STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMITTEE ON HEALTH

JULY 14, 2021

Good afternoon, Chairwoman Brownley, Ranking Member Bergman and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Michael Fisher, Chief Officer, Readjustment Counseling Service.

We are providing views on H.R. 913, H.R. 2587, H.R. 2775, H.R. 2797, H.R. 3027, H.R. 3452, H.R. 3674, H.R. 3693, H.R. 4223 and three draft bills.

H.R. 913 Build a Better VA Act

The Build a Better VA Act would require the House and Senate Committees on Veterans' Affairs to adopt resolutions approving medical facility leases rather than requiring the major medical facility leases to be specifically authorized by law. VA is supportive of this bill.

This bill would allow the House and Senate Committees on Veterans' Affairs to provide Committee Resolutions, similar to General Services Administration (GSA), authorizing committee actions, rather than requiring VA to seek Congressional authorization for any lease that exceeds the average annual rent of $1,000,000.

VA recommends the following changes to 38 U.S.C. § 8104:

- In subsection (a)(3)(B) change the language from ". . . as a new medical facility at an average annual rent of more than $1,000,000" to ". . . as a new medical facility with an average annual rent exceeding General Service Administration's prospectus threshold."

This change would increase the prospectus threshold from $1,000,000 average annual rent to mirror GSA's threshold, which is currently $3,095,000 average annual rent and will be $3,375,000 in FY 2022. By increasing this threshold, upon completion of the review and approval process, VA could proceed immediately with medical facility leases with annual rent less than $3,095,000 or $3,375,000 in FY 2022, resulting in more facilities being activated sooner to help meet the demand for Veterans' health care.

VA would welcome the opportunity to follow up with the Committee to provide technical assistance on this bill. VA estimates enactment of this bill would be cost neutral.

H.R. 2587 Supporting Education Recognition for Veterans during Emergencies (SERVE) Act

The Supporting Education Recognition for Veterans during Emergencies Act would improve the ability of Veterans with medical training to assist the United States in response to national emergencies. Section 2 of the bill would require VA to update existing VA web portals to allow identifying Veterans who had a medical occupation as a member of the Armed Forces. Section 3 of the bill would require VA to coordinate with the Department of Defense (DoD) and Department of Labor to establish a program that would share information with states and Veteran Service Organizations for the purpose of facilitating civilian medical credentialing and hiring opportunities for Veterans seeking to respond to a national emergency. Further, section 4 of the bill would require VA to implement a program to train and certify covered Veterans to work as VA intermediate care technicians.

VA agrees with the broad objective of the bill to promote the ability of Veterans with medical training to assist in national emergencies. As such, the VA looks forward to providing technical assistance to mitigate concerns. However, for the reasons set out below, including the protection of Veterans privacy, VA does not support this bill.

Regarding section 2, the proposed web portal would collect Personally Identifiable Information (PII) pertaining to Veterans. This would require a Privacy Risk Assessment (which includes a Privacy Threshold Analysis and Privacy Impact Assessment) to be completed to assure protection of Veteran data. We believe the benefit of this provision would be outweighed by the extensive administrative and technical resources necessary to implement it. We welcome the opportunity to discuss with the Committee other ways the bill's objectives could be achieved.

Regarding section 3, we assume the provision intends to refer to section 2 – as drafted, we cannot discern the intent of the provision. Assuming it does intend to refer to section 2, we would not support it, as it refers to the PII that would be collected under that provision.

VA does not support section 4 because of ongoing duplicative efforts. An existing effort, the VA Intermediate Care Technician (ICT) Program is designed to hire former military corpsmen and medics into positions at VA medical centers (VAMC) as an integral part of our medical teams was created in 2016. The ICT program trains former military combat medics, medical technicians and corpsmen to be ICTs, to augment the VA medical workforce, leveraging the skillset of this population within Emergency Medicine, Primary Care, Inpatient Critical Care, and Specialty Care areas. In FY20, the number of facilities who have implemented the ICT program grew 103%. There are currently 65 VA medical centers that have established ICT programs with the goal of continuing to expand to all 170 VA medical centers. The number of approved ICT positions have

increased 144% with 400+ approved ICT positions. Section 4 of this bill would be redundant as we have a thriving ICT program in place. VA will be glad to discuss this provision with the Committee to see how this program could be augmented to include training and certification. However, at this point we are not prepared to endorse legislation to that end.

H.R. 2775 VA Quality Health Care Accountability and Transparency Act

The VA Quality Health Care Accountability and Transparency Act would direct VA to make publicly available, on the Access to Care site or its successor, certain information including data related to patient care; staffing and vacancy information; patient wait times information; and patient safety, quality of care and outcome measures. VA does not support this bill.

VA believes this bill duplicates existing efforts to enhance quality and transparency and harmonize measurement and reporting of patient care data across U.S. health care 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 accessed from VA's homepage as well as the homepages of individual VA facilities.

VA believes the quality monitoring provisions are redundant with requirements stated under section 104 of the *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018* as well as the Access to Care website, VA's existing platform for posting wait times and quality information. The legislation would also require posting of staffing and vacancy information. This is already a requirement under the VA MISSION Act of 2018, and this information is available at: https://www.va.gov/employee/va-mission-act-section-505-data.

