STATEMENT OF
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DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

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Chairwoman Brownley, Ranking Member Bergman and other 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 Scotte Hartronft, MD, Executive Director, Office of Geriatrics & Extended Care.

H.R. 4993 Veterans Emergency Care Reimbursement Act

Section 2(a) of H.R. 4993 would amend 38 U.S.C. § 1725(c)(4)(D) to remove the phrase "or similar payment" and insert "of less than $100". This change would prohibit VA from reimbursing the cost of emergency treatment at a non-VA facility to a Veteran under this section for any copayment of less than $100 that the Veteran owes the third party or for which the Veteran is responsible under a health-plan contract. It also would define the term "copayment" to mean a fixed amount paid by an individual for a covered health service received by the individual and would not include any amount paid for a deductible or coinsurance. Section 2(b) would provide that the amendments made by section 2(a) would apply with respect to any reimbursement claim under 38 U.S.C. § 1725 submitted to VA for emergency treatment furnished on or after February 1, 2010, including any such claim submitted by a member of the certified class seeking relief in *Wolfe* v. *McDonough* (No. 18-6091 (U.S. Vet. App.)). Section 2(c) would define the terms "emergency treatment" and "health-plan contract" to have the same meanings as given in 38 U.S.C. § 1725(f). Section 2(c) also would define the term "reimbursement claim" to include any claim by a Veteran for reimbursement of a copayment, deductible, coinsurance or any other type of cost share for emergency treatment furnished to the Veteran in a non-Department facility and made by a Veteran who had coverage under a health-plan contract, including any claim for the reasonable value of emergency treatment that was rejected or denied by VA, whether the rejection or denial was final or not.

The Department is deeply interested in ensuring that Veterans who have received emergency treatment are reimbursed appropriately for those costs. We would welcome the opportunity to discuss this bill further with the Committee to clarify its intent and to ensure that any legislation in this area clearly identifies its intended goals. However, we do not support H.R. 4933 because of ambiguities in the legislation and a number of

technical concerns with the bill as written. We believe the removal of the phrase "similar payment" is intended to create a requirement that VA would be responsible for reimbursing Veterans for such "similar payments." However, the proposed changes would not affirmatively require VA to reimburse for copayments. If this is the intended result of the bill, we recommend Congress expressly authorize reimbursing Veterans for copayments of $100 or more. This language does not address liability for deductibles or coinsurance and does not expressly require VA to reimburse for these expenses or to deny them. We recommend the drafters of this legislation clearly state what they intend for VA to pay.

We are concerned that one effect of this legislation would be to further establish multiple "classes" of Veterans based upon the coverage of their health insurance plans. Some insurance plans, for example, charge percentages rather than fixed costs for the furnishing of emergency treatment. Other plans may have high copayments but low or no deductibles or coinsurance, and others may have the reverse. Depending upon the terms of these insurance plans, some Veterans may benefit significantly from these changes, while others may not.

We also have technical concerns with how VA might operationalize this legislation. The bill would define copayment to exclude deductibles or coinsurance, but when VA receives an explanation of benefits or similar document, it is often difficult, or at times impossible, to determine whether charges reflect copayments or coinsurance liability.

Another technical concern is that the prohibition on reimbursing Veterans for any copayment of less than $100 would require VA to update its systems, and the timeline for the necessary updates is uncertain. VA would need flexibility in implementing this provision.

We also are concerned that due to system limitations, VA may be unable to re-adjudicate on its own initiative all claims submitted on or after February 1, 2010; any adjudicative provision should provide flexibility to allow VA to request that claimants re-submit their claims. In addition, VA has updated its systems since 2010, which has made accessing data from the legacy system difficult. The bill also does not address what action should be taken if the Veteran is deceased or if supporting documentation is no longer available. The bill's reference to the *Wolfe* v. *McDonough* case appears to be worded inaccurately, as members of the certified class are not submitting new claims. Related to that litigation, VA was ordered to re-adjudicate claims that were previously denied because the amount was attributable to a coinsurance or deductible liability. Additional re-adjudication of these claims based on the enactment of this bill would create significant resource requirements without any guarantee of improved benefits for Veterans. This result would certainly be the case given the "application of amendment" language in section 2(b), which would make these changes retroactively applicable to February 1, 2010. If Congress were to establish such a retroactive effect, we strongly encourage Congress to limit the period under which such claims could be resubmitted (to 1 year from enactment, for example).

Critically, in section 2(c)(2), the definition of the term "reimbursement claim" raises a number of concerns. The definition refers to "any claim by a Veteran", but this would appear to exclude claims submitted by providers, which make up the majority of all claims received. The definition also refers to Veterans "who had coverage under a health-plan contract," but this would exclude Veterans who do not have other health insurance. The definition also refers to rejected claims, which may be interpreted as referring to incomplete claims that do not reflect a VA decision on the substance of the claim. We recommend removing this part of the definition. We further note that section 1725(c)(1)(C) prohibits VA from making a payment that includes any amount for which the Veteran is not personally liable. If VA is to re-adjudicate claims that have been written off by the provider due to the length of time since the claim was made, VA may still be unable to reimburse such claims if the Veteran is no longer considered personally liable. Similarly, it is unclear what would happen to such claims that have been sent to a debt collection agency by a community emergency department.

Given the pending litigation, we are particularly concerned about the potential confusion that could result from a court decision interpreting section 1725 and enactment of legislation amending that statute at or around the same time. VA is awaiting a decision on *Wolfe* v. *McDonough*, which we expect to be made within the next few months. The court's ruling and new legislation could interact in ways that are unpredictable, and the costs of such a situation would likely fall on VA and Veterans alike. We strongly recommend Congress wait until there is a final decision in *Wolfe* v. *McDonough* that clarifies the interpretation of section 1725 to ensure that Congress' intended result is realized.

We are unable to provide a cost estimate for this bill due to the numerous technical uncertainties surrounding its implementation. As the costs of this bill likely would be significant, we are concerned about the availability of appropriations needed to implement this authority. If Congress chooses to enact this authority, it is essential that additional resources be provided to cover the reimbursement expenses VA would incur, as well as the administrative costs associated with these changes.

