearing
July 12, 2023

Questions for Cynthia Gantt, PhD

1. Will the VA commit that the rulemaking for Section 3007 of Public Law 116-315 will include retroactive payments to when the bill was signed into law?
RESPONSE: VA has proposed making payments retroactive to the enactment date of the law (Jan 5, 2021). See 88 FR 60417.

2. Will the VA commit to ensuring that the rulemaking for Section 3007 of Public Law 116-315 will include a proposed rule within the next 90 days, and a final rule within the next 260 days?
RESPONSE: The proposed rule was published in the Federal Register on September 1, 2023 (88 FR 60417). The 60-day comment period ended on October 31, 2023, during which we received 4 comments. VA is currently reviewing the comments received and drafting the final rule. Although we cannot commit that the final rule will be published within the next 260 days, we can commit to working as expeditiously as possible to publish the final rule. We can further commit to delivering timely health care services and earned benefits to all Veterans, family members, survivors, and caregivers.

Statements for the Record

AMERICAN OPTOMETRIC ASSOCIATION

STATEMENT FOR THE RECORD

Submitted by
Ronald Benner, O.D.
President, American Optometric Association

Hearing to Consider Pending Legislation
U.S. Senate Committee on Veterans' Affairs
July 12, 2023

Dear Chairman Tester, Ranking Member Moran, and Members of the Committee,

Thank you for the opportunity to submit testimony today regarding the importance of ensuring that all Veterans have ready access to the eye and vision care they need. As president of the American Optometric Association (AOA), I am proud to offer AOA's support for a key provision included in the Making Community Care Work for Veterans Act which would allow Veterans to "self-refer" for certain health care services, including vision services.

The AOA represents more than 44,000 doctors of optometry, optometric professionals, and optometry students, including a large share of the more than 1,000 Department of Veterans Affairs (VA) doctors of optometry now on the frontlines providing primary and medical eye care services to millions of Veterans across the country, as well as thousands of private practice community care optometrists proudly serving as an access to care force multiplier in an effort to help VA fulfill its mission to care for those that have borne the battle.

Right now, vision and eye health care is the third-most requested service by Veteran patients, only behind primary care and mental health care services. VA doctors of optometry care for roughly 70 percent of the total unique Veteran visits involving eye care services annually and VA optometrists are currently practicing at 95 percent of the VA sites where eye care is offered and are often the only licensed independent eye care practitioner available. Despite the key role doctors of optometry play in the delivery of VA health care, the Department continues to face difficulties meeting Veteran demand for eye and vision care services due to ongoing recruitment and retention problems, and other concerns.

The AOA is proud to be working with leaders in Congress, at VA, and alongside leading Veteran Service Organizations to support advancement of S. 10, the VA Clinician Appreciation, Recruitment, Education, Expansion, and Retention (CAREERS) Act of 2023. This legislation would help the Department better meet

the vision and eye health care needs of Veterans by updating the VA optometry pay scale and giving the Department the tools it needs to boost lagging optometry recruitment and retention.

However, more can and must be done to ensure Veterans have ready access to the eye and vision care they need and deserve, when and where they need it. That's why AOA is supporting the Making Community Care Work for Veterans Act provision that would allow Veterans to "self-refer" for routine health care services, including vision services. We know that undiagnosed and treated vision problems can negatively impact Veteran quality of life. We also know that too often undiagnosed and untreated vision problems can be signs of larger health concerns. Regular comprehensive eye exams can help address vision-related quality of life issues and better ensure early diagnosis and treatment for underlying concerns, including a wide range of systemic conditions.

Eye and vision disorders have broad implications for Veterans because of their potential for negatively impacting activities of daily living, resulting in decreased quality of life. They are associated with loss of mobility, independence, employment, and can lead to reduced social interaction and depression. It is estimated that at least 40 percent of vision loss in the United States is either preventable or treatable with timely intervention, yet many Americans remain undiagnosed and untreated. Changes in visual function can affect an individual's ability to perform many activities of daily living. Since these changes can develop gradually and occur without symptoms, their effect on visual function and performance may not be readily apparent – making regular eye examination so important.

The leading causes of vision impairment and blindness in the United States, other than refractive errors, are primarily age-related diseases such as cataracts, glaucoma, and age-related macular degeneration. In addition, diabetic retinopathy, the most common microvascular complication of diabetes, can occur in adults of any age. Refractive errors, cataracts, age-related macular degeneration, and diabetic retinopathy usually reduce central vision, especially for reading and other near activities. Glaucoma characteristically affects peripheral vision, which may alter balance and walking. Untreated, these conditions lead to problems with taking medications, keeping track of personal information, walking, watching television, driving, and reading, and often create social isolation. Early detection and treatment of these conditions are likely to translate into improved quality of life.

The eye is the only part of the human body where blood vessels and nerve tissue can be viewed directly in their natural state. Alterations in retinal blood vessels allow the eye doctor to draw conclusions about the status of blood vessels in the entire body. Changes in the eye often precede or occur concurrently with various systemic conditions and can represent important prognostic indications of disease progression. A comprehensive eye examination presents a unique opportunity to observe and evaluate the impact that systemic health problems such as diabetes, hypertension, and hyperlipidemia have on the body and the eyes. For some individuals, signs of an undetected systemic disease may initially be found during an eye examination. Detection of systemic diseases through a comprehensive eye and vision examination can lead to earlier treatment resulting in better patient care, avoidance of complications, and reduced health care costs.

While the AOA is fully supportive of this provision, we also know that proper implementation is critical to ensuring that these changes are in the best interest of Veterans. Right now, Veteran patients receive

regular comprehensive eye and vision examinations through the VA and community care. When implemented, there must be assurances that the term "vision services" outlined in this legislation is not given the meaning of only tests to determine refractive error in order to issue an eyeglass prescription. Current clinical care guidelines and most state laws maintain that an appropriate patient examination to determine a spectacle or contact lens prescription requires a comprehensive eye health examination along with the determination of the refractive state. In short, any separation between the vision component and the rest of the eye health components of a comprehensive exam will be detrimental to Veteran patients, by providing a false sense of security to patients and missing key health opportunities to provide early identification and treatment for a range of eye and related systemic conditions.

Thank you, again, Chairman Tester, Ranking Member Moran, and the entire Committee for your many years of advocacy on behalf of Veterans as well as your dedication to ensuring that VA and its health care providers have the support and resources they need to continue providing world-class care for those that have borne the battle. Considering that vision and eye care services are the third-most requested service in the VA and that doctors of optometry are the overwhelming – and often the only available – provider of these essential services, we look forward to working with you and your colleagues to do all that we can to ensure that Veterans fully have the access they need and deserve to comprehensive eye and vision care when and where they need it. Please do not hesitate to contact me or AOA staffer Matt Willette (703-837-1001 / mwillette@aoa.org) if you would like additional information or to discuss this or any other matter.

Sincerely,

Ronald Benner, O.D.

President, AOA

July 12, 2023

The Honorable Jon Tester
Chairman
U.S. Senate Veterans' Affairs Committee
412 Russell Senate Office Building
Washington, DC 20510

The Honorable Jerry Moran
Ranking Member
U.S. Senate Veterans' Affairs Committee
412 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Tester and Ranking Member Moran:

On behalf of the undersigned leading organizations that represent the senior living industry, including assisted living owners, operators, and aging services providers, we commend you for holding today's hearing to consider pending legislation, including S. 495, the Expanding Veterans' Options for Long-Term Care Act.

Our veteran population is aging rapidly, as are their long-term care needs. According to the U.S. Department of Veterans Affairs, roughly half of the 9 million veterans currently enrolled in veterans' health care programs are 65 or older. Over the next decade, the number of veterans aged 75 or older is expected to approach 3 million. The number of veterans aged 85 or older receiving care from VA health services is expected to grow by 535% over the next 20 years.

Federal data shows that someone turning age 65 today has a 70% chance of needing some type of long-term care in their lifetime. The Department of Veterans' Affairs predicts that approximately 80% of veterans will develop the need for long-term services at some point in their lives. However, VA is restricted from covering "room and board fees" at assisted living communities, which precludes veterans from utilizing this long-term care option.

If enacted, S. 495 would authorize VA to carry out a three-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans who do not require nursing home care but cannot live alone. We believe this bill and the pilot program is an economically sound and sensible approach to demonstrate the benefits of assisted living to veterans and their families.

Support is growing for S. 495. In a July 7 hearing entitled "An Abiding Commitment to Those Who Served: Examining Veterans' Access to Long Term Care," members of this committee heard from Ms. Carla Wilton, Chief Operating Officer of Immanuel Lutheran Communities, a full-service retirement community offering independent living, assisted living, memory support, and long-term care to 300 older adults in Kalispell, Montana. In her testimony, Ms. Wilton shared her support for S. 495, telling the committee that "this important legislation would create a

commonsense approach to identifying and securing greater options and opportunities for Montana veterans to access important supportive long term care services."

At the same hearing, Ms. Whitney Bell, President of the National Association of State Veterans Homes, told the committee that "NASVH is pleased to offer our strongest support for S. 495. On behalf of our member State Homes and the veterans we serve, I want to thank Senators Tester and Moran for introducing this legislation, along with other Senators who have supported it, and call for its swift consideration and approval by the Committee."

In a June 21 legislative hearing of the House Veterans' Affairs Committee's Health Subcommittee, which included H.R. 1815, the House companion to S. 495, Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services at the Department of Veterans Affairs, indicated that the VA supports the bill, with some technical amendments.

In her written testimony, Dr. Scavella told the committee "VA agrees that specific authority, particularly in the form of a pilot program, to furnish assisted living services would be a helpful addition to VA's options for long-term care. VA has encountered difficulties within its current authorities in appropriately placing Veterans who may only require assisted living services because these Veterans do not qualify for nursing home care. Moreover, due to shifts in the industry to an assisted living model of care, particularly for patients with dementia, Alzheimer's, or other memory deficits, VA's lack of authority to furnish assisted living services means they have no appropriate option. The pilot authority would allow VA to determine how best to develop a program to support these Veterans' needs. VA supports the protections this bill would include to ensure that Veterans are protected and receiving safe and appropriate care.

We welcome VA's support of this important legislation. Also speaking in support of the bill were representatives of the Wounded Warrior Project, the American Legion, Disabled American Veterans, Veterans of Foreign Wars of the United States, and The Independence Fund.

In a 2021 report to Congress, the VA outlined federal savings that could be achieved if veterans were given the option of assisted living care. Approximately 5 percent of veterans residing in federally funded Community Nursing Homes (CNHs) could be appropriately housed in assisted living. In FY2020 the annual cost of a CNH placement was $120,701 compared with $51,600 for assisted living. By utilizing assisted living for individuals who meet the relevant criteria at the time of admission, the VA would realize a potential cost of avoidance of $69,101 per placement per year.

Long-term care and assisted living communities are home to two million seniors, of which 42% are veterans or their spouses. We believe that assisted living offers the best of personal and supportive care services with a team of professionals in a home environment that promotes social engagement, nutrition, and wellbeing. We are confident that, if passed, S. 495 will demonstrate the benefits of assisted living not only to veterans, but to their families as well, offering additional options to our veterans in their time of need.

