STATEMENT OF
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BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

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Chairman Tester, Ranking Member Moran and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today are Dr. Gerard Cox, Assistant Under Secretary for Health for Quality & Patient Safety, VHA; Dr. Clifford Smith, Deputy Director, Office of Mental Health Operations, VHA; and Dr. Theresa Gleason, Director, Clinical Science Research & Development Service, VHA.

We are unable to provide testimony on the Unnumbered Senate Bill Building Solutions for Veterans Experiencing Homelessness Act of 2021 or the Unnumbered Senate Bill regarding mammography screening for Veterans who served in locations associated with toxic exposure (now S.2102, the Supporting Expanded Review for Veterans in Combat Environments (SERVICE) Act. We will provide views on these bills as soon as they are available.

S.372 Ensuring Quality Care for Our Veterans Act

S.372 would require VA to enter into a contract or other agreement with a non-Federal organization to conduct retrospective clinical reviews. The clinical reviews would be for licensed providers who were hired by VA while not meeting the licensure requirements outlined in 38 United States Code (U.S.C.) 7402 and VA Handbook 5005, specifically those who have had their license terminated (revoked) and not fully reinstated prior to their VA appointment. The requirement would apply to those license revocations that were "for cause" which would be defined as resulting from substandard care provided at a non-VA facility prior to coming to VA. Additionally, the proposed legislation would require the Secretary to notify patients if substandard care is identified through the retrospective clinical review.

VA does not support this bill because procedures and resources are already in place to accomplish outlined goals. VA understands, from previous communication with the Committee, that the proposed review would only apply to those hired in violation of existing licensure qualification requirements. A contract for this purpose is unnecessary because VHA has heightened processes to ensure that providers are not hired if they do not meet licensure requirements outlined in 38 U.S.C. 7402 and VA Handbook 5005. If an unexpected oversight is made, it is unnecessary to require a contract to perform a retrospective review because VHA has internal resources and mechanisms available for objective and thorough reviews to be conducted. VHA has over 70,000 licensed

independent practitioners working throughout the Agency who represent every specialty. A vast majority of these providers have academic appointments, are board certified, are active researchers, and experts in their field. Additionally, VHA currently has a contract in place which may be utilized for retrospective file reviews if VHA is unable to complete a review timely or if there is a perceived conflict of interest.

VHA has enhanced procedures to proactively identify and review providers who have had actions by a State licensing board prior to VHA appointment as well as during their VHA appointment:

(1) In January 2018, VHA implemented a robust review process of licensed health care providers who are being considered for final selection to determine if they have had a licensure action taken by a state licensing board. The licensure actions are identified through a query of the National Practitioners Data Bank (NPDB) during the credentialing process which reveals all actions reported by state licensing boards to the NPDB. If a reported licensure action is identified, a mandatory review process is in place requiring a written review by Human Resources leadership, with consultation with the Office of General Counsel, as necessary, to determine if the individual meets the appointment requirements outlined in 38 U.S.C. 7402 and VA Handbook 5005. The review of the licensure action is also entered into a database managed by Workforce, Management and Consulting for awareness and communication with the respective Veterans Integrated Service Network (VISN) Chief Human Resource Officer for additional review. This robust review process is in place to prevent the selection of licensed health care providers who are ineligible for appointment pursuant to 38 U.S.C. 7402(f).

(2) In December 2019, VHA proactively expanded the requirement of enrolling all licensed providers (versus only Licensed Independent Practitioners as previously required) in the NPDB Continuous Query program. VHA is unique in that its electronic credentialing system, VetPro, has an interface with the NPDB system. Through this interface, the systems are linked and monitor reports submitted to NPDB related to the enrolled providers 24 hours per day, 365 days per year. If a report is submitted to the NPDB related to enrolled providers, the full report is automatically populated into the provider's electronic credentialing file, the facility receives an automatically generated email alerting it of the report, and the Medical Staff Affairs VA Central Office (VACO) Program Office also receives an alert. If a state licensing board has taken a licensure action and reported the action to the NPDB, VHA will receive immediate notification through the NPDB Continuous Query process for immediate review and action as appropriate, including removal if a provider has a licensed revoked.

It should be noted that the text of S.372 is contradictory to VA's understanding of the intent of this bill. Under the definition of a "covered provider," it would include not

just a health care provider who was erroneously appointed in violation of 38 U.S.C. 7402(f), but also a health care provider who, subsequent to his/her appointment, had a license terminated for cause by a State licensing board (i.e., a part-time health care provider had an adverse State licensing board action taken against them outside of their VA duties). Thus, if the intention is for S. 372 to apply only to providers who were improperly appointed by VA, VA respectfully recommends S.372 be amended to clarify it would only apply in that situation.

The notice requirement provided in section 2(b) is unnecessary as VHA has a policy on disclosure of adverse events to patients. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, dated October 31, 2018, provides clearly defined guidance on the ethical and policy requirements associated with a clinical disclosure to a patient when the actions of a VA staff member causes or contributes to potential or actual harm. VA facilities are already required to provide a quarterly report to VACO staff on activities that necessitate an institutional disclosure associated with death or serious injury to a patient.

S.539 Veterans' Camera Reporting Act (VCR Act)

The Veterans' Camera Reporting Act, or VCR Act, requires VA to complete a comprehensive review of policies and procedures and submit to Congress a report on its findings regarding the use and maintenance of cameras deployed by VA for patient safety and law enforcement at VA medical centers (VAMC). The VCR Act will also require VA to make recommendations to improve patient safety and law enforcement.

VA supports this bill.

S.544 To direct VA to designate one week each year as "Buddy Check Week" for the purpose of outreach and education concerning peer wellness checks for veterans, and for other purposes.

This proposed legislation would require VA to designate one week each year as "Buddy Check Week" for the purpose of outreach and educating Veterans on how to conduct peer wellness checks for Veterans. Additionally, other purposes of "Buddy Check Week" would include the following: 1) providing training on transferring Veteran's phone call to the Veterans Crisis Line (VCL); 2) providing resiliency training for Veterans on handling a Veteran in crisis; 3) making publicly available educational materials; and 4) requiring the head of the VCL to submit a plan to the Secretary for how to handle the potential increase in calls to the VCL during Buddy Check Week.

VA does not object to this legislation, as it could complement VA's robust ongoing initiatives to reach out to Veterans and encourage participation in treatment, when appropriate. VA is dedicated to ensuring all Veterans are aware of and have access to available mental health program and services when needed. VA's current outreach efforts to increase awareness and support among Veterans, with Veterans, and for Veterans is an integral part of VA's suicide prevention efforts.

Initial review indicates that media efforts dedicated to supporting implementation and engagement of S.544 may require an additional approximate $500,000 per year. Initial review indicates that indirect costs associated with this effort will likely be incurred at the local level to include and impact Suicide Prevention Coordinators, Public Affairs Officers and Peer Support Specialists.

S.612 Improving Housing Outcomes for Veterans Act of 2021

The Improving Housing Outcomes for Veterans Act of 2021 requires VA to provide VA medical center staff and homeless providers information on the centralized or coordinated assessment systems established by Continuums of Care under 24 C.F.R. § 578.7(a)(8). The information should include best practices regarding the collaboration between VAMCs; VA homelessness service providers; local partners, including the Department of Housing and Urban Development (HUD) or public housing agencies and private and public local community organizations; making referrals; and sharing data. The VA Under Secretary for Health must also communicate with employees who work with homelessness assistance programs on how to measure performance of programs by the Homeless Programs Office (HPO) and how to obtain and provide feedback about performance measures.

VA supports the proposed legislation. However, VA believes the Health Care for Homeless Veterans (HCHV) program is already operating in a way that is consistent with the intent of proposed legislation. Given that HCHV's mission focuses on outreach and community partnerships within it's already established programs, HCHV has been designated as the lead program office within the national HPO to champion the efforts underway to integrate all VHA homeless services into local coordinated entry systems. This is accomplished primarily through the VA's Coordinated Entry Initiative which provides guidance to VAMCs regarding their roles and responsibilities in each of their local Continuums of Care (CoC) and CoC's coordinated entry systems. This guidance is also available to community homelessness service providers. All VAMCs are expected to fully engage with each of their local CoCs in several areas including case conferencing, maintenance of the By-Name-Lists, assessment, data sharing and prioritization and referrals of homeless Veterans.

HCHV holds a monthly "National Coordinated Entry Integration Call" for all VA homeless programs staff members who are involved in coordinated entry activities within their communities. Topics for these calls have included the role of coordinated entry in the local COVID-19 response efforts, best practices in integrating Grant and Per Diem (GPD) transitional housing into community coordinated entry systems (including referral process and sharing of data), integrating Veterans Justice Programs into local coordinated entry systems, case conferencing, and considerations and recommendations when building community relationships and leadership teams. VAMC homeless program staff present to their peers across the country on innovative practices involving coordinated entry collaborations within their communities. There is also an opportunity for resource and information sharing.

In addition, the HPO has established a workgroup to examine innovative and promising practices to help VA staff and partner organizations accelerate progress in reducing homelessness among Veterans. These practices cover a wide range of topics related to Veteran homelessness. White papers about these practices are published to inform VA staff, partners and others of innovative ways to improve outcomes for Veterans who lack stable housing. The white papers cover topics such as integrating GPD transitional housing into coordinated entry systems; effective team building models for effective service coordination; and engaging frontline staff in coordinated efforts to end Veteran homelessness. The white papers are available to the public and can be found at the following website: https://www.va.gov/homeless/promising-practices.asp.

In addition to providing teaching assistance to VAMCs, HCHV has developed detailed expectations and requirements for each area of the initiative, including case conferencing, maintenance of the By-Name-Lists, assessment, data sharing and prioritization and referrals of homeless Veterans. VAMCs are required to report on their progress in each of these areas for review by the HCHV National Office. Feedback on the VAMCs progress and, where needed, technical assistance on specific areas of coordinated entry integration are also provided by VACO and/or VISN-level homeless programs staff.

HCHV is estimating zero cost because current operations are already fully consistent with S. 612 and this would not require any additional staffing or resources.

S.613 Puppies Assisting Wounded Servicemembers (PAWS) for Veterans Therapy Act

This draft bill would require the Secretary to: (1) pilot a program to provide grants to non-governmental entities who will conduct dog training therapy for eligible Veterans; and (2) amend title 38 U.S.C. section 1714 to authorize the Secretary to provide service dogs to Veterans with mental illnesses who do not have mobility impairments.

With regards to piloting a grant program; the draft bill spells out what type of agencies should be eligible for these grants and requires VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants: (a) improve in psychosocial functioning; and (b) improve in their dependence on narcotics medication. The legislation also requires the Government Accountability Office (GAO) to evaluate the pilot program. The bill does not mention funding or the number of grants that would be required.

VA does not support S.613 as written because the program, described as a therapeutic medium of training service dogs, although possibly helpful to a limited number of Veterans, does not have an adequate basis of evidence. Sections 1-3 of the bill describe a pilot program under which the VA Secretary would award grants to eligible non-profit organizations for the purpose of assessing the effectiveness of addressing post-deployment mental health and the symptoms of posttraumatic stress

disorder (PTSD) through a therapeutic medium of training service dogs for Veterans with disabilities. The “train the trainer” program that has been in place for many years as part of the Palo Alto VAMC recreation therapy program is the prototype for the proposed pilot program.

Veterans diagnosed with PTSD participated in the Palo Alto recreation therapy program by helping to train dogs to become service dogs for persons with mobility impairments. The “dog training” consisted of Veterans working with the dogs on basic obedience commands and socialization, neither of which alone nor together is sufficient for certifying a dog as a service dog. Veterans eligible for the program only spent a few weeks helping with “dog training.” These Veterans did not receive a service dog through the program in contrast to the bill which indicates that the Veteran who received the training as part of the pilot program will keep the dog unless the Veteran and the health care provider determine otherwise. Thus, while evaluation of the Palo Alto program, based solely on Veteran self-reports and informal observations by staff, may have been positive, it is not a model that results in Veterans being paired with service dogs.