H.R. 5738 Lactation Spaces for Veteran Moms Act

H.R. 5738 would add a new 38 U.S.C. § 1720K to require, not later than 1 year after the date of enactment of this legislation, that each VA medical center (VAMC) will contain a lactation space. It would clarify that nothing in this section would authorize an individual to enter a VAMC or portion thereof if that individual is not otherwise authorized to enter. It would define the term "lactation space" to mean a hygienic place, other than a bathroom, that is shielded from view, free from intrusion, accessible to disabled individuals, contains a chair and a working surface, is easy to locate, is clearly identified with signage and is available for use by female Veterans, VA employees and members of the public otherwise authorized to enter a VAMC to express breast milk. VA would have to carry out section 1720K by not later than 1 year after the date of enactment.

VA is dedicated to ensuring that its facilities are open and welcoming places for all Veterans, especially women Veterans during all phases of their Veteran journey. The Secretary recently began the process of establishing a Family Coordinator Program that would include Family Coordinators at each VAMC to support the needs of the families of Veterans as well. Part of this program will include ensuring our facilities are family friendly. As women Veterans become a larger portion of the VA patient population, we are actively working to renovate and retrofit our facilities to meet their lactation needs. We conduct lactation classes; provide breast pumps and supplies to Veterans; and we are hiring and training lactation specialists to ensure women Veterans are able to access the services they need. We appreciate Congress' recent enactment of the Protecting Moms Who Served Act (P.L. 117-69), which will help VA support new moms. Section 5102 of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116-315) required VA to prioritize the retrofitting of existing medical facilities with fixtures, materials and other outfitting measures to support the provision of care to women Veterans, and VA recently submitted a 5-year strategic plan to address deficiencies in the environment of care for women Veterans at VA medical facilities.

Since 2010, Federal agencies have been required to provide employees with a private space, permanent or temporary, that is shielded from view and free from intrusion from coworkers and the public, to allow employees to express breast milk for up to 1 year after the birth of the employee's child. While Veteran Health Administration facilities have at least one space that complies with policy and accommodates nursing mothers, some facilities, particularly our geographically larger campuses, likely require more than one such space. We have supported the acquisition and installation of breastfeeding pods in our facilities, and we have encouraged facilities to develop and dedicate lactation spaces for Veterans and members of the public.

While we are supportive of the goal of this bill, we have some concerns with the legislative text as written. It is not clear whether the intent of this bill is to replace any private space already provided to employees or to require the creation of new spaces. Employees need to be able to access these spaces free from intrusion from the public, consistent with VA policy and Office of Personnel Management guidance As noted before, we fully support ensuring lactation spaces are available in our facilities. The need to retrofit and renovate facilities would require a longer time period for compliance.

We are fully committed to making lactation spaces available, and we can and will find the resources needed to do this, but our biggest impediment is simply the lack of space in existing facilities. These space limitations, unfortunately, have meant this process has taken longer than we had hoped, so these efforts are still underway. In this context, we fully support the intent of this legislation, and we would like to work with the Committee to determine how VA can meet the intent of this bill.

As a technical matter, we recommend the term "female Veterans" in the bill be changed to "women Veterans." This change would be congruent with how VA otherwise uses the term when identifying women's health services and also would be more consistent with

the language typically used by Congress in other laws (see, e.g., section 101(d)(1)(A)(v) and section 401(e)1)(B)(ii) of P.L. 116-171; section 302 of P.L. 116-214, section 5201, et seq., and section 5305 of P.L. 116-315; 38 U.S.C. § 1704(1)(B); 38 U.S.C. § 1709B(a)(2)(F); 38 U.S.C. § 1714(a)(2); 38 U.S.C. § 1786; 38 U.S.C. § 2021A; 38 U.S.C. § 2022A(e)).

At this time, we do not have a cost estimate for the bill, but we will provide one as soon as possible.

H.R. 5754 Patient Advocate Tracker Act

H.R. 5754 would amend 38 U.S.C. § 7309A(c) to require the Director of the Office of Patient Advocacy to establish, not later than 18 months after the date of enactment, an information technology (IT) system that will allow Veterans or their designated representatives to electronically file a complaint that will be received by the appropriate patient advocate and to view at any time the status of the complaint, including interim and final actions that have been taken to address the complaint.

We fully agree with the intent of this legislation but do not believe it is necessary because VA has already taken efforts to ensure that complaints can be submitted and tracked. In October 2021, VA launched an application called AskVA (ask.va.gov), which is available at every VA facility. This application replaced the Inquiry Routing and Information System. Currently, any Veteran, representative or anyone else who submits a complaint or request for information related to VA health care already can have their inquiry routed for review and response. There are two different user types: authenticated and unauthenticated; authenticated users can log in and view the status and progress information related to their case or inquiry, while unauthenticated users can use an inquiry number (provided to them by email) to check on the status of the inquiry. Given that this program is less than 6 months old, we are still working to promote its availability.

While we believe AskVA meets the requirements of this legislation, to the extent that it does not, additional resources would be needed to supplement that application to comply with the requirements of this bill. We are open to demonstrating the IT system to Congressional staff to show them how it works and determine if there are additional capabilities needed. We also are working to amplify Veterans' and families' awareness of the tool to ensure they know how to use it.

H.R. 5819 Autonomy for Disabled Veterans Act

Section 2(a) of H.R. 5819 would amend 38 U.S.C. § 1717 to increase the amount available to eligible Veterans for improvements and structural alterations furnished as part of home health services. In the case of medical services furnished under section 1710(a)(1) or for a disability described in section 1710(a)(2)(C), the amount available for improvements and structural alterations would be increased from $6,800 to $10,000. For all other enrolled Veterans, this amount would be increased from $2,000 to $5,000.

