

LEGISLATIVE HEARING ON  
H.R. 41; H.R. 562; H.R. 808; H.R. 754; H.R. 693;  
H.R. 1089; H.R. 366; H.R. 542; H.R. 1256

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HEARING  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
OF THE  
COMMITTEE ON VETERANS' AFFAIRS  
U.S. HOUSE OF REPRESENTATIVES  
ONE HUNDRED EIGHTEENTH CONGRESS

FIRST SESSION

WEDNESDAY, MARCH 29, 2023

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**WEDNESDAY, MARCH 29, 2023**

U.S. HOUSE OF REPRESENTATIVES  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
*Washington, D.C.*

The subcommittee met, pursuant to notice, at 1:30 p.m., in room 2253, Rayburn House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Radewagen, Bergman, Murphy, Van Orden, Brownley, Deluzio, and Budzinski.

Also present: Representatives Takano, and Mrvan.

**OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS,  
CHAIRWOMAN**

Ms. MILLER-MEEKS. Good afternoon. The legislative hearing of the Subcommittee on Health of the Veterans Affairs Committee will now come to order.

First, I want to welcome all the members of the subcommittee, both new and those returning. I am extremely excited to be able to work with each and every one of you this Congress.

I ask unanimous consent that our fellow committee member, Representative Mrvan, be allowed to sit in at the dais to participate in today's proceed.

Hearing no objection, so ordered.

Before we get started, I would like to take a moment to introduce myself. My name is Mariannette Miller-Meeks, and I proudly serve the people of Iowa's First congressional District. Most importantly, as a member of this committee, I serve all of those veterans who rely on the VA for their care and benefits. I am also a 24 year Army veteran and an ophthalmologist and I am married to a 30 year Army veteran. Six of the eight children in my family served in the military, as well as my father, uncles, and grandfather. I also formerly served as the director of Iowa's Department of Public Health.

As a veteran myself, and one who has worked as both a nurse and a physician at the VA hospital, I have seen firsthand both the strengths and weaknesses of our VA hospitals and clinics. Veterans deserve the care of utmost quality, and I will work tirelessly to ensure that they get the care that they have earned.

We have a responsibility also in Congress to hold the VA accountable. I am honored to serve as the chairwoman of this subcommittee. The House Committee on Veterans Affairs has a reputation for operating in a bipartisan manner. I look forward to continue working closely with Ranking Member Brownley and all of our members on both sides of the aisle.

Turning to today's hearing, we are here to discuss nine bills that would address a number of issues impacting America's veterans and the healthcare services they receive from the VA.

I would first like to express my frustration that we did not receive VA testimony until late yesterday. We requested that the testimonies be sent to us 48 hours in advance, and that simply was not the case. The list of bills we are discussing today were first sent to the VA on February 28. That gave the VA ample time to review, and it makes our jobs that much more difficult. I look forward to the VA submitting their testimony on time at the next hearing.

I want to reiterate that one of my top priorities that I know is shared by many, if not all, of my colleagues is to ensure timely and quality care to veterans. As a member of a rural district, I know the challenges that come with meeting that goal.

The nine bills before us today address scheduling appointments in a timely manner, ensuring veterans have available patient advocates, ensuring veterans access to home based long-term care, and creating a stable leadership environment within the Veterans Health Administration. I cannot ignore the significance of the Toxic Exposure Fund, also called TEF, and how it impacts the legislation we are discussing today. Health programs are now subject to mandatory funding and scoring based on a percentage of the overall estimated cost. The work of this subcommittee will soon come to a halt if we do not work together to address this funding issue.

I look forward to our discussion on the merits and challenges of all the legislation before us today, and I am looking forward to the input from the VA and from other stakeholders, and thank you all for being here.

I now yield to Ranking Member Brownley for her opening remarks.

**OPENING STATEMENT OF JULIA BROWNLEY, RANKING  
MEMBER**

Ms. BROWNLEY. Thank you, Chairwoman Miller-Meeks, and I am looking forward to working closely with you. It is a pleasure to be here as our subcommittee begins its important work for the 118th Congress.

It has been my greatest honor to serve on the Health Subcommittee for more than 10 years now, since my very first term in Congress. This will be my sixth term serving as either the ranking member or chair of the subcommittee. We have been through a lot and accomplished a great deal during the time all of us have served. In just the last few years, we passed the Deborah Sampson Act and the Promise to Address Comprehensive Toxics (PACT) Act, two comprehensive laws that will greatly improve access to VA healthcare services for women veterans and veterans with toxic exposure.

Together with VA, we faced a once in a century global pandemic, a crisis that the VA healthcare system managed very, very well. However, there is one key area where I wish I could say that more progress has been made, and that is the extent to which VA is enabling veterans to age at home and avoid spending the last years of their lives in nursing homes or other institutional care settings. I doubt there is a person here today who has not grappled with a decision of how best to care for an aging or disabled loved one.

Roughly 90 percent of aging adults would prefer to remain at home versus being admitted to a long-term care facility if they can absolutely avoid it. Veterans are no different. Over the last couple of decades, we have seen states place greater emphasis on investment in home and community based services, helping Medicaid beneficiaries prevent or delay admission to nursing homes. Studies have shown that these rebalancing efforts have saved money, provide better health outcomes, and allowed Medicaid programs to serve more beneficiaries.

As of Fiscal Year 2019, Medicaid expenditures for home and community based services accounted for about 59 percent of the state's total long-term care spending. However, as of Fiscal Year 2022, VA's investments were nearly the opposite of that, with VA allocating about 65 percent of its overall geriatrics and extended care budget to institutionalized care, a category of spending that now accounts for about 10 percent of Veterans Health Administrations (VHA's) total annual budget. This is not sustainable. Aside from the budgetary implications, there simply are not enough beds or staff in institutional care settings inside the VA or in the community to meet the expected need, particularly as Vietnam War era veterans enter their later years.

More importantly, this is not what veterans, their caregivers, or their families want. That is why I am pleased the subcommittee is considering my bill, the Elizabeth Dole Home Care Act, as part of today's agenda. Among other things, it will require VA to offer the Veteran Directed Care program, the Homemaker and Home Health Aid program, the Homebased Primary Care program and the Purchase Skilled Home Care Program at all VA medical centers within 2 years of enactment. Currently, they are only available at medical centers that have chosen to implement them. These programs help veterans with activities of daily living, allowing them to receive primary care at home and provide skilled nursing care for veterans with higher levels of need. Our bill will also expand access to respite care for caregivers of veterans in these programs.

Under this legislation, VA will be required to improve coordination between the Program of Comprehensive Assistance for Family Caregivers and VA's other home based care programs. If a veteran does not meet the enrollment criteria for the Caregiver Support Program, the VA will proactively assess the veteran and their caregiver for enrollment in other home based programs.

General Bergman and I first introduced the Elizabeth Dole Home Care Act just over a year ago in February 2022. Very quickly, this bill achieved the rare feat of bipartisan bicameral support, with Senators Moran and Tester introducing a Senate companion a few weeks later. Unfortunately, we were unable to enact this bill before the end of last year, but I am very hopeful that we will get it

across the finish line during this Congress. To do that, however, we will have to overcome a major hurdle, which is the Congressional Budget Office's (CBO) score for the bill, which, to be quite frank, does not make a whole lot of sense to any of us.

In late November 2022, CBO issued a cost estimate that far exceeded our expectations. We were given a preliminary estimate in the hundreds of millions, but were shocked when the final estimate came back at \$24.6 billion over a 10 year period. We are engaged in ongoing discussions with CBO about how they arrived at that estimate, and we are actively working to help them refine it. Today's hearing will help inform these efforts, so I thank our witnesses for being here and for offering their expertise.

I also look forward to discussing many of the other bills on today's agenda and to continuing the important work of the Health Subcommittee during the 118th Congress.

With that, I yield back, Chairwoman Miller-Meeks.

Ms. MILLER-MEEKS. Thank you, Ranking Member Brownley.

We are having a video issue for live stream, but we are going to go ahead and continue the meeting with respect for everyone's time.

We have a very full agenda today, so I will be holding everyone to 3 minutes per bill so that we can get through it all.

I am honored to be joined this afternoon by several of my colleagues who are going to be testifying about the bills on our agenda. I appreciate the steadfast dedication that each of you have made to help our veterans.

With this committee this afternoon are Representative Brian Mast from Florida, Representative James Baird, a fellow veteran from Indiana, Representative John Moolenaar from Michigan, Representative Steve Womack, another fellow veteran from Arkansas, and Representative Debbie Lesko from Arizona.

First, I would like to recognize Ranking Member Takano for 3 minutes.

**STATEMENT OF MARK TAKANO, RANKING MEMBER, FULL COMMITTEE**

Mr. TAKANO. Thank you, Chairwoman Miller-Meeks, for the courtesy. I thank you for inviting me to today's hearing. I am proud to be here to discuss my bill, the Korean American Valor Act, H.R. 366.

This legislation will provide eligibility for VA healthcare to veterans who served in the Armed Forces of the Republic of Korea as allies of the United States during the Vietnam War who have since become naturalized U.S. citizens. This will be done through a reciprocal agreement. Korea would reimburse the United States for the healthcare services VA furnishes to these Korean American veterans. In exchange, the United States will reimburse Korea for health care it provides to veterans of the U.S. Armed forces residing in Korea.

My bill would provide some measure of long overdue parity for Korean American Vietnam War veterans who, up to this point, have never been eligible for VA healthcare services. This stands in stark contrast to veterans from European countries that were



United States allies during World War I and World War II, who have had access to VA healthcare for decades.

Since 1958, through its Allied Beneficiary Program, VA has had the authority to treat veterans who have served in the Armed Forces of nations that were allied with the United States during World War I and World War II. These veterans do not need to be U.S. Citizens, and VA has the authority to treat veterans of any combat era. In 2022, VA provided care to 1,360 Allied Beneficiaries, 1,153 of whom were under the age of 65. VA furnishes this care through reciprocal agreements which have been established with the United Kingdom, Australia, New Zealand, Canada and South Africa. In 1976, VA's Allied Beneficiary program was extended to certain veterans who had served in the armed forces of Czechoslovakia or Poland during World War II or World War I and who subsequently became U.S. citizens, because this authority was established when these two nations were still under Communist rule, the Czech Republic, Slovakia, and Poland do not have reciprocal agreements with the United States.

Today is National Vietnam War Veterans Day, and it is the 50th anniversary of the date of the last combat troops left Vietnam. Let this serve as a call to action. It is far past time for our Nation to properly honor the service of these Korean American veterans who serve side by side with American troops. It is the United States' obligation as a long time ally of the Republic of Korea and as a beneficiary of these veterans' sacrifices during the Vietnam War to ensure they finally receive the same respect and consideration that their European counterparts have received for generations. The needs of Korean American veterans and of the Vietnam War are no different from those of U.S. born veterans. From Agent Orange exposure to coping with complex injuries and mental illnesses, these veterans deserve the specialized care and services that VA can provide.

Am I going over time? I will stop there. I think you got the point. Thank you very much.

Ms. MILLER-MEEKS. Thank you, Representative Takano.

Representative Mrvan, you are now recognized for 3 minutes.

#### **STATEMENT OF FRANK MRVAN**

Mr. MRVAN. Thank you, Chairwoman Miller-Meeke, for inviting me today. I greatly appreciate being at the hearing.

I am pleased to be here to discuss my recently introduced bill, the VHA Leadership Transformation Act, H.R. 1256. My bill will extend the term of appointments to the VA's undersecretary of health, or USH, for 5 years. It also removes existing statutory restrictions on the number of assistant undersecretaries for health that VHA can have, and it eliminates the requirement that all but two of them be physicians or dentists.

The intent of my bill is to provide greater leadership stability at VHA by shielding the agency from leadership turnover with every change in Presidential administrations. It will also help address governance challenges that have impeded oversight and accountability and empower VHA to more effectively address veterans health care needs.

Now, I know what you may be wondering, why should VA make these changes, and would not this cause VHA to operate differently from other Federal agencies? As to why now, we only need to look back at the last 6 years or so. With the confirmation of Dr. Elnahal in July 2022, VHA got its first Senate confirmed undersecretary for health since January 2017. Between January 2017 and July 2022, six different individuals rotated through this office, either acting as or performing the delegable duties of the undersecretary of health. Long-time observers of the VA healthcare will recall that the incredible transformation that occurred between 1994 and 1999 under the leadership of Dr. Kenneth Kizer. He was a visionary who led the VHA away from being a system heavily focused on delivering inpatient care in old, often under utilized hospitals to one that is now largely focused on delivering primary care and preventative care through the vast network of outpatient clinics. The VA that so many veterans and employees now and love today simply would not be what it is were it not for the steady leadership of Dr. Kizer.

I will also add that there are a number of other positions across the Federal Government with 5 year terms, including the Social Security Administrator, the Federal Aviation Administrator, and the IRS Commissioner. The Director of the FBI Services serves for 10 year terms. If any incoming President wants to replace any of these officials prior to the expiration of their term, the President has the authority to do that, and in my bill, would allow the same for VA's undersecretary for health. Removing statutory restrictions on how many assistant undersecretaries for health VHA can have and what their professional backgrounds may be will allow VA's healthcare system to adapt to the way healthcare is delivered today and enable VA to recruit and attract the best qualified candidates.

As a new ranking member of the Oversight and Investigation Subcommittee, I firmly believe—I am so sorry.

Ms. MILLER-MEEKS. You are over time.

Mr. MRVAN. Okay. I did not have—yes. Okay.

With that, I am pleased to have this testimony, and I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Mrvan. Representative Mast, you are now recognized for 3 minutes.

#### **STATEMENT OF BRIAN MAST**

Mr. MAST. Thank you, Chairwoman.

I want to talk about the Improving Veterans Access to congressional Services Act and I guess just tell you a story about it.

This is not a new program, this has been tested since 2017. I opened up the first office in the West Palm Beach VA Medical Center. After that, other colleagues from Florida in my area surrounding the West Palm Beach VA Medical Center started doing the same thing in the same space. We shared a space in the VA where we met with our veteran constituents inside of the hospital. We met with them to deal with their issues. In that time, my office alone opened up more than 500 individual casework and dealt with them. At the time, Representative Lois Frankel, Representative Ted Deutch, Representative Alcee Hastings, they also worked for their veteran constituents at the same time. In this very moment I am not given access to the Department of Veterans Affairs to

have a space to meet with my veteran constituents, but at this very moment representatives in Orlando, in the VA there, are given access to the VA hospital to meet with their veteran constituents, which I am glad of, because it gives them the opportunity to be the loudest patient advocates that any Member of Congress could be, because they are present. You want to be in a fight, you got to be present for it. It gives them the opportunity to be the best overseers of the Department of Veterans Affairs because they are inside of the VA on a weekly basis. Darren Soto, who has been doing this almost as long as I have, is inside of the VA on a weekly basis seeing what goes right, seeing what goes wrong.