By expanding long-term care options for our rapidly aging veteran population, particularly in rural areas, S. 495 will give our veterans more options for how and where they can get the care they need while preserving taxpayer dollars. We thank you and look forward to working with

the committee to advance this legislation and ensure our veterans have access to the best long-term care and services at the time they need it most. They deserve it.

Sincerely,

American Seniors Housing Association (ASHA)
Argentum
Leading Age
National Center for Assisted Living (NCAL)

Statement for the Record

Senate Committee on Veterans' Affairs Hearing:
Pending Legislation
Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act

Prepared by:
D'Aniello Institute for Veterans and Military Families (IVMF) at Syracuse University

July 12, 2023

Chairman Tester, Ranking Member Moran, and Members of the Committee, thank you for inviting the D'Aniello Institute for Veterans and Military Families (IVMF) at Syracuse University to submit a statement for the record on the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act that is pending before you today. The Veterans Health Administration (VHA) is America's largest integrated health care system and is therefore uniquely positioned to realize the benefits of a value-based approach to delivering the full set of services that veterans need to thrive. The IVMF applauds Ranking Member Moran for his leadership on the Veterans' HEALTH Act and the Committee for convening today's hearing to consider this important piece of legislation. It is our hope that Congress can build on the VHA's successes in advancing whole health and improved outcomes for our nation's veterans.

We commend the VHA's recognition of this through their emphasis on a whole health approach to care. Effectively addressing health outcomes requires a collaborative approach that provides robust clinical *and* social care – often referred to as the social determinants of health (SDoH). SDoH are defined by the U.S. Department of Health and Human Services as "the conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks." The needs arising from these environmental factors are an individual's health-related social needs (HRSNs). Congress and the VHA have taken an important first step toward integrating health and social care to address HRSNs with the passing of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act and distribution of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program funds which support community-based organizations that deliver social services to veterans. These local nonprofits are critical frontline providers of wraparound services such as transportation, legal assistance, childcare, and peer support. By collaborating with community organizations to address the social needs of veterans and military-connected individuals, the VA continues to demonstrate their commitment to whole health care.

As we approach five years since the passing of the VA MISSION Act and four years since the Community Care Program began rolling out across the country, it is time to address the aspects

of the legislation and program that can be strengthened. The IVMF supports the proposed improvements in Title I of the Veterans' HEALTH Act, in particular the provisions that incentivize transparency and quality for Third-Party Administrators (TPAs) (Section 108) and require genuine efforts to expand value-based reimbursement models (Section 109).

While the IVMF is a proponent of the underlying purpose of the Community Care Program to improve timely access to high quality care, we recognize that its benefits have not been uniformly experienced. As noted by the Congressional Budget Office, there have been mixed effects in several areas, including the coordination of health service delivery, the ability to monitor quality, and efficient utilization of VA resources and facilities.

It is the IVMF's view that Title I's provisions to incentivize TPAs and incorporate a value-based care model into Community Care has the potential to improve and help us better understand challenges with implementation, particularly with respect to efficiently managing and monitoring the program.

The IVMF also strongly supports Title II of the legislation as an important next step toward improving the health and well-being of veterans – one that puts the individual at the center of care and acknowledges the role of community partners in achieving better outcomes.

These provisions create a unique opportunity for the VA to plan, test, measure, and thoughtfully implement a value-based care model. We now know that value-based care models improve patient outcomes and reduce patient costs, as well as improve the efficiency of care and reduce risk for the providers.

We also know that integrating health and social care is a key element in addressing a patient's whole health. Research suggests that approximately 20% of a patient's health outcomes are attributed to their access to and quality of care, while up to 55% are attributed to items not commonly addressed in a healthcare settling like healthy food, stable housing, and reliable transportation. By integrating health and social care and building collaborative partnerships within communities, the VHA can optimize care for their patients and reduce rates of unnecessary health care utilization and preventable hospital stays. This would result in improved patient outcomes, increased patient satisfaction, and cost-savings for both patients and providers. The VA has already begun to invest in pilot programs that address these additional needs and barriers to care. For example, the VA-Uber Health Connect program has helped expand access to care, reduce missed appointments, improve veteran experience, and achieve millions of dollars of cost savings at VA Medical Centers (VAMCs).

Therefore, we believe this legislation – particularly Sections 201 and 206, would benefit from including considerations for wraparound services that address the unmet social needs of veterans.

In addition to the developing body of evidence, through our community-based research and initiatives at the IVMF, we have observed, measured, and studied what happens when there are robust partnerships between the VA and the community.

Through our pilot research with the VA Center for Health Equity Research and Promotion (CHERP), we know that when veterans are assessed for eligibility by the Veterans Benefits Administration (VBA), enrolled in VHA care, and are referred for outside social services, they experience more personalized, timely, and successful care in their communities. Further, we know that these individuals served by their communities tend to be the most marginalized, hardest to reach, and highest-need members of the veteran population.[1]

What does this look like for a veteran in real life?

In 2018, a 53-year-old, African American, female, Gulf War veteran was referred by a nonprofit organization that serves homeless veterans to PAServes, a community network of health and human service providers in Pittsburgh that closely coordinates to better serve the community's military population, to receive a bed and basic household items. After a year of stability, the veteran became food insecure and again contacted the PAServes team for assistance. In addition to a referral to a local food bank, the PAServes team made a referral to the VBA which quickly determined that she was VA eligible and connected her to the local VAMC. Her VA care team diligently identified additional HRSNs and referred her back to PAServes which connected her to healthy food, basic household goods, items for her child, and social enrichment. Months later, after suffering a stroke, PAServes and her VA care team worked together to provide transportation to and from appointments thirteen times between 2019 and 2022 while recovering from her health scare. Today, the PAServes care team is proud to report that she is thriving thanks to a strategic and enduring partnership between the community network and the VHA.

Through our evaluation of the PAServes network, we know that 650 people had experiences like this in 2022 alone – experiences where they sought help in their own community, and not only received services for the underlying conditions that were barriers to their ability to thrive, but were also connected to and eligible for VHA care.

Importantly, we also understand the underlying conditions have made this level of collaboration possible. In Greater Pittsburgh, the PAServes network has the committed support of leaders within three VAMCs (Pittsburgh, Butler, and Erie) and the VBA Pittsburgh Regional Office who recognize the role communities play in ensuring veterans are connected to the resources, services, and care for which they are eligible – inside and outside of the VA.

Our research with CHERP affirmed what we have seen in Pittsburgh: successful collaboration at the local level requires mutual buy-in, willingness to adapt, and ongoing communication. The study also demonstrated that, unfortunately, commitment to this level of coordination is not universal and depends heavily on the specific leaders and supporters within individual VAMCs. These integrated approaches would benefit greatly from more enterprise support. This legislation would build on recent momentum from the Veterans Experience Office, the VA Office of Healthcare Innovation and Learning, and other efforts to champion and make building partnerships easier.

[1] Hausmann, L. (2023, April 28). *Characterizing participation of VHA medical facilities in military-centric cross-sector collaboratives*. Society of Behavioral Medicine Annual Meeting, Phoenix, AZ.

In closing, we would like to express our support and offer recommendations in two key areas that we think will lead to greater success as VA undertakes its value-based care planning and pilot efforts:

1. Incorporating the health-related social needs of veterans into planning and advising processes:
    - We appreciate the breadth of perspectives represented in the required membership of the working group outlined in Section 201. We recommend that the strategic planning process and subsequent pilot program outlined in Section 206 expand its focus beyond primary, mental health, and substance use care to include social needs that have been shown to address barriers to care, improve health outcomes, and reduce costs.
    - We commend the elevation of the Center for Care and Payment Innovation (CCPI) in Section 206 to the Secretary's office and appreciate the emphasis on seeking advice and counsel from a range of offices within the VA as well as other federal agencies, nonprofit organizations, and public and private sector entities. We recommend expanding the list of internal offices to include the Veterans Benefits Administration and broadening the focus of outside expertise to include social determinants of health.
2. Setting conditions for accountability and long-term success of value-based care in the VA:
    - We are encouraged by the provisions in Section 206 that require more direct action to pilot, measure, and scale value-based care models. We recommend that the required reports include, at a minimum, counts of providers and connections to services that address the social needs of veterans. Doing so would enable the report to examine differences in health outcomes among veterans who received different amounts and types of services. This level of analysis is important given emerging evidence that evaluating the success of collaborative care systems requires multiple measures that consider the complexity of the veterans' needs.
    - We recommend that the final report include specific consideration for how a value-based model of care at the VA will protect veterans with especially complex needs and circumstances, given that the cost of serving them may be high relative to the level of improvement in health outcomes they experience.
    - We recommend that the final report include specific attention on how extension of the program across the VA will be implemented in a way that ensures consistent support across VAMCs.

Thank you, Chairman Tester, Ranking Member Moran, and the Committee Members for your time, attention, and the opportunity to participate in your deliberations related to the Veterans' HEALTH Act. We look forward to continuing to work together to address the most pressing issues impacting veterans and their families.

185 Berry Street
Suite 400
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July 14, 2023

The Honorable Jon Tester
Chairman
Committee on Veterans Affairs
U.S. Senate
412 Russell Senate Office Building
Washington, D.C. 20510

The Honorable Jerry Moran
Ranking Member
Committee on Veterans Affairs
U.S. Senate
825A Hart Senate Office Building
Washington, D.C. 20510

Dear Chairman Tester and Ranking Member Moran:

We write in strong support of the Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023 (S. 1436), which contains a key provision that expands at-risk homeless veterans' access to transportation services across the country - including rideshare - in order to efficiently connect them with vital Department of Veterans Affairs (VA) resources. We greatly appreciate the Committee's consideration of S. 1436 during its legislative hearing on Wednesday, July 12, 2023, and encourage the Committee to expeditiously move forward with this bill.

Since the VA's authority to fund these innovative transportation options lapsed with the sunset of the COVID-19 Public Health Emergency (PHE) on May 11, 2023, the VA has had to cancel over 38,000 pre-scheduled veteran rides - resulting in over 10,000 missed medical, mental health, and employment-related appointments. Every day that this authority remains lapsed, at-risk homeless veterans throughout the country are unable to access critical support resources due to a lack of flexible transportation services.

As you are aware, lack of reliable transportation has historically been a serious obstacle for many veterans - especially homeless veterans - seeking access to essential VA services. A recent study found that 37% of high-need, high-risk veterans reported having issues accessing transportation, and 22% reported delaying a doctor's appointment due to transportation issues[1]. Additionally, veterans who rely on public transportation services face a significant barrier in accessing care,

[1] Dang, S., Desir, M., Lamba, S., Muralidhar, K., Tang, F., & Valencia, W. M. (2022). Recognizing the Needs of High-Need High-Risk Veterans. *Clinical interventions in aging*, 17, 1907–1918. https://doi.org/10.2147/CIA.S280437

with only 25% of veterans living within a 60-minute transit time of a VA medical facility.[2] For over two years prior to the current authorization lapse, Lyft worked alongside the VA and veterans organizations to provide veterans with access to reliable transportation to and from VA-approved appointments. This innovative transportation program has supplemented existing veterans transportation options and filled necessary transportation access gaps in communities across the country.