Section 2(b) would make this change effective for Veterans who first apply for such benefits on or after the date of enactment. Section 2(c) would provide that a Veteran who exhausts his or her eligibility for benefits under section 1717(a)(2) before the date of enactment would not be entitled to additional benefits by reason of these amendments. Section 3 of the bill would further amend section 1717 to include a new subsection (a)(4) that would require VA to increase on an annual basis the dollar amount in effect under subsection (a)(2) by a percentage equal to the percentage by which the Consumer Price Index (CPI) for all urban consumers (United States city average) increased during the 12-month period ending with the last month for which the CPI data is available. In the event the CPI did not increase during such period, VA would maintain the dollar amount in effect during the previous fiscal year.

VA supports this bill subject to amendments, recommended below, and the availability of appropriations. We believe a single life-time benefit would be more Veteran-centric. VA does agree with the need to increase the threshold limits, as the bill would do, but we believe the bill would reinforce the existing dichotomy that results in different levels of benefits for different Veterans. We do note that VA may be required to update its regulations to implement these changes. Regulatory updates typically take between 18 and 24 months to complete.

We recommend the bill remove the distinction between the levels of benefits available to Veterans with a service-connected disability and those without. We believe making all eligible Veterans able to receive a lifetime benefit up to $9,000 would be appropriate. The $9,000 amount seems most appropriate because the most common home improvement and structural alteration to accommodate a disability involves renovation of a bathroom, and the national average cost for a bathroom modification is $9,000. Veterans who cannot pay out-of-pocket costs for home improvements and structural alterations may seek contractors who are not licensed, bonded or insured, which could result in inadequate quality and unsafe, unsatisfactory or hazardous renovation projects. While we agree with the need to update the level of this benefit over time to keep pace with rising costs, we do not believe relying on the CPI would be the best approach. We recommend instead a more specific index, such as one focused on construction costs, would be more appropriate. VA has used the Turner construction cost index for other benefits programs, such as the Specially Adapted Housing program, which provides monetary benefits to allow home modifications for severely injured Veterans and Service members. We further note it is unclear how the adjustment for inflation that would occur as a result of section 3 would affect Veterans who have used but not exhausted their benefits as of the day before the date of enactment, as described in section 2(c) of the proposed bill. We also believe that the bill should include limitations on the number of times a Veteran could use this benefit to ensure appropriate administration of this program, proper use of Federal resources and to avoid disparate effects on similarly situated Veterans. While the benefit is a “lifetime” benefit, that establishes a maximum amount that can be spent during a lifetime, and Veterans may choose to make several alterations to their home under the program, given that the maximum amount would rise each year, we believe a limited number of disbursements

would provide a more equitable program that would also be easier to administer. We would be happy to work with the Committee on language to address these concerns.

We estimate the bill, as written, would cost $38.1 million in FY 2023, $238.5 million over 5 years, and $644.6 million over 10 years.

We estimate the bill, VA supports with amendments, would costs $41.1 million in FY 2023, $257.3 million over 5 years, and $695.6 million over 10 years.

H.R. 5941 Fairness for Rural Veterans Act

H.R. 5941 would amend 38 U.S.C. § 8135(c)(2), which generally establishes how VA accords priority to applications from States for financial assistance for construction of State home facilities. Specifically, H.R. 5941 would establish as the fourth priority category applications for construction or acquisition of a nursing home or domiciliary from a State that the Secretary determines, in accordance with regulations under subchapter III of chapter 81 of title 38, U.S.C., has a great or significant need for beds and which is located at least 100 miles away from the nearest existing State home facility.

VA supports the legislation subject to amendments. We understand the intent of the bill is to ensure that applications for projects in rural areas of great-and-significant-need States would receive greater priority in allocating funds to support State home construction, but we note that these applications would still be subject to other requirements as set forth in law and regulation. Further, States with a great need are already prioritized, so this bill appears to be intended to put applications for projects located at least 100 miles away from the nearest existing State home in great-and-significant-need States ahead of all other applications, including applications for projects in great-need States. We recommend the legislation instead focus on States with a significant-need, and that these applications be placed in a new subparagraph (E) of section 8135(c)(2), ahead of renovation projects but below projects in States with great-need. This recommendation would still ensure that these projects are placed above other projects focused solely on renovations. Our overriding goal is to ensure Veterans receive appropriate care as close to home as possible. As part of VA's market assessments and its work related to the VA Asset and Infrastructure Review (AIR) Act (title II of P.L. 115-182), we are assessing our current resources and Veteran needs to determine how best to furnish the care our Veterans have earned.

We note, as a technical matter, the legislation is unclear as to whether the State must be 100 miles or more away from an existing State home or if the application must be for a project that would be at least 100 miles away from the nearest existing State home. We recommend revision of the language to clarify this and would be happy to provide technical assistance in this regard.

VA does not anticipate that this bill would result in any additional costs. This bill will neither increase nor decrease the cost of the program. The State Veterans Home

Construction Grant Program is a program where VA awards grants to States for approved construction grants with funds appropriated to VA by Congress. VA funds as many projects as it can with the resources provided to it, and the bill would affect only how VA lists those projects in order. Changing the process for ranking projects on a priority list does not impact the availability of overall funding for the program.

H.R. 6647 Making Certain Improvements Relating to Eligibility of Veterans to Receive Reimbursement for Emergency Treatment Furnished through the Veterans Community Care Program

Section 2(a) of H.R. 6647 would amend 38 U.S.C. § 1725(b)(2)(B) to create an exception to the requirement that an enrolled Veteran has received care under chapter 17 within the 24-month period preceding the furnishing of emergency treatment at a non-VA facility in order to receive reimbursement from VA. This exception would make eligible for potential reimbursement Veterans who have not yet received care under chapter 17 but who enrolled and received emergency treatment within the first 60 days of the Veteran’s enrollment. Section 2(b) would provide that the amendment made by section 2(a) would apply with respect to emergency treatment furnished on or after the date that is one year after the date of enactment.

We support this bill, subject to the availability of appropriations; while there are only a few Veterans who might qualify under this exception, VA has no other means for reimbursing these Veterans unless VA is notified that the care was provided by a network provider under the Veterans Community Care Program. This bill would provide an important benefit to this population.

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

We appreciate that the bill provides 1 year for VA to implement necessary systems and other changes to reflect this new authority. We note that if rulemaking is required to implement this new authority, this 1-year timeline may be difficult to meet.