Through this program of allowing to be having access to serve our veterans inside of the VA, we have been able to take veterans and help them get appointments, we have been able to take veterans who had their appointments canceled and were in moments of crisis that sent them into situations where they wanted to take their lives, and help them work through that, we have been able to take them to see the director of the VA hospital so they know that they could be heard at the highest level of the hospital, we have been able to witness things that were just out of place and demand that they be fixed. Like in my local hospital, at a bathroom in the main entrance of the facility, there was no push button to allow people in wheelchairs to have the door open automatically. We have been able to look at places where there should be security but was not and demand that there was. We have been able to serve our veterans at a higher level. There has only been positive outcomes for Democrats and Republicans and to my knowledge, not one report of misuse ever taking place.

My ask is for the support of this committee to help all Members of Congress be the loudest patient advocates and the best possible overseers of the Department of Veterans Affairs and be able to serve our veterans at the highest level by hearing that space in the VA.

I look forward to answering any questions you all might have.

Thank you.

Ms. MILLER-MEEKS. Thank you, Representative Mast. As a fellow veteran, I know that serving veterans in your community is your highest priority.

Representative Baird, you are now recognized for 3 minutes.

#### **STATEMENT OF JAMES BAIRD**

Mr. BAIRD. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley. I also want to thank the committee and its staff for holding this hearing and considering my bill, H.R. 41, the VA Same Day Scheduling Act. This is an important piece of legislation that I was proud to reintroduce this Congress and I am hopeful that together we can get it across the finish line.

In President Lincoln's second inaugural, he affirmed that this Nation would care for those who shall have borne the battle. His words have stood the test of time and stand as a solemn charge as we do our work here, ringing true today as it did back then. This bill is one more step toward fulfilling that promise.

The veterans on this subcommittee alone have about 120 years of military service. That is something to be proud of. We also know

too well there are millions of veterans left in limbo when it comes to making appointments for healthcare. With about 19 million veterans in the United States, timely and reliable care are essential to those who serve. The VA Same Day Service Scheduling Act would improve veterans experiences with the VA by prioritizing the customer service. They served our country, and now it is time to serve them.

This common sense measure guarantees that any veteran who makes a phone call and is requesting care is able to schedule their appointment during that phone call. In too many instances, we have seen setbacks to the VA patient scheduling, often to tragic consequences because of delays in call-back times to schedule these appointments.

My bill is narrow but targeted in scope to guarantee priority for those that established the VA patients.

With that, I see I am out of time. No, I am not. I got another 55 minutes. Sorry.

Ms. MILLER-MEEKS. Sorry, I was going to let you know you had some more time. I will give you five more seconds.

Mr. BAIRD. Okay. My bill is narrowed, but it is targeted to scope of the guaranteed priority for those already established as VA patients. It is specific to care administered by the VA to avoid issues carried out by this task related to the community care system. We must remove any uncertainty in scheduling VA provided care over the telephone for our veterans.

Additionally, it provides for the Department considerable flexibility by making the bill applicable 120 days after enactment and allows sufficient time for the VA to set appropriate standards after the adoption of this law.

I see amount of time now, so thank you, Madam Chair, and I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Baird.

Representative Moolenaar, you are now recognized for 3 minutes.

#### **STATEMENT OF JOHN MOOLENAAR**

Mr. MOOLENAAR. Thank you and good afternoon, Chairwoman Miller-Meeks and Ranking Member Brownley, distinguished members of the committee, thank you for the opportunity to come before you today to discuss the Veterans Patient Advocacy Act.

After putting their lives on the line in service to our country, our veterans deserve the best care from the VA, and I think that is something we can all agree with. Yet when I am back in Michigan, I often hear from veterans that there are simply not enough patient advocates at the VA. They tell me they struggle getting appointments, feel the VA is letting them down, and think the Federal Government does not care about them. Patient advocates are specifically trained professionals that play a vital role in helping our veterans with problems related to their care. Whether it is assisting with paperwork or an appeal, patient advocates are there to help. Unfortunately, there are not enough of them.

In a recent report on the Patient Advocacy Program, the Government Accountability Office found staffing concerns, massive backlogs, and veterans calls going unanswered. The Veterans Patient Advocacy Act would address this problem directly. It would require

the VA to increase the number of patient advocates available to serve veterans. Specifically, it would mandate that there is at least 1 patient advocate for every 13,500 veterans enrolled in the system. This would amount to 78 new patient advocates to help veterans. These new patient advocates can address the backlogs and assist our veterans to ensure they receive the care they need.

This is bipartisan legislation. I have worked on it with Congresswoman Debbie Dingell. It is also supported by the Veterans of Foreign War (VFW) and Student Veterans of America.

I hope you will join us all in supporting it as well.

Thank you.

Ms. MILLER-MEEKS. Thank you, Representative Moolenaar.

Representative Womack, you are now recognized for 3 minutes.

#### **STATEMENT OF STEVE WOMACK**

Mr. WOMACK. I thank the chairwoman. Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, thank you for considering my bill, H.R. 693, the VA Medical Center Absence and Notification Timeline Act or VACANT Act. I also want to express my appreciation for allowing me to speak in support of this bill.

The VACANT Act is a straightforward and common sense piece of legislation that will strengthen congressional oversight of the Veterans Health Administration's leadership selection process and ultimately improve care for veterans. My bill simply requires the VA to notify the congressional Veterans Affairs Committees when a medical center director is detailed to a different position within the Department and when an acting medical center director is appointed. The bill also puts a limit on the amount of time a director can be detailed before returning to their medical center.

This legislation, which I am proud to lead with my friend Senator John Boozman, highlights the value of effective, stable leadership at VA medical centers. Like the chair, I have commanded military units, and I fully appreciate how leadership drives culture. Unfortunately, we also both understand how poor leadership or no leadership can harm an organization, and that organizations will not operate at peak effectiveness when there is a rotating cast of leaders.

Until recently in Arkansas, we faced these leadership issues with the Veterans Healthcare System of the Ozarks going almost 2 years without a permanent Director. Although our acting directors were managing the best they could, it is understood that organizations need stable leadership to be as supportive as possible for our veterans. This legislation is an important step to ensuring no other VA medical center is left without a permanent director for a significant amount of time.

Large, complex organizations require effective leadership. Effective leaders drive change. They are proactive. Failure to appoint a permanent medical center director was a hardship for the Veterans Healthcare System of the Ozarks. I am committed to ensuring our VA support systems are prepared to meet their daily challenges. The VACANT Act is an important step in this direction.

Once again, it is an honor for me to speak in support of my legislation today. With your help, we will move this legislation closer to enacted law.

Thank you so much, and I yield back the balance of my time.  
Ms. MILLER-MEEKS. Thank you, Representative Womack.  
Representative Lesko, you are now recognized for 3 minutes.

#### **STATEMENT OF DEBBIE LESKO**

Ms. LESKO. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley, for inviting me to testify in front of the subcommittee on my bipartisan bill, VA Medical Center Facility Transparency Act, H.R. 1089. I would also like to thank Nevada Congresswoman Susie Lee for being the prime lead on this bill with me.

It is hard to believe that it is been almost 10 years since the Phoenix VA Medical Center was on national news because of huge wait times for our veterans seeking care. This bill is critical to helping our veteran constituents by increasing transparency between VA medical facilities, Congress, and the veterans themselves.

As the representative of over 50,000 veterans in my district, I believe we must ensure that VA medical facilities are acting in the best interests of their patients. Transparency and accountability are key to building trust and confidence among veterans and their families who rely on VA medical facilities for their healthcare needs. When VA medical facilities are open and transparent about their practices, policies, and outcomes, quality of care will increase, which is what our veterans deserve and what we promise to deliver.

My bill requires each director of a VA medical center to submit an annual, concise, easy to read fact sheet containing statistics regarding the number of veterans treated, the number of appointments conducted, the most common illnesses or conditions treated, the satisfaction of the veterans who are treated at each facility, and a description of any successes or achievements experienced by such facilities. The bill also requires a quarterly fact sheet that provides the average wait time for veterans to receive treatment at the medical facility. This information is critical to ensuring that our veterans receive timely medical care.

It is important to note that many of the Nation's veterans have unique needs. That is why this bill requires a description of special areas of emphasis or specialization by such facilities. The VA Medical Center Facility Transparency Act is critical to ensuring that our veterans receive the best medical care possible. By increasing transparency and accountability of medical centers, we can improve access to timely and high quality medical care for our Nation's heroes.

I urge all the members of this committee to support this important legislation.

On behalf of myself and Congresswoman Susie Lee, I thank you.  
Ms. MILLER-MEEKS. Thank you, Representative Lesko.

As is our process, we will forego a round of questioning for our members. You are now excused.

We will take a slight recess or break for about 5 minutes while we get situated for the next panel, and I invite the second panel to the table.

[Recess]

Ms. MILLER-MEEKS. Now that we are situated, thank you all very much.

I would like to thank the Department of Veterans Affairs for joining us today. The members of the VA Administration that are here are Alfred Montoya, who is deputy assistant undersecretary for health for operations in the Office of the Deputy Undersecretary for Health. Accompanying Mr. Montoya today are Dr. Scotte Hartronft, the executive director for the Office of Geriatrics and Extended Care, and Mr. David Perry, the chief officer with the VHA's Workforce Management.

Mr. Montoya, you are now recognized for 5 minutes to present the Department's testimony.

#### **STATEMENT OF ALFRED MONTOYA**

Mr. MONTOYA. Good afternoon, Chairwoman Miller-Meeks, Ranking member Brownley, and other members of the subcommittee.

First, I would like to apologize formally for the lateness of our testimony. We certainly do heed your comments about that in the beginning, and certainly we will work toward getting our testimony in on a more timely fashion. Thank you for those comments.

Thank you for inviting us here today to present our view on several bills that would affect VA programs and services. Joining me today are Mr. David Perry, chief officer of Workforce Management and Consulting, and Dr. Scotte Hartronft, executive director, Geriatrics and Extended Care.

VA is grateful for the committee's dedication to providing VA the authority and resources related to access, eligibility, and staffing. H.R. 41 would require VA to ensure that whenever a covered veteran contacts VA by telephone to request the scheduling of an appointment, the scheduling for the appointment occur during the telephone call. VA does not support this bill. VA already has the authority to do what this bill proposes, and it does so whenever possible. However, requirements for clinical review and determinations of eligibility are not always possible nor desired by the veteran at the time of a phone call to complete simultaneous appointment scheduling. Additionally, some types of care require specific eligibility, and it is not always possible to know that information during a telephone call.

H.R. 366 would add a new subsection that would State that persons VA has determined served in Vietnam as a member of the Armed Forces of the Republic of Korea between January 9, 1962 and May 7, 1975, would be eligible for benefits as a discharged member of the Armed Forces of a government. VA does not support this bill. In addition to a technical concern and equity concerns for other nations, there is also a concern about expanding healthcare eligibility to persons who served in Armed Forces of other nations before we can fully address expanding eligibility to veterans and priority groups not covered within our own current veteran population.

We appreciate the close collaboration in addressing some of the concerns VA identified with previous versions of H.R. 542. We believe the current version is much improved and is a demonstration of the benefits of VA and Congress working together. VA generally supports this bill if amended, although our positions vary, as noted in my written statement.

H.R. 562 would require VA to permit a Member of Congress to use a VA facility for the purposes of meeting with constituents. VA opposes this bill because we object to the prescriptive requirements of the bill. Facilities also raise unique concerns that would make placement of an office for a Member of Congress inappropriate.

H.R. 693 would require VA to notify Congress within 90 days of detailing a Veterans Affairs Medical Center (VAMC) director to a different position in VA. VA supports this if amended. If unamended, this bill may impact continuity of operations, as well as ongoing projects and initiatives that require a VAMC director's leadership.

Section 2 of H.R. 754 would establish a commission on eligibility to examine eligibility for VA healthcare. VA has concerns with the proposed bill and opposes it as currently written. We appreciate the committee's interest in assessing eligibility for VA healthcare. Eligibility determinations can be quite complex because veterans and other beneficiaries may qualify for the same or similar services under multiple laws.

H.R. 808 would require VA to ensure that there is not fewer than one patient advocate for every 13,500 veterans, and that highly rural veterans may access the services of patient advocates. Over the last few years, the role of patient advocates has expanded, and we are working to identify the best approach to ensuring veterans can access patient advocacy services as needed to support the delivery of their care.

Section 2 of H.R. 1089 would require VA to ensure that each medical center director submits to the Secretary the Committees on Veterans Affairs of the House of Representatives and the Senate and the appropriate Members of Congress an annual fact sheet with certain statistical information with respect to the year covered by the annual fact sheet. VA does not support this bill. We understand the fundamental interests or concern of the bill, but VA already provides significant information online about patient experience, wait times, and quality for each medical center. The requirements for each director to submit to Congress directly on an annual basis these fact sheets would be very involved, requiring each facility to establish redundant processes and systems and incur significant additional costs.

Finally, VA supports section 2 of H.R. 1256. Setting a 5 year term could provide VA with continuity of operations when there is a change in Presidential administrations and could allow VA to continue providing support and care to our Nation's veterans without interruption. It would also give VA the flexibility to recruit and retain highly qualified executives with various experience to fill these critical leadership positions.

This concludes my statement.

We would be happy to answer any questions you or members of the subcommittee may have. Thank you.



[THE PREPARED STATEMENT OF ALFRED MONTOYA APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you for your testimony, Mr. Montoya. I will now yield myself 5 minutes.

Mr. Montoya, currently, when a veteran contacts the Department by telephone to request the scheduling of an appointment and the request cannot be accommodated during that phone call, what is the typical process for follow up?

Mr. MONTOYA. Chairwoman, thank you so much for that question.

When we look at scheduling and when a veteran calls in, I will actually use some of my own examples as a veteran who gets 100 percent of my care in the VA. As that veteran calls in, if they are not able to make that appointment for one reason or another, that eligibility or determination of the clinical reason would then go on to another provider or clinical staff to be able to help schedule that appointment.

A good example of this would be dental. Dental is one of those very intricate appointment types where there needs to be some evaluation of the benefit as well as the clinical application of the appointment.

Ms. MILLER-MEEKS. On average then how long does it take for a veteran to schedule that scheduled appointment?

Mr. MONTOYA. Yes, I am very happy to actually share some of our wait time data that we do have for the community. For the exact timeframe as far as when it takes a veteran to get their appointment scheduled, I will certainly get back to you on that one for the record.

I will tell you, in some cases we do this already the same time that that veteran calls in. It is a very basic appointment such as primary care and mental health. In many cases, we can do that the same day. In some cases we actually have a clinical contact center that does that 24/7, 365 days a year.

Ms. MILLER-MEEKS. I will let you know that I am a physician and when patients call me to schedule an appointment, we schedule that appointment the same day. We do not have them call back. If they walk in, I see them. I do not ask for their insurance or what their benefits are. I take care of that patient.