Innovative VA transportation programming - which S. 1436 seeks to expand authority for - was initially established by the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) as a pilot program to provide transportation assistance for at-risk homeless veterans. Of the 500 participants in this original pilot, 331 were deemed 'successful' and no therefore longer at risk for homelessness. Since then, the program has expanded to include rideshare services for additional VA-approved appointments - such as dialysis, oncology, drug rehab, physical therapy, food insecurity, and mental health appointments. Innovative transportation solutions - and especially rideshare services such as those offered by Lyft - have proven to be an essential resource for at-risk, vulnerable, and homeless veterans.

As of May 11, 2023, nearly 100,000 unique veterans had utilized the VA transportation program to access almost 600,000 rides to medical appointments, housing resources, employment opportunities, and food insecurity services since the program's inception in 2020. The program operated in all 181 VA locations across all 50 states and Washington D.C. and was instrumental in helping veterans overcome transportation barriers by providing them with additional transportation options that are uniquely tailored to their needs and schedules.

Furthermore, rideshare's role in this program can drastically improve VA transportation benefit accountability - and can reduce fraud, waste, and abuse - due to Lyft's advanced technology, which allows insight into a ride's real-time location. Rides to VA appointments and other VA-approved resources provided by rideshare drivers can also help to reduce downstream healthcare costs, such as those associated with missed appointments and extended outpatient stays related to lack of transportation. Rideshare transportation may also help ensure that adherence to complex care programs, such as dialysis or cancer treatment, is more consistent and easily accessible for veterans - potentially resulting in lessened future costs associated with prolonged treatment and, most importantly, providing at-risk veterans with transportation that is flexible and responsive to their unique medical needs.

Since the VA's authority to operate this transportation program expired in May, the VA has been unable to continue the program - resulting in a lapse in service for tens of thousands of veterans who need transportation to access critical supportive services. As you know, if passed and signed

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[2] Farmer, C. M., Hosek, S. D., & Adamson, D. M. (2016). Balancing Demand and Supply for Veterans' Health Care: A Summary of Three RAND Assessments Conducted Under the Veterans Choice Act. *Rand health quarterly*, 6(1), 12.

into law, S. 1436 would ensure that veterans are once again able to access crucial transportation services that are vital to their health and well-being.

We urge the Committee on Veterans Affairs to quickly advance the transportation provisions contained within S. 1436 - the CHARGE Act - and reiterate our strong support for this bill. The veterans who rely on this transportation program are counting on us, and we owe it to them to secure access to innovative, reliable benefits that are reflective of our nation's gratitude for their service.

Thank you for your consideration.

Sincerely,

Buck Poropatich
Head of Lyft Healthcare

Cc: The Full Membership of the Senate Veterans Affairs Committee

STATEMENT FOR THE RECORD

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

Full Committee Hearing to Consider Pending Legislation

July 12, 2023

by the

American Psychological Association
Association of VA Psychologist Leaders
Association of VA Social Workers
Association of Veterans Affairs Nurse Anesthetists
Military and Veterans Committee of the Group for the Advancement of Psychiatry
National Association of Veterans Affairs Optometrists
National Association of Veterans Affairs Physicians and Dentists
Nurses Organization of Veterans Affairs
Veterans Affairs Physician Assistant Association
Veterans Healthcare Policy Institute

(All are independent organizations, not representing the Department of Veterans Affairs)

Chairman Tester, Ranking Member Moran, and Distinguished Members of the Committee:

On behalf of our organizations, we thank you for inviting to us to submit a statement for the record for today's hearing on the U.S. Department of Veterans Affairs (VA) utilization of care in the community, prevention of veteran suicide and other veterans related bills. Many members of our organizations have published papers on these topics in peer-reviewed journals. Many of us have also had long careers serving veterans and have previously presented testimony to your committee. In today's statement, we want to convey our appreciation for your leadership and continuing commitment to ensuring veterans receive the highest level of healthcare and services that they deserve.

While there are 16 bills being considered today, below, please find our comments on seven of the bills most closely aligned with our expertise. Those are: S.1315 - Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act, Discussion Draft - Making Community Care Work for Veterans Act, S.928 - Not Just a Number Act, S.853 - VA Zero Suicide Demonstration Project Act, S.1545 - Veterans Health Care Freedom Act, S.1954 - Improving Whole Health for Veterans with Chronic Conditions Act, and S.449 - Veterans Patient Advocacy Act.

S.1315 - Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023

By design, the HEALTH Act will swiftly accelerate the outsourcing of veterans' care to the private sector and drain the Veterans Health Administration (VHA) of needed funding for the provision of in-house care. This will, in turn, cause a spiraling reduction in VHA staff and closure of programs/clinics/facilities. It proposes a pilot access program that eradicates the core integrated health care model on which VHA is based. It will ultimately subject veterans to the sort of dangerously fragmented care that is routine in the private sector.

Veterans' choices for healthcare would also be diminished, not expanded. VHA would lose its capacity to provide coordinated care and would no longer be able to provide veterans with high quality care that addresses their complex military-related conditions. As studies have documented, VHA healthcare quality surpasses the private sector in most areas.

The bill's provisions are detrimental to veterans for the following reasons:

1. By allowing veterans access to private sector care because that is their "preference," major funding will be diverted from the VHA to the private sector. This will **force more reductions of VHA staff, curtailment of in-house programs, and closures of inpatient units, emergency rooms, and even entire facilities**. It will also make it nearly impossible to upgrade existing infrastructure needed to address the demand for services, particularly in the wake of the PACT Act.

2. By allowing veterans' access to private sector healthcare without any VHA referral, authorization, or oversight, the **VHA's carefully constructed model of integrated healthcare will be dismantled**. This bill would not only disassemble this model of care but rapidly expedite the **conversion of the VHA healthcare system from its current primary role as a provider of healthcare into a payer for private sector care**.

3. In the name of offering more choice, healthcare options would diminish for veterans. Draining VHA funds and closing programs/ facilities means that **veterans – especially service-connected veterans who depend on VHA as a provider of high-quality care that is tailored to their needs – will be denied that choice**.

4. The bill's refusal to require transparency in the private sector – on wait times, care quality or provider training – means that policy makers and patients alike **will be denied information they need to make well-informed healthcare decisions.**

5. **This bill will make it difficult, if not impossible, for the VHA to continue to collect data and conduct research on veterans' complex health conditions.** Every VHA patient and their electronic medical record is available for analysis, which, for decades, has enabled researchers to make impressive big data breakthroughs on veterans' complex healthcare problems. Those innovations will fade if veterans' care becomes scattered across the fragmented private sector where there is no dependable way to study veterans. The bill will also jeopardize the critical role the VHA plays in the training of future

healthcare professionals. Further, there will be fewer ER and inpatient beds so that VHA will fail to fulfill its Fourth Mission as backup for national emergencies.

We draw these conclusions from specific sections of the bill:

Sec. 103: This language, for the first time, would provide veterans with the ability to seek care in the private sector even when high-quality care is available at the VHA in a timely and convenient manner. All a veteran would need to do is indicate his/her "*preference*" for where, when, and how to obtain their care. The percent of VHA veterans eligible for the Veterans Community Care Program (VCCP) will increase from 33% to 100%. The guardrails of the VCCP eligibility standards – travel time to or wait time for a VHA appointment – would become moot.

This stipulation violates the intent of the VA MISSION Act. When MISSION passed, there was bi-partisan agreement that the VCCP was meant, in Senators' words, to "supplement, not supplant" VHA healthcare. A veteran would be offered the option of receiving healthcare outside of the VHA under six narrowly defined criterion. Legislators understood that veterans would get the option to choose whether to receive care in the private sector or the VHA if, and only if, they qualified under the six eligibility rules. This carefully constructed language was the firewall that ensured the long-term viability of the VHA healthcare system. The HEALTH Act would violate that core agreement.

The HEALTH Act will predictably accelerate the proportion of VHA funds flowing to the VCCP. As *U.S. Medicine* reported, "between FY 2017 and FY 2021, VA spending on community care rose from $10.1 billion to $21.8 billion – a 116% increase that does not factor in the costs of administering the program. At the same time, VA spending on healthcare in its own facilities grew 32%." By last year, VCCP's share of VHA's health services reached 44 percent -- and mounting. The proposed legislative language in this bill will vastly increase spending through the VCCP and threaten the viability of the VHA system.

The HEALTH Act will divert funds away from the VHA, forcing reductions of staff and in-house programs and closing entire facilities. As VA Secretary Denis McDonough predicted in September 2022, if use of private sector care continues to rapidly increase, "VA medical facilities, particularly those in rural areas, may not be able to sustain sufficient workload to operate in their current capacity." Closing programs/ facilities means that veterans – especially service-connected veterans who depend on VHA as a provider of care that is tailored to their needs – will no longer have that choice.

Independent RAND and Dartmouth analyses – among many others – continually affirm that the quality of VHA's healthcare in regional markets is as good as, and in many instances, superior to private options.

Siphoning VHA funds will also make it nearly impossible to upgrade existing infrastructure required to address the demand for services. That demand is continuing to grow - the PACT Act of 2022 has already contributed to an influx of a quarter million newly enrolled veterans with serious toxic exposure-related medical conditions.

This (and other) sections of the bill claim to reduce the wait-times for veterans accessing care. However, delays for outpatient, inpatient and emergency room care for veterans and non-veterans in a local area would increase. Today, the average VCCP wait times for primary care, mental health, and all other specialties are roughly 20% longer than wait times at the VHA. As millions more veterans flood the private sector, and/or if a VHA facility is downsized, veterans and non-veterans alike will struggle to get care in an overburdened private sector healthcare system, which is still suffering from healthcare worker shortages in the wake of the Covid-19 pandemic.

Our nation faces an intractable physician shortage. A recent report by the American Association of Medical Colleges warns of an estimated shortfall by 2034 of between 17,800 to 48,000 primary care physicians and 21,000 to 77,100 non-primary care physicians. Another report projects a workforce shortage of approximately a million registered nurses by 2030. Most of our nation also suffers from severe shortages of mental health providers.

The delivery of health care to rural populations is a particular challenge. While 20% of the U.S. population is rural, only 12 percent of PCPs are working in rural areas (and only 8% of other specialties), and these provider numbers are declining. According to The Center for Healthcare Quality and Payment Reform between 2005 and 2019, 150 rural hospitals closed. In 2020, an additional 19 closed. In 2023, it was reported that another 600, or more than 30% of rural hospitals are at risk closing.

Sec. 206: This statute will accelerate the privatization of the VHA via a pilot program that will drastically modify the process by which veterans obtain mental health and substance use disorder (SUD) care.

Veterans would be allowed to receive outpatient mental health or SUD care in at least five private sector locations **without VHA referral, authorization, or oversight**. An enrolled veteran could simply make an appointment with any VCCP mental health or SUD provider for care for any duration. VHA's only role would be to pay the invoice.