VA does not support expansion of the scope of the program as the bill seeks to do by pairing the Veterans who received the training with the dogs because this method has an increased risk of Veteran/service dog team failure. This method does not ensure that the service dog is specifically trained to perform tasks that mitigate the Veteran’s disability or that the dog is matched to the Veteran’s personality, lifestyle and physical traits. Qualified service dog providers use an extensive matching process (based on the criteria referenced above) to ensure the Veteran/service dog team is compatible and is set up for success. This is especially true because of the additional challenges associated with identifying service dog organizations willing to commit their dogs to be trained by non-professionals, and the administrative infrastructure needed to ensure a safe and effective program for Veterans. The financial support of this type of effort would be considerable. For these reasons, VA does not support S.613.

Additionally, VA does not support providing grants to entities to provide Veterans with service dogs. VA currently does not provide dogs or grants in the administration of the Service Dog Veterinary Health Insurance Benefit; rather, VA provides Veterinary Health Insurance through a contractor to individual Veteran patients (not organizations). If VA were to provide grants, this legislation appears inconsistent with existing VA regulations that state that entities that provide service dogs must be accredited by Assistance Dogs International (ADI) or the International Guide Dog Federation (IGDF). This requirement allows VA to have reasonable confidence that dogs are well trained, healthy, and not likely to pose a threat of harm to Veterans or their families. Veterans who received dogs from non-ADI or IGDF organizations would not be eligible for the VA Service Dog Veterinary Insurance Benefit. We note that section 3(c)(12) affords VA discretion to require entities submitting applications to include certain information, certification and assurances; however, we are concerned such discretion will be limited by section 3(c)(1) which must be read in conjunction with section 3(c)(12).

S.613 does not give VA a role in determining when a service dog needs to be replaced for health or training problems and instead leaves that decision to the service dog organization and the Veteran. VA has serious concerns about this omission. A reputable service dog organization should not have concerns about a funding agency having a role in protecting Veterans. VA knows from experience, as do service dog training organizations, that once people bond to a dog, they are very reluctant to give it back even if its behavior or health are a serious problem. Unfortunately, VA has first-hand experience with this issue and has experience with service dog training organizations taking advantage of it to avoid having to replace a service dog with another dog at considerable expense.

Similarly, S.613 does not give VA the ability to evaluate and monitor the quality of the grant recipient organization's facilities, staffing, training and service dogs to ensure Veterans with PTSD receive a well-trained and high-quality service dog. VA has learned through the Phase I PTSD Service Dog study performed in Tampa that it was necessary to evaluate the performance of service dogs before they were paired with Veterans, because VA could not trust most organizations to disqualify poorly trained or poorly socialized dogs due to the cost to the organization of finding replacement dogs or the cost of committing additional training resources to the same dog.

Also problematic is the requirement that Veterans who participate in the pilot program receive training from a certified service dog training instructor. Unfortunately, there are no Federal standards for service dog training that VA can apply, and VA does not have the expertise to design its own accreditation program or standards.

Additionally, the legislation requires VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants improve in psychosocial functioning, and dependence on narcotics medication. VA does not believe that this data would be meaningful, as VA recently completed a study entitled "A Randomized Trial of Differential Effectiveness of Service Dog Pairing Versus Emotional Dog Pairing to Improve Quality of Life for Veterans with PTSD" (www.research.va.gov/ptsd-service-dogs.cfm) that found no differences on three primary outcome measures of quality of life, mental functioning, and physical functioning. However, among secondary outcome measures, Veterans paired with a service dog experienced a reduction in severity of PTSD symptoms (PCL-5) compared to Veterans paired with an emotional support dog, and had fewer suicidal ideations and behaviors, particularly at 18 months post-pairing. Also, narcotic medications are not typically prescribed for PTSD; rather, they may be prescribed for co-morbid conditions (such as chronic pain).

VA does not support amending title 38 U.S.C. section 1714 as proposed in section 4 of the Act. Section 4 of the Act authorizes the Secretary to provide a service dog to a Veteran pursuant to 38 U.S.C. 1714(c)(3) regardless of whether the Veteran has a mobility impairment. The Secretary's authority to provide a Veteran diagnosed with a mental illness, including PTSD, with a service dog already exists in 38 U.S.C. 1714(c)(3) and is not conditioned upon the Veteran having a diagnosis of a mobility

impairment. Separate authority exists in 38 U.S.C. 1714(c)(2) for the Secretary to provide a Veteran diagnosed with a mobility impairment with a service dog. Thus, section 4 of the Act neither provides the Secretary with any additional authority nor does it confer upon the Veteran an additional benefit.

S.727 CHAMPVA Children's Care Protection Act of 2021

If enacted, S.727 would allow a child to be eligible to receive medical care benefits under VA's Civilian Health and Medical Program (CHAMPVA) up until the age of 26. VA's CHAMPVA program is primarily for dependent spouses and children of certain Veterans, provided they do not qualify for the Department of Defense's TRICARE program for dependents. In the absence of a CHAMPVA-specific definition, CHAMPVA relies on the definition of "child" that is codified in section 101 of title 38, U.S.C., and applicable to other VA benefits available to a child. Generally speaking, a child reaches the age of majority when the child attains 18 years of age. Some exceptions exist, namely for a child who, before attaining the age of majority, became permanently incapable of self-support, or who after reaching the age of majority is pursuing a course of instruction at an approved education institution up until the age of 23 years.

In 2010, the Patient Protection and Affordable Care Act, as amended (the "Act"), required individual health insurance coverage plans that provide dependent coverage of children to make such coverage available for an adult child who is not married until the child turns 26 years of age. To clarify, it did not require health insurance plans to provide dependent child coverage, but for those that do, it required them to continue this coverage until a child reached the age of 26. This requirement addressed policy concerns that young adults were, in general, uninsured, had the least access to employer-sponsored health insurance, and lacked the financial resources needed to purchase health care insurance. For instance, prior coverage under their parents' plans typically ended after they graduated from college, or for others, it ended once they reached certain age thresholds. The Act remedied this problem.

VA is not subject to the Act, as CHAMPVA is not a health insurance plan; rather, it is a medical care benefit grounded in statute. No provision in the Act amended the title 38 definition of "child." Yet, because CHAMPVA operates in effect like a health insurance plan, this has resulted in confusion and disputes.

Senate bill 727 would extend a child's eligibility for CHAMPVA up until the age of 26, thereby aligning the age criterion for CHAMPVA eligibility with that applicable to health insurance dependent care coverage. It would, however, be a greater benefit than found in plans covered by the Act because this extended eligibility would be *regardless of a child's marital status*.

CHAMPVA is required by law to provide medical care to CHAMPVA beneficiaries in the same or similar manner as that which is provided to TRICARE dependents, and subject to the same or similar limitations as TRICARE. TRICARE provides extended

medical coverage for a young adult up until the age of 26 (provided the child is unmarried and meets certain other requirements such as ineligibility for employer-sponsored health insurance based on the young adult's own employment). Nonetheless, an unmarried child between the ages of 18 and 23 who is pursuing a course of instruction at an approved educational institution is eligible for CHAMPVA medical benefits only up until the child's 23rd birthday because, absent an amendment to section 1781, VA is still obligated to rely on the title 38 definition of a child.

For all these reasons, VA supports enactment of S. 727, noting that it would align eligibility for CHAMPVA with TRICARE and private insurance plans and go even further by extending the age limitation regardless of marital status, student status, or the child's eligibility for employer-sponsored health insurance. To be eligible for CHAMPVA medical care, the child is not eligible for TRICARE and the child's sponsoring Veteran-parent must have a total disability permanent in nature, resulting from a service-connected disability, or must have died as a result of a service-connected disability; or at the time of death had a total disability permanent in nature; or must have died in active service in the line of duty not due to personal misconduct. This patient cohort unquestionably merits the bill's generous extension of eligibility.

The estimated cost for medical benefits and additional full-time employees to provide this expanded CHAMPVA eligibility up to age 26 in FY 2022 is estimated at $82.4 million. The 5-year estimate from FY 2022 through FY 2026 is estimated at $459 million while the 10-year estimate from FY 2022 through FY 2031 is $1.1 billion.

S. 796 Protecting Moms Who Served Act of 2021

Senate bill 796 is the companion bill to H.R. 958 on which VA testified before the Subcommittee on Health, House Committee on Veterans' Affairs on April 15, 2021. If enacted, section 3(a)(1) of the bill would require the Secretary to carry out the maternity care coordination program currently established in VHA Directive 1330.03, *Women Veterans Maternity Health Care and Coordination*, and any successor policy. Section 3(a)(2) would require the Secretary to provide community maternity care providers who are furnishing authorized maternity care (under VA's Veterans Community Care Program or other contract authority) with training and support with respect to the unique needs of pregnant and post-partum Veterans, particularly regarding mental and behavioral health conditions. Section 3(b) would authorize to be appropriated $15 million for FY 2022, which would be intended to supplement, not supplant, other amounts authorized for VA's maternity care program.

VA supports the intent of section 3(a)(1) but believes it is duplicative of ongoing efforts. VA welcomes further discussion and would be happy to work with staff on issues related to maternity care. Currently, VA has 134 Maternity Care Coordinators (covering 140 health care systems) who support pregnant Veterans throughout pregnancy and the post-partum period. Coordinators screen pregnant Veterans for conditions such as post-partum depression and intimate partner violence. In addition, coordinators help patients access the following: VA-authorized maternity care services in the community;

VA care or VA-authorized care in the community for other physical and mental health conditions (needed during pregnancy and after delivery); and other private sector community resources from which they may benefit. Coordinators also connect patients to services after miscarriage and answer non-care questions such as those related to VA's maternity care authorization process and copayment obligations that may apply in connection with the receipt of maternity care through VA.

As to section 3(a)(2), VA already has training modules that are available to community maternity providers, and these meet the educational goals described in the bill. For instance, VA has developed web-based training titled "Caring for Women Veterans in the Community," which is housed on VHA's TrainingFinder Real-time Affiliate-Integrated Network, the most comprehensive national catalog of public health training opportunities. This training addresses the unique health care needs of women Veterans, the potential to employ different assessments, care, and resources, and the array of reproductive services available to this cohort. This training underscores the importance of screening for sexual trauma and how a woman Veteran's service might affect her post-deployment health. VA also shares this same information with maternity care providers in the community through myriad professional avenues. For instance, VA educates community providers on the needs of women Veterans as part of our participation as a member of the American College of Obstetrics and Gynecology (ACOG) and the Armed Forces Section of ACOG.

VA's Maternity Care Coordination Program is efficient and successful in meeting the needs of pregnant enrolled Veterans and in sharing medical information with community providers. Indeed, the drafters tacitly acknowledge this, as section 3, if enacted, would not remedy any identified current gap in policy or clinical practice (to include our manner of sharing medical information with community providers). It would merely mandate and codify in law what we do now in policy to ensure this program's continuity. Although we agree that policy can always be changed by an Under Secretary for Health, VA considers this program and the work of these coordinators to be key and more importantly, aligned with VA's standard of practice in delivering health care to women Veterans. VA cautions against mandating any program or practice currently established in policy, as VA requires flexibility in determining how best to deliver health care services, including coordination services, across the VA health care system. The Committee might consider an alternative approach to achieve its goal: VA could be required to give the Committee advance notice of any plan to rescind the subject policy (or successor thereto), the rationale for the decision, and a description of how VA will continue to deliver maternity care coordination services (or similar services) for pregnant women Veterans. The Committee can then pursue legislative action if it deems necessary.