In addition to which, I understand the challenges that you are having, but there are often times when veterans have extreme need and need to be addressed. We know one of those because we have a bill named after a veteran who committed suicide who could not get into the VA and was declined service or not made an appointment in a timely fashion.

It is a bill that I support. I understand the challenges that you face at the VA, but I think that sometimes when there is a will, there is a way and perhaps we need to give the VA the will to make the way happen.

When a veteran contacts a call center, should not they be able to complete that scheduling request in a single call? It sounds like you are supportive of that.

Mr. MONTOYA. Yes, ma'am. Thank you for that.

As I did mention in my previous answer, many of our basic appointments, such as primary care or mental health, those are scheduled on the same day. In fact, when veterans do call into our

clinical contact centers, they are able to schedule those appointments.

Where it does actually present an opportunity or a challenge is when there are some of those more complex medical appointments, such as cardiology or dental, as I mentioned with my previous example, where it does take more time to dig into what the eligibility is, what the clinical concern is, to make sure that we are scheduling the right appointment for that veteran at the right time.

Ms. MILLER-MEEKS. In your view, how would veterans benefit from having representatives of their Members of Congress available in VA facilities during business hours?

Mr. MONTROYA. Yes, thank you so much for that question.

As well, as a former medical center director of three different stations, I can not underscore enough the importance of the relationship with our congressional stakeholders in the community. Often times we hear those concerns from them first and foremost about our veterans. When they are in the facility, we actually run into a couple of concerns. First and foremost, our primary reason for our medical centers is to provide that space for clinical care. Often times in our medical center, there is not enough space to be able to do that. We do feel that having that blanket requirement to provide office space would detract from that clinical care or the potential for that clinical care to be provided.

Additionally, when you look at it, there are other things that come alongside that, such as parking, the flow, going into the campuses and the like that tend to be a little detracting.

Ms. MILLER-MEEKS. Your conference rooms are full? 24/7?

Mr. MONTROYA. They are not. In fact, thank you for that, because I think there are the opportunities for our congressional members to, on an ad hoc basis, to be able to coordinate space within those medical centers. All they have to do is reach out to their medical center director, and they can work through the process of making that happen.

Ms. MILLER-MEEKS. Thank you very much.

As a fellow veteran, I think sometimes it is good to go into the VA hospital when you are unannounced and not having an officially guided tour.

Thank you.

I am going to yield 5 minutes to Ranking member Brownley.

Ms. BROWNLEY. Thank you, Madam Chair. I appreciate it.

Dr. Hartronft, I wanted to ask you a couple of quick questions here at the beginning, and I would just appreciate if you could just answer yes or no, okay.

Is home and community based care good for veterans? Do veterans who use home and community care generally have positive experiences and good health outcomes?

Dr. HARTRONFT. Yes, ma'am.

Ms. BROWNLEY. Is home and community based care usually less expensive than institutionalized care?

Dr. HARTRONFT. Yes, ma'am, in most cases.

Ms. BROWNLEY. How many veterans does VA expect would benefit by increasing—in section 2 of the bill—by increasing the cap to 100 percent?

Dr. HARTRONFT. We do not have the exact number, but the populations that are primarily affected by the current cap are veterans with Amyotrophic Lateral Sclerosis (ALS) and also some spinal cord injury and disorder patients, especially when they need ventilator care 24/7 care, the primary population that most likely has issues with the cap.

Ms. BROWNLEY. In no way does the bill say that every veteran who receives home based care would use the full amount?

Dr. HARTRONFT. No, ma'am.

Ms. BROWNLEY. It would be a much smaller amount.

Dr. HARTRONFT. We would estimate that.

Ms. BROWNLEY. Yes. Well, you estimated approximately \$1.2 billion in terms of the cost.

Mr. Montoya, maybe you know this, but there had to be some kind of an assumption of how many veterans would utilize the cap at 100 percent. Roughly, 200, 500?

Dr. HARTRONFT. I can bring those to—for the record, exact numbers. Again, we were primarily looking at those populations that were specifically hitting the cap.

Ms. BROWNLEY. Okay, I am looking for like exact numbers because we have some work to do with CBO. I would definitely, definitely, definitely like those numbers.

Do you think the way CBO—because CBO did score this at roughly \$24 billion, which is, you know, quite different from your \$1.2 billion. That is quite a difference. Do you think that what they did was they assumed that everyone, every veteran that would utilize the homebased care, they scored it at 100 percent? Do you think that is how they possibly came up with a \$24 billion figure?

Dr. HARTRONFT. My apologies, but I can not really comment on the CBO's estimates.

Ms. BROWNLEY. The secretary said the same thing.

Dr. HARTRONFT. Yes, ma'am.

Ms. BROWNLEY. If you are not going to comment on this, then I need you to comment on how you came to your conclusion of what you think the bill costs.

Dr. HARTRONFT. Yes, ma'am.

Ms. BROWNLEY. We have got to figure out this discrepancy, okay. Yes, okay.

I guess then I would just go on to ask if did the CBO ask the VA for data to make their assessments of cost?

Dr. HARTRONFT. I am unaware and can not comment on how much they reached out.

Ms. BROWNLEY. Are you unaware or you can not comment?

Dr. HARTRONFT. I am unaware.

Ms. BROWNLEY. Okay, good. All right. So, unaware. We have just got to kind of get to the bottom of this. I know on the Senate side of the bill, they are equally as interested in figuring this out. I know this is a section of the bill that the VA absolutely supports.

Again, if you can give me the exact numbers for the record, I would appreciate it.

With that, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Brownley.

I would now like to recognize General Bergman for 5 minutes.

Mr. BERGMAN. Thank you, Madam Chairwoman.

As you all know—I guess let us start with first things first. To any of our fellow Vietnam veterans, March 29, several years ago, was designated Vietnam Veterans Day. Welcome home. I would like to extend that welcome home to all our fellow brothers and sisters and for all of you in the Veterans Service Organizations (VSOs) and the VA community who serve, in my case, my generation of veterans. It is not too little, too late, but it was too late for some. And as we look at providing care for veterans now in their seventies and eighties, that the dynamics of healthcare have changed.

The reason I would start with that is that With H. 542, the Elizabeth Dole Community Based Services for Veterans And Caregiver Act, Mr. Montoya, what does VA consider to be the cost of 100 percent institutional care? Now, I know it could possibly vary by geography or that cost of living, whatever, but what factors go into determining that cost?

Mr. MONTROYA. Yes, General, thank you so much for that question.

For that, I am going to actually turn to my colleague, Dr. Hartronft to be able to answer this.

Dr. HARTRONFT. Yes, sir.

It does vary from region to region, as you are aware, but what we usually look at is the average cost for region for the VA Community Living Center is kind of what we look at. Then we adjust that cap with a 65 percent with the average. That is kind of how we peg to that.

Mr. BERGMAN. When we are costing out, then what we are going to do with, if you will, Community Based services, do you feel that you have really here is the cost of providing this in Roanoke, Virginia or Escanaba, Michigan, that you can compare and contrast the costs associated with home based healthcare, that we are not using a metric that does not really match the geographic area, you can determine how much this is going to cost.

Dr. HARTRONFT. That is why we currently support not only the 100 percent, but then also the waiver availability, for both certain conditions that exceed that. Yes, we would be interested in meeting and going specific into VA methodologies in more detail if you are—

Mr. BERGMAN. We accept and understand that there could be cost variances in different parts of the country. Unless VA can, through your procedures for evaluating cost, give us as Members of Congress who would appropriate money to the VA for general funds or specific programs, sometimes we get a little nervous that we are throwing—we are not getting the right cost benefit for the dollar.

I for one like to see numbers and I am not afraid of cost comparisons, because either it is worth the value or it is not. How do we balance that spectrum of care? If we—and we—and this is kind of a partnership between the House and VA, do not have our fiscal act together when it comes to implementing good programs for care, the confidence that the veterans and their families and even within your systems, within your Veterans Integrated Services Networks (VISNs), one might feel handicapped by the numbers, other

one might feel advantaged by the numbers because it came out in their favor.

I see my time is running out here. Anything that the VA can do to give realistic numbers for all of us to take a look at as we make these decisions is going to be helpful in the end to the care we provide for the veterans, and in the end, all of us—all of us will be proud of what we did. It will vary a little bit.

I just wanted to say thank you for all you do and let us not quit because we got a lot of veterans out there and their families who are counting on us.

With that, Madam Chairwoman, I yield back.

Ms. MILLER-MEEKS. Thank you.

The chair now recognizes Representative Budzinski from Illinois for 5 minutes.

Ms. BUDZINSKI. Thank you, chairwoman.

It is great to be with all of you. Thank you for being here.

I actually had a question I wanted to ask about H.R. 542, the Elizabeth Dole Home Care Act, introduced actually by Ranking Member Brownley. I have heard from many of the veterans back in my district and from several VSOs on the need to enable elderly and disabled veterans to be able to enjoy a higher quality of life at home as they age, as well as the increasing need to support their caregivers. According to the VA Geriatric and Gerontology Advisory Committee, over half of the VHA enrolled veterans are 65 or older, and this population is only increasing, meaning we need to take immediate action to support long-term care and invest in VA's home and community based services, especially those in rural areas like the district that I represent, where health care options are already limited.

Really, my first question is for anyone on the panel, what challenges do current caregivers and elderly veterans face and how do you think this bill in particular works to address some of those concerns?

Dr. HARTONFT. Thank you for that question, ma'am.

Actually, this bill has been very helpful in us aligning our timelines. As you all may be aware, we currently had had a multi year expansion for many of our programs and home community based. Due to feedback—and we had previously said we were going to make that directed care be available at all VA over 5 years, but recently, due to feedback from this subcommittee and others and external stakeholders, we have actually compressed that now to where we are going to do it over eight quarters. We are going to go from 71 sites that were available in 2022 to where we are going to add 70 more sites over the next 8 quarters. We also were expanding number of home based primary care and also medical foster home, which is not a program that is well known.

Right now we have also made homemaker home health care, purchased skilled home care, and home based primary care is now available at all VAs. Now we are working on getting that vet directed care, medical foster home to all VAs, as well as trying to make veterans known.

I think some of the barriers, of course, is especially in rural areas, and it is a problem for all the American demographics, not just for veterans, in the sense that there may not be many vendors

or home healthcare agencies in many of the rural areas or highly rural areas. That is why many people really like the veteran directed care program where they can hire a family member, neighbor, and others to fill in that gap. That has really helped us in many significant rural areas.

We are also trying to push the limits when it comes to telehealth and other modalities to really kind of improve access to our rural veterans and others who can not get it by traditional means.

Ms. BUDZINSKI. Right. That is great to hear. I actually have a follow-up question.

In the same vein, there is also critical need to address the complex and unique mental health concerns, of course, of aging vets. Again, for anyone on the panel, how can this bill help address the behavioral health concerns older veterans are facing today?

Dr. HARTONFT. I think for us, especially with behavioral health and mental health covers many aspects unique to veterans as well as that of aging in itself, with whether you have dementia or other reasons. We work closely with the Office of Mental Health and Suicide Prevention and we look at both how we can improve both the home care level, as well as making sure that our institutional facilities are aware of veteran specific unique needs as well as behaviors, especially as you see in certain populations of aging veterans with dementia and other disorders. A lot of it is education, training, availability of services, and us working closely with the Mental Health Program office.

Ms. BUDZINSKI. Great. Thank you.

I guess I would just last like to say I am really a proud co-sponsor of the Elizabeth Dole Home Care Act, and I am grateful to my colleagues on both sides of the aisle because it does have a lot of really great bipartisan support.

Thank you again for being here today.

I yield back my time.

Ms. MILLER-MEEKS. Thank you.

The chair now recognizes Representative Van Orden from Wisconsin for 5 minutes.

Mr. VAN ORDEN. Thank you very much, Madam Chairman.

Write this down. I agree with Congressman Takano. I think that is a first. He is right. These Korean War veterans served alongside my Uncle Bob, Robert Francis Mulligan, who was nearly killed by a Chinese Communist grenade thrown into his pit. They became American citizens. These are not just random people on the street.

I completely disagree with you, Mr. Montoya. These people deserve the respect that they earned fighting next to our relatives.

Did you say you support H.R. 1256? I did not hear that. That is the 5 year term and that sort of stuff.

Mr. MONTOYA. Yes, sir, we do.

Mr. VAN ORDEN. Okay, thank you.

I want to talk to you about H.R. 562. I am 100 percent disabled, service-connected disabled veteran. My care has been outstanding. The one issue that I have had consistently with the VA is the bureaucracy involved with it. I noticed that your testimony was requested a month ago. We got it last night. Could you say that your testimony was lost in the bureaucracy? Probably. Okay, let us put that one there.

Senior Chief Mike Day committed suicide 2 days ago. He was shot 27 times in Iraq. His primary weapon was disabled. He drew his pistol and he killed the 3 people in the room that shot him 27 times.

We have to have an on ramp into the VA. I have had good experiences with the VA, but a lot of people wearing the same hat that I got back there did not. I will tell you why. It is because you walk into the VA and you do not know anybody. You do not. If we are able to walk into the VA and see someone who was sent by them to represent them, that is a friendly agent. I will do anything I possibly can to prevent another damn veteran suicide. By excluding us from sitting in a room, and I have been to I do not know how many VA facilities, so that we can be the friendly on ramp for our veterans so they can get into the system and not kill themselves, is imperative. I am concerned because I do not believe what you just testified. I do not believe that you think there is not enough room for this. I do not believe that. What I do believe is that your agency is concerned about having on the ground oversight by congressional people who control your budget. That is unacceptable. That is putting your job and the jobs rest these cats herein front of my brothers and sisters in arms, and I will not accept that. So you guys need to change your opinion on that.

H.R. 1256 says can allow for more flexible numbers of assistant undersecretaries, correct?

Mr. MONTROYA. That is correct.

Mr. VAN ORDEN. You are capped at eight, right? Can you envision any scenario, if you have flexible options that that number would become seven?

Mr. MONTROYA. Thank you very much for that question, sir.

For that I am going to turn to Mr. Perry to be able to answer.

Dr. PERRY. Yes, sir, thank you for that question.

I think what we are looking for is the flexibility to not have a predefined number of assistants.

Mr. VAN ORDEN. I get you. I am just asking you a pretty clear question, Mr. Perry. You are capped at eight right now. Can you envision that ever becoming seven?

Dr. PERRY. It could potentially, yes.