The bill would require the website to be easily understandable and usable by the public. However, research, history and experience inform us that solutions intended to serve all possible audiences often do not serve any of them effectively. Therefore, 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 systematically across all payers and providers, and VA has recently worked with the Defense Health Agency and the Centers for Medicare and Medicaid Services toward this end. VA is also participating in the Core Quality Measure Collaborative (http://www.qualityforum.org/cqmc/), which has a similar focus of making the process more meaningful and less burdensome to providers and patients. VA would welcome the opportunity to follow up with the Committee to provide further technical assistance on this bill.

H.R. 2797 National Green Alert Act of 2021

The National Green Alert Act of 2021 would establish a Green Alert System Advisory and Support Committee, comprised of interagency Federal and private sector personnel, empaneled to outline best practices and provide technical assistance to states for establishing state “Green Alert” systems that would be activated when a Veteran with a history of mental health issues, including neurocognitive disorders, suicide attempts or impulses, or substance use disorders goes missing. VA does not support this bill.

VA believes the proposed legislation may be stigmatizing for Veterans with mental health conditions. Alert systems for missing individuals with cognitive impairment already exist in many jurisdictions.

In addition, VA has existing Federal Advisory Committees that could immediately explore this matter without forming a new committee. Our legacy committees could yield results in the next six months. Establishing a new committee, could take at least 16-18 months. VA committees whose missions would allow them to examine the merits of creating a “Green Alert” system include the Special Medical Advisory Group, National Research Advisory Council, Advisory Committee on the Readjustment of Veterans and the Veterans and Community Oversight and Engagement Board.

VA welcomes the opportunity to follow up with the Committee to provide further technical assistance on this bill.

H.R. 3027 Veterans Improved Access to Care Act of 2021

The Veterans Improved Access to Care Act of 2021 would amend the VA MISSION Act of 2018 to expand reporting on hiring in VHA. The bill defines the onboarding process as the process of bringing on a medical provider after the provider is offered a tentative selection. The proposed bill seeks to implement an onboarding goal of 60 days for Title 38 and Hybrid Title 38 occupations. The onboarding goal would be piloted for 2 years, at not fewer than 10 VA facilities. VA would also have to submit a strategy to reduce the duration of the hiring process for licensed professional medical providers by half, with a major focus on expediting credentialing. VA does not support this bill; however, we welcome the opportunity to provide technical assistance.

VA uses a Time to Hire (T2H) model that measures from the date a hiring need is validated to the actual start date of a new hire. This is in line with the Office of Personnel Management (OPM) requirements for all Federal agencies. For Hybrid Title 38 occupations, VHA uses the OPM standard 80-day model and for Title 38 occupations VHA uses a customized 100-day model to account for the additional time expected for clinical hires. The onboarding process as defined in the proposed bill is included within these models, with current target goals of 45 days for onboarding in the 100-day model and 26 days in the 80-day model. In summary, the existing onboarding goals are faster than the goal proposed in this proposed bill.

Some provisions of this proposed bill, namely section 2 (a) and (c) were already enacted into law under the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*, and the new information about T2H is reported in the most recent quarterly VA MISSION Act 505b report. VHA is currently averaging 62 days to onboard a Title 38 hire and 45 days for a Hybrid Title 38 hire, for an overall average of 51 days, exceeding the goal proposed in this draft bill.

T2H continues to be a critical effort for VA. During the COVID-19 pandemic, VA utilized various flexibilities to expedite hiring and onboarding. There are ongoing efforts within VA to evaluate the flexibilities used during the COVID-19 pandemic to determine which flexibilities may be permanently implemented to help reduce the overall T2H. Even prior to the COVID-19 pandemic, VHA had a national initiative underway to share best practices in reducing hiring timelines, including ongoing education efforts, T2H guidebooks and performance targets for operational and human resources leaders. The efforts in the proposed bill would be duplicative of current VA efforts.

Additionally, there are elements of the hiring process that are not within VA's control, which makes the goal of reducing the hiring process for licensed professional medical providers by half challenging. For instance, the VA/American Federation of Government Employees collective bargaining agreement requires all Hybrid Title 38 bargaining unit positions to be posted for 15 business days. This introduces some rigidity in the early portion of the hiring process for competitive hires that may not be easily compressed. In addition, for licensed independent providers it is common industry practice to provide 60-120 days' notice prior to leaving a position to ensure patient loads can be transferred to other clinicians. This means that when VHA selects a physician who is currently employed at a non-VA health system, their start date may be restricted by these provisions and therefore extend the overall T2H.

VA T2H is already lower than the Federal government average and we continue to work actively to reduce T2H while maintaining adequate pre-employment processes. This proposed bill would not assist VA in improving time to hire.

H.R. 3452 Veterans Preventive Health Coverage Fairness Act

The Veterans Preventive Health Coverage Fairness Act would amend 38 U.S.C. §§ 1710 and 1722A(a)(3) to eliminate copayments by VA for hospital care, medical services and medications related to preventive health services. The proposed legislation would also amend 38 U.S.C. § 1701(9) to expand the definition of "preventive health services." VA supports this bill subject to the availability of additional appropriations to replace lost revenue from the elimination of these copayments.