We estimate this bill would cost $6.8 million in FY 2024, $36 million over 5 years, and $77 million over 10 years.

H.R. XXXX Long-Term Care Veterans Choice Act

Section 2(a) of the draft Long-Term Care Veterans Choice Act would amend section 1720 to add a new subsection (h) providing authority for a 5-year period for the Secretary to pay for long-term care for certain Veterans in Medical Foster Homes (MFH) that meet Department standards. Specifically, the bill would allow Veterans for whom VA is required by law to offer to purchase or provide nursing home care to be offered placement in homes designed to provide non-institutional long-term supportive care for

Veterans who are unable to live independently and prefer to live in a family setting. VA would pay MFH expenses by a contract, agreement or other arrangement with the home. VA could pay for care for a Veteran in an MFH before the date of enactment, if the home meets VA standards, pursuant to a contract, agreement or other arrangement between VA and the MFH. Veterans on whose behalf VA pays for care in an MFH would have to agree, as a condition of payment, to accept home health services furnished by VA under section 1717. In any year, not more than a daily average of 900 Veterans could receive care in an MFH at the expense of the United States. The limitations in section 1730(b)(3), which provide that payment of the charges of a community residential care facility to a Veteran whom VA has referred to that facility is not the responsibility of the United States or VA, would not apply. The changes made by this subsection would take effect 90 days after the date of enactment.

VA endorses the concept of using MFHs for Veterans who meet the appropriateness criteria to receive such care in a more personal home-like setting. VA endorsed this idea in its FY 2018, FY 2019, FY 2020 and FY 2022 budget submissions . Our budget proposals would require VA to include in the program of extended care services the provision of care in MFHs for Veterans for whom VA is required to provide nursing home care. VA appreciates the Committee's consideration of this concept. Our experience has shown that VA-approved MFHs can offer safe, highly Veteran-centric care that is preferred by many Veterans at a lower cost than traditional nursing home care. VA currently manages the MFH program at over two-thirds of our VAMCs, partnering with homes in the community to provide care to nearly 1,000 Veterans every day. However, Veterans are solely responsible for the expenses associated with MFH care today. Of the nearly 800 Veterans in MFHs currently, nearly 200 would be eligible for care at the MFH at VA expense under this bill. Our experience also shows that MFHs can be used to increase access and promote Veteran choice-of-care options. We are concerned with the short period of time to implement this new authority. We believe 1 year would be more appropriate than 90 days to ensure contracts or agreements are in place, and that policies and regulations, if needed, are in effect.

While VA fully supports the MFH concept, we look forward to working with you to resolve a few technical issues in this bill. For example, the limitation in proposed subsection (h)(3), regarding a limit "in any year" of a "daily average" of 900 or fewer Veterans receiving care, is ambiguous. It is unclear how the limitation to a given year qualifies the daily average and how VA could operationalize this concept effectively. VA would like to work with the Committee to ensure we can effectively incorporate MFHs into the continuum of authorized long-term services and support available to Veterans. We are happy to provide the Committee with technical assistance on this matter and are available for further discussion.

Section 2(b) of the bill would require VA to create a system to monitor and assess VA's workload in carrying out this new authority under proposed section 1720(h), including by tracking requests by Veterans to be placed in an MFH; denials of such requests and the reasons for such denials; the total number of MFHs applying to participate (disaggregated by those approved and those denied); Veterans receiving care in an

MFH at the expense of the United States; and Veterans receiving care at an MFH at their own expense. VA would be required to identify and report to Congress on such modifications to implementing the new authority as VA considers necessary to ensure the authority is functioning as intended and care is provided to Veterans as intended.

To implement the requirements of section 2(b) and to meet potential demand nationwide, VA would have to expand operations and oversight of the existing MFH program to ensure timely placement and payments for Veterans requesting placement. Requirements associated with additional monitoring and data tracking would necessitate additional staff and information technology support.

Section 2(c) of the bill would require the Comptroller General, not later than 3 years and 6 years after the date of enactment, to submit to Congress an assessment of the implementation of the amendments made by this bill; an assessment of the impact of the monitoring and modifications under subsection (b) on care provided under section 1720(h), as amended; and recommendations for improvements to the implementation of such section as the Comptroller General considers appropriate.

VA defers to the Comptroller General on this subsection.

We estimate the new costs associated with section 2(b) would be $1.19 million in FY 2022 and $19.10 million over 5 years. We estimate the cost savings of section 2(a), due to the diversion of Veterans from nursing home care to MFHs, would be $15.32 million in FY 2022 and $165.32 million over 5 years. We estimate the total cost savings resulting from the bill, after factoring out the additional costs, would be $14.14 million in FY 2022 and $146.22 million over 5 years.

H.R. 6823 Elizabeth Dole Veterans Home and Community Based Services Improvement Act of 2022, or the Elizabeth Dole Home Care Act

Section 2(a) of the bill would amend 38 U.S.C. § 1720C(d) to increase the maximum percentage of the total cost of providing services or in-kind assistance to Veterans eligible for medical, rehabilitative and health-related services in non-institutional settings for Veterans who are eligible for and in need of nursing home care. Specifically, it would increase this amount from 65% of the cost that would have been incurred by the Department during that fiscal year if the Veteran had instead been furnishing nursing home care under section 1710 to 100% of that cost. Further, it would authorize VA to exceed 100% of the cost that would have been incurred under section 1710 “if the Secretary determines such higher total cost is in the best interest of the Veteran.” Section 2(b) would provide that the amendments made by section 2(a) would apply with respect to fiscal years beginning on or after the date of enactment.

VA strongly supports increasing the allowable amount to cover 100% of the cost of nursing home care that would otherwise have been incurred. This was one of the Department’s legislative proposals for the FY 2022 budget. However, we have concerns with the change that would authorize VA to exceed that limitation in the best interest of

the Veteran. Based on other programs that include “in the best interest” eligibility criteria, this exception would be difficult, if not impossible, to administer consistently and fairly.

VA does not have cost estimate for this section at this time.