Mr. VAN ORDEN. Well, I could potentially grow my hair back, but the chance of that happening are zero, right? No, this is the problem here. The only one of these things that you vigorously supported was growing the bureaucracy. The only reason your testimony was a month late is because of your bureaucracy. The only problem I have ever had with the VA is with your bureaucracy. We got to stop this. I am not going to vote to grow the bureaucracy. I will vote to refine the bureaucracy. I will vote to make sure that you are empowered to do your job better, that my fellow reps on this panel have the ability to conduct oversight so it can become more efficient, but I am not voting for this. It is inappropriate. I mean, my goodness, this whole pack of them, the only thing you supported was growing your bureaucracy. That is not good. We cannot have another veteran commit suicide because of bureaucracy. There is a framed letter on my desk from a veteran, his brother, who wrote me, who committed suicide and they got the letter 2 days later that he got accepted to the VA because of the bu-

reaucracy. His request was lost with your testimony, and we have had enough of that.

With that, I yield back.

Ms. MILLER-MEEKS. Thank you, representative.

On behalf of the committee, I thank all of our witnesses for their testimony and for joining us today. You are now excused. We will wait a moment as the third panel comes to the witness table.

[Recess]

Ms. MILLER-MEEKS. Welcome everyone, and I thank you for your participation today. On our third panel we have Mr. John Retzer, assistant national legislative Director with Disabled American Veterans, Mrs. Tiffany Ellett, the deputy director of health policy for the American Legion, and Mr. Morgan Brown, national legislative director of Paralyzed Veterans of America.

Mr. Retzer, you are now recognized for 5 minutes.

#### STATEMENT OF JON RETZER

Mr. RETZER. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, thank you for inviting Disabled American Veterans (DAV) to testify at this legislative hearing.

I will focus my remarks on the bills under consideration today that most affect service disabled veterans.

DAV is pleased to support H.R. 542, the Elizabeth Dole Home Care Act. By 2037 the age cohorts are the greatest need for long-term care, veterans who are at least 85 years and those who have disability ratings of 70 percent or higher, which guarantees mandatory long-term care, is expected to grow by almost 600 percent. Cost of long-term care services support must double by 2037 just to maintain our current services.

In order to meet the overwhelming increasing demand for long-term care needs for the veterans in the years ahead, VA must significantly expand and fund home and community based services as proposed in H.R. 542. The programs are not only more affordable, but often preferred by veterans and their families.

We also support the increasing of the expenditure cap for home and community services to create the financial incentives to expand these important services.

DAV is pleased to support H.R. 41, the Same Day Scheduling Act. In the recent years, the Government Accountability Office and others have reviewed VA scheduling process and identified very specific challenges that the Veterans Health Administration has in ensuring all appointments, including those at community care, are scheduled in a timely manner. This legislation would require VA to schedule an appointment during the veterans telephone call, regardless of the prospective date of the appointment being scheduled. This would improve the current scheduling procedures at the VA and provide more accurate waive time data.

DAV also supports H.R. 808. The bill would improve the patient advocates program at VA medical facilities by ensuring there are no fewer than one patient advocate for every 13,500 veterans. Patient advocates play a critical role in assisting veterans to get the care they need. They have direct effect, the ability to address veterans' complaints and resolve issues with access to care. Impor-



tantly, patient advocates also assist veterans with clinical appeals. Advocates should be able to provide timely assistance to veterans in accessing health care and the clinical appeals process..

Therefore, we recommend additional research be conducted to ensure that the ratio of patient advocate to veterans is adequate and balanced.

DAV supports H.R. 693, the VACANT Act, legislation that would limit the detailing's of the VA medical center director to the different deposition within the Department. Staffing shortages and vacancies in the VA healthcare system, especially the critical management positions, can impede the delivery of care for veterans who rely on VA for their care. This legislation would help improve accountability to sustain needed leadership, to ensure VA healthcare runs seamlessly during a period of transition and that veterans continuity care and benefits are not disrupted.

H.R. 1256 would extend the term of appointment for the undersecretary for health to 5 years and remove restrictions for the number of assistant undersecretary for health that can be appointed. We understand the intent of this bill is to provide greater leadership stability at VHA and believe it would empower the undersecretary for health to more effectively manage and carry out their responsibilities to ensure veterans health care needs are met. While DAV does not have a resolution that speaks to this issue, we have no objections to moving this bill forward.

The final bill I will comment on is H.R. 754. This legislation would establish a commission to examine policies guiding veterans health care eligibility and make recommendations, if advisable, make changes. DAV is concerned that previous reform efforts have proposed to diminish the size and scope of the veterans health care system, whether by proposing changes in eligibility to limit the number of veterans who may have received care or by pressing for privatization of the VA medical services.

Historically, Congress has made thoughtful decisions about assigning priority for care and eligibility for various veteran groups. Most recently, Congress expanded eligibility for veterans who experienced combat and were exposed to toxic exposures or radiation under the PACT Act, veterans in mental health crisis under the Comprehensive Prevention Access to Care and Treatment (COMPACT) Act. Rather than a commission, we, believe Congress should continue to make these decisions in the best interest of veterans by conducting oversight of VA healthcare eligibility and legislating the changes that are deemed necessary.

Chairwoman Miller-Meeke, this concludes my statement. I am happy to address questions you or the members of subcommittee may have.

[THE PREPARED STATEMENT OF JON RETZER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Retzer.

The chair now recognizes Ms. Ellett. You are recognized for 5 minutes.

#### **STATEMENT OF TIFFANY ELLETT**

Ms. ELLETT. I sit before you today as a disabled veteran, a VA patient, and a veteran advocate. I receive all of my care through

the Department of Veteran Affairs and have personally experienced the evolution of the VA benefit and healthcare system since my separation from the United States Army in 2013.

It is through this lens that I am able to see what our members see, to feel the frustrations and aggravation they exude when discussing obtaining an appointment, navigating the system, and receiving appropriate care. With their voices in mind, I would like to take this opportunity to touch on a few points.

Chairwoman Miller-Meeks, Ranking member Brownley, and distinguished members of the subcommittee, on behalf of our National Commander Vincent “Jim” Troiola, and our more than 1.6 million dues paying members, we thank you for inviting the American Legion to testify today.

VA has made a number of changes to appointment scheduling through their website, healthcare facilities, and updated Internet applications. However, there are still veterans having difficulty scheduling an appointment within the setting of a phone call to their VA facility. With the current process for appointment scheduling via phone, many veterans are able to successfully obtain an appointment in that timeframe. However, others are told they will need to be contacted at a later date, with some going weeks without follow up. At times, this can make a simple task tedious and cause frustrations.

In Dorn VA, Columbia, South Carolina, there is a pilot program where staff can schedule an appointment without spending time on technical issues or information searching. Instead, all necessary information for scheduling is in a single sign on interface. In this one screen, the scheduler can see all open appointment times and days for not only VA providers, but also for the community care provider to which the veteran was referred. With this type of system, scheduling an appointment takes an average of about 7 minutes. This is ideal for simplifying the scheduling needs of a veteran. The American Legion supports the VA Same Day Scheduling Act of 2023 and its intent to increase and simplify access to veterans care.

Separately, in 2003, the American Legion dubbed the VA healthcare system a system worth saving, and in doing so, created a program where veterans and local VA medical center staff could meet with us to discuss the challenges and successes in delivering and receiving efficient health care. In the last three trips we have conducted, the American Legion has found that VA patient advocates are utilized by both veterans and VA with the same goal in mind, successful navigation through the VA Healthcare system.

As expected, with the increase of veterans enrolling in VA care, the patient advocates have a heavy workload and at times are not able to assist veterans to the extent needed. The American Legion supports the Veteran Patient Advocacy Act and the improvements it will bring through establishing a standard of at least one advocate per 13,500 veterans. We are also encouraged to see an increase in access to patient advocates for veterans in rural communities. The availability of patient advocates is a priority of the American Legion and will continue to be a focal point when speaking with veterans about their representation as a VA patient.

Finally, I would like to address the Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act of

2023. Recently, our national commander testified that there is a concern for caregivers and their health. Often, caregivers will put their veterans health and care above their own, leading them toward poor health and burnout. The American Legion is pleased to see that respite care is addressed in this legislation, as it is beneficial to caregivers, their families, and the veterans they care for. We are also pleased to see consideration given to caregivers in terms of support services and education on possible benefits. We also agree that successful transition and care are critical to the overall well-being of both the caregiver and the veteran.

As consistently stated by Secretary McDonough, VA has a priority of providing timely world class health care to veterans. The American Legion supports the necessary legislation to help VA accomplish this endeavor. We have seen VA work to identify deficiencies, and we have seen Members of Congress work with VA to create solutions. The American Legion supports VA as they continue to evolve. We also call upon Congress to pass legislation such as these to allow for and encourage VA's evolution toward health equity for veterans.

I conclude by thanking Chairwoman Miller-Meeks, ranking member Brownley, and this subcommittee for your incredible leadership and for always keeping veterans at the forefront of your mission.

It is my privilege to represent the American Legion for the subcommittee, and I look forward to answering any questions you may have.

[THE PREPARED STATEMENT OF TIFFANY ELLETT APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Ellett.

The chair now recognizes Mr. Brown. You are recognized for 5 minutes.

#### **STATEMENT OF MORGAN BROWN**

Mr. BROWN. Thank you. Chairwoman Miller-Meeks, Ranking member Brownley, and members of the subcommittee, Paralyzed Veterans of America (PVA) thanks you for this opportunity to present our views on pending legislation impacting the Department of Veterans Affairs that is before the subcommittee.

My written statement covered PVA's positions on the nine bills being reviewed today, so in the interest of time, I am going to focus on the one bill that most directly impacts our membership.

PVA gives its strongest endorsement to H.R. 542, the Elizabeth Dole Home Care Act, which would make urgently needed improvements to VA's home and community based services, including several that target our concerns about current program shortfalls. VA projects the demand for long-term care will continue to increase, driven in part by growing numbers of aging veterans and veterans with service-connected disabilities. Expenditures for long-term care will increase as well and are projected to double by 2037. While greater investment in the Department's long-term care infrastructure is badly needed, VA must also expand veterans access to non-institutional programs when appropriate to prevent or delay nursing home care and to reduce costs. Fixing VA's challenges to meet veterans long-term care needs will be difficult because it is a multi-dimensional problem that requires a comprehensive solution.

Section two of this bill raises the cap on how much VA can pay for the cost of home care. Currently, VA is prohibited from spending more than 65 percent of what it would cost to care for the veteran in a nursing home. When VA reaches this cap, the Department can either place the veteran into a VA or community care facility at a significantly higher cost or rely on the veteran's caregivers, who are often family members, to bear the extra burden. Depending on the services available in their area, some veterans must turn to their state's Medicaid program to receive the care they need, even for service-connected disabilities.

Last month, the Senate Veterans Affairs Committee advanced a similar version of this bill without the language raising VA's cap on care, primarily due to its cost. CBO score for this section is perplexing because only a few hundred veterans are currently exceeding the 65 percent threshold. Some may need rates to be raised to the full cost of nursing home care, but the majority would not.

VA is committed to enhancing and maintaining the quality of life for veterans, but the current limitations on the cap of services is contrary to this vision. Nothing in this legislation expands the number of veterans in this category and the number of them in this situation is relatively stable from year to year. We recommend the subcommittee work with CBO and your Senate counterparts to review the current calculations to determine their accuracy.

Section Four of the bill requires the VA to administer programs like Veterans Directed Care (VDC) at all VA medical centers within 2 years. The VDC program allows veterans to receive Home and Community Based Services (HCBS) in a consumer directed way and is designed for veterans who need personal care services and help with their activities of daily living. Last year, the VA announced plans to expand the VDC program to 75 additional sites over a 5 year period, and we were pleased when VA's undersecretary for health recently directed VHA to accelerate that timeline. We understand several sites may be ready to launch their programs but lack the financial resources to do so. We urge Congress to provide the necessary funding so every VA medical center can offer a robust VDC program as quickly as possible.

And, finally, even when veterans have access to programs like VDC or Homemaker Home Health, it can be challenging to find home care workers. One PVA member told us he regularly spends weekends in bed because no staff is available to assist him, and he is depressed and frustrated because he can not find the direct care workers he needs.

The shortage of caregivers or direct care workers is not unique to VA. Across the country, there is an increasing shortage of direct care workers, and a national effort is needed to expand and strengthen the workforce. We believe the pilot program established in section seven would lessen the difficulty in finding direct care workers at the sites VA selects and may reveal additional ways the VA could alleviate this problem for many veterans nationwide.

I close again by stressing that this important bill addresses several major concerns for catastrophically disabled veterans, and we urge Congress to pass the Elizabeth Dole Act this year.

I thank you again for this opportunity to share our views on this legislation, and I am happy to answer any questions you may have.

[THE PREPARED STATEMENT OF MORGAN BROWN APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you so much, Mr. Brown.

I am going to go last as my prerogative. I think my predecessor did that as well. I am now going to recognize Ranking Member Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair.

Mr. Brown, thank you for your testimony. Given the population of veterans that PVA serves, I was sadly unsurprised to see the significant challenges veterans and their families face due to statutory cap on how much VA can spend on home care you highlighted in your testimony. For those who did not get a chance to read his testimony or review it, would you briefly highlight some of those issues and the impact on veterans quality of life?

Mr. BROWN. Certainly.

We have numerous veterans that have—their family is attempting to provide their care, and because of the cap and VA is limited the number of hours, they have to make a choice basically. They are forced to choose between going into either a VA facility or into a local facility, which often times provides them a lesser quality of care, or to have the family assume that burden. In many cases, it is the family that is attempting to do the right thing here and to care for their loved one in the home. Many of these veterans, and I believe it was touched on earlier, are veterans with ALS that are in their final years in life. It is a great disappointment to us that we cannot figure out a way to provide them the full care that they earned and deserve.

Ms. BROWNLEY. Thank you for that.

You mentioned in your testimony that you thought there would just be really there is a couple of hundred veterans, you believe?

Mr. BROWN. Yes, ma'am. It is our understanding that it is only a few hundred veterans that are currently exceeding the cap, and that not all would require 100 percent. You may have some that maybe need 70 percent, some that need 80. Certainly there are some that would need the full increase.

Ms. BROWNLEY. Very good.

Mr. BROWN. The number is stable from year to year.

Ms. BROWNLEY. Very good. Where did you get that data from?

Mr. BROWN. From talking with our own members and then with conversations with VA.

Ms. BROWNLEY. Okay, very good. Well, the VA has promised me those numbers on the record.

Mr. Brown—really this is a question for all three of you. There is a section in the bill, I think, that the VA is not necessarily supporting, and that is about transparency and having a singular website with all of these services together on a website so a veteran knows where to go and does not have to go to five or six different sites to figure out what programs and services are out there—one centralized location on a website to get that information. Do you think that is a good idea?

Mr. BROWN. Absolutely.

Ms. BROWNLEY. Ms. Ellett.

Ms. ELLETT. Yes, I absolutely think that that is a good idea. I was an analyst in the Army and I can find those things and I can spend all day on that. I am also a veteran advocate, so it is kind

of my job. My wife has five head injuries, and for her, if she is going to find—if she is going to look for any resources, if she has to go past two clicks, it is not going to work. In order to benefit our caregivers and our veterans, I think that it is not a hard ask to have them all in one location.