The proposed legislation does not appear to impact VA's authority to assess a copayment when an outpatient visit includes services beyond preventive health services or VA's authority to recover reasonable charges from a third-party under 38 U.S.C. § 1729. VA notes that under existing regulatory provisions at 38 C.F.R. § 17.108, outpatient visits solely consisting of preventive screening and immunizations and

laboratory services, flat film radiology services and electrocardiograms are not subject to copayment requirements and, pursuant to existing 38 C.F.R. § 17.4600, an eligible Veteran who receives urgent care consisting solely of an immunization against influenza is not subject to a copayment.

If this bill is enacted, VA would incur a loss of revenues impacting first party pharmacy and outpatient copayment collections. VA estimates that approximately 3% of all outpatient copayments are from services that are included in the expanded definition for preventive health services. This 3% was applied to the 10-year outpatient copayment collections amounts and resulted in a 5-year impact of -$24.2 million and a 10-year impact of -$49.1 million. For medication copayments, VA estimates the 5-year revenue impact on Pharmacy collections would be -$193 million and the 10-year impact would be -$399 million. The total MCCF collections impact would range from a 5-year impact of -$218 million to a 10-year impact of -$448 million.

H.R. 3674 Vet Center Support Act

The Vet Center Support Act would require VA to submit to the House and Senate Committees on Veterans' Affairs a report regarding mental health care services provided by VA to Veterans in each covered state. The report would be required to include an assessment of counseling services provided to Veterans, the feasibility of establishing additional Vet Centers and increasing staff at existing Vet Centers and an outreach strategy to ensure mental health services reach Veterans in underserved areas. VA does not support this bill.

VA is committed to identifying and reaching all Veterans, Coast Guard members, and active duty Service members (ADSM), including members of the Reserve component, and their families, who meet the eligibility criteria for Readjustment Counseling Service (RCS) Vet Center Services. VA understands that the intent of the proposed legislation is to support Vet Centers by ensuring services and resources are available for eligible individuals in each state. However, the Congressional report on Vet Center services and resources that would be required by this legislation appears redundant with Congressional reports required of VA under existing legislation.

The following are reports by VA to Congress that include this information:

Activities of Readjustment Counseling Services: Pursuant to 38 U.S.C. § 7309(e), VA is required to submit to the House and Senate Committees on Veterans' Affairs an annual report on the activities of the Readjustment Counseling Service during the preceding fiscal year (FY). The report must include the following components:

- A summary of activities of RCS, including Vet Centers;
- A description of workload and additional treatment capacity of Vet Centers, including, for each Vet Center, the ratio of the number of full-time equivalent (FTE) employees at such Vet Center and the number of individuals who received services or assistance at such Vet Center;

- A detailed analysis of demand for and unmet need for readjustment counseling services and the Secretary's plan for meeting such unmet need including the resources required to meet such unmet need, such as additional staff, additional locations, additional infrastructure, infrastructure improvements, and additional Mobile Vet Centers; and
- A prediction of trends in demand for care and long-term investments required with respect to the provision of care for each even numbered year in which this report is submitted. This information will be provided in the FY 2022 report.

The FY 2020 report was submitted to Congress in March 2021. The FY 2021 data will be submitted in March 2022.

Report to Congress Outlining Vet Center Services: House Report 116-445 to the Military Construction, Veterans Affairs, and Related Agencies Appropriations Bill, 2021, page 69 directs VA to report to the Committees on Appropriations of both Houses of Congress on the Vet Center services and outreach conducted by VA in each state or U.S. territory that does not have a Vet Center located within its jurisdiction. The report must also include an evaluation of service and outreach activities and an assessment of the need to establish a Vet Center in states and U.S. territories that do not have a Vet Center, and should include input from Veterans residing in these areas. If VA determines there is no need to establish a Vet Center in a particular jurisdiction, VA is directed to include in the report its plans to continue serving Veterans and their families in such areas. VA will also include information in this report regarding staffing levels and the RCS methodology for determining appropriate staffing levels. The report is due to Congress by July 13, 2021.

Plan to Provide Vet Center Services to Veterans Living in Areas Where No Vet Center is Located: Pursuant to section 3 of the Vet Center Eligibility Expansion Act (P.L. 116-176), VA is required to submit to the Senate and House Committees on Veterans' Affairs a plan to provide Vet Center services to Veterans living in geographic areas where no Vet Center is located, including in the United States insular areas. The plan is due to Congress by October 20, 2021.

H.R. 3693 Department of Veterans Affairs Continuing Professional Education Modernization Act (VA CPE Modernization Act)

The VA Continuing Professional Education Modernization Act would amend 38 U.S.C. § 7411 to increase the amount of money that VA shall reimburse board-certified physicians and dentists for continuing professional education (CPE) from $1,000 a year to $4,000 per year and remove the requirement for board-certification eligibility; establish a limit of $2,000 a year for other types of VA clinicians for CPE reimbursement; and include a mechanism to allow VA to adjust the annual caps for CPE reimbursement in the future based on inflation.