Section 4 of the bill would require the Comptroller General of the United States to submit, not later than two years after the date of enactment of the bill, a detailed report to Congress on the mortality and severe maternal morbidity rates among pregnant and post-partum Veterans, with a particular focus on racial and ethnic disparities in maternal health outcomes for Veterans. (Section 2 of the bill would define the clinical and other

terminology relevant to the mandated report.). This report would need to include extensive data for the most recent 10 years of available data, draw research conclusions, and make a number of recommendations such as on how to improve coordination of care between VA and non-VA facilities for pregnant and post-partum Veterans and how to improve health record interoperability and training. The Comptroller General would need to obtain various and extensive data from VA and other Federal departments and agencies. As to this section, VA defers to the views of the Comptroller General.

If enacted, this bill would have no new costs.

S.887 VA Supply Chain Resiliency Act

The "VA Supply Chain Resiliency Act 2021" would direct the Secretaries of Defense and VA to enter into an agreement to allow for VA participation in the Defense Logistics Agency "Warstopper Program." The proposed legislation would establish reporting requirements for physical inventory and projected needs for critical items as well as implementation of VA integration into Warstopper.

As reported to the Committee in its March 24, 2021, hearing regarding VA's medical supply chain, VA has come a long way in strengthening its supply chain logistics. VA identified the immediate need for national personal protective equipment (PPE) asset visibility. VA's existing legacy system, a 50-year old inventory system, was unable to provide visibility into on-hand inventory and the usage or burn rate at each VAMC. VA defined standards for reporting PPE inventory levels and burn rates; developed the methodology, standard operating procedures, and SharePoint site for data collection; and within 30 days, deployed an electronic dashboard. This dashboard, still in use today, provides enterprise-wide visibility of PPE on-hand inventory, burn-rates, and projected demand, from the individual VAMC-level to enterprise-level.

To overcome the supply chain challenges, VA increased the amount of critical medical materiel held at each VAMC from 30 days to 60 days of supply. VA also established Regional Readiness Centers, geographically distributed to support the four VISN Consortiums. In doing so, we built resiliency into our internal supply chain to enable VHA to sustain continuous services to Veterans even when there are interruptions in support from the commercial supply chain. In the long term, the Regional Readiness Centers will support VHA preparedness for regional and national public health emergencies, including those secondary to national disasters (e.g., hurricane, flood).

VA is engaged with our interagency partners to ensure that the U.S. Government is prepared for future pandemics or other biological incidents by enabling a more integrated, responsive and aware system that can adapt to new conditions while maintaining the delivery of health care and other essential services. VA appreciates and supports the intent of S. 887, VA Supply Chain Resiliency Act, including providing durable guarantees that each department lives up to its commitments to the other. With

regard to the reporting requirements in the bill, Executive Order 14001, *A Sustainable Public Health Supply Chain* (Jan. 21, 2021), directed multiple agencies, including VA, to, among other things, determine the identification of emergency needs. VA requests time for the development and initiation of the *Pandemic Supply Chain Resilience Strategy* Implementation Plan required by Executive Order 14001 with the expectation that VA and DOD enter into an agreement described in section 2(b) of S. 887 not later than 365 days from enactment.

VA is unable to provide a cost estimate at this time. The plan required by Executive Order 14001 is not due until July 20, 2021 and this strategy will impact any potential costs. Costs will be determined by a number of factors to include approval/disapproval of the "strategy" and the number of agencies that participate.

S.951 PAWS Act of 2021

This bill would direct the Secretary to make grants to eligible organizations to provide service dogs to Veterans with severe PTSD and for other purposes.

VA does not support this bill. Among other concerns, as written, there is the potential to introduce a disparity in Veteran eligibility for the VA Service Dog Veterinary Insurance Benefit as well as concerns related to the health and training of service dogs provided. Although we understand the appeal of having VA provide service dogs for Veterans, the vast majority of reputable service dog organizations provide service dogs at no cost to Veterans (costs are covered by charitable contributions). Therefore, it is not necessary for VA to provide dogs or grants in the administration of the Service Dog Veterinary Health Insurance Benefit pursuant to title 38 C.F.R. section 17.148. Instead, VA provides veterinary health insurance through a contract to individual Veteran patients prescribed a service dog by a VA clinician and who obtain a service dog through an ADI or IGDF accredited organization, as opposed to unaccredited service dog organizations. For these reasons, VA does not support providing grants to organizations that provide service dogs and service dog training to Veterans with PTSD.

VA commends Congress for including in the bill the ADI and IGDF accreditation requirement which is critical in administering service dog benefits because VA must ensure that tested and proven criteria regarding service dog training and behavior are in place to allow VA to have reasonable confidence that dogs are well trained, healthy and not likely to pose a threat of harm to Veterans, their families and others who might come into contact with the dog. However, VA does not support that portion of section 3(c) that would make organizations eligible for grants that are not ADI or IGDF accredited because Veterans that receive service dogs from these unaccredited service dog organizations would not be eligible for the VA Service Dog Veterinary Insurance Benefit.

Pursuant to 38 C.F.R 17.148, VA requires Veterans to obtain service dogs from ADI or IGDF accredited provider organizations in order to receive the VA Service Dog Veterinary Insurance Benefit. VA's service dog veterinary insurance policy is not commercially available, is extensive in its coverage of wellness and medical/surgical

care and has no-out of pocket expenses to the Veteran. Thus, the commercial veterinary health insurance policy that eligible organizations would be required to provide in accordance with section 3(b) of the Act would be vastly inferior to the VA insurance benefit and any attempt to provide a policy comparable to that of VA would be a significant financial burden for these organizations. Even the largest and most financially solvent service dog provider organizations cannot provide a commercial insurance policy comparable to that of the VA service dog insurance policy. Thus, the inclusion of organizations other than ADI or IGDF accredited organizations would create a distinct and unfair inequity between Veterans in maintaining their service dog.

Section 3(c) would also allow organizations to meet the publicly available standards of the Association of Service Dog Providers for Military Veterans (ASDPMV) as an alternative to accreditation from ADI or IGDF. ADI and IGDF are national, industry-recognized organizations with established and proven health and training criteria. In addition, ADI has specific standards related to the training and placement of service dogs for Veterans with military-related PTSD. VA does not agree with allowing eligible organizations to meet the inferior standards and ethical principles of ASDPMV as opposed to the more rigorous standards and ethics that form the basis of the ADI and IGDF accreditation programs. For example, ASDPMV assesses the risk of hip dysplasia by the absence of clinical signs for this condition. Hip dysplasia cannot be diagnosed by physical examination and/or clinical signs alone; this condition dramatically shortens the working life of the service dog.

VA does not support the bill as written because it does not appear to afford VA oversight of the service dog training programs administered by the grant recipients after the grants are awarded. While, if enacted these grants would be subject to the Uniform Administrative Requirements for Federal Awards (2 CFR 200 et seq), VA would also need a mechanism to determine on an on-going basis if the dogs, trainers and facilities are of satisfactory quality. VA cannot support the award of grants to service dog organizations on behalf of Veterans without allowing sufficient oversight, including additional accountability mechanisms. VA understands the grant program is aimed at Veterans with PTSD whose VA clinical team determines based upon medical judgment that the Veteran may potentially benefit from a service dog. As such, the service dog would be adjunctive to other mental health treatment. Therefore, it is essential that the service dog pairing and training be administered appropriately and as part of a comprehensive mental health treatment program for Veteran participants.

Similarly, the bill does not give VA a role in determining when a service dog needs to be replaced for health or training problems and instead leaves that decision to the service dog organization and the Veteran. VA has serious concerns about this omission. A reputable service dog organization should not have concerns about a funding agency having a role in protecting Veterans. VA knows from experience, as do service dog training organizations, that once people bond to a dog, they are very reluctant to give it back even if its behavior or health are a serious problem. Unfortunately, VA has first-hand experience with this issue and has experience with

service dog training organizations taking advantage of it to avoid having to replace a service dog with another dog at considerable expense.

Furthermore, VA cannot support the bill because it requires VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants improve in psychosocial functioning, and dependence on narcotics medication. VA does not believe that this data would be meaningful as VA recently completed a study entitled “A Randomized Trial of Differential Effectiveness of Service Dog Pairing Versus Emotional Support Dog Pairing to Improve Quality of Life for Veterans with PTSD” that found no differences on three primary outcome measures of quality of life, mental functioning, and physical functioning. Additionally, narcotic medications are not typically prescribed for PTSD; rather they may be prescribed for co-morbid conditions (such as chronic pain).

VA notes that the evidence on the benefits of service dogs for Veterans with PTSD is still at a preliminary stage and currently does not provide a confident basis for programmatic expansion. Specifically, the evidence does not support the statement in the legislation that “service dogs ameliorate the symptoms associated with PTSD.”

Section 3(f) would allow a service dog, in addition to VA hospital care or medical services, to be provided to Veterans with PTSD, and any improvement in PTSD symptoms due to provision of a service dog would not affect eligibility to any VA benefits. VA cannot support the bill and section 3(f) as written. Generally, VA supports service dogs as an adjunct to evidence based mental health treatment, in addition to other options available such as yoga, art therapy, massage etc. VA encourages all Veterans to seek treatment for service-connected disabilities. However, under the Veterans Benefits Administration’s (VBA) current process, if treatment results in a disability materially improving, VBA may reduce a disability rating percentage. Disability rating reductions may occur, to include ratings that have not been in effect for 5 years or are otherwise stable, if the evidence of record includes a thorough completed examination and the evidence reflects an improvement in the ability to function under the ordinary conditions of life, including employment.

As such, if the evidence of record shows material improvement in the Veteran’s PTSD symptoms, VA may reduce a Veteran’s disability rating percentage. Based on the current language in the bill, there would be an exception made to reducing disability rating percentages for service-connected Veterans with PTSD who use service dogs as part of the grant program. As a result, this would create an inequity between these Veterans and other Veterans who receive different types of treatment for PTSD, as well as other groups of Veterans who use service dogs for conditions other than PTSD.

VA also notes that it would be unlikely that the evidence of record would be able to clearly indicate whether the improvement in symptoms was due to the provision of the service dog. Due to the above-stated concerns, VA recommends reconsidering the language in section 3(f) to allow VA to at least consider whether the effects of having a

service dog result in material improvement in a Veteran's PTSD condition and remain consistent with current practice.

S.1040 To expand eligibility for hospital care, medical services, and nursing home care from the Department of Veterans Affairs to include veterans of World War II

S.1040 would amend 38 U.S.C. § 1710(a)(2)(E) to expand hospital care, medical services, and nursing home care to Veterans of World War II. Currently, this provision provides VA hospital care, medical services, and nursing home care to Veterans of the Mexican border period and World War I.

VA supports this bill, assuming appropriations are provided for this purpose. The proposed legislation could potentially provide health care services to a Veteran population who may not otherwise be eligible for VA health care. While VA expects that the majority of the World War II (WWII) Veteran population is already eligible for Medicare and will rely on Medicare coverage for a significant portion of their health care needs, VA health care may be more appealing to Veterans who are unsatisfied with their current Medicare provider or who seek to reduce their copays. For example, VHA provides prescription drugs at copayment levels that tend to be significantly below the cost sharing requirements of Medicare beneficiaries.

If enacted, this legislation would grant priority group 6 eligibility to all WWII Veterans. Veterans that are currently enrolled in VA health care under priority groups 7 and 8 would be reclassified under priority group 6. Copayments for Veterans in priority group 6 are less than copayments for priority groups 7 and 8. The lower copayments could also induce higher reliance for those already enrolled and encourage new enrollment by currently eligible WWII Veterans that are not enrolled.

Reliable data is not available regarding the number of currently ineligible WWII Veterans who would enroll with VA; therefore, a total cost estimate has not been calculated. If passed, only a portion of WWII Veterans that become eligible are likely to enroll with VA health care. However, VA estimates that 14,000 ineligible WWII Veterans would be eligible to enroll in FY 2022 and 5,000 in FY 2025. The projected average annual expenditure per enrollee for FY 2022 would be $2,803 and $3,328 for FY 2025.