Ms. BROWNLEY. Yes. Very good.

Mr. RETZER. Yes, we agree too. I think the veterans experience, as VA speaks about it, should be as simple and easy and streamlined in the virtual world along with the VA healthcare that they get.

Ms. BROWNLEY. Yes, I think, Mr. Brown, in your written testimony, I think you had a case where there was a veteran, was associated with a medical center that had the directed care program, he needed that program, but the two never came together.

Mr. BROWN. That is correct. Actually, that was our national president.

Ms. BROWNLEY. Oh, my goodness.

Mr. BROWN. He is currently in home health program. It was not until last year that we realized that Veterans Directed Care was available at the facility that serves him. He had a little bit of difficulty contacting the staff, but when he did and inquired about why he was not offered that program, they told him that they felt that he probably would have difficulty finding the workers that he needs to care for him, but in fact, the opposite was true. He actually had people that were willing to step forward and care for him and it would have been an ideal situation for him to participate in that program.

Ms. BROWNLEY. Terrific. Thank you so much.

I yield back, Madam Chair.

Ms. MILLER-MEEKS. Thank you, Representative Brownley.

I now recognize Representative Van Orden from Wisconsin for 5 minutes.

Mr. VAN ORDEN. The angry senior chief. I am just kidding, man.

Mr. Retzer, I understand you support the bill that I do not. It is not that I do not support the whole thing, it is just I do not want to grow the bureaucracy. Having a term longer for the secretary I think, is a great thing because it does get rid of that gap. Again, we need to work for efficiencies.

Ms. Ellett, is your wife a vet?

Ms. ELLETT. Yes, sir.

Mr. VAN ORDEN. Is she getting taken care of now?

Ms. ELLETT. Yes, she is.

Mr. VAN ORDEN. Where does she get seen?

Ms. ELLETT. We both go to Richmond VAMC. We are also rural veterans.

Mr. VAN ORDEN. So am I.

Ms. ELLETT. It takes us about 45 minutes to get to a local Community Based Outpatient Clinics (CBOC)—

Mr. VAN ORDEN. Okay.

Ms. ELLETT [continuing]. and about an hour and a half to get to the VA medical center. When we make appointments, we make them all day, make them for the whole day, and it is the day trip for the both of us.

Mr. VAN ORDEN. Have you had problems getting access to community care?

Ms. ELLETT. Yes and no. Some of the community care providers are very—we get the referral quickly, and some of the community care providers are very helpful and very willing to work—working through a third-party administrator is a little bit difficult because they have you on the phone and they have somebody else on the phone. We have had those same day struggles, however, when we do schedule for like our CBOC, it is immediate. We can call and schedule an appointment like that. It is the community care appointments that have a real problem with the same day scheduling.

Mr. VAN ORDEN. Okay, well, thank you for that.

You know that you have friends here on this committee, right?

Ms. ELLETT. Yes, sir.

Mr. VAN ORDEN. Okay. I am a Legionnaire myself.

H.R. 562. Does anybody on this panel believe that the VA cannot find space for us to see veterans that come in to visit to hopefully get care and benefits?

Mr. Retzer, I will start with you.

Mr. RETZER. DAV is a resolution based organization. We do not have a resolution that supports that. However, in our experiences that we have, I think that is something that Congress can definitely look into with the administration to see what spaces they have. We know that they have some challenges with regards to some localities not having the conference rooms available and things of that nature. But definitely we would be willing to work with you to see if we can assist that process.

Mr. VAN ORDEN. Yes. Okay.

Ma'am. Army guy. Were you an intelligence analyst? You said you are an analyst.

Ms. ELLETT. Yes, I was an intelligence analyst.

Mr. VAN ORDEN. What was your Military Occupational Specialities (MOS)?

Ms. ELLETT. 35 Fox.

Mr. VAN ORDEN. Okay, roger that. Did you go to Huachuca?

Ms. ELLETT. I did.

Mr. VAN ORDEN. Okay, check. Do you think we should be able to see our fellow vets?

Ms. ELLETT. We have a lot of veterans that—first, thank you for that question.

Mr. VAN ORDEN. You are welcome.

Ms. ELLETT. We have a lot of veterans who do communicate with our Congress individuals, especially our rural veterans. They would like to interact more due to more representation, more representation opportunities. However, we do not have a specific position on that. We are talking about taking it back to our members. It would be nice to have that kind of direct communication.

As far as space, I know that I have been to quite a few VA facilities, and they are struggling to find space for their services. However, it is going to be a compromise. If that is how they move forward, then I am sure that we can all figure it out.

Mr. VAN ORDEN. It would be awesome if you brought that back to our fellow Legionnaires.

Ms. ELLETT. Absolutely.

Mr. VAN ORDEN. I honestly believe I think they are afraid of oversight

Sir. Mr. Brown.

Mr. BROWN. So availability, space is always a perennial concern in VA. It sounds like we are all in agreement here. PVA did not take a formal position on this bill.

Mr. VAN ORDEN. I read your stuff.

Mr. BROWN [continuing]. I am really supportive of it.

Mr. VAN ORDEN. Okay.

Mr. BROWN. Like DAV, we certainly would hope that the committee and VA will be able to work something out.

Mr. VAN ORDEN. Excellent. Thank you.

I would like to go on a record again to say that the vast majority of my healthcare provided by the VA is excellent. I am incredibly proud of my local office in La Crosse. I also go to Tomah. That is where that whole—the drug stuff started. I am very, very proud of them. I am also very proud of you. It takes a lot of guts to come here and speak in front of these committees. You are doing a good thing, and you are helping my brothers and sisters, of which you are also. God bless you guys and you take care and take care of your wife, will you.

All right, with that, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Van Orden.

I now recognize myself for 5 minutes.

I will just go down the panel.

Do VSOs have space in VA medical centers, Mr. Retzer?

Mr. RETZER. For the DAV, we are fortunate to have space where we have our transportation program that is in there with our hospital service coordinators. At the same time, many of times, we have the Veterans Affairs Medical Regional Office Centers (VAMROCs) (phonetic 1:35:49), which have National Service Officers co-located inside, or we have National Service Officers that are close by at Federal buildings.

Ms. MILLER-MEEKS. Ms. Ellett.

Ms. ELLETT. Thank you.

Yes, s we do have some space. We share typically with other VSOs. We have our representatives or our Service Officers that do have space in most VAs, usually with DAV or PVA in the same office?

Ms. MILLER-MEEKS. Mr. Brown.

Mr. BROWN. Yes, ma'am, PVA does have space in many VA facilities. The majority of those are the spinal cord injury centers and the hub locations.

Ms. MILLER-MEEKS. Having been a nurse who worked on the neurosurgery floor at Walter Reed, I am glad that you have some space. It also seems to me that if VSOs have space in VA medical centers, that Members of Congress who want to meet with their constituents and fellow veterans should also.

Thank you for your candid answers.

Ms. Ellett, in your testimony, you mentioned that many medical centers are trying to make the scheduling process easier, but it varies from VISN to VISN. What are your members experiences when trying to schedule an appointment via a call center?



Ms. ELLETT. Typically call centers will have to—they have to log out of one VAMC and into another area, which usually takes more time. There is also more confusion with that. Like I said, there is a pilot program that is—I think it is VISN eight, and it is a call center that has that one screen, and it is able to combine 14 VA instances. A person does not have to log out of one and log into another. It makes it a lot easier, but it depends on the VISN. There are some that are very responsive, there are individuals that are very willing to assist and move mountains to help make those appointments happen, and there are others that are less motivated.

Ms. MILLER-MEEKS. Thank you.

I also provided community care and took care of veterans as part of my practice. You had mentioned that many community care referrals require multiple phone calls to establish an appointment. How can this bill impact that process? Is there anything we need to add?

Ms. ELLETT. We are hoping that with that bill, there is more of the technology of—the pilot might happen and you would also have the buy in with the community care providers. I think with this legislation that we do not want to get lost in making an appointment happen that day or scheduling an appointment that day, but losing any quality. We do not want to lose any quality of care or anything to take care of the veteran. We do not want anything negative, any negative impact with it. That is what we are concerned about.

Ms. MILLER-MEEKS. Understood.

With the PACT Act increasing eligibility, I am even more concerned about scheduling processes and delays in cares. Many veterans prefer online portals and direct scheduling. Even so, these sites often require veterans to follow up with phone calls. If you miss the phone call, sometimes you miss an appointment.

Does the bill require any additional language to apply to these types of scenarios? What type of oversight would be required to make sure the VA implements this bill if passed? Like I said, sometimes when you create the will, they find a way.

Ms. ELLETT. Thank you for that.

I think maybe adding an additional timeline for a follow up to allow that room for those specific ones. I know that personally, getting community care for Gastrointestinal (GI) appointment is impossible to schedule the same day. I think that having a timeline for any follow ups and then keeping oversight of those tracking, that is where kind of the Transparency Act would come in.

Ms. MILLER-MEEKS. Excellent. Thank you so much.

I yield back the remainder of my time.

Ranking member Brownley, do you wish to make any closing remarks?

Ms. BROWNLEY. Well, thank you for that.

No, I do not really have any closing remarks, except I am excited about this hearing. I am excited about the Elizabeth Dole bill, obviously, but there are many other good bills here. I thank the chairwoman for making this hearing happen so we can begin to move these bills along in the 118th Congress.

Thank you.

Ms. MILLER-MEEKS. Thank you. I look forward to working through these issues and many more with the Department, with my colleagues, and with the ranking member, and the members of this subcommittee.

The complete written statements of today's witnesses will be entered into the hearing record. I also thank all of the witnesses for making the time and the effort to appear before us.

I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material.

Hearing no objections, so referred.

I thank the members and the witnesses for their attendance and participation today. This hearing is now adjourned.

[Whereupon, at 3:09 p.m., the subcommittee was adjourned.]

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**A P P E N D I X**

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## PREPARED STATEMENT OF WITNESSES

### Prepared Statement of Alfred Montoya

Chairwoman Miller-Meeks, Ranking Member Brownley, 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 Dr. Scottie Hartronft, Executive Director, Office of Geriatrics and Extended Care and Mr. David Perry, Chief Officer, Workforce Management.

#### **H.R. 41 VA Same-Day Scheduling Act**

This bill would redesignate current 38 U.S.C. § 1706A as § 1706B and create a new § 1706A regarding timely scheduling of appointments at VA facilities. Specifically, it would require VA to ensure that whenever a covered Veteran contacts VA by telephone to request the scheduling of an appointment, the scheduling for the appointment occur during that telephone call (regardless of the prospective date of the appointment being scheduled). “Covered veterans” would be those enrolled in VA health care. These amendments would apply with respect to requests for appointment scheduling occurring on or after the date that is 120 days after the date of enactment.

#### **VA Position:** VA does not support this bill.

VA already has the authority to do what this bill proposes, and it does so whenever possible. However, requirements for clinical review and determinations of eligibility are not always possible, nor desired by the Veteran, at the moment of a phone call to complete simultaneous appointment scheduling. Some specialty care appointments require referrals to be reviewed by a Referral Coordination Team with a Veteran before an appointment is scheduled; this would make this section, as written, difficult or even impossible to meet. The text provides no flexibility in terms of VA’s requirement to schedule an appointment during the call itself, which could result in non-compliance through no fault of VA (if, for example, the call was interrupted, or the Veteran chose to end the call before VA could schedule an appointment). It also does not acknowledge the growing number of Veterans who prefer to self-schedule appointments. The text also does not contemplate a Veteran who is eligible for community care and may prefer instead to seek care under the Veterans Community Care Program.

Additionally, some types of care, such as dental care, require additional eligibility be met, and it is not always possible to know that information during a telephone call. We are already pursuing information technology solutions that will improve tracking timely scheduling of appointments for Veterans.

We do not currently have a cost estimate for this bill.

#### **H.R. 366 Korean American Vietnam Allies Long Overdue for Relief (VALOR) Act**

H.R. 366 would amend 38 U.S.C. § 109 by adding a new subsection (d) that would State that persons VA has determined served in Vietnam as a member of the armed forces of the Republic of Korea between January 9, 1962, and May 7, 1975 (or such other period determined appropriate by VA for purposes of this subsection), would be eligible for benefits under subsection (a) to the same extent and under the same conditions (including with respect to applicable reciprocity requirements) as a discharged member of the armed forces of a government specified in such subsection who is eligible for such benefits under such subsection.

Currently, 38 U.S.C. § 109(a) authorizes VA, upon request of the proper officials of the Government of any Nation allied or associated with the U.S. in World War I (except any nation which was an enemy of the U.S. during World War II), or in World War II, to furnish to discharged members of the armed forces of such Government, under agreements requiring reimbursement in cash of expenses so incurred, at rates and under such regulations as VA may prescribe, medical, surgical, and

dental treatment, hospital care, transportation and traveling expenses, prosthetic appliances, education, training, or similar benefits authorized by the laws of such Nation for its Veterans, and services required in extending such benefits. Hospitalization in VA facilities is not allowed except in emergencies, unless there are available beds surplus to the needs of the Veterans of this country. VA may also pay the court costs and other expenses incident to the proceedings taken for the commitment of such discharged members who are mentally incompetent to institutions for the care or treatment of the insane. VA may contract for necessary services with private, State, and other Government hospitals in carrying out this authority. All amounts received by VA as reimbursement for such services must be credited to the current appropriation from which expenditures were made under section 109(a).

**VA Position:** VA does not support this bill.

We appreciate that this version of the bill generally subjects these benefits to the same terms and conditions as is available to allied beneficiaries in that benefits and services must be furnished only upon request of the proper officials of the Korean Government and under agreements requiring reimbursement. These changes address some of the equity concerns VA identified with an earlier version of this bill in the previous Congress (H.R. 234). However, H.R. 366's amendments to 38 U.S.C. § 109 still raise some concerns. While the bill's addition of a new subsection (d) would seemingly authorize the provision of benefits notwithstanding the current limitations in subsection (a), we believe the bill should be clearer as to how these authorities can be reconciled.

VA is in the process of expanding health care eligibility to Veterans who served in Armed Forces as authorized by the PACT Act (Pub. L. 117-168). As Congress considers this and other legislation, we note our concern that VA will need adequate appropriations to ensure that we can deliver on the promise of VA benefits and services for all eligible Veterans.

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

**H.R. 542 Elizabeth Dole Veterans Home and Community-Based Services for Veterans and Caregivers Act of 2023, or the Elizabeth Dole Home Care Act**

We appreciate the close collaboration of Committee staff, the Elizabeth Dole Foundation in addressing some of the concerns VA identified with previous versions of this legislation in the prior Congress (H.R. 6823). We believe the current version is much improved and is a demonstration of the benefits of VA and Congress working together.

**VA Position:** VA generally supports this bill if amended, and subject to the availability of appropriations, although our positions vary as noted below; more specific discussion of each provision appears below.