VA requests the opportunity to work with the Committee on the specifics of the bill, to ensure parity across critical occupations. VA looks forward to collaborating with the

Committee to achieve parity across critical occupations, recognizing that this would impact the cost of the bill. VA supports this bill because the provision of CPE is in the best interest of taking care of Veterans, provided that additional appropriations are provided for this purpose. Expanding the scope of this resource to other types of VA clinicians would allow the organization to address its other clinical mission critical shortages that have been identified in the 2020-2021 VHA Workforce and Succession Strategic Plan. As the plan is adjusted annually and as the COVID-19 pandemic has illuminated the importance of the interdisciplinary health care team, no member of the clinical team should be excluded from protected funding for CPE. Additionally, the availability of CPE is a powerful recruitment and retention tool and the potential expansion by this bill aligns with two of VHA's key priorities to execute improvement to affect system-wide transformative change to include:

- Restoring trust in VHA by ensuring Veterans receive top-quality service and highly reliable care that improves their health and prevents harm; and
- Creating a learning organization in which science and informatics, Veteran-clinician partnerships, incentives and culture are aligned to promote and enable continuous and real-time improvement in both the effectiveness and efficiency of care.

Allowing VA to adjust the annual caps, based on inflation, aligns with the High Reliability Organizational Model managerial framework for facilitating transformational change. Specifically, this allows the organization to be agile and adjust according to the needs of the market, allow health care providers to gain quality CPE and most importantly, to serve the Veteran patient population with quality care by receiving some of the most updated education and training with their private-sector peers.

VA estimates the enactment of this bill would result in costs of $83,457,000 for FY 2022; $2,305,573,071 over the 5-year period from FY 2022 through FY 2026; and $5,342,549,225 over the 10-year period from FY 2022 through FY 2031.

H.R. 4223 Student Veterans Counseling Centers Eligibility Act

This bill would amend 38 U.S.C. § 1712A to provide Vet Center readjustment counseling and related mental health services to Veterans and members of the Armed Forces using certain educational benefits. The Comptroller General would also be required to submit a report to the House and Senate Committees on Veterans' Affairs assessing the mental health needs of Veterans pursuing education using covered educational assistance benefits and VA's efforts to address those mental health needs. VA does not support this bill for the following reasons.

The mission of RCS is to provide readjustment counseling services to eligible individuals who have a military service-related trauma; served in a combat zone or area of hostility; or were activated in response to a national emergency, major disaster or civil disorder. As written, the bill proposes to expand eligibility solely based on the individual pursuing education using covered educational assistance benefits and may result in

individuals seeking services that fall outside the focus areas of Vet Centers and present significant challenges to the therapeutic milieu for those already receiving Vet Center services.

As noted above, VA is committed to identifying and reaching all Veterans, Coast Guard members and ADSMs, including members of the Reserve component, and their families, who meet eligibility criteria for Vet Center services. It is possible that some of the Veterans and members of the Armed Forces using certain educational assistance benefits that are the focus of this proposed legislation may already meet Vet Center eligibility. The timeframe associated with the review of this proposed legislation does not adequately allow RCS and VA to conduct a thorough assessment on how the proposed expansion of eligibility would impact delivery of Vet Center services, access to services for existing eligible individuals, organizational culture and structure, and budgetary considerations associated with these changes. VA would welcome the opportunity to follow up with the Committee to provide further technical assistance on this bill.

Draft Bill VA Infrastructure Powers Exceptional Research Act of 2021 (VIPER Act of 2021)

The VA Infrastructure Powers Exceptional Research Act of 2021 would amend 38 U.S.C. to improve research conducted within VA.

As currently written, section 2 of the bill would exempt all of VA from the Paperwork Reduction Act (PRA). It is not clear if the Committee intended the exemption to be this broad. The Paperwork Reduction Act serves important public purposes related to transparency, public and veteran involvement in data collection, burden reduction, and scientific integrity.

Section 3 of the bill would amend subchapter I of chapter 5 of 38 U.S.C. by adding a new section 513A, Other Transactional Authority.

Although VA has authority to conduct innovative research and development via Cooperative Research and Development Agreements (15 U.S.C. § 3710a) and a number of authorities under Public-Private Partnerships including 38 U.S.C. §§ 513, 523 and 6306, these authorities do not permit VA to provide any funding. Other Transactional Authority (OTA) would permit VA to provide funding to third parties in industry, academia and the nonprofit sector to bring forward transformational research, development and demonstrations of innovations to meet emerging VA priorities and Veteran needs. OTA would provide the flexibility to tailor transactions to meet the specific requirements of a project as awards are not subject to the Federal Acquisition Regulation (FAR). The additional flexibility OTAs would provide in structuring projects may allow the agency to engage non-traditional contractors that would otherwise not be willing to do business with a Federal agency. For example, the intellectual property and cost accounting provisions required by typical government procurement and assistance programs are often viewed by industry as obstacles to doing business with a Federal agency. Also, unlike funding instruments governed by the FAR, OTA is not subject to

the Bayh-Dole Act (35 U.S.C. §§ 200-212), and the potential for government march-in rights would not be applicable.

OTA would allow the flexibility to tailor transactions to meet the specific requirements of a project. This flexibility would be appealing to attract participation from entities that are new to engagement with Federal agencies.

OTA has been in use by the Federal government for the past 60 years and has become increasingly sought by agencies as a means of agile development to source high quality innovations from the private sector. To date, Congressional legislation has authorized 11 Federal agencies to use OTA. In a January 2016 report, *Federal Acquisitions: Use of 'Other Transaction' Agreements Limited and Mostly for Research and Development Activities*, the Government Accountability Office (GAO) found that most agencies—9 of the 11—used OTAs for RD&D activities for a range of projects from medical research to energy development research. Two of the nine agencies—DoD and the Department of Homeland Security—also used OTAs for prototype activities. VA would use this authority to advance new technologies and processes via prototype design, development, testing and implementation.