Section 3 of the bill would further amend section 1720C by creating a new subsection (f). This subsection would provide that in furnishing services to a Veteran under this section, if a VAMC through which such program is administered is located in a geographic area in which services are available to the Veteran under the PACE Program, VA would have to establish a partnership with the PACE Program operating in that area for the furnishing of such services.

We understand the interest in and support of the PACE Program, but we are concerned that this section could introduce conflict between this authority and the Veterans Community Care Program that VA operates under 38 U.S.C. § 1703. We would appreciate the opportunity to discuss these issues with the Committee before taking a position on this section of the bill. We believe it may be possible to develop an arrangement that would allow VA’s programs and the PACE Program to complement each other, but this arrangement would require further collaboration between VA, the Centers for Medicare & Medicaid Services (CMS) and Congress. We also believe the legislation is ambiguous in terms of what is meant by a “partnership” and what services are intended to be covered. We would be happy to work with the Committee to try to address these concerns. We also are concerned about the requirement that VA establish a partnership, rather than merely “seek to enter,” as is usually the formulation established in law.

Section 4(a) would create a new 38 U.S.C. § 1720K governing home- and community-based services and programs. Proposed section 1720K(a) would provide that in furnishing non-institutional alternatives to nursing home care pursuant to section 1720C or any other authority, VA would have to carry out each of the programs specified in the new section 1720K in accordance with such relevant authorities, except as otherwise provided in this section.

We generally appreciate the interest and emphasis of this bill on VA’s existing programs, which are critical to ensuring that Veterans are able to live where they want and in settings that are appropriate to them. We interpret proposed section 1720K, as would be added by section 4 of the bill, to codify existing practice, rather than to replace VA’s existing programs of the same names with new programs with different rules or requirements. We are concerned, however, that in the effort to legislate these programs, Congress could be creating a presumption that other programs VA currently operates (such as Adult Day Health Care, ambulatory geriatric care and others), or that VA may wish to implement in the future, would not be authorized. We would appreciate the opportunity to work with the Committee to discuss these programs and how Congress can best support those efforts. For example, we are looking to begin work on managed long-term care programs later this year, and we believe this could be done under the

existing section 1720C. We are concerned about the suggestion that VA currently lacks authority to act under section 1720C that may be created by providing specific authority to act under the same, as well as the suggestion that VA would lack authority to act under section 1720C in the future.

Proposed section 1720K(b) would require VA, in collaboration with the Department of Health and Human Services (HHS), to carry out a program known as the Veteran Directed Care program under which VA could enter into agreements with an Aging and Disability Resource Center, an area agency on aging, a State agency or a center for independent living to provide to eligible Veterans with funds to obtain such in-home care services and related items as may be appropriate (as determined by VA) and selected by the Veteran, including through the Veteran hiring individuals to provide such services and items or directly purchasing such services and items. In carrying out the Veteran Directed Care program, VA would have to administer such program through each VAMC, ensure the availability of the program in American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Commonwealth of Puerto Rico, the U.S. Virgin Islands and any other territory or possession of the United States. VA also would have to ensure the availability of the program for eligible Veterans who are Native American Veterans receiving care and services furnished by the Indian Health Service (IHS), a tribal health program, an Urban Indian organization or (in the case of a Native Hawaiian Veteran) a Native Hawaiian health care system. If a Veteran participating in the Veteran Directed Care program were catastrophically disabled, the Veteran could continue to use funds under the program during a period of hospitalization in the same manner that the Veteran would be authorized to use such funds under the program if the Veteran were not hospitalized.

Veterans enrolled in the Veteran Directed Care program hire their own workers to provide personal care services in their homes and communities. This program is managed by local aging and disability network providers (e.g., area agency on aging), who support the Veteran, their caregiver and families. This support includes managing employer paperwork, filing taxes and paying workers. In addition, providers in the program have case managers in the community to help Veterans develop a plan for hiring workers, monitor the care being delivered and facilitate delivery of other community services to meet their needs.

Currently, there are approximately 3,400 Veterans enrolled in this program at 69 VAMCs. Research has shown that Veteran Directed Care is a critical resource for VAMCs in supporting Veterans at risk of hospital and nursing home placement who may be able to receive necessary care and support in non-institutional alternatives. Veterans in Veteran Directed Care are typically sicker, more service-connected, more likely to live in rural areas, younger and have more chronic conditions compared to Veterans enrolled in other VA personal care services programs. In addition, an evaluation of Veteran Directed Care has shown even though the needs of Veterans in Veteran Directed Care are more complex, it is more effective at reducing hospital and nursing home use and improving patient outcomes when compared to other VA personal care services. Since Veterans, their caregivers and families are able to make decisions about

their care, Veteran Directed Care also increases overall satisfaction and improves trust with VA for Veterans. Given this, we support continued operation of the Veteran Directed Care program, but as noted above, we have concerns about legislating this program and others (but not all such programs) and the effect that might have on VA's broader authority.

We support the provision that would allow catastrophically disabled Veterans to continue using funds to procure in-home care services during a period of hospitalization. This provision would provide needed consistency and assurances for such Veterans.

We note VA would experience significant challenges in ensuring these programs are available in some of the U.S. territories with small Veteran populations and limited service availability. Some U.S. territories may lack nursing homes in the first place, and their ability to offer non-institutional alternatives likely is limited as well. We note that Puerto Rico operates a Veteran Directed Care program, and the U.S. Virgin Islands is scheduled to adopt the program later this year.

Proposed section 1720K(c) would require VA to carry out a program known as the Home Maker and Home Health Aide program under which VA would be able to enter into agreements with home health agencies to provide to eligible Veterans such home health aide services as may be determined appropriate by VA. VA would have to ensure this program was available in the same territories and for the same populations that VA must "ensure the availability" of the Veteran Directed Care program under proposed section 1720K(b).

VA's Home Maker and Home Health Aide program has been in operation for approximately 30 years. The program uses licensed and Medicare- and Medicaid-certified agencies to provide care to Veterans needing assistance with activities of daily living (e.g., bathing and dressing) and instrumental activities of daily living (e.g., meal preparation). VA purchases Home Maker and Home Health Aide services from approximately 6,000 agencies, mostly through Community Care Network (CCN) contracts. In FY 2021, nearly 140,000 Veterans were served in this program.