We estimate the bill, overall, would cost \$74.4 million in fiscal year (FY) 2023, \$105.1 million in FY 2024, \$536.2 million over five years, and \$1.23 billion over 10 years. Much of this projected cost is attributable to section 4(b) of the bill. As included in the FY 2024 President's Budget, a portion of these costs may be paid for from the Cost of War Toxic Exposures Fund, as authorized in the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics Act of 2022 (Public Law 117-168; PACT Act), and the remaining portion from discretionary appropriations.

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 percent 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 percent of that cost. Further, it would authorize VA to exceed 100 percent of the cost that would have been incurred under section 1710 if the Secretary determines, based on a consideration of clinical need, geographic market factors and such other matters as VA may prescribe through regulation, that 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 Position:** VA strongly supports section 2.

VA strongly supports increasing the allowable amount to cover 100 percent of the cost of nursing home care that would otherwise have been incurred. This is one of the Department's legislative proposals for the FY 2024 budget. We appreciate that this text includes criteria VA would consider in exceeding 100 percent of the cost of care while still providing discretion to VA, through regulation, to consider other factors as well. These changes should make it much easier for VA to administer this authority consistently and fairly. We are experiencing situations where Veterans with serious medical conditions, such as amyotrophic lateral sclerosis (ALS), that can be managed safely in a non-institutional setting are being forced to transition to institutional care because VA is no longer able to provide support within this statutory cap. This institutional care is both less clinically appropriate and more expensive. A change to the authorized cap, as section 2 would do, would allow these Veterans to remain in their homes and with their loved ones. VA does not have any other option in these situations given its current statutory authority, which is why we strongly support this legislation. While this likely only affects a small number of Veterans (particularly those in need of ventilator care), we believe their unique circumstances justify this type of exception and support from Congress and VA. We know that several States with similar caps have included exceptions that permit these Veterans to remain in their homes, but we believe all Veterans deserve this same opportunity.

VA estimates that it would exercise this new authority within its current budget authority and so would result in no additional costs. This estimate is consistent with the estimate for VA's legislative proposal in the FY 2024 budget request. This section could theoretically cost more due to the ability to exceed 100 percent of the cost of care in this bill. However, it is difficult to predict how many Veterans would qualify for rates in more than 100 percent of the cost of care. VA has used other strategies, such as the combination of Veteran-Directed Care and VA Home-Based Primary Care, for many Veterans to remain below the cap, and while this does not work for every Veteran, it does work for many of them. Further, and as noted above, by reducing the need for institutional care, VA will save money in this regard, so even being able to pay for non-institutional care at a higher rate would still likely result in a budget neutral result. We have not had an opportunity to develop a full methodology showing these cost tradeoffs, but we would appreciate the opportunity to discuss these matters more with the Committee to ensure that the Congressional Budget Office estimate for this provision reflects an accurate estimate.

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 VA Medical Center (VAMC) through which such program is administered is located in a geographic area in which services are available to the Veteran under the Programs of All-Inclusive Care for the Elderly (PACE) Program, VA would have to seek to enter into an agreement with the PACE Program operating in that area for the furnishing of such services.

**VA Position:** VA supports the PACE Program and has no objection to this provision.

We appreciate that this version of the bill has addressed VA's prior concerns regarding the use of the term "partnership"; the bill, by requiring VA to seek to enter into an agreement, provides greater flexibility and should ensure that this authority could be exercised consistent with other programs, in particular the Veterans Community Care Program that VA operates under 38 U.S.C. § 1703. We do note that there may be some locations where the PACE Program would be unable to offer convenient care for Veterans, and so while VA would seek to enter into agreements in these locations, it may be inadvisable to do so.

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.

**VA Position:** VA generally supports section 4(a) if amended; we recommend clarifications as noted in detail below.

We generally appreciate the interest and emphasis of this bill on VA's existing programs, which are critical to ensuring that Veterans can 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 appreciate the proposed rule of construction in pro-

posed section 1720K(g), which would clarify that nothing in the proposed section 1720K could be construed to limit VA's authority to carry out programs providing home-and community-based services under any other provision of law. This change would ensure that VA could continue to develop and implement innovative programs that meet the needs of Veterans.

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, a center for independent living or an Indian Tribe or Tribal organization receiving assistance under title VI of the Older Americans Act of 1965 (42 U.S.C. § 3057 et seq.) to provide to eligible Veterans 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, seek to 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, or an Urban Indian organization. VA also would have to ensure the availability of the program for eligible Native Hawaiian Veterans in a Native Hawaiian health care system, to the extent practicable. 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 participating 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, case managers in the community 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 6,300 Veterans participating in this program at 71 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 participating 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. Because Veterans, their caregivers and families can make decisions about where and how to receive 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. We also support the provision that would allow catastrophically disabled Veterans to continue using funds during a period of hospitalization in the same manner the Veteran would use such funds if they were not hospitalized. This provision would provide needed consistency and assurances for such Veterans.

We appreciate the bill providing flexibility to VA given the 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 and the Commonwealth of the Northern Mariana Islands operate a Veteran Directed Care program, while 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 Homemaker 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 as the Veteran Directed Care program under proposed section 1720K(b).



VA's Homemaker 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 Homemaker and Home Health Aide services from approximately 6,000 agencies, mostly through Community Care Network (CCN) contracts. In FY 2022, nearly 149,000 Veterans were served in this program.

We note that the proposed legislation, in proposed 1720K(b)(3)(B), clearly requires VA, to the extent practicable, to seek to ensure the availability of the Veteran Directed Care program in the territories and possessions of the U.S. We believe the incorporation by reference proposed in section 1720K(c)(2)(A) is intended to and could be interpreted to extend the same flexibilities to the Homemaker and Home Health Aide program, but we recommend further clarification on this point. As discussed above regarding the Veteran Directed Care program, we are also concerned that the requirement to ensure the availability of this program in all U.S. territories would be difficult to meet.

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 percent of the Veterans served in the program have short-term, post-acute needs. The remaining 25 percent 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 2022, approximately 171,000 Veterans were served in the Purchased Skilled Home Care program.

Proposed section 1720K(f)(1) would provide that, with respect to a resident eligible caregiver of a Veteran participating in a program under this section, 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 30 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 contact of such caregiver. Under proposed section 1720K(f)(2), covered respite care could exceed 30 days annually for resident eligible caregivers 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.

Several aspects of existing section 1720G(b) are not consistent with proposed section 1720K(f)(1). It is not clear whether Congress intends to alter section 1720G(b) for caregivers under section 1720K(f). There is no requirement in existing section 1720G(b) that the caregiver reside with the Veteran, unlike proposed section 1720K(f)(1). Nor does VA currently administer in-home wellness contacts of caregivers under the general caregiver program in section 1720G(b), but VA would be required to do so per proposed section 1720K(f)(1)(C). We suggest clarifying any differences between the support VA provides to caregivers who under section 1720G(b) generally relative to those caregivers who provide care under proposed section 1720K.

We also 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. The utility of codifying 30 days is not apparent.

Proposed section 1720K(g) would establish a rule of construction that nothing in this section could be construed to limit VA's authority to carry out programs providing home-and community-based services under any other provision of law.

As stated earlier, we support and appreciate this clarification.

Proposed section 1720K(h) would define various terms. In particular, it would define "covered respite care" to have the meaning given such term in section 1720G(d) (as would be added by section 5(b)(3) of the bill); this would be defined to mean respite care under section 1720B that is medically and age appropriate for the Veteran (including 24-hour per day care of the Veteran commensurate with the care provided by the caregiver) 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 "resident eligible caregiver" would mean a caregiver, or a family caregiver of a Veteran who resides with the Veteran and has not entered into a contract, agreement or other arrangement for such individual to act as a caregiver for that Veteran unless such individual is a family member of the Veteran or is furnishing caregiver services through a medical foster home.

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 need nursing home care, rather than simply being "at increased risk for...placement in a nursing home". We continue to not support adoption of the phrase "resident eligible caregiver," as this would create a new classification (beyond caregivers and family caregivers) that could cause confusion among VA's programs. We appreciate various clarifications and revisions made in this draft to address some of VA's previous concerns.

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

**VA Position:** VA supports this subsection, which is consistent with VA's current timeline for expansion. VA already has a Homemaker and Home Health Aide programs at all its VAMCs, and we are working diligently to expand the Veteran-Directed Care program to be available at all VAMCs by Spring 2025.

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 home and community-based services for which the Veteran or caregiver may be eligible and, with respect to the Veteran, 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 that is 180 days after the date of enactment.

**VA Position:** VA supports this subsection with amendments.

We agree with the intent of these provisions, and we appreciate the Committee's willingness to receive technical assistance on this bill in the previous Congress to ensure VA has the resources and authority to successfully assist Veterans and their caregivers. VA is already working to enhance our efforts in this area. 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 appreciate that this version would provide VA 180 days to implement, but we estimate VA would need at least one year to hire staff and develop the systems and training to implement the changes made by paragraph (1).

Section 5(a)(3) 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 objections to these amendments.

Section 5(b) would make further amendments to section 1720G to conform with changes described above regarding respite care benefits.

**VA Position:** VA has no objection to section 5(b).

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 Position:** VA does not support this subsection because it is unnecessary.

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 subsection 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 that explains the administrative eligibility, if applicable, of a Veteran or caregiver for any covered program and provide information, because of such explanation, on any covered program for which the Veteran or caregiver (as the case may be) 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 Position:** VA does not support this section because it is unnecessary.

VA supports efforts to ensure Veterans and their caregivers are aware of our programs. We appreciate the bill’s clarification that the website need only describe administrative eligibility criteria. VA’s existing websites ([www.va.gov/geriatrics](http://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, within 18 months of enactment, to carry out a 3-year pilot program under which VA would provide homemaker and home health aide services to Veterans who reside in communities with a shortage of home health aides. VA would have to select not fewer than five 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.

**VA Position:** VA does not support this subsection.

We agree with the Committee’s interest in ensuring that Veterans in need of homemaker and home health aide services can 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 do not support this subsection 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 2012 and ending in FY 2023 containing an identification of the amount of funds that were included in a VA budget during such period for the provision of in-home care to Veterans under the Homemaker and Home Health Aide program but were not so expended, disaggregated by VAMC (if such disaggregation is possible). It also would have to include, to the extent practicable, 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 and a detailed description of the reasons why any such reductions may have occurred.

**VA Position:** VA does not support this subsection because it is unnecessary.

We certainly welcome congressional oversight, and we appreciate the flexibility this bill would provide relative to prior drafts. However, we do not believe this subsection is necessary. VA already has analyzed and compared appropriated and obligated amounts (including unused funds) related to the Homemaker 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 one year after the date of enactment, to issue updated guidance for the Homemaker and Home Health Aide program. This guidance would have to include a process for the transition of Veterans from the Homemaker 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 Homemaker and Home Health Aide program because of the clinical needs or behavioral issues of the Veteran.

**VA Position:** VA does not support this subsection because it is too prescriptive.

VA recently published new guidance and procedures relating to the Homemaker and Home Health Aide program generally (including the transition process), so we do not believe a statutory requirement would be beneficial or necessary.

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 also would have to assess 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 one 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.

**VA Position:** 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 Centers for Medicare & Medicaid Services Administrator for extended care. Not later than one year after the date of enactment, VA would have to submit to Congress a report on the findings of this review.

**VA Position:** VA does not support this subsection.

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 two 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 Position:** 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 two 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 (DoL). 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. VA would have to consult with DoL in carrying out these requirements. 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 or section 1720K 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 Position:** VA does not support this subsection.

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 expertise in addressing labor shortages of home health aides and recommend DoL 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.

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 Position:** VA has no unique objections or concerns with this section.

#### **H.R. 562 Improving Veterans Access to congressional Services**

H.R. 562 would require VA, upon request of a Member of Congress and subject to regulations, to permit the Member to use a VA facility for the purposes of meeting with constituents of the Member. VA and the General Services Administration (GSA) would have to jointly identify available spaces in VA facilities for such purposes. Within 90 days of enactment, VA would have to prescribe regulations regarding the use of facilities by Members of Congress. The regulations would have to require that a space within a facility of the Department provided to a Member is available during normal business hours, located in an area that is visible and accessible to constituents of the Member, and subject to a rate of rent that is like the rate charged by GSA for office space. The regulations could not prohibit a Member from advertising the use by the Member of a space within a VA facility, and would have to comply with the Hatch Act (5 U.S.C. §§ 7321–7326) and 38 C.F.R. § 1.218(a)(14) by prohibiting activities including: campaigning in support of or opposition to any political office; statements or actions that solicit, support or oppose any change to Federal law or policy; any activity that interferes with security or normal operation of the facility; photographing or recording a Veteran patient at such facility; photographing or recording a patient, visitor to the facility, or VA employee without the consent of such individual; and photography or recording for the purpose of political campaign materials. The regulations also could not permit a Member of Congress to use such a facility during the 60-day period preceding an election for Federal office in the jurisdiction in which such facility is located and could not unreasonably restrict use of a VA facility by a Member if there is space in such facility not in regular use by VA personnel and if use of such space would not impeded VA operations in the facility.

**VA Position:** VA opposes this bill both because we can already provide space to Members of Congress in VA facilities under certain circumstances and because we object to the prescriptive requirements in the bill, requirements that could restrict VA's ability to serve Veterans effectively.

Initially, in August 2017, VA's Office of Real Property issued Real Property Policy Memorandum 2017–06, Issuance of VA Revocable Permits to Members of Congress for Use of VA Space. This Memorandum contains helpful information for Members of Congress or their staffs to request space in VA facilities for purposes of providing constituent outreach. The Memorandum provides VA Form 10–6215 within as Exhibit C to request revocable permits. VA Form 10–6215 contains special conditions to ensure compliance with the Hatch Act and to protect patient privacy and confidential health information; no deviations from these special conditions are permitted. Legal review and concurrence from VA's Office of General Counsel must also be received prior to issuing a revocable permit.

We object to the bill's requirement for VA to make available space in VA facilities for Members of Congress upon their request. Many of our facilities do not have space that would be conducive to an office for a Member of Congress, let alone multiple Members who may ask for office space in the same facility; other facilities raise unique concerns (such as medical facilities or cemeteries) that could make placement of an office for a Member of Congress inappropriate. In addition to the physical imposition on space that could otherwise be used for other purposes, such as furnishing health care, we note that the ancillary effects such as parking and in-

creased traffic would present problems for many facilities that would require additional resources (e.g., security, maintenance, etc.). We believe the bill could create significant additional demands on our facilities for services that may not even be directly related to Veterans' benefits; we note the legislation includes no requirement that the constituent services provided by the Member of Congress be limited only to VA benefits or claims. Additionally, and as noted above, we are concerned about the potential Hatch Act complications that could arise from guaranteeing the use of VA facility space "for the purposes of meeting with constituents of the Member". We realize the bill would require VA's regulations to comply with the Hatch Act and 38 C.F.R. § 1.218(a)(14), but these arrangements would create an elevated risk for partisan political activities, and VA would have little to no means of monitoring compliance. Last, we want to emphasize that VA facilities are not public fora, and it is not consistent with VA's mission to allow their use for matters not related to VA business, such as general press conferences or interviews not related to Veterans or VA.