S.1198 Solid Start Act of 2021

This bill would codify VA's Solid Start Program (VASS) and would implement improved and expanded program initiatives. VA supports S.1198 but has some concerns regarding the requirements to implement certain program initiatives.

VA and the Departments of Defense (DoD) and Homeland Security (DHS) issued a joint action plan to provide seamless access to mental health care and suicide prevention resources in response to Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life.* On December 2, 2019,

VA, in coordination with DoD and DHS, launched VASS to implement Task 1.1 of that joint action plan to make early and consistent caring contact with recently separated Service members three times during their first year after separation (at around 90, 180 and 365 days following separation). The purpose of these calls is to help each Veteran establish a relationship with VA, increase their awareness of available VA benefits and services, lower their barrier to entry to VA mental health care services and support their successful transition to civilian life.

Since the launch of the VASS program on December 2, 2019, through May 31, 2021, VASS has successfully connected with over 127,000 VASS eligible individuals achieving a 59.2% successful contact rate. During this same period, VASS has successfully connected with over 21,000 Priority Veterans, achieving a 73.2% successful contact rate. For VASS, a Priority Veteran is defined as an individual who had a mental health care appointment during the last year of active duty. A successful contact is defined as speaking with the Veteran and completing at least one VASS conversation during the period of eligibility.

Assuming appropriations are provided for this purpose, VA supports the program initiatives set forth in proposed new section 6320(b)(1) in section 4(a) of the bill. Subsections (b)(1)(A)-(E) of section 6320 would require VA, in coordination with DoD, to: collect up-to-date contact information of transitioning Service members; call each recently separated Veteran, regardless of separation type or characterization of service, three times within the first year after separation; provide information about VASS on VA's website and in transition booklets and other resources; ensure calls are tailored to the needs of the Veteran; and prioritize outreach to Veterans who accessed mental health resources prior to separation from service. The remaining requirements for the proposed initiatives align with current VASS practices. Subsection (b)(1)(F) would require that women Veterans be provided with information tailored to their specific health care and benefits. Subsection (b)(1)(G) would require that VA, where feasible, provide information on access to state and local Veteran resources, to include Vet Centers and Veterans service organizations. Subsection (b)(1)(H) would require the collection and analysis of data to evaluate the effectiveness of the program. VA is also currently developing new VASS performance measures, which will include a means of assessing long-term outcomes to confirm that the VASS program is providing concrete improvement throughout a Veteran's post-separation life journey.

However, VA notes some concerns with the provisions of proposed new section 6320(b)(2) in section 4 of the bill, recognizing that these provisions are permissive and not mandatory. Subsection (b)(2)(A) would authorize VA, in coordination with DoD, to encourage transitioning Service members to authorize alternate points of contact whom VA may contact if the Veteran is unavailable at the time of VA contact attempts during the first year after their separation from service. VA believes this provision may be duplicative of current efforts under section 101 of the Veterans COMPACT Act of 2020, Pub. L. No. 116-214, which requires VA to develop a pilot program to allow transitioning Service members to designate up to 10 individuals to whom VA may send information regarding VA assistance and benefits for Veterans.

Subsection (b)(2)(B) would authorize VA to send tailored mailings to Veterans whom VASS is unable to contact by phone. VA is concerned that tailored mailings may be less effective than emails to recently separated Veterans and may be duplicative of emails.

Subsection (b)(2)(C) would authorize VA, where feasible, to reach out to Veterans who separated from service prior to the initiation of VASS to provide these individuals with similar services. VA is concerned that this provision may not align with VASS's specific mission to provide tailored support to Veterans during the critical first year after their separation from service as these individuals transition from military to civilian life. VA currently has comprehensive outreach programs and strategies in place to reach Veterans who are beyond the first year of their transition period from military to civilian life. VA also notes that more information would be needed to define the Veteran group Congress intends to include under this section for receipt of VASS services, and implementation of this provision may require additional appropriations.

While this bill would require appropriations to fund VASS, VA cannot provide cost estimates at this time.

S.1220 United States Cadet Nurse Corps Service Recognition Act of 2021

This bill would recognize and honor the service of individuals who served in the Cadet Nurse Corps during World War II.

Section 2 of the bill would amend 38 U.S.C. § 106 to deem as active duty for purposes of eligibility and entitlement to benefits under chapters 23 and 24 of title 38, U.S.C. the service of persons who served in the United States Cadet Nurse Corps during the period beginning on July 1, 1943, and ending on December 31, 1948. Within one year of the date of the bill's enactment, the Secretary of Defense would be required to issue to each member with qualifying Cadet Nurse service a discharge from service under honorable conditions.

VA has no authority to determine whether service provided to the U.S. Armed Forces by civilian or contract employees constitutes service for title 38 purposes. The authority to recognize civilian service as active duty has been specifically granted by Congress to DoD under Public Law 95-202. Should DoD characterize Cadet Nurse service as "active duty" in 38 U.S.C. 106, VA would support recognition of the service of the Cadet Nurse Corps as active duty for purposes of eligibility and entitlement to benefits under chapters 23 and 24 of title 38, U.S.C.

While VA recognizes the great contribution of the United States Cadet Nurse Corps, we cannot support the bill as drafted because of the potential for confusion in the application of benefits. If DoD characterized Cadet Nurse service as "active duty" in 38 U.S.C. 106, but only for certain but not all VA benefits as indicated in the bill, that would create a disconnect across VA benefit programs. The bill would provide that an

individual who receives a discharge for qualifying Cadet Nurse service would be honored as a Veteran with deemed active duty service. The bill would administratively establish active duty service, but not for purposes of all VA benefits. The bill would limit eligibility and entitlement to benefits under chapters 23 and 24 of title 38, U.S.C., but the bill text does not specify which benefits under those chapters are applicable. VA is concerned that the bill language may be confusing to beneficiaries and result in inconsistencies in the administration of benefits among VA benefit programs. Chapter 23 benefits include monetary allowances, burial flag and memorial products. These benefits are administered by the National Cemetery Administration (NCA) and VBA. Chapter 24 benefits would include burial in a national cemetery, which is managed by NCA.

Additionally, the lack of clarity in the bill text because of the inclusion of the parenthetical language (describing benefits "including with respect to headstones and markers") makes the scope of eligibility to other NCA-administered benefits unclear. For example, eligibility for burial in a national cemetery would ordinarily also entitle one to receive a Government-furnished headstone or marker under 38 U.S.C. § 2306 and a Presidential Memorial Certificate under 38 U.S.C. § 112, but the bill language makes this unclear. Further, section 2306 authorizes VA to furnish a medallion to signify a Veteran's grave in a private cemetery in lieu of a headstone or marker. It is unclear whether VA would be authorized to also furnish a medallion to a member of the Cadet Nurse Corps with qualifying service. VA welcomes the opportunity to discuss these concerns with the Committee and to offer technical assistance to address them.

S.1220 would authorize DoD to design and produce a service medal or other commendation or memorial plaque or grave marker to honor those who receive an honorable discharge for service in the Cadet Nurse Corps. The bill would also exclude eligibility for members of the Cadet Nurse Corps with qualifying service from interment in Arlington National Cemetery. VA defers to DoD concerning these provisions. However, VA does not support the provision of a separate DoD grave marker or memorial plaque to Cadet Nurse Corps members with qualifying service as it would directly conflict with VA's memorialization authorities governing the same benefits.

VA is unable to estimate the costs at this time for the additional funding and resources that would be needed if the bill were enacted.

S.1280 Veteran Families Health Services Act of 2021

Title I of the bill relates to DoD. Section 102 of the bill would require the Secretary of Defense to furnish fertility treatment and counseling, including through the use of assisted reproductive technology (ART), to a covered member of the Armed Forces, a spouse or partner to a covered member of the Armed Forces, or a spouse, partner or gestational surrogate of such member. Eligibility under this section would be without regard to the sex, gender identify, sexual orientation or marital status of the covered member. In in vitro fertilization (IVF) cases, the Secretary of Defense would be limited to furnishing no more than three completed cycles or six attempted cycles,

whichever occurs first. In cases where a covered member is unable to provide their own gametes, the Secretary of Defense is required upon the election of the member, to let the member use donated gametes and to pay or reimburse the member for the reasonable costs of procuring gametes from a donor. The Secretary of Defense would not, however, be required to find or certify a gestational surrogate for a covered member, or to find or certify gametes from a donor for a covered member or to connect a covered member with gametes from a donor. VA defers to the views of the Secretary of Defense.

Section 103 would require the Secretary of Defense, acting through the Assistant Secretary of Defense for Health Affairs, to establish procedures for the retrieval of gametes, as soon as medically appropriate, from a member of the Armed Forces in cases in which the fertility of the member is potentially jeopardized as a result of an injury or illness incurred or aggravated while serving on active duty. This would be done to preserve the member's (fertility) medical options. A retrieval of gametes procedure could occur only with the specific informed consent of the member, or if the member lacks the decision-making capacity to consent, if a medical professional determines the following:

- The future fertility of the member is potentially jeopardized as a result of an injury or illness as a result of an injury or illness incurred or aggravated while service on active duty or will be potentially jeopardized as a result of treating such injury or illness;
- The member lacks the capacity to consent to the retrieval of gametes and is likely to regain such capacity; and
- The retrieval of gametes under this section is in the medical interest of the member.

It would also provide that gametes retrieved from a member of the Armed Forces under this section could be used only with the specific consent of the member, or if the member has lost the ability to consent permanently (as determined by a medical professional) as specified in an advance directive or testamentary instrument executed by the member.

This section would require the Secretary of Defense, pursuant to regulations to be prescribed by the Secretary of Defense, to dispose of gametes retrieved from a member with the specific consent of the member, or if the member has lost the ability to consent permanently (as determined by a medical professional) and has not specified the use of gametes in an advance directive or testamentary instrument executed by the member. VA defers to the views of the Secretary of Defense.

Section 104 of the bill would require the Secretary of Defense to provide members of the Armed Forces with the opportunity to cryopreserve and store their gametes prior to deployment to a combat zone or to a duty assignment that includes hazardous assignment, as determined by the Secretary of Defense. It would provide these members with free cryopreservation and storage of gametes in a DoD facility or in

a private entity, including transportation of such gametes. These medical benefits would continue until the date that is one year after the member's retirement, separation or release from the Armed Forces. At the end of this one-year period, the Secretary of Defense would be required to permit an individual whose gametes are stored in a DoD facility to select, including pursuant to an advance medical directive or military testamentary instrument, one of the following options: to continue such cryopreservation and storage in the DoD facility at personal cost; to transfer the gametes to a private facility selected by the individual; or to transfer the gametes to a VA facility if cryopreservation and storage are available to the individual there. If the individual does not make any of these three selections, then the Secretary would be authorized to dispose of the gametes not earlier than the date that is 90 days after the end of the one-year period described above. While VA defers to the views of the Secretary of Defense, we note that with respect to the option to transfer gametes to a VA facility for cryopreservation and storage, this would not be practicable. VA has no in-house capacity to provide either of these services. Under VA's current IVF program, we contract for both of these services using specialists and facilities in the community.

This provision would also require a member of the Armed Forces who elects to cryopreserve and store their gametes under this section to complete a DoD advance medical directive and a military testamentary instrument that explicitly specifies the use of their cryopreserved and stored gametes if such member dies or otherwise loses the capacity to consent to the their use.

This section would authorize the Secretary of Defense to enter into agreements with private entities that provide cryopreservation, transportation, and storage for gametes. Again, VA defers to the Secretary of Defense.

Section 105 would require the Secretary of Defense to ensure DoD employees assist members of the Armed Forces in navigating fertility treatment (including those using ART) and counseling services, in finding a provider that meets their needs with respect to these services, and in continuing their receipt of such treatment and services without interruption during a permanent change of station. VA defers to the views Secretary of Defense.