Similar to our discussion regarding the Veteran Directed Care program, we are concerned that the requirement to ensure the availability of the program in all U.S. territories would be difficult to meet. We note that the use of the general term "agreements" does not create new authority for VA to enter into contracts or agreements. VA would be able to authorize only contracts or agreements already authorized by other provisions of law.

Proposed section 1720K(d) would require VA to carry out a program called the Home Based Primary Care program, under which VA could furnish to eligible Veterans in-home health care, the provision of which would be overseen by a VA physician.

VA's Home Based Primary Care program furnishes primary care to Veterans in their homes. A VA physician leads the interdisciplinary health care team that provides

comprehensive longitudinal health care. This evidence-based program is for Veterans who have complex health care needs for whom routine clinic-based care is not effective. This program is already available at every VAMC.

Proposed section 1720K(e) would require VA to carry out the Purchased Skilled Home Care program under which VA could furnish to eligible Veterans such in-home care services as may be determined appropriate and selected by VA for the Veteran.

VA's Purchased Skilled Home Care program uses licensed and Medicare- and Medicaid-certified agencies to provide care to Veterans with short-term and long-term skilled care needs. Approximately 75% of the Veterans served in the program have short-term, post-acute needs. The remaining 25% of Veterans require care for a longer period for conditions such as non-healing wounds, long-term catheter management, medication management and ventilator care. VA purchases skilled home care services from approximately 4,000 agencies, mostly through CCN contracts. In FY 2021, approximately 100,000 Veterans were served in the Purchased Skilled Home Care program.

Proposed section 1720K(f)(1) would provide that, with respect to a resident caregiver of a Veteran participating in a program under this section who is a family caregiver, VA would have to, if the Veteran meets the requirements of a covered Veteran under section 1720G(b), provide to such caregiver the option of enrolling in the program of general caregiver support under section 1720G(b), provide to such caregiver not fewer than 14 days of covered respite care each year and conduct on an annual basis (and to the extent practicable, in connection with in-person services provided under the program in which the Veteran is participating) a wellness check of such caregiver. Under proposed section 1720K(f)(2), VA would have to provide not fewer than 30 days of covered respite care each year to any resident caregiver who provides services under the Veteran Directed Care program. Proposed section 1720K(f)(3) would allow VA to provide respite care to resident caregivers of Veterans participating in one of the programs in this section to exceed 14 days annually, or 30 days annually for resident caregivers under the Veteran Directed Care program, if such extension is requested by the resident caregiver or Veteran and determined medically appropriate by VA.

We agree that informing caregivers of the option to enroll in the program of general caregiver support under section 1720G(b) is advisable, and our current efforts have focused on ensuring that caregivers participating in the general caregiver program under current section 1720G(b) are provided robust support. We focus on educating caregivers of Veterans in current programs and referring those caregivers to the general caregiver support program when they are interested. VA does not currently administer in-home wellness checks of caregivers under the general caregiver program in section 1720G. We note that under our existing authorities, VA offers at least 30 days of respite care to primary family caregivers of covered Veterans under section 1720G and up to 30 days of respite care each year for other caregivers, so the provision in proposed 1720K(f)(3) regarding 14 days of covered respite care would actually be less than VA's existing programs provide.

Proposed section 1720K(g) would define various terms. In particular, it would define "covered respite care" to mean, with respect to a caregiver of a Veteran, respite care that includes 24-hour per day care of the Veteran commensurate with the care provided by the caregiver, is medically and age-appropriate and includes in-home care. "Eligible Veteran" would mean any Veteran for whom VA determines participation in a specific program under this section is medically necessary to promote, preserve or restore the health of the Veteran and who, absent such participation, would be at increased risk for hospitalization, placement in a nursing home or emergency room care. The term "home health agency" would have the meaning given that term in section 1861(o) of the Social Security Act (42 U.S.C. § 1395x(o)). The term "resident caregiver" would mean a caregiver, or a family caregiver, of a Veteran who resides with the Veteran.

The definition of eligible Veteran would be broader than our current authority by including reference to an increased risk of hospital care and emergency room care. Current section 1720C also states that Veterans must be in need of nursing home care, rather than simply being "at increased risk for…placement in a nursing home". We have some concern with the phrase "resident caregiver," which appears to create a new classification (beyond caregivers and family caregivers) that could cause confusion among VA's programs. This phrase also could apply to caregivers in other programs where eligibility for VA respite benefits do not appear to have been intended. We do not believe it would be appropriate to provide respite care to at least some parties (except for those who are family members or furnishing services through the medical foster home program) who have a contractual relationship to furnish care and services to Veterans.

Section 4(b) would require VA to ensure that the Veteran Directed Care and the Home Maker Home Health Aide Programs are administered through each VAMC by not later than 2 years after the date of enactment.

VA is currently planning to fully implement the Veteran Directed Care program within the next 5 years, but we do not believe that VA could establish programs at the remaining 70 facilities in only 2 years. We recommend this subsection either be deleted or that the timeline be extended to 5 years to match VA's current plans and budget. VA's Home Maker and Home Health Aide Program is already available at all sites.

Section 5(a)(1) would amend 38 U.S.C. § 1720G to add a new paragraph (14) to subsection (a). This paragraph would state that in the case of a Veteran or caregiver who seeks services under subsection (a) and is denied such services, or a Veteran or the family caregiver of a Veteran who is discharged from the program under this subsection, VA would have to, with respect to the caregiver, ensure the caregiver is provided the option of enrolling in the program of general caregiver support services under subsection (b); assess the Veteran or caregiver for participation in any other available VA program for which the Veteran or caregiver may be eligible and store (and make accessible to the Veteran) the results of such assessment in the medical record of the Veteran; and provide to the Veteran or caregiver written information on any such

program identified pursuant to that assessment, including information about facilities, eligibility requirements and relevant contact information for each program. For each Veteran or family caregiver who is discharged from the program under this subsection, a caregiver support coordinator would have to provide for a smooth and personalized transition from such program to an appropriate VA program (including the programs specified in section 1720K, as added by section 4 of the bill). Section 5(a)(2) would provide that the amendments made by section 5(a)(1) of the bill would apply with respect to denials and discharges occurring on or after the date of enactment.