In part, section 4 would allow for a waiver of the 4-year limit in the Intergovernmental Personnel Act (IPA) Mobility Program. It also would permit researchers with dual appointments to receive outside funding to perform VA research outside their VA tour of duty. The ability to utilize research personnel assigned to perform research under the IPA program provides a great deal of benefit to VA, and a waiver on the 4-year time limit would be very beneficial. Personnel on IPA agreements are assigned to a local VA facility (i.e., “field based”) and are not located in the Office of Research and Development (ORD). IPAs are field research office assignments to carry out specific VA funded projects. There is currently a four-year time limit on IPA assignments after which the individual needs to return to their home institution for a minimum of one year before accepting an additional VA assignment. When a member of the research team on an IPA takes a required break in service, the investigator who leads the team must find and train another qualified person, assuming that such a person can be identified. This causes significant delays and increased costs, which impacts productivity and makes it more difficult for VA to bring individuals with needed research skills to VA. Thus, a waiver on the 4-year time limit would be beneficial to VA’s research program and would represent a better use of taxpayer dollars. VA recommends clarifying the language in this section so that it applies to personnel who are on IPAs with any VA research office and not just ORD at VA Central Office.

The provision allowing researchers with dual appointments to receive outside funding to perform VA research outside their VA tour of duty supports the collaborative relationships with universities and VA non-profit corporations (NPC) that are foundational for VA research and which VA strongly favors. However, there are several problems with the phrasing of this section that if addressed would enhance VA researchers’ ability to bring in research sponsored by non-VA entities to the benefit of Veterans.

For example, the phrase, “regardless of whether the research is approved by an element of the Department” is problematic. Current policy requires that all research conducted in VA be approved by the appropriate Department research oversight committees. As written, a VA employee could conduct a clinical trial with VA patients outside their VA duty hours without approval of the study by the Department or any approval by any VA entity if a non-profit corporation or academic entity was providing compensation to the VA employee. This would directly impact patient and research subject safety. It also appears to be counter to the intent of the statute that created the VA-affiliated NPCs specifically to provide a flexible funding mechanism for the conduct of approved research and education at VAMCs.

Also, based upon the current wording of the proposed legislation, a VA employee who is also an academic faculty member receiving compensation from an academic entity could use VA time to conduct research that is not approved by VA but which would directly benefit the employee’s academic employer. That would lead the employee to violate Federal ethics laws, including 18 U.S.C. § 208, under which Federal government employees are prohibited from participating personally and substantially as part of official duties in a particular matter that has a direct and predictable effect on their financial interests or the financial interest of their spouse, minor child, outside employer or certain others.

VA recommends the following language to allow for outside compensation while also ensuring transparency and protecting Veterans:

(b) OUTSIDE COMPENSATION FOR VA RESEARCH
- (1) Compensation by a VA-affiliated nonprofit corporation established under subchapter IV or VA affiliated university may be paid to and accepted by an employee, without regard to section 18 U.S.C. § 209, for research conducted pursuant to 38 U.S.C. § 7303 if –
  - (A) The research has been approved in accordance with procedures prescribed by the Under Secretary for Health; and
  - (B) The employee conducts research under the supervision of Department personnel; and
  - (C) The Department has negotiated, agreed to, and reduced to writing the terms of such compensation.
- (2) Irrespective of the compensation source, an employee described in this subsection will hold a with or without compensation appointment and is considered an employee of the Department.

The Secretary may prescribe and enforce any regulations, policies, and procedures necessary to carry out the purposes and administration of this provision.

Under section 5 of 38 U.S.C. § 7401(3) would be amended to expand hiring authorities for certain classes of research occupations, including statisticians, economists, informaticists and data scientists.

VA needs these occupational categories to keep up with the rapid changes in data analytics including artificial intelligence. VA needs to be able to compete with the private sector in bringing data analytic talent to VA. We strongly support the inclusion of these occupational categories.

Section 6 would authorize a career development award grant program for medical research at R3 research institutions. The Chief Research and Development Officer may establish a grant program to fund research related to health care furnished by VA; that is a CDA-1 level award of the career development program of VA; and modelled on the Historically Black Colleges and Universities Research Scientist Training Program of the Department.

This section would appear to authorize VA to provide career development research awards to individuals who have appointments at universities with relatively smaller (i.e., R3) research programs. VA currently has the authority to work with researchers from these institutions, so the benefit of this provision is not clear. We do not support this provision.

Section 7 would authorize for FY 2022, $42,000,000 for research information technology and $100,000,000 for repairs to the physical infrastructure of research facilities of VA.

VA appreciates the Committee's support for the information technology and physical infrastructures needs of the Department's research program and looks forward to working with the Committee to continue to improve the program.

The $42,000,000 information technology (IT) appropriation would be used to upgrade and to secure additional data storage needed immediately to avoid the loss of irreplaceable research data. This level of funding would provide VA a much-needed IT infrastructure patch for critical areas of immediate need. The proposed legislation would also authorize much needed remediation, including minor construction, non-recurring maintenance and non-capital solutions to close the condition gap.