Section 106 would require the Secretary of Defense and the Secretary of Veterans Affairs to share best practices and to facilitate referrals (related to fertility treatment and services), as they consider appropriate. Additionally, they would be required to enter into a memorandum of understanding (MoU) whereby the Secretary of Veterans Affairs would receive access to gametes stored by DoD, for purposes of furnishing VA fertility treatment under new section 1720K of title 38, as added by section 202(a) of this bill. The required MoU would also authorize VA to compensate DoD for its costs of cryopreservation, transportation and storage of gametes under section 104, discussed above. VA defers to the Secretary of Defense.

Title II of the bill relates to VA. We want to stress that VA believes strongly in fuller reproductive health options for Veterans and their families. However, as outlined

below, we believe more discussion on the details of this legislation is necessary for VA to support the bill. We are eager to work with the Committee to secure additional authorities that will improve these types of services for Veterans.

Section 201 of S.1280 would add new paragraph (I) to the definition of "medical services" codified in section 1701(6) of title 38, U.S.C., to include "fertility treatment and including treatment using assisted reproductive technology."

Section 202(a) would add new section 1720K to title 38, U.S.C., requiring the Secretary of Veterans Affairs to furnish fertility treatment and counseling, including through the use of ART, to a covered Veteran or a spouse, partner or gestational surrogate of a covered Veteran if the Veteran, and the spouse, partner or gestational surrogate of the Veteran, as applicable, apply jointly for such treatment and counseling through a process prescribed by the Secretary. A covered Veteran means a Veteran:

- Who has an infertility condition, unless the Secretary can show that the Veteran was completely infertile before service in the active military, naval or air service; and
- Who is enrolled in VA's health care system.

As to the first eligibility requirement, we note that the language "completely infertile" seems an impossible bar to meet because managing uncertainty is central to (and unavoidable in) the practice of medicine. The practice of medicine, including diagnosis, is based on informed and trained medical judgments. Knowledge of the absolute causation of any medical condition is not, in general, ascertainable.

Under this section, this treatment and counseling would have to be furnished without regard to the sex, gender identity, sexual orientation or marital status of the covered Veteran. In cases of in vitro fertilization, the Secretary could provide no more than three completed cycles or six attempted cycles of IVF, whichever occurs first. If the Veteran is unable to provide the Veteran's own gametes for purposes of fertility treatment under this section and the covered Veteran elects, the Secretary would be required to let the Veteran use donated gametes and to pay or reimburse the Veteran for the reasonable costs of procuring the donor gametes. We note that in contrast to section 102, above, this section is silent on whether VA would be required to find or certify gametes from a donor for a covered Veteran or to connect a covered Veteran with gametes from a donor. We further note that it does not include donation of embryos, despite the fact that many couples have donated their excess embryos to facilities/banks for use and adoption by others. Inclusion of donated embryos available for adoption might therefore be considered.

The bill would require ART to be provided to a covered Veteran ***or*** a spouse, partner or gestational surrogate of a covered Veteran if the Veteran, and the spouse, partner or gestational surrogate of the Veteran, as applicable, apply jointly for such treatment and counseling through a process prescribed by the Secretary. Although the provision of the benefit is contingent on a joint application process, it is unclear why the

care that is required to be delivered could be provided to one, the other, or both. The required use of a joint application does not avoid this ambiguity.

The use of the disjunctive here is problematic because at any point the personal circumstances or health of a Veteran might change such that the Veteran would not wish to pursue ART or continue ART, even if the spouse, partner or gestational surrogate does. A Veteran should be able to reject this treatment at any stage and for any reason. In some cases, as this is a lifetime benefit for an eligible Veteran up to its exhaustion, a Veteran may still want to bear a child or build a family but not with their current spouse, partner or surrogate. Due to the use of the disjunctive, VA could be required to provide the Veteran's spouse, partner or gestational surrogate with fertility treatment under this section, even without the consent (or even knowledge) of the Veteran. These non-Veterans could rely on the fact that a joint application was submitted originally. Is the use of the disjunctive deliberate to cover cases where a dying Veteran or one losing capacity permanently might agree that the spouse, partner or surrogate could alone use this benefit to use previously cryopreserved gametes with which to bear a child after the Veteran's death or after declaration of incompetency?

Under our current IVF authority, referenced above, the consent of each party is legally required to be obtained each cycle and third-party consent is prohibited. That would not apply to care and services provided under section 202(a), as added. Instead, VA's normal informal consent requirements and procedures would apply. ART does not require special or signature informed consent, and the joint application process that would be required to be established in regulation would not supersede applicable informed consent procedures and requirements, which allows for a surrogate decision maker to make treatment decisions for a Veteran who has lost decision-making capacity or who has been judicially declared to be incompetent.

Thus, unless amended, retrieval of a Veteran's gametes or use of the Veteran's gametes could occur if the Veteran's surrogate decision maker provides full and free informed consent. Yet, it would still be incumbent on the medical professional, as part of his or her clinical duties, to identify the range of medically acceptable procedures for the patient. That is, whether retrieval or use of a Veteran's gametes is medically appropriate in cases where the patient lacks decision-making capacity would remain a clinical analysis no different from what is done for those with decision-making capacity. For example, now when providing fertility treatment, including the use of ART under our current IVF authority, medical professionals address both the clinical (reproductive) needs of the Veteran as well as any psychological treatment needs (including those needed for quality of life). So, the responsible treating provider must exercise reasonable clinical judgment to determine if this treatment will produce the intended clinical benefits or quality of life goals. Despite the personal treatment preferences of the Veteran or surrogate, fertility treatment using ART may be determined to be medically inappropriate in a specific patient case. We therefore recommend, as discussed further below, that the bill be amended to ensure that this benefit is subject to the responsible treating provider's having determined that the fertility treatment and counseling, including the use of ART, is medically necessary and appropriate for the

Veteran. If not amended, VA would still impose this as an implicit requirement (to accord with generally accepted standards of medical practice and to protect our providers from licensure challenges by their state boards), but VA could be exposed to challenges for limiting the law beyond its terms.

For instance, there could be scenarios where gamete retrieval or gamete use is sought after a Veteran permanently lacks decision-making capacity, has been judicially declared to be incompetent, or is dying. In these cases, the Veteran's desire to have a child may be based on a past wish based on a prior clinical situation, which may no longer apply or may now, if provided, result in clinically inappropriate action or treatment inconsistent with the patient's prior stated preferences. Even if use of gametes were included in a Veteran's advance directive (and the Veteran currently lacks decision-making capacity), the purpose of this type of treatment would still require interpretation between the authorized surrogate decision-maker and the responsible practitioner as to whether its provision is clinically warranted and medically appropriate.

Apart from the noted clinical concerns, Veterans could also arguably experience potential domestic (interpersonal)-based abuses of this benefit if a surrogate decision maker could provide consent in his or her stead, particularly if there could be a conflict of interest, e.g. surrogate is the spouse or partner who would benefit financially from having a child with the Veteran. Another scenario: If the nexus is not required and the Veteran's spouse's, partner's or surrogate's eligibility for ART is not conditioned on the eligibility and consent of the Veteran, could a Veteran who later regains decision-making capacity later sue VA for wrongful birth? It is unclear that a mere joint application process, even if carefully crafted, could avoid some negative consequences or abuses if the law leaves in place unintentional ambiguity (i.e., not limiting this benefit to treatment that is medically necessary and appropriate as determined by VA).

In our view, VA should not be required to deliver this benefit against the current informed consent and will of the Veteran. It is a benefit targeted at Veterans and their reproductive health needs. Again, the eligibility of the Veteran's spouse, partner or gestational surrogate should clearly derive only from, and be contingent on, the Veteran's eligibility for this benefit and the Veteran's ability to provide informed consent per cycle. One must bear in mind that this is a treatment benefit required to help overcome the inability to procreate due to the infertility condition of the Veteran, or to restore the health of the Veteran, which includes, among other things, that which restores the quality of life that has been lost as a result of the Veteran's (infertility) condition.

If the drafters' use of the disjunctive is deliberate to ensure that a single Veteran would have access to ART, then be assured that we would not interpret the use of the conjunctive to require them to have a spouse, partner or surrogate or to exclude them. Veterans seeking to bear a child or build a family can only take advantage of ART if they have another individual or donor by which to complete the benefit. (This is precisely why our current general treatment authority, applicable only to Veterans, is inadequate to provide enrolled Veterans with a complete IVF benefit.) We recognize

that some single Veterans may only require donated gametes to have the opportunity to conceive or build a family, and, if eligible, we would ensure they have access to these services under new section 1720K, as added by section 202(a).

To address these various concerns, we recommend as a technical matter that the draft bill language be amended to establish eligibility for a covered Veteran "and, if applicable, the Veteran's spouse, partner, or gestational surrogate." This would cover both single Veterans and those with spouses, partners or gestational surrogates. Further, while VA supports expansion of fertility services and counseling, to include the use of ART, to enrolled Veterans and, if applicable, their spouses, partners or surrogates, we believe the language of new section 1720K(a)(1), as added by section 202(a), should be amended to ensure these are provided only in cases where VA has determined their provision or continuation is medically appropriate, *e.g.,* decisions such as whether the care would be consistent with the patient's preferences, in accord with accepted standards of medical practice, and based on existing standards of informed consent (*i.e.,* adequate practitioner disclosure, patient understanding and patient voluntariness). Otherwise, the bill, as drafted, could result in beneficiaries described in the draft bill assuming, in error, that they could receive these services on demand, as long as they meet the eligibility criteria stated in the bill. As discussed, requirements of this bill should not require VA to contravene applicable standards of medical practice or providers' professional ethical obligations. This could be accomplished by inserting in new section 1720K(a)(1) the words "medically necessary and appropriate, as determined by a VA provider employed by the Department" after "furnish" and before "fertility."

The bill should be amended to make clear that matters of ownership, future embryo or gamete donation, disposition or destruction would be matters governed solely by applicable state law and an agreement required to be entered into between the Veteran, the spouse, partner or gestational surrogate, and the facility storing the cryopreserved gametes or embryos to avoid potential ownership or custody issues. The Veteran and the spouse, partner, surrogate or donor should also be required to enter into a private agreement(s) governed by applicable state law that controls the use of donated gametes or embryos, including embryos donated for adoption, or, if applicable, the terms of gestational surrogacy arrangements to ensure understanding of ownership or custody issues. It should also be clarified that VA is not a party to any such private agreements and has no ownership or custody of cryopreserved gametes or embryos, and that VA is not to be involved in the disposition of excess gametes or embryos. The language of the bill should make clear that VA is solely a payer for the services covered by new section 1720K, as added by section 202(a).

The eligibility criteria raise other technical concerns. To be eligible under new section 1720K, as added, a Veteran would need to have an infertility condition, unless the Secretary can show that the Veteran was completely infertile before service in the active military, naval or air service. First, it is unclear if this is intended to include infertility resulting from the receipt of necessary VA-treatment, but VA would interpret it as including this cohort.

Additionally, while we welcome expanding coverage for ART to Veterans enrolled in VA's health care system without regard to their sex, gender identity, sexual orientation or marital status, Veterans in same-sex relationships, transgendered Veterans or those who are not in a relationship/single may need ART to conceive. If they lack access to ART, the clinical outcome is the same, even if the Veterans do not carry a diagnosis of infertility.

Some administrative eligibility procedures or contract or payment mechanisms will deny eligibility or payment if the ART is not for treatment of infertility based on a diagnostic code(s) for infertility. These Veteran-cohorts may have healthy physiological reproductive function from the strict view of infertility experts yet require ART on the basis of another clinical diagnoses such as gender dysphoria or another medical condition (or have diminished but not diagnosable fertility due to hormonal or other treatment required to treat gender dysphoria) or they may simply lack a partner at the stage in time when they are ready to start a family, as many have postponed childbearing or building a family until after they completed their military careers. This draft bill would still not cover these Veterans unless they have a diagnosis of infertility, which some will not. Inclusion of donor and surrogate benefits under this section would not remedy this gap. It would need to be amended to ensure that their reasons for needing ART are covered.