The provisions of the bill are particularly problematic for VA facilities managed by the National Cemetery Administration. In addition to the concerns stated above regarding parking and increased traffic, VA national cemeteries have limited office space and are carefully designed to maximize burial space for Veterans and other eligible individuals. Requiring the national cemeteries to use available office space or to increase usable office space for this purpose would seriously detract from VA's mission of honoring the memory of those who served by providing burial in national shrines. In addition, requiring national cemeteries to allow signage that directs constituents to the location of a space for congressional consultation could disrupt the serenity of the national cemeteries and disturb the quiet contemplation of the families who have come to remember their loved ones in these solemn spaces.

On a technical level, we have some concerns regarding the requirement to issue regulations under the bill. It is not immediately apparent what exactly VA would be regulating; presumably such regulations would only govern the process for approving requests or conditions on the use of space, but these would seem more appropriately established through policy (such as the Memorandum mentioned above) or through the permit or agreement allowing the Member of Congress to use the facility's space. VA would have no remedy for a violation of the regulation beyond terminating the permit or agreement to use space, which again could be established through the permit or agreement itself. If regulations were required, we caution that 90 days would be inadequate to promulgate regulations.

VA is unable to develop a cost estimate at this time because we are unable to determine how many Members of Congress would request to use a VA facility or which facilities would be the subject of such requests. We believe the costs could be significant if there is great demand under this authority by Members of Congress.

#### **H.R. 693 VACANT Act**

H.R. 693, the VA Medical Center Absence and Notification Timeline Act (the VACANT Act), would require VA, within 90 days of detailing a VAMC director to a different position in VA, to notify Congress of such detail. The notification would have to include the location at which the director is detailed, the position title of the detail, the estimated time the director is expected to be absent from their duties at the medical center, and such other information as VA determines appropriate. Within 120 days of detailing a VAMC director to a different position, VA would have to appoint an individual as acting director of such medical center with all the authority and responsibilities of the detailed director. Within 120 days of detailing a VAMC director to a different position within VA, and not less frequently than every 30 days thereafter while the detail is in effect or while the director position at the VAMC is vacant, VA would have to report to Congress with an update regarding the status of the detail. In general, not later than 180 days after detailing a VAMC director to a different position within VA, for a reason other than an ongoing investigation or administrative action with respect to the director, VA would have to return the individual to the position as VAMC director or reassign the individual from the position and begin the process of hiring a new director. VA could waive these requirements with respect to an individual for successive 90-day increments for a total period of not more than 540 days from the original date the individual was detailed away from the position as VAMC director, but VA would have to notify Congress of the waiver and provide to Congress information as to why the waiver is necessary not later than 30 days after exercising such a waiver.

**VA Position:** VA supports, if amended.

VA can notify Congress when a VAMC director is detailed out of their position. VHA immediately identifies and appoints a qualified individual to act in a VAMC director position as soon as the position becomes vacant. As such, the requirement to detail within 120-days is already being done in the agency.

Submitting updates to Congress every 30-days would be a significant administrative burden to implement. VA proposes an amendment to H.R. 693 that would reduce this burden by removing the requirement for a 30-day update and replacing it with notification to Congress of any waiver of the 180-day limitation by the Secretary of Veterans Affairs.

VA also proposes to amend H.R. 693 by removing the 540-days limitation on details and replacing it with the statutory and regulatory limits that govern details in the senior executive service (5 CFR 317.903) for positions at the GS-15 level or below or to a position with unclassified duties or from a senior executive service equivalent excepted service position.

If unamended, H.R. 693 may imcontinuity of operations as well as on-going projects/initiatives that require the VAMC director's leadership.

VA does not have a cost estimate for this bill.

### **H.R. 754 Modernizing Veterans' Health Care Eligibility Act**

Section 2 of H.R. 754 would establish a Commission on Eligibility to examine eligibility for VA health care. For ease of understanding, the provisions of this bill will be summarized in terms of their requirements related to the appointment of the Commission and other personnel matters, then the powers and duties of the Commission.

#### **Appointment and Personnel Matters**

The Commission would be composed of 15 voting members appointed by congressional leaders and the President (who would appoint the Chairperson). At least one member would have to represent an organization recognized by VA for the representation of Veterans under 38 U.S.C. § 5902; at least one member would have to have experience as senior management for a private integrated health care system with an annual gross revenue of more than \$50 million; at least one member would have to be familiar with Government health care systems (including those of the Department of Defense (DoD), IHS or federally qualified health centers); and at least one member would have to be familiar with, but not currently employed by, the Veterans Health Administration. The appointment of the Commission members would have to be made within 1 year of enactment, and members would be appointed for the life of the Commission. If a vacancy arose, it would not affect the powers of the Commission and would be filled in the same manner as the original appointment. The Commission's first meeting would have to occur not later than 15 days after the date on which eight voting members have been appointed. The Commission would meet at the call of the Chairperson, and a majority of members would constitute a quorum, but a lesser number could hold hearings.

Members of the Commission who are not an officer or employee of the Federal Government would be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under 5 U.S.C. § 5315 for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. Members of the Commission who are officers or employees of the United States would serve without compensation in addition to that received for their services as officers or employees of the United States. Members of the Commission would be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized under subchapter I of chapter 57 of title 5, U.S.C., while away from their homes or regular places of business in the performance of services for the Commission. The Chairperson of the Commission could, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other personnel as may be necessary to enable the Commission to perform its duties. The Chairperson could fix the compensation of the executive director and staff without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, except that the rate of pay for these staff could not exceed the rate payable for level V of the Executive Schedule under 5 U.S.C. § 5316. Any Federal Government employee could be detailed to the Commission without reimbursement, but such would be without interruption or loss of civil service status or privilege. The Chairperson could procure temporary and intermittent services under 5 U.S.C. § 3109(b) at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under 5 U.S.C. § 5316. The Commission would terminate 30 days after the date on which the Commission submits its final report. VA



would make available to the Commission such amounts as the Secretary and Chairperson jointly consider appropriate for the Commission to perform its duties under this section.

#### Powers and Duties

The Commission would have the power to hold hearings, sit and act at such time and places, take testimony and receive evidence as the Commission considers advisable. The Commission could secure directly from any Federal agency such information as it considers necessary to carry out this section, and upon request of the Chairperson, the heads of such agencies would be required to furnish such information to the Commission. The Commission would be required to undertake a comprehensive evaluation and assessment of eligibility to receive health care from VA. In undertaking this evaluation, the Commission would have to evaluate and assess general eligibility; eligibility of Veterans with service-connected conditions; eligibility of Veterans with non-service-connected conditions; eligibility of Veterans who have other insurance or health care coverage (including Medicare and TRICARE); eligibility of Veterans exposed to combat; eligibility of Veterans exposed to toxic substances or radiation; eligibility of Veterans with discharges under conditions other than honorable; eligibility for long-term care; eligibility for mental health care, assigned priority for care, required copayments and other cost-sharing mechanisms; and other matters the Commission determines appropriate.

The Commission would submit to the President, through VA, a report not later than 90 days after the date of the initial meeting on the Commission's findings with respect to the required evaluation and assessment and such recommendations as the Commission may have for legislative or administrative action to revise and simplify eligibility to receive health care from VA. Not later than one year after the date of the initial meeting, the Commission would have to submit a final report on the findings of the Commission with respect to the required evaluation and assessment and such recommendations as the Commission may have for legislative or administrative action to revise and simplify eligibility to receive VA health care. The President would require VA and such other heads of relevant Federal Departments and agencies to implement such recommendations set forth in the Commission's final report that the President considers feasible and advisable and determines can be implemented without further legislative action. Not later than 60 days after the date on which the President receives a report from the Commission, the President would have to submit to the Committees on Veterans' Affairs of the House of Representatives and Senate and such other Committees as the President considers appropriate, a report. The report would have to include an assessment of the feasibility and advisability of each recommendation contained in the Commission's final report, and for each recommendation assessed as feasible and advisable, whether such recommendation requires legislative action (and if so, whether such legislative action is recommended), a description of any administrative action already taken to carry out a recommendation and a description of any administrative action the President intends to be taken to carry out a recommendation and by whom.

#### **VA Position:** VA opposes this bill.

We appreciate the Committee's interest in assessing eligibility for VA health care. Eligibility is the doorway that allows Veterans and other beneficiaries to access VA services, so it is fundamental to everything we do. In some respects, though, it is inaccurate to think of eligibility as a single door – there are many laws that establish eligibility for certain VA benefits and for certain veterans and other Veteran affiliated populations. The President believes we have a sacred obligation to care for those who we send into harm's way – and to care for them and their families when they return home. Eligibility criteria for VA benefits are a key enabler of how we do that as a Nation, and VA was established out of this sacred obligation. Eligibility for benefits have evolved over time as warfare and national security requirements have shifted in a manner to support the All Volunteer Force. We continue to owe our Nation's Veterans access to world-class benefits and services. Eligibility determinations can also be quite complex because Veterans or other beneficiaries may qualify for the same or similar services under multiple different laws – laws enacted by Congress to ensure we meet the needs of a diverse Veteran population. As an example, VA recently reviewed its authorities related to the provision of mental health care and identified more than 20 different statutes that defined eligibility for different services or different populations. These varying standards and rules can make for Veterans and the public to understand. However, complexity is not necessarily a problem if it produces the right results for Veterans. Our primary focus, is ensuring that our system is designed to provide what is best for Veterans. To the extent Congress believes eligibility has become too complex, we believe VA and Con-

gress can work together directly to address these issues and that a Commission would be unnecessary.

VA opposes this bill as currently drafted, due to several concerns. First, the intended outcome of the Commission is not clear. As drafted, the tasking to the Commission is exceptionally broad and there is no language to help direct or frame their review. Depending upon the composition and specific focus of the Commission, it may recommend narrowing or expanding eligibility (or both, but in different ways or for different populations). Given the central role of eligibility in accessing VA health care services, proposed changes could have far-reaching effects and unintended consequences, including effects on the amount of resources VA needs to execute its responsibilities. We are particularly mindful of the potential effects changes to eligibility may have on current beneficiaries. We would appreciate the opportunity to discuss with the Committee the underlying concerns motivating this bill, as we may be able to identify alternatives to strengthen the system. As noted earlier, VA is authorized to provide forms of mental health care under more than 20 different authorities. Addressing some of these areas first could have a more immediate beneficial impact.

There are elements of the Commission on Eligibility's duties that we believe should be reconsidered as well. First, we note that the Commission is not required to consider the definition of who is a Veteran for purposes of VA health care. As important as eligibility is, the definition of who is a Veteran precedes that analysis. This may be an important element to consider given the bill's focus. Second, the bill does not specifically address eligibility for community care, and it is unclear if that is within the intended scope. Given the relatively recent enactment of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 and the creation of the Veterans Community Care Program in 2019, that may be unnecessary, but the Commission should contemplate the effects that eligibility changes might have on modeling for demand and our network of community providers. Third, we believe it would be important for the Commission to focus on disparities in access to health care and to consider whether there is equitable access to VA health care as well. These are important issues to VA, as we strive to understand barriers to opportunity with the goal of providing everyone, especially those in underserved communities, with fair access to health care and benefits.

The bill would direct the Commission to consider Veterans exposed to toxic substances or radiation during military service. We note that VA is already working to expand its focus on environmental exposures and to implement the Honoring our PACT Act (PL 117-168). Another area of focus in the bill is on Veterans eligible for Medicare and TRICARE. As VA previously testified before the Oversight and Investigations and Technology Modernization Subcommittees on March 30, 2022, we agree that the Federal Government should not pay twice for the same medical services. The bill would also have the Commission examine eligibility for long-term care. Eligibility for institutional extended care was established by law more than 20 years ago and has remained stable. The elderly population in America, though, is growing. As Veterans age, approximately 80 percent will develop the need for long-term care services and supports. Some of VA's top efforts focus on helping Veterans as they age at home, and VA operates a spectrum of Home-Based and Community-Based Services. We want to emphasize that the Commission's examination of eligibility for long-term care should consider the increasing number of non-institutional alternatives VA has developed and offers to ensure an accurate reflection of the availability of clinically appropriate care. Additionally, the bill would provide the Commission with authority to directly secure information it considers necessary, and agencies would be required to provide such information. As drafted, this authority resembles the authority of the Inspector General or Comptroller General to obtain documents. The bill appears to allow parties external to VA to be members of the Commission; as a result, this sweeping authority could pose issues not generally present when information is shared within an agency or between two or more agencies of the executive branch.

VA has additional concerns about this bill relative to the Federal Advisory Committee Act (FACA) and other provisions of law. The bill establishes a potential inconsistency with FACA given that the Commission's mission may overlap with multiple existing VA Federal Advisory Committees (e.g., the Special Medical Advisory Group, the Advisory Committee on Women Veterans, the Advisory Committee on Minority Veterans, the Advisory Committee on Former Prisoners of War, the Veterans Rural Health Advisory Committee, and others). The bill also establishes potential inconsistencies with both FACA and the Government in the Sunshine Act based on its provisions allowing for a quorum of Commissioners to meet and make decisions without a Charter, a Federal Register notice of meeting, or a Designated Federal Officer present. The bill presents another potential inconsistency with

FACA by allowing for less than a quorum of Commissioners to meet and make decisions without being designated an official subcommittee without a Designated Federal Officer present. The bill would override important civil service laws for Commission personnel that govern merit systems, whistleblower, anti-discrimination, and prohibited personnel protections, as well as for suitability and security. The bill could also present challenges with the Office of Personnel Management Special Government Employee workday limit (less than 130 days per year) given the estimated level of effort that would be involved with this Commission. The bill does not clarify whether the Commission must abide by the National Records Act or the Presidential Records Act. Finally, the bill presents issues concerning the Federal employee status of the Commissioners.

We note for the record that, while this bill would not alter eligibility for any care or services, the Commission's recommendations ultimately could lead to such changes through subsequent action, and the financial effects of eligibility changes could be significant. We recommend the Committee bear this in mind as it continues to consider this bill. We further note that, if VA is responsible for the activities of the Commission, there would be increased costs to the Department to cover the administrative expenses of the Commission.

We do not have a cost estimate for this bill.

#### **H.R. 808 Veterans Patient Advocacy Act**

H.R. 808 would amend 38 U.S.C. § 7309A to require, beginning no later than 1 year after enactment, VA to ensure that there is no fewer than one patient advocate for every 13,500 enrolled Veterans and that highly rural Veterans may access the services of patient advocates, including, to the extent practicable, with respect to assigning patient advocates to rural Community-Based Outpatient Clinics (CBOCs). Within 2 years of enactment, the Comptroller General would have to submit to Congress a report evaluating the implementation by VA of these changes.