VA is already working to enhance our efforts; we agree with the intent and are committed to providing technical assistance to the committee to ensure VA has the resources and authority to successfully assist Veterans and their caregivers. VA currently offers every caregiver who is discharged or denied from the Program of Comprehensive Assistance for Family Caregivers the opportunity to participate in the Program of General Caregiver Support Services (PGCSS) when appropriate. This opportunity is offered in the letter notifying them and often by phone. VA also notifies these caregivers of other services and support through other programs, but it does not evaluate the caregivers for such programs.

Concerning the timeline established in section 5(a)(2), we estimate VA would need at least 1 year to hire staff and develop the systems and training to implement the changes made by paragraph (1).

Section 5(b) of the bill would amend the definitions of section 1720G(d) to modify the definitions of the terms “caregiver,” “family caregiver,” “family member” and “personal care services” to refer to Veterans denied or discharged as specified in section 1720G(a)(14), as added by section 5(a)(1) of the bill.

We have no unique objection to this subsection, but again, VA does not support subsection (a), to which these amendments would give effect.

Section 5(c) would require VA to conduct a review of its capacity to establish a streamlined system for contacting all caregivers enrolled in PGCSS under section 1720G(b) to provide program updates and alerts to such caregivers relating to emerging services for which such caregivers may be eligible.

VA currently has a list-serve with more than 150,000 recipients where VA shares information regarding the caregiver program. This list is not limited to general caregivers but is available to anyone interested in the program. VA also regularly updates its website to provide new information or updates. While VA can conduct a review of how VA could establish a streamlined system for contacting caregivers, we do not believe this section is necessary.

Section 6 would require VA to develop and maintain a centralized and publicly accessible internet website as a clearinghouse for information and resources relating to covered programs. The website would need to include a description of each covered

program, an informational assessment tool to enable users to assess the eligibility of a Veteran or caregiver for any covered program and to receive information on any such program for which the Veteran or caregiver may be eligible. It also would have to include a list of required procedures for the directors of VAMCs to follow in determining the eligibility and suitability of Veterans for participation in a covered program, including procedures applicable to instances in which the resource constraints of a facility or the community where the facility is located may result in the inability to address the health needs of a Veteran under a covered program in a timely manner. VA would have to ensure the website is updated periodically.

VA supports efforts to ensure Veterans and their caregivers are aware of our programs. We also believe it could be very difficult to implement as written. Many of the programs that would be covered by the website include both administrative and clinical eligibility determinations, and the website could not assess a person's clinical eligibility in practice. VA's existing websites (www.va.gov/geriatrics and https://www.caregiver.va.gov/) provide general information about VA's programs and contain resources for additional information. VA has existing national policies in place that define how facility directors and staff implement these programs.

Section 7(a) would require VA to carry out a 3-year pilot program under which VA would provide Home Maker and Home Health Aide Services to Veterans who reside in communities with a shortage of home health aides. VA would have to select 10 geographic locations in which VA determines there is a shortage of home health aides at which to carry out the pilot program. VA would be authorized to hire nursing assistants as new VA employees or reassign nursing assistants who are existing employees to provide Veterans with in-home care services (including basic tasks authorized by the State certification of the nursing assistant) under the pilot program in lieu of or in addition to the provision of such services through non-VA home health aides. Nursing assistants could provide services to a Veteran under the pilot program while serving as part of a health care team for the Veteran under the Home-Based Primary Care program. VA would be required to submit a report to Congress not later than 1 year after the pilot program terminates on the result of the pilot program.

We agree with the Committee's interest in ensuring that Veterans in need of Home Maker and Home Health Aide Services are able to access them, particularly in areas with shortages of such health aides, but we do not believe this pilot program would allow VA to recruit such health aides any more effectively than we can today. We currently have several pilot programs that are struggling to hire such health aides. We also are concerned about the prescriptive nature of some elements of the pilot program. For example, section 7(a)(2) provides that VA would select exactly 10 geographic locations. We do not support this section as it seems unlikely to produce the intended results.

Section 7(b) would require, not later than 1 year after the date of enactment, VA to provide a report to Congress with respect to the period beginning in FY 2011 and ending in FY 2022 containing an identification of the amount of funds available to VA

during that period for the provision of in-home care to Veterans under the Home Maker and Home Health Aide program but were not so expended, disaggregated by VAMC; and an identification of the number of Veterans for whom, during such period, the hours during which a home health aide was authorized to provide services to the Veteran were reduced for a reason other than a change in the health care needs of the Veteran. The report also would need to include a detailed description of the reasons why any such reductions may have occurred.

We certainly welcome Congressional oversight, but the specific elements of this reporting requirement, namely disaggregating funds by medical facility and identifying specific instances where the hours were reduced for reasons other than a change in the health care needs of the Veteran, would be virtually impossible to provide because VA does not track this level of detail and information. We recommend this subsection be removed from the bill. VA already has analyzed and compared appropriated and obligated amounts (including unused funds) related to the Home Maker and Home Health Aide program at an aggregate level, and we would be happy to share this information with the Committee.

Section 7(c) of the bill would require VA, not later than 1 year after the date of enactment, to issue updated guidance for the Home Maker and Home Health Aide program. This guidance would have to include a process for the transition of Veterans from the Home Maker and Home Health Aide program to other covered programs and a requirement for VAMC directors to complete such process whenever a Veteran with care needs has been denied services from home health agencies under the Home Maker and Home Health Aide program as a result of the clinical needs or behavioral issues of the Veteran.

We do not support this subsection because it is too prescriptive. VA is already in the process of updating guidance and direction to facilities relating to the Home Maker and Home Health Aide program generally (including the transition process), but we do not believe a statutory requirement would be beneficial.