Though this is initially a small-scale pilot program, the bill also mandates that the VHA "develop appropriate metrics and measures to assess and mitigate any barriers to extending the pilot program across the entire Veterans Health Administration." Subsequent legislation will create universal opportunities for veterans to select private sector providers. Within a few years, eligibility would likely expand so that all diagnoses, not just mental health and SUD, would be covered. All levels across the continuum of care, not just outpatient, would be added. Similarly, veterans throughout the country would be eligible, not just in a handful of locations.

Not only does this hasten the siphoning of funds out of VHA, but it will also transform the VHA from an integrated healthcare system, like Kaiser Permanente, to an insurance carrier, like Blue Cross/Shield or Aetna. In this new insurance system, everything that is indispensable and unique to the VHA will disappear – integrated and coordinated team-based care, comprehensive prevention screenings, wrap-around services, veteran-centric specialization, training of providers with veteran expertise, and research on veterans' conditions that also helps all patients. VHA social work connecting patients to veteran-specific follow-up resources for legal, transportation,

home health, and housing services would fade. Even the Office of Inspector General's oversight of veterans' healthcare will be compromised, since its ability to access private sector health care records is limited.

The total cost of a proposal to create a system of unfettered community care was calculated when this idea was first proposed, in 2016. At that time, it was estimated to be $96 to $179 billion yearly. Figures today would be even higher and, as such, **CBO scores for this and other sections are urgently needed.**

Sec. 108: This section gives great latitude to the VCCP third-party administrators (TPAs) to offer extra pay to private sector providers to participate in the VCCP. Disturbingly, financial incentives are offered to providers to join the VCCP in the absence of any quality control over, or training requirements for, these providers. This statute will also lead to an escalation in funds being drained from VHA.

Sec. 101: This statute jeopardizes veterans' timely access to VHA in-house care by explicitly depriving the VA Secretary of the ability to assess and revise eligibility access standards devised by former VA Secretary Robert Wilkie based on unsubstantiated drive time and wait time standards. Codifying these misguided standards into law will, along with other provisions in the bill, guarantee the increased outsourcing of VHA patients to the private sector.

Sect. 101 further promotes patient outsourcing by prohibiting the Secretary to reverse a troubling double standard governing the provision of the VHA's world class telehealth services. The Trump-era standards prohibited telehealth from being considered as access to care if offered by VHA while allowing VCCP telehealth to be furnished without any constraints. Arguing that this double standard should be reversed, VA Secretary Denis McDonough last year stated that this error unnecessarily redirects up to $1 billion annually to VCCP.

Under existing law, the VA has the authority to make changes so that telehealth appointments count as meeting timely access standards. The HEALTH Act would remove VA's authority to do so, even when telehealth is a veteran's chosen modality to receive care. To legislatively prohibit correcting this mistake harms veterans.

A far better – and more fair – legislative fix would ensure that VHA-delivered telehealth shall count as meeting access standards, but that no veteran would be required to accept a telehealth appointment, either in the VHA or VCCP, when they want to see their provider in-person.

Sec.106: This statute removes VHA administrators' authority to override provider recommendations that a patient should be referred to private sector care because it is in the veteran's "best medical interest." This new stipulation is fixing a problem with a machete when a small scalpel is needed.

There are instances when "best medical interest" fits for a veteran who doesn't qualify for VCCP under the five other existing criteria. For example, a veteran might have to travel over a steep mountain pass in winter snow to the nearest VHA facility when there is an alternative in his/her hometown. But there are too many instances when this category is currently being misused.

That's occurring when the provider's only justification for the "best medical interest" recommendation is that a veteran "prefers" non-VA care.

According to the Independent Budget's analysis of the MISSION Act, the "best medical interest" criterion "is to be considered when a veteran's health and/or well-being would be compromised if they were not able to be seen in the community for the requested clinical service. When using this community care eligibility criteria, the ordering provider should include the following considerations: nature or simplicity of service; frequency of service; need for an attendant; and potential for improved continuity of care. 'Best medical interest' is not to be used solely based on convenience or preference of a veteran." When it is used as such, then VHA's administrative oversight is the appropriate response.

Going forward, VHA must retain – not lose -- the authority to have final say on whether external referrals meet explicit referral standards. Further, VHA employees making referrals to the VCCP need far better education about what does and does not constitute "best medical interest."

Sec. 108 and related sections. The HEALTH Act ratifies unjustifiable double-standards by holding the VHA accountable while allowing the VCCP to operate with no significant oversight. Some examples:

- The timeliness and travel eligibility access standards apply to VHA, but not VCCP.
- The Inspector General is tasked with assessing the performance of the VHA, but not the VCCP, in delivering timely care.
- VHA, but not VCCP, is required to regularly publish wait-time information.
- Performance metrics will be implemented for VHA employees who are responsible for veterans accessing care. Similar metrics are not required for VCCP employees who have equivalent operational responsibilities.
- VHA providers are already mandated to take military cultural competency and other trainings like suicide prevention, and, in the wake of the PACT Act training in toxic exposures, as well as screen for a multitude of conditions. Trainings are one reason why the VHA has a better record of delivering higher quality mental and behavioral health services than the VCCP. Section 108 prohibits that any penalty be applied to VCCP providers who fail to take relevant trainings and gain even minimal expertise, The ethical and clinical consequences of this double standard are deeply worrisome.

Sec. 205: This statue includes provisions to create new staffing models for the VHA, ignoring the fact that VHA already has them. What's needed instead is oversight and enforcement of existing VHA staffing standards to correct the wide variation in local VA health care system compliance.

In proposing new staffing models, this bill makes yet another error by explicitly trying to create staffing models that conform with private sector health care systems. To compare private sector staffing to the VHA neglects a critical fact: that VHA patients are far more complex than those seen in the private sector. VHA patients are 14 times more likely to have 5 or more medical conditions and 14 times more likely to have poor health status than the general population. Compared to the general civilian population, former service members have higher rates of

depression, mental illness, suicidal thoughts, chronic disease, chronic pain and substance use disorder. Staffing models should also account for VHA's clinical environment, one that prioritizes genuine teamwork and time collaborating with providers and other staff.

Sec. 108, 109 and 201: This language contains provisions that would force the VHA to change its model of healthcare delivery to one based on value-based care and reimbursement mechanisms. The guiding assumption behind these sections of the bill is that the VHA does not already deliver care that is person-centered, relationship-based, and recovery-focused, doesn't provide good value for cost, and is not focused on "continuous innovation and quality improvement."

While there may be a need to revise the current iteration of the VERA resource allocation model and to reconsider various scheduling mechanisms that VHA leadership has launched, like "bookable hours," value-based care models do not address these problems, and in fact, would create many others.

Despite the claim that VBC is a proven and successful model of delivering healthcare, a body of scholarly literature concludes that it is more rhetoric than reality. According to a number of articles and analyses, including a 2021 article in *JAMA*, the vast majority of value-based models used by the Centers for Medicare and Medicaid Services (CMS) "do not show significant improvements in quality." The article goes on to point out that: "In many cases, national or regional benchmarks combined with adverse selection can make it appear as if participants have saved money when they in fact have not."

A chapter in a 2019 Report to Congress on Medicare stated that "the treatment effect of being in an ACO (one of the primary VBC models) does not show savings." In fact, these models often showed higher spending growth. The chapter added that ACO's use of wellness visits resulted in gaming the system through upcoding.

Most disturbing was a 2022 an article in the *New England Journal of Medicine.* It reported that value-based payment systems not only "failed to meaningfully reduce health care expenditures and improve quality" but "hampered the pursuit of health equity," and actually "perpetuated structural racism." The value-based model penalized health systems that cared for low-income patients, encouraged system gaming, and diverted funds from those providing direct care to patients toward investments in "external consultants."

One JAMA report found that "high-proportion Black hospitals were more likely than other hospitals to be penalized" by certain value-based models. Another study suggested that value - based models had resulted in decreased access to knee and hip replacement operations for adult Black patients. To impose unproven mechanisms, documented to negatively impact the kind of patients the VHA cares for could harm veteran patients.

An article last month assessing Value-Based Care that appeared in *JAMA Network* reiterated these concerns and added additional ones. Not only do financial incentives fail to improve quality, but the focus on cost also often comes at the expense of patient preferences which, not surprisingly, prioritize outcomes, experience, and safety over efficiency. The study went on to

underscore the fact that Value-Based Models may penalize "smaller, rural, low volume, nonteaching hospitals that serve more deprived areas."

To impose unproven mechanisms, documented to negatively impact the kind of patients the VHA cares for, could harm veterans.

The Department of Veterans Affairs has long administered the most successful healthcare system in the country. As a recent summary of research yet again confirms, the quality of care delivered by the VHA is as good as or better than the care veterans receive from VA-paid community care or the general public obtains through private care.

Our organizations are happy to support legislation that encourages the appropriate use of the private sector to "support, not supplant" VHA healthcare. We also back legislation that ensures VHA has robust resources needed to care for current and future cohorts of veterans. The HEALTH Act does neither.

Discussion Draft - Making Community Care Work for Veterans Act of 2023

The Making Community Care Work for Veterans Act of 2023 has several sections that contain some useful improvements but does not go far enough in addressing problems with the Veterans Community Care Program.

Sec. 109 addresses a serious problem in the VCCP – that is the failure to require VCCP providers to provide VHA with data on the quality of the healthcare that they furnish. Despite the original MISSION Act mandate, VHA has never required third party administrators to collect or report such data. Lacking data, veterans have consistently been referred to care of completely unknown, and sometimes dubious, quality. That should never occur.

This section ostensibly fixes the gaping lack of data and accountability on VCCP's efficiency, effectiveness, quality, timeliness, and safety of care. But rather than requiring all VCCP providers to submit needed data during a veterans' treatment, the language exempts providers from submitting data if VHA deems that doing so *constitutes too heavy of a burden* on the provider's time and resources. This is too broad of an exemption. By its very nature, the collection of data is burdensome. To assure high quality veteran care and that VHA, as mandated, would coordinate with the VCCP, this kind of data collection cannot be exempted. By contrast, VHA is not exempt from data collection requirements, burdensome as they may be. Accountability and transparency should be mandatory for those who participate in VCCP and are paid to do so.

Not only does this provision provide too much latitude to providers, but it also fails to emphasize outcome data. The Institute of Medicine defines health care quality as "improvement of outcomes." Patients considering health care options benefit most from information about treatment effectiveness and symptom reduction.

This section also requires that a list of VCCP's "High-Performing Providers" (HPP) be published. This requirement could greatly benefit veterans if high performance was rigorously

and transparently defined. Yet, as has been previously identified, serious problems with the HPP designation must be addressed and remedied: (a) A public reporting is needed of which specific measures comprise the HPP algorithms, (b) Calculating the HPP designation needs to be primarily based on outcome measures, which thus far has not occurred, (c) Behavioral and mental health conditions, which are intentionally "not included in HPP monitoring," must be included.

If all these problems are addressed and clearer legislative language is incorporated, only then is the bill's accompanying Sec. 302 beneficial. That statute expands the data collected on VHA care quality. VHA already obtains and reports far more data than does VCCP about veterans' care. The gap must be closed, not widened.