Section 8 would require the Comptroller General of the United States to conduct a study on the amount of time dedicated for research for VA clinicians and scientific and professional personnel. The study would be required to include a review of VA policies and practices regarding time dedicated for research and an assessment of the effect of such policies and practices on VA recruitment and retention efforts and the productivity of VA clinicians and scientific and professional personnel with respect to research.

The proposed study would help VA Research understand the challenges for clinician researchers to have adequate protected time to dedicate to performing research activities. Clinician-scientists may share time doing clinical work as well as research work where their clinical duties prevent them from taking on clinical studies that may benefit Veterans. The issue is not critical for research personnel who are hired only to

work on research projects and who are hired on part-time and temporary assignments. Therefore, VA recommends that any such study be limited to clinician-scientists.

The provisions within this proposed legislation that VA supports will generally be cost-neutral or potentially cost-saving. For example, the time saved as a result of VA research being exempted from the PRA will lead to more efficient conduct of research and use of researcher time. Similarly, removal of the 4-year limit on IPA assignments will save resources that are currently required to hire and train personnel when IPAs expire.

Draft Bill **Bill requiring an independent assessment of VA health care delivery systems and management processes**

This bill would amend chapter 17 of 38 U.S.C. to require an independent assessment of VA health care delivery systems and management processes to be conducted once every 10 years.

The bill would create redundancy of effort for VA. VA is already subject to many forms of external review and assessment, including targeted assessments required under the *Veterans Access, Choice and Accountability Act of 2014 and the VA MISSION Act of 2018*. VA is also subject to assessments and audits by The Joint Commission as well as periodic and ongoing reviews by GAO and the Office of Inspector General.

The bill would require VA to enter into one or more contracts with a private sector entity or entities to conduct the independent assessment of the hospital care, medical services and other health care furnished by VA. To conduct these assessments, the private sector entity or entities would still rely on VA staff and subject matter experts to supply and interpret data and meta-data, which significantly interferes with VA's day-to-day operational efficiency.

The proposed legislation would require the independent assessment to be completed not less than once every 10 years; however, it would not provide for sunset or modification of scope. The proposed legislation would provide specific topic areas that reflect headlines of the present, but recent history demonstrates that the challenges facing health care systems can evolve rapidly. For these reasons, VA does not support this bill.

Draft Bill **Bill to amend title 38, United States Code, to clarify and improve the Program of Comprehensive Assistance for Family Caregivers of the Department of Veterans Affairs**

Section 2 of H.R. ___ would amend 38 U.S.C. § 1720G to clarify the appeals process associated with decisions under the Program of Comprehensive Assistance for Family Caregivers (PCAFC or Program), provide flexibility to VA to amend the timeline for expanding PCAFC to eligible Veterans of all eras and require a new quarterly report. VA supports this draft bill and strongly recommends Congress take action to ensure its

timely enactment. However, VA welcomes the opportunity to provide technical assistance, including the technical assistance included below, to eliminate any possible confusion as to the effect of the bill language.

VA supports section 2(a) of the draft bill, which would add a new paragraph to 38 U.S.C. § 1720G to clarify that "review of any decision affecting the furnishing of assistance under [PCAFC] shall be subject to the clinical appeals process of the Department, and such decisions may not be appealed to the Board of Veterans' Appeals." Enactment of section 2(a) of the draft bill would, consistent with VA's long-standing interpretation of 38 U.S.C. § 1720G(c)(1), make clear that PCAFC determinations are not subject to Board of Veterans' Appeals (Board) review, but rather are only appealable through the VHA clinical appeals process because they are clinical decisions.

On April 19, 2021, the United States Court of Appeals for Veterans Claims (Court), in the case of *Jeremy Beaudette & Maya Beaudette v. Denis McDonough, Secretary of Veterans Affairs*, issued an Order that makes Board review available to individuals who have received a decision under VA's PCAFC. Previously, PCAFC decisions were appealable only through the VHA clinical appeals process. VA disagrees with the Court's Order because it undermines Congress' statutory mandate in 38 U.S.C. § 1720G(c)(1) and, in doing so, dictates an outcome that is precisely the opposite of the intention expressed by Congress. On May 10, 2021, the Secretary filed a motion for full court review of the April 19, 2021, Order.

PCAFC is a health care program designed to support the clinical needs of eligible Veterans who receive personal care services from Family Caregivers at home. Identifying the personal care service needs of Veterans and determining whether Veterans meet the PCAFC eligibility criteria require complex clinical assessments. Accordingly, the clinical appeals process is far better suited than the Board for resolving disputes concerning PCAFC decisions. By clarifying that PCAFC decisions are reviewable only through the VHA clinical appeals process, section 2(a) of the draft bill would ensure that PCAFC decisions remain within the purview of clinical providers, and that decisions concerning a patient's health care and treatment are made by medical professionals with appropriate training and expertise. Moreover, it would ensure that appeals of PCAFC decisions are decided in a timely manner in accordance with the timelines for clinical appeals set forth in Appendix G of VHA Directive 1041, *Appeal of Veterans Health Administration Clinical Decisions*, September 28, 2020.

Since enactment of 38 U.S.C § 1720G in 2010, Congress has recognized the clinical nature of PCAFC, and that Veterans' personal care service needs can improve or worsen over time. In contrast to decisions under other VA benefit programs over which the Board has jurisdiction, Congress made clear that PCAFC benefits are not entitlements. 38 U.S.C. § 1720G(c)(2)(B) (providing that "[n]othing in [section 1720G] shall be construed to create . . . any entitlement to any assistance or support provided under [section 1720G]"). Fittingly, VA is required by statute to periodically evaluate the needs of the eligible Veteran and the skills of the Family Caregiver to determine if additional instruction, preparation, training or technical support is necessary (38 U.S.C.