The new section 1720K, as added by section 202(a) of the draft bill, would also require the Secretary to carry out an outreach and training program to ensure Veterans and VA health care providers are aware of these benefits and any changes thereto. The Secretary would not be required to find or certify a gestational surrogate for a covered Veteran or connect the gestational surrogate with a covered Veteran. Neither would the Secretary be required to furnish maternity care to a covered Veteran, spouse, partner or gestational surrogate in addition to what is otherwise required by law.

The new section 1720K(c), as added by section 202, would require VA to coordinate fertility treatment and counseling for Veterans seeking fertility treatment and counseling but not eligible under section 1720K(a). It is unclear which patient population this provision intends to cover. Unless they are eligible for these services under this or other VA authority, it would be inappropriate to furnish them with care coordination services, which should be the responsibility of their treating provider(s). The Committee may have intended to authorize VA to provide referral services to non-Department sources as done for those ineligible for readjustment counseling services under 38 U.S.C. § 1712A(c) or military sexual trauma counseling under 38 U.S.C. § 1720D(b)(2)(C).

Section 203 of the draft bill would add a new section 1789 to title 38, U.S.C., authorizing the Secretary to pay an amount, not to exceed a specified amount, to assist a covered Veteran (as defined in section 202) in the adoption of one or more children regardless of the Veteran's sex, gender identity, sexual orientation or marital status. The allowable amount would be the cost that the Department would incur by paying the

expense of three adoptions, as determined by the Secretary. It is unclear to us if the monetary adoption benefit would include authority to reimburse adoption costs already incurred. By authorizing VA to pay, not reimburse, these costs, is it intended that VA would pay the monetary benefit in advance of the costs actually being incurred by the Veteran, like a set allowance similar to an annual clothing allowance? How would VA confirm the adoption expenditures occurred? In addition, the requirement to set a limitation on the amount that can be paid under this section is unclear; the limit would be equal to the cost the Department would incur by paying the expenses of three adoptions (as determined by VA). Given the variances across the country in adoption costs and in the types of adoptions, it is unclear how the Committee intends for VA to determine this limit, yet alone use it for all claimants.

Section 204 of the draft bill would require the Secretary to ensure that VA employees assist Veterans in navigating fertility treatment (including that which uses ART) and counseling services; in finding a provider that meets the needs of these Veterans with respect to these services; and in continuing their receipt of such services without interruption if they move to a different geographic location. We note this section does not include, however, the authority to transfer or transport gametes. We recommend section 204 of the bill be amended to authorize VA to pay for the costs of transporting the Veteran's gametes and/or embryos to the new storage facility.

Section 205 would add new section 7330D to title 38, U.S.C., requiring the Secretary to facilitate research conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services to improve VA's ability to meet the long-term reproductive health care needs of Veterans who have a genitourinary service-connected disability or a condition that was incurred or aggravated inline of duty in the active military, naval or air services, such as a spinal cord injury, military sexual trauma, or a mental health condition, that affects the ability of the Veteran to reproduce. It would require the Secretary of Veterans Affairs to ensure that information produced by this research is disseminated across VHA if it may be useful for other VHA activities. It would also require the Secretary, not later than three years after the date of enactment, to submit a detailed report to Congress on the research activities conducted under section 7330D, as added. The report would need to include data disaggregated by Veteran's age, race, ethnicity, sex, gender identity, sexual orientation, marital status, type of disability (if applicable) and geographic location. As section 205 would impose VA-collaborative research requirements on DoD and the U.S. Department of Health and Human Services, VA defers to the views of these Departments on the feasibility of this provision.

Section 206 of the draft bill would require the Secretary to submit, starting not later than one year after the date of the enactment of this Act and not less frequently than annually thereafter, a detailed report on the fertility treatment and counseling furnished by VA, including through non-VA providers during the year preceding the submittal of the report. The annual report required by this section would yield no meaningful information. Fertility and infertility evaluation and treatment, including that using ART, is a clinical process that typically takes longer than one calendar year to complete. Therefore, an annual report would have overlapping and incomplete data.

This would create the potential for misinterpretation of the results. In addition, some of the listed reporting requirements, including “the number of veterans who self-reported difficulty becoming pregnant or successfully carrying a pregnancy to term to a health care provider of the Department or a non-Department provider,” would be impossible to gather without performing an individual record review, which is not feasible. Inclusion of self-reports by patients are also inherently subject to bias, lack of recall, unreliability, etc., and they do not necessarily correlate with or substantiate clinical findings or evidence.

Section 207 would require the Secretary to submit, not later than 180 days after the date of the enactment of this Act and not less frequently than every 180 days thereafter, a report to Congress containing data on the timeliness and adequacy of access by Veterans to fertility treatment and counseling services under this title (to include that delivered by non-VA providers). We believe this report would be of little utility for the same reasons provided in connection with section 206. Many valid reasons exist for variance in timelines for when the services covered by this bill would be requested, scheduled and delivered. In our current IVF program, VA aims to comply with its policies on outpatient scheduling, but we consider this in terms of a treatment episode. The use of ART, like IVF, is a complex clinical area dependent on availability of highly specialized medical professionals in the community willing to contract with VA, and requiring myriad clinical steps and stages, with up to three completed cycles allowed. Section 207 would appear to presume that services provided under section 1720K, if enacted, would not be a complex, time-intensive procedure. It fails to appreciate that this treatment area requires the psychological readiness of the Veteran and, if applicable, the Veteran’s spouse, partner or surrogate. Failures to become pregnant may understandably delay a beneficiary’s desire to start a new cycle. It also assumes VA is readily able to purchase the required professional medical services and the required cryopreservation and storage services wherever an eligible Veteran is located.

Section 208 of the draft bill would require the Secretary, not later than 18 months after the date of enactment of this Act, to prescribe regulations to carry out sections 202(a) and 203(a) in title II of the draft bill. To complete rulemaking, we believe this timeframe is not practicable.

We welcome the opportunity to discuss S. 1280 and these technical issues with you and fully share your goal of providing a complete reproductive health care benefit that includes the use of medically necessary and appropriate assisted reproductive technology to Veterans and, as applicable, their spouses, partners, or gestational surrogates. To this end, we are eager to work with the Committee on addressing the technical issues identified. Until we can work with the Committee to address these issues, VA recommends the Committee reserve consideration of S. 1280.

S.1307 Department of Veterans Affairs Provider Accountability Act

S.1307 would amend title 38, U.S.C., to enforce licensure and related requirements for VA health care professionals. Specifically, section 2 would add a new

section, section 7414, to subchapter I of chapter 74 of title 38, U.S.C. Section 7414 would require VHA to: (1) verify licensure, certification and registrations of health care professionals; (2) determine if the health care professional holds a Drug Enforcement Administration registration; (3) understand education, training, clinical experience and clinical competence; (4) be aware of malpractice history and occurrence; and (5) continuously monitors any changes to provider status.

VA supports the enactment of the bill. The amendments in section 7414(a) are consistent with VHA policy. VHA currently monitors any changes to the matters under paragraph (a)(2) through participation in the National Practitioner Data Bank Continuous Query Program (NPDB CQ). Licensed Independent Providers (LIP) have been required to be enrolled in the program for many years. In 2019, the monitoring was increased for ongoing monitoring through the NDPB CQ process for all licensed providers.

Section 7414(c)(1) would require the Secretary to ensure each Department medical center carries out ongoing, retrospective and comprehensive monitoring of the performance and quality of the health care delivered by each Department health care professional located at the medical center. Additionally, each Department medical center must timely carry out timely and documented reviews if an individual notifies the Secretary of any potential concerns related to a Department health care professional's failure to meet generally accepted standards of clinical practice. Section 7414(c)(2) would require the Secretary to establish a policy to carry out these monitoring and reviews. VHA already reviews concerns relating to quality of clinical care which is outlined in the guidance document titled "Privileged Competency – Reviews, FPPE for Cause, and Investigations" published in 2018. This document will be converted to formal VHA policy in the near future.

Section 7414(e) prohibits certain settlement agreement terms. Specifically, it would prohibit the Secretary from entering into a settlement agreement relating to an adverse action against a health care professional if such agreement includes terms that require the Secretary to conceal the employees serious medical error or lapse from the employees personnel file. This prohibition already exists in VHA regulation (see 38 C.F.R. 46.7) and VHA policy (see VHA Handbook 1100.19, *Credentialing and Privileging*).

Section 7414(f) would require "not less frequently than annually," the Secretary to provide mandatory training for the employees responsible for carrying out requirements in section 7414. Development of this training is already underway. VA's Employee Education System expects to have all modules completed and in the VA Talent Management System by FY 2022.

Since VHA has established policies and trainings in place for many of the requirements set forth in section 7414, if enacted, this bill would have no new costs.

S.1319 VA Quality Healthcare Accountability and Transparency Act

The "VA Quality Health Care Accountability and Transparency Act 2021" would direct the Secretary to make certain information publicly available on the Access to Care site or its successor. VA does not support this draft bill without amendment. We believe the bill is redundant with current VA efforts and requirements and are unclear about what problem the bill is trying to solve or the desired outcome of the legislation.

VA believes this bill duplicates existing efforts to enhance quality and transparency and harmonize measurement and reporting across U.S. payers and providers. The portions of the proposed legislation that are feasible and consistent with medical confidentiality requirements are already in place – i.e., aggregate reporting of quality, safety and access metrics. The website www.accesstocare.va.gov is publicly accessible and can be linked to from the VA homepage as well as the homepages of individual VA facilities.

We believe the quality monitoring provisions are redundant with requirements stated under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in section 104 as well as VA's existing platform for posting Waiting Time and Quality information at our Access to Care website. The legislation also requires posting of MISSION Act-related staffing and vacancy information, which is already available on VA's website at the following link: https://www.va.gov/employee/va-mission-act-section-505-data.

The bill also requires that the website should be easily understandable and usable by the general public. However, research, history and experience inform us that solutions intended to serve all possible audiences often do not serve any of them effectively. This is why VA believes any statutory mandate for website content needs to be very carefully considered.

VA believes the more sustainable approach is to harmonize the entire process of quality measurement and reporting across all payers and providers, and VA has recently worked with the Defense Health Agency (DHA) and the Department of Health and Human Services (HHS) toward this end. VA is also participating in the Core Quality Measure Collaborative (http://www.qualityforum.org/cqmc/), which has a similar focus – making measures more meaningful and less burdensome to providers and patients.

We would welcome the opportunity to follow up with the Committee to provide further technical assistance on this bill.

S.1467 VA Medical Cannabis Research Act of 2021

S.1467 would require VA to conduct a series of clinical trials of at least seven strains of cannabis, with varying ratios of tetrahydrocannabinol (THC) to cannabidiol (CBD), and to collect, analyze and report on the effect of these strains on multiple symptoms of chronic pain and PTSD.

VA has a history of scientifically driven research and high-quality clinical trials that have advanced Veterans' and the Nation's health care. VA's Office of Research and Development regularly funds clinical trials approved through its expert peer review system, which evaluates studies for scientific merit based upon the rationale, design and feasibility of the study proposal. Such trials already include medical uses of cannabis for conditions that impact Veterans.

The proposed legislation is not consistent with VA's practice of ensuring scientific merit as the basis for a randomized clinical trial. The requirement in the legislation to study at least seven types of cannabis and their effects on symptoms of PSTD and chronic pain is not consistent with the current state of scientific evidence, which suggests that smaller, early phase, controlled clinical trials with a focused set of specific aims are optimal to determine proof of concept for use of cannabis in treating specific conditions.