Sec. 110 would publish the "high compliance" of community care network providers that take VHA trainings (yet to be determined) and meet records timeliness goals. Public accounting of VCCP providers could potentially improve the program. However, as written, trainings that would lead to the high compliance designation are voluntary not mandatory.

VHA providers are mandated to take specified trainings, e.g., suicide prevention, lethal means safety, complex toxic exposures, and military culture. VCCP providers have no requirements. This continues to encourage lower standards in the community program.

Rather than making critical training and timely submission of records mandatory, this provision provides financial incentives to providers. A vast literature on the failure of financial incentives to enhance quality (noted above) demonstrates that such incentives rarely work. They will also increase the cost of VCCP care for what may be minor improvements in quality at best and none at worst.

Sec. 111 prompts faster movement toward electronic interoperability between VHA and VCCP healthcare records. The utility of interoperability cannot be overstated. Care coordination for veterans receiving some of their care via VHA and some via VCCP is severely hampered by hard copy records.

Sec. 201 would help VHA recruit and retain Medical Support Assistants (MSAs), whom the bill rightly describes as "the linchpin" to ensuring that veterans are scheduled for care in VHA or in the community in a timely manner. We support these efforts if they particularly target MSAs who work in offices supporting the delivery of VHA inhouse care, (not the scheduling of private sector care), where the major retention difficulties lie.

Sec. 102 codifies into law the problematic Trump-era VCCP wait time and drive time access standards and makes it impossible for the VA Secretary to ever modify those standards. As Congress intended when it passed the MISSION Act, the VA Secretary is supposed to reassess whether the access standards to the VCCP need to be adjusted. One out of every three VHA patients now qualifies for VCCP based on drive time alone. Myriad evaluations of the VCCP have documented that it is a costly and flawed experiment that delivers care that is not only less timely but also dangerously fragmented and of lower quality than the VHA. It is essential that access standards be allowed to be continually reevaluated and revised in terms of the care the

private sector delivers and the overall impact on veterans who depend on VHA for their care. This provision of the bill should be strongly opposed.

Sec. 103 would allow VHA to designate telehealth appointments as meeting timely access standards, thus allegedly addressing the previous Administration's mistake that prohibited such designation.

But it then adds an extremely consequential – and system crushing -- qualification. Even when the VHA can provide telehealth within the 20/28-day wait time or 30/60-minute drive time access standard, a veteran would be allowed to indicate that his/her preference is to receive telehealth from the VCCP anyway.

As we note above, the VA MISSION Act was very clear that veterans would get the option to choose whether to receive care in the private sector or the VHA if and only if they already qualified under the six eligibility rules. This original carefully constructed language was the firewall that ensured the long-term viability of the VA healthcare system.

The Sec. 103 statute has perilous implications. Veterans are offered a VHA telehealth appointment when the access standard is met but are nonetheless given the option for telehealth in the VCCP. In short order, they will be given that same "preference" prerogative for in-person appointments. At that point, the firewall alluded to above will be completely broken.

A far better – and more fair -- legislative fix would ensure that VHA-delivered telehealth shall count as meeting access standards, but that no veteran would be required to accept a telehealth appointment, either in the VHA or VCCP, when they want to see their provider in-person.

Sec. 303 modifies the standards for veterans accessing residential mental health or substance use disorder care in the private sector. The intention is laudable -- to ensure quick placement when a veteran is in urgent need of treatment for substance use, PTSD, or other mental health issues. The VHA has, at times, been too slow initiating such care.

The statute ensures diligent tracking of the timeliness of screening and treatment placement. But the opposite is true for the quality of care. There is not a single requirement (or even mention) pertaining to the essential elements of care – high-quality, evidence-based, measurement of outcomes, or prompt exchange of medical records.

Unregulated quality of care in the private sector that prioritizes profits is no trivial matter. To cite just one example, a year ago, two unscrupulous operators of addiction treatment facilities in Florida were convicted of a $112 million fraud scheme that included medically unnecessary services. In 2017, The New York Times also did a series of impressive articles exposing the unscrupulous practices of private sector addiction treatment programs.

The Office of Inspector General recently voiced the same concern. At an April 2023 HVAC hearing, Dr. Julie Kroviak, Principal Deputy Assistant Inspector General stated, "Our office has published reports related to community care detailing delays in diagnosis and treatment, lack of

information sharing or miscommunication between providers, and significant quality of care concerns."

The statute must be amended to assure that quality standards are applied to VHA and non-VA providers. VHA should be mandated to do the following (which is supported by language in the MISSION Act and the Parker Gordon Fox Suicide Prevention Grant Program bills):

- create its own certification requirements for a facility participating in the Mental Health Residential Rehabilitation Treatment Program. The certification standard should include that there is:
    - scientific evidence for a program's treatment approach,
    - a standard ratio of licensed independent practitioners (LIPs) per resident,
    - semi-annual peer review quality assurance system,
    - treatment planning,
    - accreditation by the Commission on Accreditation of Rehabilitation Facilities (CARF) or equivalent organization, and
    - forwarding of treatment records to VHA within 30 days of a veteran leaving residential care,
- recertify programs every three years,
- mandate the mental/behavioral health measures that are required in the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program be administered to every VA-paid veteran participant at the point of entry, exit, and six months (if reachable) following discharge from the program. Additional measures could be added at the VHA's discretion, for example, the Brief Addiction Monitor (BAM) or PTSD Checklist (PCL).
- require that the scores of veterans be sent to the VHA for data analysis and evaluation of each program. VA will provide technical assistance for testing administration,
- publish the program outcome data on VA's Access to Care website https://www.accesstocare.va.gov/,
- require mental health and substance use disorder LIPs to take a minimum of four hours of VA's TRAIN courses corresponding to the patient population they serve, and four hours on military culture.

The statutes' new referral, review and placement standards will add significant administrative burden and strain on VHA's health care budget absent new, dedicated resources for those purposes. The demands on VHA to screen and find a placement for "priority" referrals within a 72-hour window are considerable, and too rushed, especially for patients who have not already been recently evaluated. Adding "self-referrals" to the mix is certain to balloon the number of veterans needing evaluation. Funding for additional staff is essential. Plus, there must be assurance that supplemental medical center funding would go to increased staffing so that VHA can meet this tight review deadline mandate.

CBO score is urgently needed for this section.

Sec. 104 removes VHA administrators' authority to override provider recommendations that a patient should be referred to private sector care because it is in the veteran's "best medical interest." As we explained in detail for Sec. 106 of the HEALTH Act, there are too many

instances when providers' only justification for the "best medical interest" recommendation is that a veteran "prefers" non-VA care. Regulations are very clear that "best medical interest' is not to be used solely based on convenience or preference of a veteran." When it is used as such, then VHA's administrative oversight is the appropriate response.

As we indicated in our remarks for the HEALTH Act, VHA must retain – not lose -- the authority to have final say on whether external referrals meet explicit referral standards. Further, VHA employees making referrals to the VCCP need far better education about what does and does not constitute "best medical interest."

S.928 - Not Just a Number Act

We recognize the many benefits to this bill, which we enthusiastically support.

The bill would expand a key VHA document, the National Veteran Suicide Prevention Annual Report, to examine how veteran suicides correlate with the utilization of VA health care and benefits, such as the GI Bill, job training programs, and disability compensation. It calls for a study of the feasibility and advisability of creating a suicide prevention office separate from the Office of Mental Health – a review that has much merit.

Most importantly, it mandates that the report's findings be shared with the public. As such, it recognizes that publicizing and utilizing data are pivotal to forming policy that affects veterans' suicides.

That said, as has been written elsewhere, the Not Just a Number Act needs a simple amendment. While the bill requires the VHA to disclose its important suicide data, it doesn't disclose data generated by recipients of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. The program includes 80 non-profit, private, and government groups ranging from veterans' associations to social service agencies to tribal nations who are aiding VHA in the fight against veteran suicide in local communities. They are generating a treasure trove of invaluable information that could help policymakers, veterans, social scientists, public health officials, and others drive down the still distressing number of veteran suicides.

Yet most of that information is rolled up into aggregate numbers for the whole program. There is no way to determine whether a particular organization's services are effective. An amendment to the Not Just a Number Act should require the VHA to crunch those pre-post figures, itemize them for each grantee and place them in the public domain. Results should include items such as whether and how much scores on the five measures improve for veterans who complete the grantee's services.

S. 853 - VA Zero Suicide Demonstration Project Act

This bill requires the VA to establish a Zero Suicide Initiative pilot program for the purpose of improving safety and suicide care for veterans.

VHA is continuously endeavoring to decrease veteran suicides. Its' public health approach to suicide prevention is the national gold standard, guided by both the White House Strategy for Reducing Military and Veteran Suicide and VA National Strategy for Preventing Veteran Suicide (2018-2028) including both clinical and community-based strategies.

Examples of VHA clinical strategies:

- Veterans Crisis Line with follow-up consultations to VHA suicide prevention coordinators
- Suicide Prevention (SP) NOW Initiative (includes some community-based strategies as well)
- VA/DoD Clinical Practice Guidelines for the Assessment and Management of Patients at Risk for Suicide
- Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment (REACH VET) predictive analytics program
- SP 2.0 Clinical Telehealth Program for Evidenced-Based Therapies
- VHA (internal) Suicide Prevention Demonstration Projects/Pilots
- Suicide Prevention in Emergency Departments (SPED)
- VHA Suicide Risk Management Consultation Program
- VHA Post-Traumatic Stress Disorder (PTSD) Consultation Program
- Required suicide prevention training that includes VA S.A.V.E. and VA Lethal Means Safety training

Examples of VA community-based suicide prevention strategies:

- VA Housing/Homeless Programs
- Suicide Prevention (SP) 2.0 Community-Based Interventions for Suicide Prevention
- Lethal Means Safety partnership with the American Foundation for Suicide Prevention and the National Shooting Sports Foundation
- Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program
- "Don't wait. Reach out" (donated media) and "Keep It Secure" (paid media) campaigns
- Governors' & Mayors' Challenges to prevent suicide among service members, veterans and their families
- Mission Daybreak Grand Challenge and related pilots (both clinical and community-based concepts)
- Distribution of cable gun locks and other outreach materials available across the country from both VHA suicide prevention coordinators and VHA community engagement and outreach coordinators

We are aware that the Zero Suicide Institute Curriculum has had promising results in the private sector, and we support further tests of its efficacy and cost effectiveness. In fact, the Manchester, NH VA already completed such a funded yearlong pilot. "There were no measurable improvements that could be directly attributed to the Zero Suicide processes (and some key performance indicators worsened)."The considerable costs for the Demonstration Project would likely divert resources from successful VHA suicide prevention efforts. We believe it is presently premature to implement it within the VHA without more specificity as to what aspects of the VHA's extensive safety and suicide prevention care for veterans that it aims to improve.

S.1545 - Veterans Health Care Freedom Act

The Veterans Health Care Freedom Act is an attempt to rapidly privatize the VHA. For three years, in a quarter of the country, all VHA-eligible veterans would be issued the option to obtain all hospital care, medical services and extended care services in the VCCP without VA authorization, referral or oversight. Once a veteran has a VCCP primary care provider, further specialty care would be referred to VCCP providers. There are no limits to utilization or over-utilization. VA's only role would be to pay the invoices.