§ 1720G(a)(3)(D)) and to monitor the well-being of each eligible Veteran (38 U.S.C. § 1720G(a)(9)(A)), which VA conducts through reassessments (38 C.F.R. 71.30) and wellness contacts (38 C.F.R. 71.40(b)(2)), throughout the eligible Veteran's participation in the Program. It is also critical to recognize that PCAFC assistance consists of far more than just the monthly stipend. PCAFC clinically supports Veterans and Family Caregivers throughout their participation in the program by providing Family Caregivers with training and technical support to assist them in their caregiving role, as well as counseling and mental health services, and respite care, among other benefits. Section 2(a) would maintain the clinical nature of PCAFC and ensure that appeals concerning PCAFC decisions receive timely resolution so that VA can provide appropriate clinical interventions and additional support as quickly as possible.

In addition to ensuring PCAFC decisions remain within the purview of clinical providers, ensuring that appeals of PCAFC decisions are decided in a timely manner and preserving the clinical nature of PCAFC, maintaining PCAFC appeals exclusively within the clinical appeals process would result in substantial cost avoidance that would otherwise result from VA's implementation of the Court's Order in *Beaudette*. Carrying out the Court's Order in *Beaudette* is expected to require substantial investment in IT development and changes across multiple systems, the hiring of additional personnel across VA and marked changes in the workflows for reviewing appeals that will require re-training and education of employees numbering in the thousands, among other expenses needed to implement the fundamental transition required to permit meaningful and timely review of PCAFC decisions appealed to the Board.

Even if Congress enacts section 2(a), VA's work is not done. It is critical that VA continues to monitor and refine the manner in which PCAFC eligibility and appeals decisions are made, and to improve transparency regarding PCAFC decisions by enhancing VA's communications with Veterans and their caregivers. In October 2020, VA made significant changes to improve consistency and standardization in PCAFC decision-making, to include in decisions made through the clinical appeals process. This included establishing one or more Centralized Eligibility and Appeals Teams (CEAT) within each Veterans Integrated Service Network (VISN), which are composed of a standardized group of inter-professional, licensed independent practitioners, with specific expertise and training in the eligibility requirements for PCAFC. CEATs make determinations of PCAFC eligibility (other than limited determinations made at the VA medical facility level) and whether the Veteran is determined to be unable to self-sustain in the community for purposes of determining the stipend level. CEATs also provide reviews and recommendations regarding PCAFC decisions through the clinical appeals process, as outlined in Appendix G of VHA Directive 1041, *Appeal of Veterans Health Administration Clinical Decisions*, which was published on September 28, 2020. Appendix G of this directive outlines a unique and improved process for appealing a PCAFC decision through the VHA clinical appeals process. While VA has made substantial progress, VA continues to engage with stakeholders and explore opportunities to improve PCAFC.

To ensure there is no uncertainty as to the impact of the amendment in section 2(a), VA recommends the technical assistance that follows. Instead of adding a new paragraph (14) to 38 U.S.C. § 1720G(a), the recommended bill language below would amend 38 U.S.C. § 1720G(c)(1), which was left undefined by the *Beaudette* Order. Additionally, the recommended bill language would remove "affecting the furnishing of assistance" and replace "subsection" with "section" to affirm that all decisions under 38 U.S.C. § 1720G, to include decisions under subsections (a) and (b) of 38 U.S.C. § 1720G, are subject to the VHA clinical appeals process and may not be appealed to the Board. The following bill language would also align with similar language in 38 U.S.C. § 1703(f) that the Court contrasted with current 38 U.S.C. § 1720G(c)(1) in the *Beaudette* Order.

VA recommends section 2(a) be replaced with the following:

> (a) CLARIFICATION RELATED TO APPEALS.—Paragraph (1) of section 1720G(c) of title 38, United States Code, is amended to read as follows:
>
> > "(1) The review of any decision under this section shall be subject to the clinical appeals process of the Department, and such decisions may not be appealed to the Board of Veterans' Appeals.''

Subsection (d) of section 2 of the draft bill would specify that the "amendment made by subsection (a) shall apply with respect to reviews occurring on or after the date of the enactment of this Act." Section 2(d) could create confusion as to the applicability of subsection (a). Therefore, VA's support for section 2(d) is conditioned on the adoption of the technical assistance provided below.

Section 2(d) refers to "reviews" that occur on or after the date of enactment. VA would interpret the term "reviews" to refer to VA's consideration of a decision on appeal. Accordingly, any VA review of a decision described in subsection (a) would, on or after the date of enactment, occur only through the clinical appeals process. The Board would not have jurisdiction to conduct any such reviews on or after the date of enactment, regardless of the date of the decision or the date an appeal regarding such a decision is submitted to VA (whether occurring before, on, or after the date of enactment). This would have the effect of overturning the *Beaudette* Order insofar as such Order authorizes Board review of 38 U.S.C. § 1720G decisions.