Section 8(a) of the bill would require the Under Secretary for Health (USH) to conduct a review of each program administered through the Office of Geriatric and Extended Care (GEC) to ensure consistency in program management, eliminate service gaps at the medical center level and ensure the availability of, and the access by Veterans to, home- and community-based services. VA would have to conduct an assessment of the staffing needs of GEC, and the GEC Director would have to establish quantitative goals to enable aging or disabled Veterans who are not located near VAMCs to access extended care services (including by improving access to home- and community-based services for such Veterans). The GEC Director also would have to establish quantitative goals to address the specialty care needs of Veterans through in-home care, including by ensuring the education of home health aides and caregivers of Veterans in several areas. Not later than 1 year after the date of enactment, VA would have to submit to Congress a report containing: the findings of the review of each program, the results of

the assessment of the staffing needs of GEC; and the quantitative goals required in this subsection.

We do not believe this subsection is necessary, but we have no objection to it, provided additional resources were made available to complete this review.

Section 8(b) of the bill would require VA to conduct a review of the financial and organizational incentives of VAMC Directors to establish or expand covered programs at such medical centers; any incentives for such directors to provide to Veterans home- and community-based services in lieu of institutional care; the efforts taken by VA to enhance VA spending for extended care by shifting the balance of such spending from institutional care to home- and community-based services; and the USH's plan to accelerate efforts to enhance spending to match the progress of similar efforts taken by the CMS Administrator for extended care. Not later than 1 year after the date of enactment, VA would have to submit to Congress a report on the findings of this review.

VA has already conducted an analysis of these incentives and does not believe this subsection is necessary. We would be happy to brief the Committee on the results of our earlier work.

Section 8(c) of the bill would require VA, not later than 2 years from the date of enactment, to conduct a review of the use, availability and effectiveness of the respite care services furnished by VA.

VA does not believe this section is necessary, but we have no objection to it.

Section 8(d) of the bill would require that, not later than 2 years after the date of enactment, VA, in collaboration with HHS, submit to Congress a report containing recommendations for the expansion of mental health services and related support to the caregivers of Veterans. The report would have to include an assessment of the feasibility and advisability of authorizing access to Vet Centers by family caregivers enrolled in a program under section 1720G and family caregivers of Veterans participating in a program specified in section 1720K, as added by section 4 of this bill. VA would have to develop recommendations in two areas. First, VA would have to develop recommendations as to new services with respect to home- and community-based services. These recommendations would have to be developed in collaboration with HHS. Second, VA would have to provide recommendations regarding methods to address the national shortage of home health aides in collaboration with HHS and the Department of Labor. VA would have to submit to Congress a report containing these recommendations and an identification of any changes in existing law or new statutory authority necessary to implement these recommendations. In addition, VA would have to solicit from Veterans Service Organizations (VSO) and non-profit organizations with a focus on caregiver support, as determined by VA, feedback and recommendations regarding opportunities for VA to enhance home- and community-based services for Veterans and their caregivers, including through the potential provision by the entity of care and respite services to Veterans and caregivers who may not be eligible for any

program under section 1720G of title 10 [sic] or section 1720K of such title [sic] but have a need for assistance. VA also would have to collaborate with the IHS Director and representatives from tribal health programs and Urban Indian organizations to ensure the availability of home- and community-based services for Native American Veterans, including Native American Veterans receiving health care and medical services under multiple health systems.

VA has no objection to reporting to Congress on the feasibility and advisability of authorizing access to Vet Centers by family caregivers, but we do not believe it would be appropriate to expand access to Vet Centers for family caregivers in the manner intended as the focus of Vet Centers is on helping Veterans, Service Members, and their families cope with deployment-related issues. Currently, Vet Centers provide a range of support for family members, including assistance to help loved ones cope during a Service member's deployment, bereavement services to eligible family members or services in connection with assisting the eligible Veteran or Service member in attaining their readjustment goals. Prior to providing readjustment counseling services to a family member of a Veteran or member of the Armed Forces, Vet Center counselors must confirm: (1) that a presenting problem inclusive of family relationship problems is clearly linked to the eligible Veteran's or Service member's military service and post military readjustment and (2) that the severity of the problem, as manifest in any family member, is one that can be addressed by Vet Center professionals acting within the scope of the Vet Center readjustment mission (a non-medical counseling service). The Vet Center facility and mission is not designed to address general mental health problems not linked to the eligible Veteran's or Service member's readjustment; caregivers who require support in relation to an eligible Veteran's or Service member's readjustment are already eligible for Vet Center services. When a family member, including family caregivers, receives readjustment counseling services through Vet Centers, these records are included as part of the eligible Veteran's or Service member's record. We do not establish separate records for the family members. VA can already provide support to such family caregivers in connection with a covered Veteran's treatment under section 1782. We are concerned that expanded eligibility to family caregivers who do not meet current eligibility requirements for family services would result in family caregivers presenting issues and concerns that would be outside the scope of Vet Center counselors, whose focus is on the effects of military service-related trauma and reintegration into civilian life. We also are concerned that making this population eligible for Vet Center services could result in significant additional demand on Vet Centers that would require additional resources to ensure that VA's current efforts to support combat Veterans and other eligible populations are not diluted.

VA could develop recommendations regarding home- and community-based programs, but we have no particular expertise in addressing labor shortages of home health aides and recommend the Department of Labor prepare this report. VA can provide information specific to its programs upon request.

VA regularly meets with VSO and non-profit organization staff on operations and improvements for home and community-based services. We also solicit Veteran and

caregiver feedback through satisfaction surveys, listening sessions, a peer support mentoring program and other means.

As a technical matter, the reference to “title 10” in section 8(d)(3)(A) should be to title 38. We also note that it is unclear what population is intended to benefit from this language, but we would welcome feedback from VSOs and non-profits on this issue. It is also unclear what is intended by the collaboration required with IHS in section 8(d)(4).

Section 9 of the bill would define various terms, including “covered program” and “home and community based services.” The term “covered program” would mean any VA program for home- and community-based services and would include the programs specified in section 1720K, as added by section 4 of the bill. “Home and community based services” would mean the services referred to in section 1701(6)(E) and include services furnished under a program specified in section 1720K, as added by section 4 of the bill. VA has no unique objections or concerns with this section.

We do not have a cost estimate for the bill at this time.

Conclusion

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