The bill makes no attempt to hide its intention to completely replace the VHA integrated healthcare system from being a provider of healthcare into a payer for private sector care. Not only does the bill transform the VHA into just another insurer, but it does so at the expense of the stellar clinical care the VHA provides. The bill explicitly states that, "No additional funds are authorized to be appropriated to carry out this section and the amendments made by this section, and this section and the amendments made by this section shall be carried out using amounts otherwise made available to the Veterans Health Administration." This language assures that every dollar spent on private sector care is a dollar taken out of the VHA' inhouse, clinical care budget. The bill thus deprives veterans of high quality, patient-centered care delivered in a system that has amassed decades of expertise understanding, recognizing, and treating veterans' complex health conditions.

As we said above, our organizations are happy to support legislation that encourages the appropriate use of the private sector to judiciously "support, not supplant" VHA healthcare. We also back legislation that ensures VHA has robust resources needed to care for current and future cohorts of veterans. This bill does the exact opposite.

S.1954 - Improving Whole Health for Veterans with Chronic Conditions Act

We wholeheartedly support this much needed legislation to provide dental care to veterans who have diabetes and heart disease. The bill would set up a four-year pilot program to study the efficacy and cost of providing such care. The pilot would also offer loan reimbursement to dental professionals for participating in all four years of the program.

It is hard to overstate the need for such a program. According to VHA figures, over three million veterans suffer from diabetes and heart disease, yet only approximately 1.4 million of the total nine million enrolled veterans qualify for comprehensive dental care from the VHA. This gap has serious consequences for veterans as well as to efforts to contain VHA healthcare costs. Studies confirm the close links between diabetes and gum disease and the vicious spiral that can occur if patients with diabetes do not get proper dental care. Diabetes, for example, puts patients at great risk for gum disease, and gum disease makes it far harder to control diabetes. Gum disease also escalates the risk of strokes and heart attacks, cardiovascular disease, respiratory diseases such as pneumonia, progression of Alzheimer's disease and cancers such as kidney cancer and blood cancers. These are just a few of the devastating health problems that can occur from lack of dental care.

VHA dental care is also critical because, in many regions of the United States, the VHA may be the only provider of dental care for veterans. According to analyses done by the Rural Health Information Hub, the majority of counties in the nation have shortages – sometimes severe – of dental professionals. This is particularly true in rural and highly rural areas. By providing loan reimbursement to dental professionals, the VHA would deliver needed care to veterans and help attract more people into the profession, helping to ease the shortage of dental professionals in the nation.

Failing to provide appropriate dental care to veterans with diabetes and heart disease also has severe financial consequences. According to AIDPH and Care Quest estimates, providing dental care to only half of the enrolled veterans with diabetes or heart disease would save $3.4 billion a year in medical costs – almost 1.5 times the annual VHA budget for dental care. This legislation saves suffering, lives, and money.

Additionally, ensuring that VHA is the central provider of dental care would save tens of billions of dollars yearly, given the costs associated with VA-paid dental care in the community care program. VA needs a plan to quickly hire more dentists and dental staff, create larger dental clinics and fully support VA dentistry caring for these veterans before flooding the community system that has insufficient capacity to absorb them.

We enthusiastically support this legislation and urge Congress to quickly pass it as a benefit for veterans.

S.449 - Veterans Patient Advocacy Act

The importance of patient advocacy cannot be understated. Many of the issues being discussed today hinge on the quality of care that veterans receive within VHA as well as the clarity of information provided about those services. This bill would require the Office of Patient Advocacy within the VHA to ensure there are patient advocates (one patient advocate per 13,500 enrolled veterans) to listen to the veterans' concerns and offer advice on next steps.

It also provides those in highly rural areas access to a patient advocate, which is critically important as veterans in these areas often encounter difficulties and gaps in care. A patient advocate will be able to provide timely information, answers health care questions and coordinate next steps in that care.

We endorse VHA continuing to hire more support staff and patient advocates to provide veterans with a warm hand-off, so they receive the appropriate guidance that best fits their individual needs regarding the care and services within VHA.

We support what this bill affords veterans and look forward to reading the GAO report on implementation of this policy.

We thank you for the opportunity to provide our perspective on these essential matters.

Respectfully,

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July 12th, 2023

Dear Chairman Tester, Ranking Member Moran, and distinguished members of the Senate Committee on Veterans' Affairs. The National Coalition for Homeless Veterans (NCHV) offers a statement for the record on two of the many worthy pieces of legislation before the committee.

In the United States, there is broad bipartisan agreement that no man or woman who has sacrificed for and served our country should struggle to meet their basic needs. Despite this, over 33,000 veterans experience homelessness on any given night. The Department of Veterans Affairs (VA) continuing ability to assist these vulnerable veterans expired on May 11th with the end of the COVID-19 Public Health Emergency (PHE).

NCHV urgently asks you to pass into law the *Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023* (S.1436) to codify positive moves toward ending veteran homelessness once and for all.

Since 2009, the United States has cut the number of veterans experiencing homelessness by over half. We know what works and what more is needed to cross the finish line. S.1436 includes extremely useful tools in the fight to end veteran homelessness, as evidenced by the general support for its provisions. Congress in its wisdom passed these provisions into law to enable VA to better serve veterans, albeit during a time of national emergency. The initial data from this response shows certain measures provided more capability enhancements than others.

The *Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023* would preserve and enhance VA's proven effective PHE program improvements for Supportive Services for Veteran Families (SSVF) from the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020* (P.L. 116-315) and would strengthen programs that emphasize permanent solutions to housing instability and homelessness experienced by veterans across the country. Section 4201 of P.L. 116-315 also known as Isakson/Roe, is a best practice that must be maintained since, as VA officials have recently testified, "we will not eliminate veteran homelessness without these additional authorities."

Veterans are better able to get to appointments, access supportive services, have access to necessities as well as be contacted facilitating access to telehealth services in remote locations.

Using section 4201 authority under Isakson/Roe, VA medical centers (VAMCs) provided additional services ranging from items like tents and food, to communications, and transportation in the form of bikes and ride shares for tens of thousands of veterans during the public health emergency. These provisions were also referred with bipartisan support by voice vote in the House Veterans Affairs Committee's Subcommittee on Economic Opportunity.

We also highlight that S. 1436 would adjust the maximum reimbursement rate for VA grantees for shelter, clinical services, and essential sustenance for veterans, as the daily amount available for reimbursement dropped to $64.52 a day. The increased financial burden of prioritizing safety measures paired with ongoing operating and maintenance costs makes these programs unsustainable at this level and may leave grantees with no option but to discontinue providing these essential services altogether. Every veteran deserves access to safe shelter and housing, whether they are currently experiencing homelessness or are facing housing-associated costs that put them at risk of homelessness.

Supports - S.1436 – *Critical Health Access Resource and Grant Extensions* (CHARGE) *Act of 2023.*

This legislation would extend successful, essential veterans' programs and authorities from the last few years that expired on May 11, 2023. Veterans, providers, and VA have felt the immediate impact of the loss of these common sense authorities. The bill includes extensions of critical provisions related not only to homelessness but health care access, caregivers, and State Veterans Homes as well:

- Increases the maximum reimbursement amount for grantees receiving funds from VA to provide temporary housing for homeless veterans. Without this provision, most of these programs, especially in rural and isolated areas with minimal financial support alternatives, will be forced to reduce services, beds, and even cease their programs due to the limitation on reimbursement amounts.
- Allows VA to continue providing gap services and support to homeless veterans in circumstances where other support is not available, including providing necessary personal and hygiene items, transportation services, food, landlord incentives for housing homeless veterans, and more.
- Extends authority to allow veterans and caregivers to elect for virtual home visits or until VA finalizes its new regulations for the Caregivers program.
- Extends the State Veterans Homes' occupancy rate requirement waiver so that state homes are not financially penalized for staffing shortages.
- Makes permanent an authority that allows VA to share PPE, vaccines, medical supplies, and other resources with State Veterans Homes.

Supports – (Draft) - *Making Community Care Work for Veterans Act*

This legislation provides an array of community care improvements, addresses needs of VA health care employees and provides incentives for retention and updates VA's Mental Health Residential Rehabilitation Treatment Program (RRTP) as well as provides:

- A requirement that appointments for care of services under community care program of Department of Veterans Affairs are timely scheduled.

- Modifications to access standards for care furnished through the community care program of Department of Veterans Affairs.
- For consideration of telehealth in determining whether an appointment can be scheduled within the access standards of the Department of Veterans Affairs.
- The finality of the decision by the veteran and the veteran's referring clinician.
- Benefits for persons disabled by treatment under community care program of the Department of Veterans Affairs.
- Program access on self-referral of veterans for certain services under Veterans Community Care Program.
- For adoption of national interoperability standards between Department of Veterans Affairs and community care providers.
- A pilot program on consolidating the community care dental treatment plan approval process of Department of Veterans Affairs.
- The establishment of Start and Stay at VA Program and Expansion of period of payment under Employee Incentive Scholarship Program.
- Modification of scheduling thresholds and modifies standards for VA Quality of Care
- For electronic document submission option for the CHAMPVA program.

These legislative initiatives are testaments to the dedication and challenging work of communities nationwide, and the responsiveness and bipartisanship of the House and Senate Committees on Veterans' Affairs, its Members, and their dedicated staff. We are committed to working with Congress and our partners across the country to end homelessness among veterans, and passage of S.1436 will be crucial in this endeavor. Thank you in advance for your continued consideration and support.

Very respectfully,

The National Coalition for Homeless Veterans

NEW ENGLAND CENTER
AND HOME FOR VETERANS
EDUCATION | SUPPORT | EMPLOYMENT | HOUSING

11 July 2023

Statement for the Record from The New England Center and Home for Veterans on the United States Department of Veterans Affairs Grant and Per Diem Program

From: The New England Center and Home for Veterans, 17 Court Street Boston, MA
To: United States Senate Committee on Veterans Affairs
Via: The Honorable Elizabeth, United States Senator Massachusetts
The Honorable Edward J. Markey, United States Senator Massachusetts
Subj: Statement for the Record on VA Grant and Per Diem Rates

Chairman Tester, Ranking Member Moran, and distinguished members of the Senate Committee on Veterans Affairs, the NECHV is honored to submit this statement for the record.

About The Center

The New England Center and Home for Veterans (NECHV) is one of the leading community-based service providers to Veterans who are experiencing, or at risk of, homelessness in the Nation. Located in Downtown Boston Massachusetts, the Center has provided services to Veterans from across the country for over two decades through a range of Federal, State and locally funded grants and programs. One of those programs is the Department of Veterans Affairs (VA) Grant and Per Diem (GPD) Program. The Center is a long-time VA GPD Provider, and is currently contracted to provide 60 GPD beds to Veterans. These include 40 beds under the Clinical Treatment service model and an additional 20 beds under the Low Demand service model. In fiscal year 2024 the Center will add an additional five Clinical Treatment beds, which will result in a total of 65 beds to better meet the demand in the Center's Veteran service catchment area. These beds have consistently remained in high demand. The NECHV's occupancy rate for the existing GPD Program beds throughout Fiscal Years 2021 and 2022 has been 81%, with Clinical Treatment Bed occupancy averaging 80%.