To ensure the term "reviews" in subsection (d) is not interpreted to refer to "decisions" occurring on or after the date of enactment or "appeals" submitted to VA on or after the date of enactment, which would result in disparate appeal processes depending on whether the decision was made or the appeal was submitted before or after the date of enactment, VA recommends adding, " regardless of the date of a decision referred to in such subsection or the date an appeal regarding such a decision is submitted to VA" at the end of subsection (d).

Accordingly, VA recommends subsection (d) be revised as follows:

(d) APPLICABILITY.—The amendment made by subsection (a) shall apply with respect to reviews occurring on or after the date of the enactment of this Act, regardless of the date of a decision referred to in such subsection or the date an appeal regarding such a decision is submitted to VA.

VA supports subsection (b) of section 2, which would amend 38 U.S.C.§ 1720G(a)(2)(B) to provide flexibility to VA to accelerate the timeline for expanding PCAFC to eligible Veterans of all eras. Currently, to qualify for PCAFC, a Veteran must have incurred or aggravated a serious injury in the line of duty in the active military, naval or air service on or before May 7, 1975 or on or after September 11, 2001, among other eligibility criteria. Pursuant to current 38 U.S.C. § 1720G(a)(2)(B), PCAFC cannot expand to eligible Veterans who incurred or aggravated a serious injury in the line of duty between May 7, 1975 and September 11, 2001, until two years after the Secretary submitted to Congress the certification required by 38 U.S.C. § 1720G(a)(2)(B)(i) regarding implementation of the information technology system required by section 162(a) of the VA MISSION Act of 2018. Because that certification was submitted to Congress on October 1, 2020, under current 38 U.S.C. § 1720G(a)(2)(B)(iii), PCAFC will expand to all eligible Veterans who incurred or aggravated a serious injury in the line of duty, on October 1, 2022.

Section 2(b) would authorize the Secretary to begin expanding PCAFC to eligible Veterans of all eras, before (but no later than) October 1, 2022. Currently, VA does not expect it will have sufficient resources to implement this expansion before October 1, 2022. This is because PCAFC continues to process new applications received since October 1, 2020, (the number of which has significantly exceeded VA's original projections); carry out reassessments of legacy participants and legacy applicants; and implement programmatic changes needed to improve efficiencies and streamline internal process in anticipation of further PCAFC expansion to eligible Veterans of all eras. While it is not currently feasible for VA to further expand PCAFC before October 1, 2022, this legislation would afford VA the opportunity to continue to assess whether doing so would be possible. If it is, section 2(b) would authorize VA to accelerate PCAFC expansion under 38 U.S.C. § 1720G(a)(2)(B)(iii).

No costs would be associated with section 2(b) unless VA exercised the authority to accelerate the timeline for PCAFC expansion under 38 U.S.C. § 1720G(a)(2)(B)(iii).

Subsection (c) of section 2 would require VA to submit reports to the House and Senate Committees on Veterans' Affairs specifying the total number of PCAFC applications denied by VA based on a determination that PCAFC "participation is not in the best medical interest of an eligible Veteran." The first report would be due no later than 90 days after enactment, and subsequent reports would be due quarterly thereafter. The number of denied applications would have to be disaggregated by CEAT or VA facility.

VA generally supports any opportunity to improve transparency about PCAFC decision making and is therefore supportive of quarterly reports like those contemplated in

section 2(c). However, VA seeks clarification on the reference to “best medical interest” in subsection (c)(1), and the disaggregation sought by the drafters in subsection (c)(2).

Whether PCAFC participation is “in the best interest” of a Veteran or Service member is one of several eligibility criteria for PCAFC. The term “in the best interest” is explicitly defined in regulations implementing PCAFC at 38 C.F.R. 71.15. VA does not delineate best “medical” interest from other matters considered in determining whether PCAFC participation is in the best interest of a Veteran or Service member. Additionally, a determination that it is not in the best interest of the Veteran or Service member to participate in PCAFC is only one basis upon which an individual may be deemed ineligible for PCAFC – whether following submission of a PCAFC application or following a reassessment of eligibility under 38 C.F.R. 71.30. Although VA also tracks the other bases of PCAFC application denials and bases of revocation and discharge as part of its ongoing program monitoring, section 2(c) refers only to PCAFC applications denied by VA based on a determination that PCAFC “participation is not in the best medical interest of an eligible veteran.”

Further, VA is not currently able to disaggregate, by CEAT, determinations on PCAFC applications concerning the “in the best interest” criterion. VA can disaggregate this data by the VISN currently associated with the Veteran in the Caregiver Record Management Application (CARMA), but the CEAT that made the determination may not be in the same VISN that is currently associated with the Veteran. This is because the Veteran could have moved immediately after the CEAT determination was made and may be associated with a different VISN in CARMA at the time the data is captured for the quarterly report that would be required by section 2(c). Additionally, CEATs regularly make determinations on PCAFC applications from other VISNs, as PCAFC works to balance workload among CEATs. Also, in the case a VISN has multiple CEATs, VA cannot currently disaggregate data to identify which specific CEAT within a VISN rendered a determination.

VA notes that only CEATs make determinations as to whether PCAFC participation is “in the best interest” of a Veteran or Service member. In making these determinations, CEATs consider input provided by the local VA medical facility, but the determinations are not made by the local VA medical facility. Therefore, there would be no need to disaggregate this data by local VA medical facilities.

Conclusion

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