Human subjects research must include an evaluation of risks and benefits and should include the smallest number of participants needed in order to avoid unnecessarily putting subjects at risk. In any study, the size of the experimental population is determined statistically so that the power to detect differences between the control group and the experimental group is based on known effects, using a specific outcome measure. With cannabis, some of these effects are not known, thus a circumscribed approach to determine dose, administration modality, and best outcome measure must be shown in a proof of concept approach to ensure the validity of the research.

Further, the scientific peer review system would not favor simultaneously studying seven variants of cannabis and their effects on varying diagnoses without first demonstrating a specific rationale for each of the queries. Progress in cannabis research must start with a scientific query of what is already known for specific diagnostic categories of interest, then moving to next level clinical investigation.

To that end, VA has and continues to examine the current clinical evidence regarding use of marijuana for medical purposes and agrees that more research is needed. VA has utilized the scientific peer review system and is currently supporting a clinical trial of CBD to treat PTSD where CBD is used as an add-on treatment to standard of care psychotherapy. The results from this study should be available next year.

Additionally, VA recently convened a team of experts who worked together to design another interventional cannabis study, focused on chronic, diabetic neuropathic pain. The resulting study is a double-blind, randomized, placebo-controlled study with randomization to one of 4 treatment arms: placebo, THC, CBD or a combination of THC and CBD. The first subjects are scheduled to enroll in January 2022.

VA is already dedicating resources and research expertise to study the effects of cannabis on conditions affecting Veterans. VA's approved interventional studies were

subject to peer review and have been approved as scientifically valid and posing the least possible risk to our Veteran subjects. Further, the proposed legislation is redundant to the extent that VA is already examining risks and benefits of cannabis in treating PTSD and chronic pain. For these reasons, VA does not support this proposed legislation.

S.XXXX Draft Veterans' Emergency Care Claims Parity Act

Section 2 of the proposed legislation would amend 38 U.S.C. 1725, *Reimbursement for emergency treatment*, and 38 U.S.C. 1728, *Reimbursement of Certain Medical Expenses*. The amendments would limit the timeframe in which an individual or entity may file a claim seeking payment for treatment for non-contracted community emergency care to 180 days after the care is provided. Additionally, the proposed legislation would allow for a Veteran to be held harmless for the cost of care provided to the Veteran in the event an individual or entity submits claims for payment to the wrong Federal agency or in the event an administrative error is made by VA, such as misplacement of a paper claim.

VA supports section 2. As currently written, the language which requires heath care entities or providers to submit claims prior to 180 days after care is provided, duplicates language in the VA MISSION Act of 2018 under Chapter 2, Paying Providers and Improving Collections, section 111, Prompt Payment to Providers, which amended 38 U.S.C. 1703D(b). VA is currently working on regulations to implement this provision in section 111 and would have included this requirement for 38 U.S.C.1725 and 1728(b).

The additional language is related to removing a Veteran's financial liability and provides additional financial support for Veterans in the event an individual or provider fails to meet timely filing requirements, when certain administrative errors occur during claim submittal, or when the claim is processed by VA. Providing Veterans with protection from being billed for non-contracted community emergency treatment when claims for the care are not submitted in a timely manner removes the potential financial burden when a Veteran seeks emergency treatment. Additionally, providing the authority not to hold a Veteran responsible for when certain administrative errors are made decreases the potential for balance billing as well as limiting those situations where a Veteran could be submitted for debt collection.

On a technical level, we have some concerns regarding some of the terms used in this bill. The term 'individual' should be defined and the term 'entity' should be replaced with 'health care entity or provider' to be consistent with the definition in 38 U.S.C. 1703D(i)(5).

Section 3 of the proposed legislation would require VA to publish on one or more of VA's publicly available internet websites a summary list of all VA emergency care authorities to authorize community emergency care, along with corresponding deadlines for submission of claims; an illustrated summary of steps, such as a process map, with

a checklist of how to comply with VA's requirements for submission of clean community emergency claims that non-Department providers can follow to assure compliance with claim-filing procedures; and VA's contact information to address community provider process questions. Additionally, VA would be required to review the information published, as described in this bill, at least every 180 days.

VA supports section 3, as VA already publishes community emergency care fact sheets and can refine the information with additional detail to meet the specific requirements in this bill.

Currently, VA develops and publishes community emergency care fact sheets with information of program requirements for both Veterans and community providers on the VA public-facing website. VA can refine these fact sheets with additional detail to meet the specific requirements in this bill illustrating a summary of steps, such as a process map with a checklist for the submission of clean claims for community care providers to follow and assure compliance with the claim filing process. VA has established timelines for publication reviews on a reoccurring basis.

VA estimates that there is no new cost to VA as a result of this proposed legislation.

S.XXXX To direct the Secretary of Veterans Affairs to improve long- term care provided to veterans by the Department of Veterans Affairs, and for other purposes

Section 2 of this bill would require the Secretary of VA to develop a strategy for the long-term care of Veterans. The strategy must: (1) identify current and future needs for the long-term care of Veterans based on demographic data and availability of services from VA and non-VA providers; (2) identify the current and future needs of Veterans for both institutional and non-institutional long-term care taking into account the needs of growing Veteran population groups; and (3) address new and different care delivery models, including by assessing the implications of such models for the design of facilities and how those facilities may need to change, and examining the workforce needed to support aging populations of Veterans.

VA has no objection to section two of the draft bill. We would note that VHA is developing a Geriatrics and Extended Care strategic plan for services focused on keeping eligible Veterans safely at home and would be happy to provide this plan once completed.

Section 3(a) of the bill would require the Secretary to develop a standardized process throughout VA for entering into sharing agreements between State homes and medical centers of the Department. Section 3(b) would require the Secretary to ensure that all Veterans who are catastrophically disabled are not required to pay a copayment for medication received at a State home. Section 3(c) would require the Secretary to monitor any contractor used by VA to conduct inspection of State homes, require that

any deficiencies of a State home noted during the inspection be reported to the Secretary, and require the Secretary to publish the results of any inspection of a State home on a publicly available internet website.

VA does not support section 3(a) of the draft bill unless amended. On a technical level, clarification is needed regarding the definition of “sharing agreements” in the proposed bill. Because sharing agreements are made at the local facility level due to varying needs from market to market, we are unable to provide a cost estimate for this section.

VA does not support section 3(b), as VA does not have the authority to comply with this section. Veterans enrolled in the VA health care system are generally eligible for care set forth in VA’s medical benefits package which includes drug coverage. However, certain care is excluded from the medical benefits package, including outpatient care for a Veteran who is a patient in an institution of another government agency, if that agency has a duty to provide the care or services. State Veterans Homes are owned and operated by States. Section 511 of the Caregivers and Veterans Omnibus Health Services Act of 2010 prohibits VA from requiring a catastrophically disabled Veteran from making any copayment for the receipt of VA hospital care or medical services, to include medications. This law, however, does not prohibit States from imposing charges on Veterans in their State homes. For catastrophically disabled Veterans using their private prescription plan coverage for medications received at the State Veterans Homes, the Veteran will be responsible for any copayments and/or coinsurance under their plan.

VA supports section 3(c) of this bill. We have a current process to review inspections, aggregate data, and report to leadership in place and can make changes to inform the Secretary of inspection data. Additionally, reporting inspection results to a public-facing website aligns with current industry standards.

There will be costs associated with placing inspection reports on a public-facing website and additional resources will be needed to manage the website. VA estimates that the costs for section 3(c) will be $300,000 in FY 2022 and $1.64 million over the 5-year period between FY 2022 and 2026.

Section 4 of the bill would require the Secretary to commence, not later than one year after the date of the enactment of this Act, a pilot program under which the Secretary shall provide geriatric psychiatry assistance to eligible Veterans at State homes. The pilot shall run for a two-year period. The assistance provided under the pilot program may include the following: (1) direct provision of geriatric psychiatry services, including health care if feasible; (2) payments to non-VA providers in the community to provide such services; (3) collaboration with other Federal agencies to provide such services; or (4) such other forms of assistance as the Secretary considers appropriate. In providing assistance under this pilot program, the Secretary shall consider the geriatric psychiatry needs of the local area including by considering State homes with a high proportion of residents with unmet mental health needs, State homes located in

mental health care health professional shortage areas, or State homes located in rural or highly rural areas.

VA supports section 4 of the draft bill. Exploring ways to provide mental health services is currently being explored within the Geriatrics and Extended Care strategic plan. We estimate that the pilot program will cost approximately $1.37 million in FY 2022 and $1.41 million in FY 2023.

Section 5 of the bill would require the Secretary to work with public housing authorities and local organizations to assist aging homeless Veterans in accessing existing housing and supportive services, including health services such as home-based and community-based services from VA or non-VA providers, even if the Veteran is not eligible for such services from VA. The Secretary may and is encouraged to pay for these services.

VA has no objection to section 5 of the draft bill, but we note that the discretion provided to VA is an important feature, especially as it concerns ensuring adequate services for Veterans who are eligible for VA services.

S.XXXX Draft Guaranteeing Healthcare Access to All Personnel Who Served

Subtitle A of title I this bill deals with access to community care.

Section 101 of this bill would amend section 1703B of title 38, U.S.C., Access Standards. The amended section would create access standards to be used in determining eligibility for the Veterans Community Care Program. There would be access standards based on average drive times and number of days a Veteran would need to wait to receive an appointment within VA. When VA cannot schedule a VA appointment for a covered Veteran for primary care, mental health and non-institutional extended care service within 30 minutes average driving time from the Veteran's residence, or within 20 days of the date of the Veteran's request, the Veteran would be eligible under these access standards for treatment through a community provider. For specialty care or services, the standard would be within 60 minutes average driving time from the Veteran's residence, or 28 days from the Veteran's request for such an appointment. These access standards would apply both to VA when determining eligibility, and to community providers providing care when the Veterans Community Care Program (VCCP) eligibility has been established. In determining eligibility under these standards VA is not to consider the availability of telehealth appointments within VA. Driving time calculations would require VA to use geographic information system software. These access standards along with wait times would be required to be published and be updated on at least a monthly basis.

VA does not support section 101. VA has already designated access standards as required by section 104, Access Standards and Standards for Quality, in the VA MISSION Act of 2018. These access standards were implemented in regulation at Part 38 of the CFR, section 17.4040, Designated Access Standards. Section 104 of the

MISSION Act also requires the Secretary to conduct a review of the Department's access standards no later than three years "after the date on which the Secretary establishes access standards" and to submit a report to Congress on "the findings and any modifications to the access standards with respect to the review." While it has only been 2 years since the MISSION Act access standards were established by regulation, Secretary McDonough has directed an internal review to assess the impact of the MISSION Act's access standards on Veteran access and outcomes, and VA's ability to continue to deliver high quality, evidence-based, integrated care. Placing these requirements in statute prior to the completion of the statutorily mandated review of VA's access standards will not only prevent the Department from incorporating any key takeaways from the access standards review required by the MISSION Act, but it will also eliminate VA's flexibility to react to changes in market conditions and other emerging issues. VA believes that mandating the current access standards would be premature until a full analysis of their impacts has been conducted.

Additionally, VA agrees with the critical importance of ensuring Veterans have access to high-quality health care in VA's direct care delivery system and in the community but does not believe that mandating these access standards in all of VA's Community Care Network (CCN) contracts would be appropriate. The three key reasons are supply of providers in the private sector, provider choice, and projecting community care demand. Throughout the U.S., there are geographic regions with gaps in access to care, due to shortage of health care providers. The supply of community providers in these areas cannot be influenced by VA. Additionally, community providers choose where to locate their practices. Even in areas with community providers, the providers may ultimately choose not to participate in VA contracts, VA's goal is to provide outstanding access to high-quality care for Veterans and is proud of the more than 1.1 million providers that are a part of VA's CCN. VA and our third-party administrators have worked extensively to build a network that meets the needs of Veterans and takes into account local and regional needs and both parties continue to work together to build and refine the network based on needs that are identified. While we recognize that this statute allows for waivers to the requirements, network adequacy is an issue that is best addressed in the contracts with the third party administrators so VA has the ability to change them as needed due to changes in market conditions, or when new contracts are awarded.