Background

With the expiration of the Federal COVID-19 Public Health Emergency (PHE) on 12 May 2023, the reimbursement rate that the VA had been able to provide to GPD Program participants was reduced from a daily maximum of $300% of State Veteran Homes' Domiciliary Rate to 115%. These rates, which have always been tied to the State Domiciliary Rate, have never been sufficient to cover the full costs that Program providers actually incur to offer services to Veterans in-need. Prior to the PHE, community-based, non-profit GPD providers, like the NECHV, found it necessary to seek additional funding sources, both public and private, to cover actual Program and service costs. As a result, many provided GPD service to Veterans at a loss. The authority to increase payments to up to 300% of State Domiciliary Rates during the COVID-19 Pandemic allowed the VA to pay providers up $156.59 per day. This helped to ensure the health and safety of vulnerable Veterans in congregate transitional living situations by defraying additional expenses associated with the precautions mandated during the Pandemic. Unfortunately, many of those increased expenses remain, which makes the recent cut back in Per Diem rates even more problematic.

Discussion

The current Per Diem rate, now set at 115% of the State Domiciliary Rate, or $64.52 per day, represents a very slim increase over the pre-COVID rates. However, as operating costs for service providers have

risen across the board through the COVID-19 Public Health Emergency, the gap between costs and reimbursements has, if anything, only grown wider. While this is due to a number of factors, a major driver of increasing costs in transitional housing, and all Veteran human services, has been escalating staffing expenses. The Pandemic increased the need and demand for all human services, and specifically, the demand for qualified mental health professionals in organizations that support higher risk populations such as vulnerable and at-risk Veterans experiencing homelessness. These societal and market trends have caused significant and permanent increases in labor and staffing costs at the NECHV over pre-pandemic levels. According to the Bureau of Labor Statistics, the average weekly wage for Social Assistance Workers (NAICS Code 624) in the State of Massachusetts increased by 18% between October 2020 and September 2022 (U.S. Bureau of Labor Statistics, 2023). These wage gains are a permanent increase in expenses, making the reduction in per diem rates even more acute for providers.

An additional source of increased costs for many agencies, including the NECHV, is the move to provide more private living accommodations as an alternative to open dormitory facilities for Veterans with increased health risks. In 2021 and 2022, the VA offered Capital Funding grants to providers, encouraging them to reconfigure existing congregate living spaces into private bedroom and bathroom sets, in order to provide the ability to isolate Veterans at greater risk from infection and other hazards. Like many other organizations, the NECHV is currently in the midst of converting a portion of congregate transitional housing space into ten individual bedroom and bathroom combinations, funded in part through a VA Capital Grant award. While these new rooms will be able to provide more appropriate living spaces to an aging Veteran population, operation and support of these rooms will be more expensive, due to increased costs for cleaning. However, they will still be funded at the same rate as open-bay, dormitory beds. This means that provider and service organizations that make the investment to create these accommodations will have to bear the higher costs of operating them.

The return to significantly lower and inadequate VA GPD reimbursement rates, as requirements and costs continue to increase, makes all transitional housing and overall Veteran service provision more challenging. NECHV's 17 Court St. facility possesses the physical capacity of 200 Transitional Veteran Beds, in an array of configurations and service program designs, to ensure the ability to provide the optimal support to every Veteran it serves. Additionally, the facility includes 97 units of Permanent Supportive Veteran Housing, under various complementary programs, including HUD VASH, HUD Mod-Rehab, and Mobile Section 8 Vouchers. subsidies. Permanent Veteran residents have the benefit of both VA case management services (HUD VASH) and access to the full array of human service and support programs offered by the Center. In the most recent 12-month period, the NECHV served 898 unique Veterans consumers across 22 programs, with an increasing number of those Veterans reflecting an aging and first-time homeless population. Sixty percent of all recent Veterans consumers were age 55 or older and almost forty percent were age 62 or older. During those same months, the Center's transitional housing programs provided Transitional/Low Threshold housing to 403 unique Veterans (of whom 89 percent reported a disabling condition), with a median nightly census of 138. The ability to continue providing all these services at the same breadth and scope will be placed at increased risk as funding shortfalls in the GPD program cascade across other components.

While the return to the statutory rate of $64.52 per day may be sustainable for providers with strong alternate funding augments or those located in relatively low-cost areas of the country, it creates a daunting challenge and potential significant barrier for others to continue as GPD providers, especially those in higher cost urban areas. The Center has already heard anecdotally of other area providers either dropping current programs, or planning not to renew them at the start of the next Fiscal Year. This loss in services

will likely result in remaining providers having to pick up some of the lost capacity, which will place them under even greater financial strain.

In addition to VA and other federal, state and municipal funding, the NECHV does have the benefit of a well-established and respected private fundraising component, that helps generate more than 20 percent of the Center's total annual revenue, (more than $3M in philanthropic support each year). Without this augment to public funding, providing VA GPD services to Veterans at the current rate of reimbursement would likely not be feasible.

Impact

NECHV reviewed the daily costs of operating its Clinical Treatment and Low Demand transitional housing programs and compared them to the statutory rate of $64.52. At the current rates, NECHV can only operate its 20-bed Low Demand and 40-bed Clinical Treatment Programs at full capacity by incurring an annual operating loss of up to $1.3 Million.

The tables below show the disparity between allowable rates and actual costs for NECHV. Note that the daily operating cost of the Clinical Treatment Beds, while greater than the allowable rate, is still well below the maximum rate permitted during the Public Health Emergency.

The difference in operating costs between the Clinical Treatment and Low Demand programs is clear when compared side by side. Yet, as noted, both have the same daily rate. As a result, the Low Demand Program, despite being smaller, has a slightly larger funding shortfall.

Actual NECHV Costs versus Per Diem Rate for Low Demand and Clinical Treatment Programs

	20 Bed Low Demand Program	**40 Bed Clinical Treatment Program**
Staffing Costs	$747,277	$714,260
Food Services / Meals	$88,421	$172,189
Facilities & Utilities	$155,000	$415,000
Supplies & Other	$5,000	$14,000
Total Direct Costs	$1,002,698	$1,315,448
Admin	$200,540	$263,090
Total Costs	**$1,203,238**	**$1,578,538**
Daily Cost per Bed	$164.83	$108.12
Allowable Per Diem Rate	$64.52	$64.52
Daily Shortfall (Per bed)	**$100.31**	**$43.60**

Current Financial Impact and Shortfall for the NECHV at Existing Per Diem Rates

	20 Bed Low Demand Program	40 Bed Clinical Treatment Program
Daily Funding Shortfall	$2,006	$1,744
Annual Shortfall	**$732,242**	**$636,546**

While the Center enjoys strong (but always uncertain) charitable community support that has helped offset some of the public funding shortfalls, such support is not guaranteed in the future, and is being allocated to the overall increasing costs of operations and service. The recent decrement in VA GPD reimbursement rates puts at risk the NECHV's ability to continue providing the same depth and scope of services to Veterans in need. Other organizations that do not have the ability to make up for the funding shortfall may find themselves unable to continue as a GPD service provider.

Recommendation

An effective and realistic funding model, which takes into account the differences in costs between GPD bed programs, and adequately covers the costs to operate them, is clearly needed. We respectfully urge that these measures be considered and adopted at the earliest possible date to ensure there is no loss of vital service to Veterans.

Paralyzed Veterans of America

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STATEMENT FOR THE RECORD

PARALYZED VETERANS OF AMERICA

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

ON PENDING LEGISLATION

JULY 12, 2023

Chairman Tester, Ranking Member Moran, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. No group of veterans understand the full scope of benefits and care provided by VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). PVA provides comment on the following bills included in today's hearing.

S. 449, the Veterans Patient Advocacy Act

The Veterans Patient Advocacy Act seeks to ensure there are an adequate number of patient advocates at VA medical facilities. Patient advocates are highly trained professionals who can help resolve veterans' concerns about any aspect of their health care experience, particularly those concerns that cannot be resolved at the point of care. These advocates listen to any questions, problems, or special needs that a veteran has and works to resolve them. PVA supports S. 449, which directs VA medical center directors to ensure there is no fewer than one patient advocate for every 13,500 veterans enrolled annually in the system. Another provision ensures patient advocates are assigned to rural community-based outpatient clinics to ensure timely access to health care, and assistance with requests for information, compliments, complaints, reimbursements, and clinical appeals. Although we support this legislation, we are concerned that the ratio of one advocate per 13,500 veterans seems rather high and believe it should be examined further to ensure that this number of advocates is adequate.

S. 495, the Expanding Veterans' Options for Long Term Care Act

The VA can refer veterans to assisted living facilities, but it cannot directly pay for that care. PVA strongly supports the Expanding Veterans' Options for Long Term Care Act, which would create a three-year pilot program at six Veterans Integrated Service Networks (VISN), including at least two program sites in rural areas and two in State Veterans Homes to test the benefit of having VA pay for this care. Veterans eligible for the pilot would include those already receiving nursing home-level care paid for by the VA and those who are eligible to receive assisted living services or nursing home care. At the conclusion of the pilot program, participating veterans will be given the option to continue receiving assisted living services at their assigned site, paid for by the VA. We believe this would help veterans and the VA alike by giving greater access to assisted living and reducing costs for long-term care, allowing more veterans to receive needed assistance.

S. 853, the VA Zero Suicide Demonstration Project Act of 2023
PVA supports this measure, which directs the VA to establish the Zero Suicide Initiative pilot program at five VA medical centers across the country. This proposed pilot program would help the VA identify gaps in care and create a multi-layered approach with evidence-based interventions to ensure veterans at risk of suicide do not slip through the cracks and transform the culture around suicide prevention. The pilot program would require the VA to consult with several outside stakeholders and agencies such as the National Institutes of Health, the Department of Health and Human Services, and different offices within the VA.

According to a recent VA Office of Inspector General report, approximately 163,000 veterans were referred to a Suicide Prevention Coordinator between March 2019 and June 2020.[1] This statistic paints a stark picture for veterans. The current system needs strengthening. The Zero Suicide Institute has seen impressive results from its quality improvement model, transforming system-wide suicide prevention and care to save lives. They report a reduction in suicide deaths and hospitalizations, an increase in quality and continuity of care, improvements in post-discharge follow-up visits, and improvements in screening rates.[2] Implementing a similar project through the VA could reduce veteran suicides and should be pursued.

S. 928, the Not Just a Number Act
VA has implemented many programs in recent years to help combat veteran suicide and it is time to evaluate the efficacy of those efforts. PVA supports the Not Just a Number Act, which directs VA to take a comprehensive look at the factors that best prevent veteran suicide. It requires VA to examine veterans' benefits usage in their annual suicide prevention report, in order to evaluate the relationship between VA benefits and suicide outcomes. It also directs the Department to determine which VA benefits have the greatest impact on preventing suicide, and requires them to issue recommendations for expansion of those benefits.

S. 1037, the Department of Veterans Affairs EHRM Standardization and Accountability Act
PVA supports this bill, which would increase oversight and accountability of VA's Electronic Health Record Modernization (EHRM) and its deployment across the VA health care system. VA has implemented its new electronic health record (EHR) at five of its medical centers, but the system has been plagued with many problems. Passage of this bill would prevent the VA from deploying its new EHR system to additional sites until the Department can demonstrate that significant improvements have been made. Necessary improvements would include the achievement of a minimum up-time and system-wide stability for the EHR system and a report detailing the completion status of the corrections to the customization and configuration of workflow designs. We strongly believe it would be irresponsible to ignore the many challenges and patient safety concerns that have already been triggered by the new system without ensuring they are completely resolved in a timely manner.

[1] VAOIG Report 20-02186-78, Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight
[2] Zero Suicide Results; the Zero Suicide Institute

S. 1125, the EHR Program RESET Act of 2023
The EHR Program RESET Act would implement much-needed changes to improve the management and monitoring of the EHRM program to ensure health care providers can deliver the highest quality of care to veterans across the country. It would prohibit the VA Secretary from rolling out the new EHR system to additional sites without submitting written certification to the House and Senate Committees on Veterans' Affairs that the EHR system has met the improvement objectives outlined in the bill and the facility's staff and infrastructure are adequately prepared to receive it. Also, it mandates specific reporting requirements to better inform Congress on how the VA and Oracle Cerner are working to address known problems like those listed in the Government Accountability Office's March 15, 2023, report on the EHRM project.[3] Like many in Congress, PVA believes there has been a lack of accountability and this bill will help ensure the appropriate individuals and entities bear greater responsibility for the success or failure of future implementations of the EHR system.

S. 1172, the Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act
In August 2019, the VA Office of Inspector General reported that a significant number of emergency care claims were inappropriately denied.[4] As a result, many veterans faced an undue financial hardship. Failing to cover a veteran's emergency care during a period without coverage can result in a crippling amount of debt that could take a lifetime to pay off. PVA supports the RELIEVE Act, which proposes to close a current gap in coverage of emergency care by treating enrollment in the VA health care system the same as receiving health services at the VA. Upon entering the VA health care system, veterans would have 60 days to complete their first doctor's appointment. Emergency care at non-VA facilities will be insured during that time, and once a veteran completes their first appointment, they will qualify for regular coverage under the VA's 24-month rule, eliminating the gap.

S. 1315, the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023
PVA appreciates and supports provisions in this bill that require the VA to publicize wait times at its medical facilities and document veterans' preferences for scheduling of appointments for health care and related services. Together with the online education portal established by Section 207, these provisions will help veterans make more educated decisions about the health care they receive. However, we have strong concerns with how two provisions in this bill would affect care for disabled veterans with the greatest support needs. First, care in the community should only be offered when it is unavailable at VA facilities, or when it is based on sound medical judgement in the best interest of the veteran. Section 101 expands the criteria the VA must consider when authorizing community care, and the additional variables could result in expanding the community care program beyond these tenets, which would harm VA's ability to provide the care. Second, Section 109 allows VA to negotiate with third party administrators to establish the use of value-based reimbursement models under the Veterans Community Care Program (VCCP). Value-based models were designed for the "for profit" health care sector and are often not suitable for the management of complex medical conditions.

[3] GAO-23-106685, ELECTRONIC HEALTH RECORD MODERNIZATION: VA Needs to Address Change Management Challenges, User Satisfaction, and System Issues
[4] VA OIG Report #18-00469-150, Non VA Emergency Care Claims Inappropriately Denied and Rejected

We have concerns about how VA might implement such a model. Codifying access standards or implementing financial incentives would not measurably improve catastrophically disabled veterans' access to care, but investing in VA's health care infrastructure and improving staffing would expand services. This is particularly true in more rural areas where VA and the private sector's medical footprint is extremely limited. As always, we appreciate the Committee's interest in this area and look forward to working with you on improving access to VA-provided quality specialty care.

S. 1436, the Critical Health Access Resource and Grant Extensions (CHARGE) Act of 2023

PVA supports the CHARGE Act, which reauthorizes several essential programs and authorities for homeless veterans, caregivers, and State Veterans Homes that expired with the end of the national emergency on May 11, 2023. The bill would increase the maximum reimbursement amount for VA grant recipient organizations providing temporary and transitional housing for homeless veterans. This is especially essential for organizations in rural areas with limited access to alternative funding sources. Further, it allows the VA to provide gap services and support to homeless veterans when other supportive programs are not available—including shelter, transportation, landlord incentives for permanent housing, and more. It also extends authority to allow veterans and caregivers in the VA's Program of Comprehensive Assistance for Family Caregivers to elect for virtual home visits through September 30, 2023, or until VA finalizes their new regulations for the program.

S. 1545, the Veterans Health Care Freedom Act

This bill would require VA's Center for Innovation for Care and Payment to implement a three-year pilot program in four VISNs and would allow veterans participating in the test to receive care thru any VA facility or VCCP provider with virtually no restrictions. Four years after enactment, the pilot would automatically be rolled out to the entire country, all VA access standards would be eliminated, and all enrolled veterans could choose any primary, specialty, or mental health care provider in VA or in the Community Care Network (CCN). PVA supported the VA MISSION Act (P.L. 115-182) as a means to supplement VA care not supplant it. Preserving and strengthening VA's specialized systems of care—such as SCI/D care, blinded rehabilitation, amputee care, and polytrauma care—remains the highest priority for PVA and it should be for Congress, too. We urge the Committee to reject efforts like this which would undermine the VA health care system and in particular, it's capacity to provide the specialized services that veterans with catastrophic disabilities need.

S. 1612, the Reimburse Veterans for Domiciliary Act

The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116–315) authorized the VA to cover the costs of in-home care for veterans provided by State Veterans Homes, but the VA has still not begun processing the reimbursements. This delay puts an unnecessary financial burden on State Veterans Homes, veterans, and their families. PVA supports this bill, which directs the VA to publish a proposed rule to implement reimbursements as required by Section 3007(a) of P.L. 116-315, and ensure payments that were made by State Veterans Homes are reimbursed retroactively to January 5, 2021.

S. 1828, the Veterans Homecare Choice Act

The VA currently excludes nurse registries in the CCN, which prevents them from qualifying for reimbursement. Meanwhile, veterans want to live independently in their own homes but sometimes they need extra assistance to do so. For many of our members, this is not an option.

Across the country, there is an increasing shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. Until then, we should leverage as much of the existing workforce as possible to help ensure veterans' needs are being met. Previously, the VA would reimburse veterans who employed a home care professional via a nurse registry, making it a great option for many veterans. The practice ended with the June 2018 passage of the VA MISSION Act. Since that time, only services provided by a home care agency have been covered. PVA supports this bill, which seeks to correct an obvious error, giving veterans more options for their home care needs.

S. 1954, the Improving Whole Health for Veterans with Chronic Conditions Act
Even though dental benefits are the bridge to health and wellness, the VA closely rations these services citing the severe underfunding of its dental departments. Currently, VA dental care is limited to a small number of veterans, such as those who are 100 percent disabled or have a service-connected dental condition, former prisoners of war, and homeless veterans. Dental care may also be available if a dental condition is aggravating a service-connected condition or complicates treatment of that condition. Numerous studies show that poor dental hygiene is directly linked to chronic health care conditions such as diabetes and heart disease. PVA supports this legislation, which establishes a four-year pilot program to provide dental care to veterans diagnosed with these conditions. It also directs VA to study the health outcomes and cost effectiveness of providing such care, and offers loan reimbursement opportunities for qualified dental care professionals who agree to serve for the duration of the pilot at VA dental clinics with high needs.

S. 2067, the Service Dogs Assisting Veterans (SAVES) Act
Service dogs provide invaluable assistance to disabled veterans with the greatest support needs, allowing them to live more independent lives in their communities. PVA supports the SAVES Act which requires the VA to establish a competitive grant program to fund nonprofit organizations that provide service dogs to veterans with a variety of disabilities, such as mobility or vision impairments or post-traumatic stress disorder. Nonprofit organizations would be required to submit an application to the Secretary that includes a description of the training that will be provided by the organization to eligible veterans; the training of dogs that will serve as service dogs; the aftercare services that the organization will provide for the service dog and eligible veteran; the plan for publicizing the availability of service dogs through a marketing campaign; and the commitment of the organization to have humane standards for animals. Nonprofit organizations would also need to certify that they are accredited by Assistance Dogs International or another widely recognized accreditation organization.

Senate Discussion Draft, the Making Community Care Work for Veterans Act of 2023
PVA believes that investing in VA's health care infrastructure and improving staffing is the quickest and most effective way to improve health care access for veterans. Therefore, we strongly support provisions in this draft bill to expand VA's capacity to provide care by expanding recruitment and retention programs for critical health care positions. We also support provisions in the draft bill that seek to increase training and compliance by community care providers, expand reporting of quality metrics by community care providers, and ensure that community care appointments are scheduled in a timelier manner. However, we believe care in the community should only be offered when it is unavailable at VA facilities, or when it is based on sound medical judgement in the best interest of the veteran.

We do not believe codifying access standards would improve catastrophically disabled veterans' access to care. Instead, it could actually harm the ability of VA to continue providing critically needed specialty health care services.

Senate Discussion Draft, the Department of Veterans Affairs Income Eligibility Standardization Act
This draft legislation would expand entitlement to VA health care for certain veterans by directing VA to eliminate all subcategories of priority for enrollment in Priority Group 8. Veterans in that group do not have compensable service-connected disabilities, their gross household income exceeds the VA national income threshold and the geographically adjusted income threshold for their resident location, and they agree to pay copays. PVA would be generally supportive of this draft bill as long as eliminating the subcategories does not adversely impact service-connected veterans' priority access to care, as well as that of catastrophically disabled veterans.

Senate Discussion Draft, the Leveraging Integrated Networks in Communities for Veterans Act
This draft legislation requires VA to carry out a pilot program to establish community integration network infrastructure for services for veterans and collect information from veterans about social determinants that may be impacting their health. Using a new or existing network, the program would test the coordination of public and private providers and payors of services for veterans for things such as nutritional assistance, transportation, job training, caregiving or respite care, and disability assistance. PVA supports the draft bill and is confident the results of the pilot will enable VA and Congress to better understand the needs of veterans in certain subpopulations, such as those with catastrophic disabilities; racial or ethnic minorities; LBGTQ+ groups; women veterans; and those residing in rural or underserved parts of the country.

Senate Discussion Draft, the Rural Vital Emergency Transportation Services (VETS) Act
This draft legislation directs the VA to reimburse highly rural veterans for the cost of ambulance service, to include air ambulance service, to either VA or non-VA facilities for care, regardless of whether the veteran qualifies for payment or allowances for beneficiary travel. Concerns about transportation costs may deter veterans from getting the care they need. PVA supports this bill, which seeks to eliminate that concern for veterans residing in highly rural areas.

PVA would once again like to thank the Committee for the opportunity to submit our views on some of the bills being considered today. We look forward to working with you on this legislation and would be happy to take any questions for the record.

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