Section 102 requires VA to develop and periodically update a strategic plan that would ensure there is a continuity of care under the VCCP. Specifically, this would be in cases when Veterans are transitioning to receiving care under VCCP due to a realignment, move or closure of their VA medical facility.

The strategic plan shall include an assessment and identification of realignments of VA medical facilities and what impacts they may have with VCCP health care providers in the areas where the changes are occurring to include potential gaps. Additionally, the strategic plan would describe how VA can inform Third Party Administrators (TPA) in area of the realigning VA medical facility and develop a process with the TPAs to ensure provider coverage for Veterans during the realignment.

VA does not support this section. Section 102 legislates what should be internal VA business processes. Placing these types of business processes in statute not only imposes unnecessary restrictions on VA's resources, but also limits VA's ability to quickly and effectively adapt to changes in circumstances.

Subtitle B of title I of this bill deals with the creation of a "Community Care Self-Scheduling Pilot Program".

Sections 111, 112, 113 and 114 of the bill would require VA to create a pilot program which would allow Veterans to use an internet website or a mobile application to request, schedule and confirm appointments made with a participating Veteran Community Care (VCC) provider. The pilot program would need to be implemented in five or more VISNs for a minimum of 18-months.

In order to implement the pilot, VA would need to be able to modify existing self-scheduling tools or enter a contract using competitive practices with one or more contractors to provide the needed services. The required capabilities include the Veteran having the ability to request, schedule, modify, view and cancel appointments for primary, specialty and mental health care and to be able to search for participating providers and have all of the relevant provider's contact information available. VA would also need to be able to load relevant patient information, store, and print VCC authorization letters and to have it integrated with the Veterans Health Information Systems and Technology Architecture of the Department or any successor information technology system.

VA supports this subtitle in principle; however, it is unclear if or how VA could contract for these services. Moreover, while VA has had similar initiatives in the past and has built a basic system, this system does not have the extensive capabilities that would be required by these sections. Additional time is required to understand the feasibility of these approaches and to consider the potential costs. This section would also be subject to availability of appropriations.

Section 121 of this bill adds new 38 U.S.C § 1703G, Credentialing verification requirements for providers of non-Department health care services. This new section provides specific requirements for VA's TPAs and credential verification organizations to ensure certain health care providers are excluded from participating in the community care network. Among other things, TPAs and credential verification organizations would need to: hold and maintain an active credential verification accreditation from a national health care accreditation body; conduct initial verification of provider history and license sanctions for all States and U.S. territories for a period of time that includes the period before the provider began providing non-Department health care services; and dating back not less than 10 years; perform recredentialing, including verifying provider history and license sanctions for all States and U.S. territories not less frequently than once every three years; and implement continuous monitoring of each provider through the

National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

VA does not support this section. This section imposes specific requirements for reviewing providers' credentials. These requirements would need to be cross-checked against existing CCN contracts and their requirements. It is unclear if these requirements go beyond the CCN contract requirements for credentialing. If they do go beyond the CCN contract requirements, this could disrupt the entirety of the CCN networks, as all of those networks would need to be re-credentialed. Additionally, codifying such requirements in statute is overly prescriptive and can cause VA to fall behind future industry standards. For example, VA currently utilizes the National Practitioner Databank (NPDB) for monitoring whenever applicable, but also utilizes additional sources such as state boards, the Federation of State Medical Boards (FSMB), and other sanction sites. Historically, the NPDB was a recommended source for sanction and adverse action monitoring. However, current industry standard practice now includes additional reviews for ongoing monitoring because NPDB is reliant upon organizations submitting a report which has the potential for gaps. VA believes it is more efficient to work with our TPAs and credentialing services to make necessary changes to keep up with industry standards without requirements mandated by Congress.

Section 122 of this bill amends section 108 of the VA MISSION Act of 2018 to deny or revoke the eligibility of a community health care provider to provide care to Veterans when, on or after of the date five years before the date of the enactment: 1) a provider was removed from employment with VA for violating policy regarding safe and appropriate health care; or 2) violated the requirements of a medical license of the health care provider that resulted in the loss of such medical license that occurred.

VA does not support this section. This section is unnecessary as VA already reviews whether a provider was terminated for violating policy regarding safe and appropriate health care or violated the requirements of a medical license of the health care provider that resulted in the loss of such medical license. In fact, VA does not restrict how far back this review goes. Section 122 potentially limits VA's ability to properly vet a community provider on past employment.

Section 201 of this bill would require VA, not later than one year after enactment of this bill, to develop a strategic plan to ensure the effectiveness of the telehealth technologies and modalities delivered by the Department. The strategic plan would be required to be updated not less frequently than once every three years. The strategic plan must include a list of all services provided through telehealth, an assessment of the effectiveness and patient outcomes for each specialty for which telehealth is provided, an assessment of Veteran satisfaction with telehealth services, an assessment of the modalities used to provide telehealth services, an outline of all partnerships related to telehealth, an assessment of barriers faced by VA in delivering telehealth, a detailed plan showing how VA is working with other Federal agencies to enhance the availability of telehealth to rural, highly rural and medically underserved areas, the feasibility of partnering with certain other entities to provide telehealth services in these underserved

areas, and an evaluation of the number of enrolled Veterans who have previously received care through the VCCP. The section would also require VA to periodically submit the strategic plan to Congress along with an identification of areas of needed improvement by VA.

While VA understands and supports the intent of section 201 of the proposed legislation, it does not support the bill as written. VA has significant reservations about the specific language and timelines. As one example, the bill requires VA to complete "An assessment of the effectiveness and patient outcomes for each type of health care specialty delivered by telehealth or virtual care by the Department." This requirement would require tremendous organizational coordination and resources. Telehealth is essentially delivered by every specialty, meaning this bill would require a complete assessment of every service delivered in VA. This is not a feasible requirement within the allotted timelines.

VA welcomes the opportunity to work with Congress to provide technical assistance to help resolve concerns about specific language and timelines in the bill.

VA defers to the Comptroller General on the requirements of sections 202 and 203 of this bill.

Section 301 requires VA to undertake an analysis of the feasibility and advisability of expanding assistance and support to caregivers to include caregivers of Veterans in the Republic of the Philippines.

VA does not support section 301 of the draft bill without amendment. While we appreciate the intent of the bill to determine the feasibility and advisability of expanding assistance and support to caregivers to include caregivers of Veterans in the Republic of the Philippines, we are unable to comply with the reporting requirements of section 301(c)(3) as written. Of the Veterans who are enrolled in the patient enrollment system and reside in the Republic of the Philippines VA would be unable to identify those who also have a caregiver and who also would be determined eligible to receive support and assistance under 1720G.

VA defers to the Comptroller General on the requirements of section 302 of this bill.

Section 401 of this bill would require VA to complete an analysis of the feasibility and advisability of making repetitive transcranial magnetic stimulation (rTMS) available at all medical facilities and electroconvulsive therapy (ECT) available at one medical center located within each VISN. Included within the report shall be an assessment of the final report of the COVER Commission, the number of Veterans with treatment resistant depression (TRD), the number of Veterans with TRD who received rTMS or ECT, and the number of facilities offering rTMS and ECT.

VA supports this section. VA recognizes the importance of providing evidence-based treatment for Veterans with TRD. In addition to evidence-based pharmacotherapy and psychotherapy, VHA currently provides the following evidence-based somatic treatments for Veterans with TRD: ECT, rTMS, ketamine infusions, and esketamine (Spravato®). Given the nature of the severity of TRD and its associated risk of suicide, these somatic treatments are considered essential services and as such ensuring access to Veterans who need these treatments is of upmost importance.

VA has been monitoring the utilization of ECT, rTMS, as well as the safety and effectiveness of ketamine infusions since FY 2015. Annual monitoring of these treatments and the newer esketamine (Spravato®) treatment will continue going forward, with assessments of the number of patients treated with one of these treatments and the locations where these treatments are provided. The most recent data available is for FY 2020.

VA suggests the final report not be limited to analysis of rTMS and ECT alone, but rather all four of the essential somatic treatments as listed above. VA recommends the analysis be based on requiring ketamine infusions and esketamine (Spravato®) treatments be available at one medical center located within each VISN.

VA estimates a cost of $38,600 associated with the requirements of this section.

Section 402 states that within a year of the enactment of the Act, VHA shall modify the Veterans Equitable Resource Allocation (VERA) system, or successor system, to ensure that resource allocations under the system include peer specialists.

VA supports this section. VHA peer specialists document all their work with Veterans in the Veterans' medical records. In 2014, clinic stop codes and a Current Procedural Terminology (CPT) code for peer specialists were established in the documentation system to accurately identify the individual and group encounters that peer specialists have with Veterans. Although the designated peer specialist H0038 CPT code does not have an associated work relative value unit (wRVU) value for reimbursement of services, the H0038 CPT code is used to document peer specialists' workload and is already considered in the VERA patient classification process that ultimately determines resources are allocated. Peer specialists and their supervisors have received guidance about how to appropriately document encounters using the H0038 CPT code so that peer specialists' workload can be counted toward their facilities' VERA. VHA's Office of Mental Health and Suicide Prevention continues to provide training and guidance for staff to ensure that appropriate coding of peer specialists' documentation occurs so that their workload can be accurately captured for inclusion in the VERA patient classification process.

Section 403 of this bill would require VA, not later than 270 days after enactment, to perform a gap analysis throughout the VHA on the use and availability of psychotherapeutic interventions recommended in widely used clinical practice guidelines as recommended in the final report of the COVER Commission. The gap

analysis must include an assessment of psychotherapeutic interventions that are available and routinely delivered at VAMCs, and an assessment of the barriers faced by medical centers in performing such interventions.

VA supports this section if amended to allow for sufficient time to perform the analysis. While VA supports the intent of this bill to identify gaps in VA's ability to provide psychotherapeutic interventions, the requirement to complete this analysis within 270 days is not realistic. Time is needed to define the parameters and to develop the mechanisms to collect and validate the information needed to provide a meaningful analysis. VA believes it would take 24 months to perform the analysis and provide a report.

VA has some concern about the scope of the term "psychotherapeutic interventions." Additionally, VA thinks it could be beneficial to include psychotherapeutic interventions performed via telehealth in the analysis. VA welcomes the opportunity to discuss these matters with the committee and to offer technical assistance if it is requested.

VA estimates a $750,000 cost associated with performing this analysis, if the section is amended to allow for a 24-month timeline.

Section 501 of this bill would require VA, not later than 180 days after enactment, to establish an online health care education portal to ensure Veterans are aware of health care services provided by VA. The portal must include modules on the Veterans Community Care Program, telehealth services, the VHA appeals process, patient aligned care teams, mental health services, suicide prevention services, specialty care services, dental health services, women's health services, navigating VHA websites and mobile applications, vaccines, toxic exposure, military sexual trauma, and the topics listed in section 121(b) of the VA MISSION Act of 2018. These modules must be updated not less frequently than once each year. The portal must be directly accessible from the main website of the Department, and the websites of each of the VAMCs. The portal must be easily understandable and usable by the general public.

VA must also ensure that all materials in the portal are available in print form at VAMCs. VA must consult with Veterans Service Organizations. VA may enter into a contract for the design of the portal and modules. Not later than one year after the establishment of the portal, VA must provide a report on the use of the portal, its effectiveness, and suggestions for improvement.

VA does not object to this section subject to the availability of appropriations as there would be some cost involved in creating the system.

Section 502 of this bill would exempt VHA's conduct of research from application of the Paperwork Reduction Act.

VA does not object to this section. VA does not believe there will be any cost impact to this provision.

Conclusion

This concludes my statement. We would be happy to answer any questions you or other Members of the Committee may have.