**VA Position:** VA supports the intent of this bill but does not support this bill as written.

VA supports the goal of the Veterans Patient Advocacy Act to ensure Veterans have adequate access to patient advocacy services no matter where they live. Over the last few years, the role of the patient advocate has expanded since the enactment of the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114–198), the VA MISSION Act of 2018 (P.L. 115–182), Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (P.L. 116–315), the Veterans COMPACT Act of 2020 (P.L. 116–214), and the Honoring our PACT Act of 2022 (P.L. 117–168).

VA has been working to identify the best approach to ensuring Veterans can access patient advocates and advocacy services as needed to support the delivery of their care. VA has explored establishing a set ratio, as the bill would do, but believes that a focus on program outcomes would be a better model. Focusing on outcomes ensures that the things that matter most to Veterans are VA's focus, while preserving flexibility in hiring and staffing to ensure that our facilities have the personnel and resources needed to deliver timely, high quality, and high satisfaction care. VA is concerned that a specific staffing ratio for patient advocates could result in facilities having too many patient advocates and too few providers or other necessary support staff. Advances in technology or different staffing models may yield the same or even better outcomes for Veterans than a codified staffing ratio would do.

VA is currently analyzing data from its facilities to determine how best to proceed in this area, and we request the Committee refrain from further action until this analysis is complete. VA wants to ensure that the Patient Advocacy Program is responsive to Veterans' needs based on evidence of what those needs are. VA would be happy to brief the Committee on its efforts in this regard. Although the data collected provided insights to overall staffing levels, it is not clear to what extent across VA a patient advocate is designated specifically to rural or highly rural CBOCs. VA will analyze the data with this consideration in mind to advance and expand access to patient advocacy services across VA.

VA also expresses some concern regarding the timeline for implementation that would be required; we are uncertain that one year would be enough time to implement the changes the bill would institute.

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

#### **H.R. 1089 VA Medical Center Facility Transparency Act**

Section 2 of the bill would require VA to ensure that each VAMC director submits to the Secretary, the Committees on Veterans' Affairs of the House of Representatives and the Senate, and the appropriate Members of Congress an annual, concise, easy-to-read fact sheet with certain statistical information with respect to the year covered by the fact sheet. The fact sheets would also need to include a description of any successes or achievements experienced by such facilities, a description of special areas of emphasis or specialization by such facilities (such as efforts aimed at meeting the needs of women Veterans, suicide prevention and other mental health initiatives, opioid abuse prevention and pain management, or special efforts on Veteran homelessness, or other matters as the director determines appropriate), and a description of matters that have previously been identified as deficient and are still in need of remediation. Directors would also have to publish quarterly fact sheets containing the average wait times for Veterans to receive treatment at the VAMC. Each fact sheet would have to be made publicly available in a physical form at the facility in a conspicuous location and in an electronic form on the facility's website. Fact sheets would have to be submitted during the first fiscal year beginning after the date that is 180 days after the date of enactment and would have to be submitted at least annually (for the annual fact sheets) and quarterly (for the quarterly fact sheets). VA would have to establish a standardized format for the fact sheets to ensure that each VAMC director carries out this authority in a consistent manner. The term "appropriate Members of Congress" would mean, with respect to a VA medical facility about which a fact sheet is submitted, the Senators representing the State, and the Member, Delegate, or Resident Commissioner of the House of Representatives representing the district that includes the facility.

**VA Position:** VA does not support this bill.

VA has several concerns with this bill as written because of its specificity. We understand the fundamental interest or concern of the bill, but VA already provides significant information online about patient experience, wait times, and quality for each VAMC. Wait time data is further broken down into primary care and specialty care areas, while the bill would require VA to report a single wait time standard. Repackaging or revising this information to meet the specific requirements in this bill would further increase costs without an expected benefit, and in some ways could result in misleading or inaccurate information being provided to Veterans and the public.

The requirement for each VAMC director to submit to Congress directly on an annual basis these fact sheets would be very involved and would require each facility to establish redundant processes and systems; allowing the Secretary to distribute this information instead would allow for economies of scale and better standardization. Further, fact sheets of the Department are required by (the Veterans and Family Information Act (P.L. 117-62) to be published in more than 10 different languages. Again, requiring 140 different VAMCs to produce this content separately would result in significant additional costs than a centrally managed process.

We also believe some of the specific requirements that must be included in the fact sheets are unclear or would be difficult to gather or likely of little use. For example, the bill would require the fact sheets to provide statistics regarding the number of Veterans who were treated at "a medical facility of the Department under the jurisdiction of the director". In some areas, VA operates contracted CBOCs that are not legally under the jurisdiction of the VAMC director; excluding these locations could create an inaccurate representation of the care VA furnishes. Further, Veterans who are eligible to and elect to receive their care upon VA authorization from community providers may not be "treated at a medical facility of the Department" but still reflect VA workload. The bill also requires providing statistics regarding "the most common illnesses or conditions for which treatment was furnished" would likely result in concerns common among primary care appointments (such as the common cold or the flu). Finally, the required congressional audience is likely too narrow. Many facilities serve Veterans from more than one State and more than one congressional district. Limiting the distribution to only those Senators who represent the State and the Representative, Delegate, or Resident Commissioner of the district where the facility is located would likely result in some Members with legitimate interest in the facility not being included in the distribution.

We do not currently have a cost estimate for this bill.

#### **H.R. 1256 VHA Leadership Transformation Act**

Section 2(a) of the draft bill would amend 38 U.S.C. § 305(a)(1) to establish a 5-year term for the Under Secretary for Health.

**VA Position:** VA has no objection to this subsection. Setting a 5-year term could provide VA with continuity of operations when there is a change in Presidential administrations and could allow VA to continue providing support and care to our Nation's Veterans without interruption.

Section 2(b) of the draft bill would amend 38 U.S.C. § 7306(a)(3) to allow VA to appoint as many Assistant Under Secretaries for Health as it determines appropriate.

**VA Position:** VA fully supports this subsection, which is consistent with a VA legislative proposal in the FY 2024 budget request.

This change would give VA the flexibility to recruit and retain highly qualified executives with various experience to fill these critical leadership positions.

Section 2(c) of the draft bill would further amend section 7306 by striking subsection (b), which provides certain qualifications and limitations regarding Assistant Under Secretaries for Health. It would also make other conforming changes.

**VA Position:** VA supports this subsection, which is also consistent with VA's legislative proposal in the FY 2024 budget request.

This subsection would allow VA to recruit the best qualified candidates, regardless of their health care professional background. This is critical to achieving VA's goals for quality, timely, and safe patient care. While VA recognizes the need for a clinical background for some Assistant Under Secretary for Health positions, the requirements of those positions should be identified in the position description or policy establishing that position, rather than statute.

VA estimates this bill would result in no additional costs as there are no new resources required to implement these flexibilities.

### **Conclusion**

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

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### **Prepared Statement of Jon Retzer**

Chairwoman Miller-Meeks, Ranking Member Brownley and Members of the Subcommittee:

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

### **H.R. 41, the VA Same-Day Scheduling Act**

H.R. 41, the VA Same-Day Scheduling Act of 2023, would direct the Secretary of Veterans Affairs to ensure the timely scheduling of appointments for health care at medical facilities of the Department of Veterans Affairs (VA).

The Veterans Health Administration (VHA) operates the largest integrated health care delivery system in the United States, providing health care to approximately 6.4 million veterans annually. In the last decade, Congress has taken steps to expand access for eligible veterans to receive care from community providers when they face challenges accessing care at VHA medical facilities; these steps include establishing the Veterans Community Care Program in 2019. While most veterans still receive the majority of their care at VHA facilities, including 170 VA medical centers (VAMC) and over 1,000 outpatient facilities, approximately 2 million veterans received care from non-VHA providers in the community in Fiscal Year 2021, according to VA.

In recent years, the Government Accountability Office (GAO) and others have reviewed VA's scheduling process and identified specific challenges that VHA has in ensuring that both VHA and community care appointments are scheduled in a timely manner. For example, GAO reported (GAO 23-105617) that VHA's appointment scheduling process for care from community providers was structured in a way that made it difficult to meet the statutorily required timeframes for veterans to receive care. This required timeframe specified the number of days it should take for a veteran to receive care under the Veterans Choice Program—the precursor to the current community care program. GAO recommended that VHA establish an achievable

wait-time goal for the new community care program to monitor whether wait times for veterans to receive care in the community are comparable with those at VHA facilities. Due to this concern with wait times and other issues, VHA health care continues to be on GAOs' High Risk List.

This legislation would require the Secretary to ensure that whenever a veteran contacts the Department by telephone to request the scheduling of an appointment for care or services at any VA facility, the scheduling for the appointment occurs during that telephone call (regardless of the prospective date of the appointment being scheduled).

DAV strongly supports H.R. 41, in accordance with DAV Resolution No. 435, as it would improve current scheduling procedures and require real-time scheduling practices that ensure more timely access to quality health care services.

#### **H.R. 366, the Korean American VALOR Act**

H.R. 366, the Korean American Vietnam Allies Long Overdue for Relief Act, or the Korean American VALOR Act, would recognize and treat certain individuals who served in Vietnam as a member of the armed forces of the Republic of Korea as a veteran of the Armed Forces of the United States for purposes of the provision of health care by the VA.

Currently, section 109 of title 38, United States Code, provides benefits for discharged members of allied armed forces of governments associated with the United States in World War I and II, except any nation which was an enemy of the United States during World War II. The Secretary may prescribe medical, surgical, and dental treatment, hospital care, transportation and travel expenses, prosthetic appliances, education and training. Hospitalization in a Department facility shall not be afforded under this section, except in emergencies, unless there are available beds surplus to the needs of veterans of this country.

This legislation would add a new subsection to section 109 of title 38, United States Code, to allow a person whom the Secretary determines served in Vietnam as a member of the armed forces of the Republic of Korea at any time during the period beginning on January 9, 1962, and ending on May 7, 1975, or such other period as determined appropriate by the Secretary to be eligible for health care treatment by the VA.

DAV does not have a specific resolution to provide VA health care treatment for individuals who served in Vietnam as a member of the armed forces of the Republic of Korea alongside the Armed Forces of the United States as outlined in H.R. 366 and takes no formal position on this bill.

#### **H.R. 542, the Elizabeth Dole Home Care Act**

H.R. 542, the Elizabeth Dole Home-and Community-Based Services for Veterans and Caregivers Act would improve VA home-and community-based services for veterans by expanding options for long-term care (LTC) services and supports.

Title 38, United States Code, subsection 1720 C(a)(1), (2) notes that "the Secretary may furnish medical, rehabilitative, and health-related services in noninstitutional settings for veterans who are eligible under this chapter for, and are in need of, nursing home care for veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a service-connected disability; or have a service-connected disability rated at 50 percent or more."

This bill adds new subsections to subsection 1720 that would direct the Secretary to expand options for LTC through:

- The Program of All-inclusive Care for the Elderly (PACE);
- Veteran-Directed Care;
- Homemaker and Home Health Aide;
- Home-Based Primary Care; and
- Purchased Skilled Home Care.

Additionally, the Purchased Skilled Home Care Program would provide caregiver support services, which includes covered respite services and annual wellness contact.

Subsection 1720 C(d), states that the total cost of providing services or in-kind assistance may not exceed 65 percent of the cost during that fiscal year. This bill would amend this section by increasing the expenditure cap from 65 percent to 100 percent for provided services or in-kind assistance—not to exceed 100 percent of the cost per year.

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

In order to meet the exploding demand for LTC for veterans in the years ahead, Congress must provide the VA resources to significantly expand home-and community-based programs, while also modernizing and expanding facilities that provide institutional care. The VA must focus on addressing staffing and infrastructure gaps in order to maintain excellence in skilled nursing care. The VA also needs to expand access nationwide to innovative and cost-effective home-and community-based programs, such as veteran-directed care and medical foster home care. Unfortunately, funding for home-and community-based services in recent years has not kept pace with population growth, demand for services or inflation. For noninstitutional care to work effectively, these programs must focus on prevention and engage veterans before they have a devastating health crisis that requires more intensive institutional care.

DAV supports H.R. 542, the Elizabeth Dole Home-and Community-Based Services for Veterans and Caregivers Act, in accordance with DAV Resolution No. 016, which calls for legislation to improve the VA's program of long-term services and supports and increase timely access to both institutional and noninstitutional long-term services and supports.

#### **H.R. 562, the Improving Veterans Access to congressional Services Act of 2023**

H.R. 562, the Improving Veterans Access to congressional Services Act of 2023, would direct the Secretary of Veterans Affairs to permit Members of Congress to use VA facilities for the purposes of meeting with constituents.

The VA Secretary and the Administrator of General Services would jointly identify available spaces in facilities of the Department for such purposes.

The space within a facility of the Department provided to a member would be:

- Available during normal business hours;
- Located in an area that is visible and accessible to constituents of the member;
- Subject to a rate of rent (payable from the member's Representational Allowance or the Senator's Official Personnel and Office Expense Account) that is similar to the rate charged by the Administrator of General Services for office space in the area of the facility; and
- May not prohibit a member from advertising the use by the member of a space within a facility of the Department.

Prohibited activities include:

- Campaigning in support of or opposition to any political office;
- Statements or actions that solicit, support, or oppose any change to Federal law or policy;
- Any activity that interferes with security or normal operation of the facility;
- Photographing or recording a veteran patient at such facility;
- Photographing or recording a patient, visitor to the facility, or employee of the Department without the consent of such individual;
- Photography or recording for the purpose of political campaign materials;
- Using a facility during the 60-day period preceding an election for Federal office in the jurisdiction in which such facility is located; and
- Unreasonably restricting use of a facility of the Department by a member if:
  - there is space in such facility not in regular use by personnel of the Department; and
  - use of such space shall not impede operations of the Department in such facility.

DAV does not have a specific resolution that directs the Secretary of Veterans Affairs to permit Members of Congress to use VA facilities as proposed in H.R. 562 and takes no formal position on this bill.

### **H.R. 693, the VACANT Act**

H.R. 693, the VA Medical Center Absence and Notification Timeline Act or the VACANT Act, would limit the detailing of VA medical center directors to different positions within the Department.

Over the past several years, the GAO added VA health care and acquisition management to its High-Risk List. This list identifies areas that are most vulnerable to fraud, waste, abuse, mismanagement, or the need for transformation. VA has made marked progress recently in addressing these high-risk issues by identifying root causes of the deficiencies and establishing action plans to address them. However, these are only the initial steps of the long-term commitment required to achieve transformational change.

The total number of veterans enrolled in VA's health care system increased from 7.9 million to about 9.2 million from FY 2006 through FY 2022. GAO has identified challenges related to VA's management and oversight of its health care system, including:

- Ensuring veterans' health care appointments are scheduled in a timely manner;
- Having complete information to determine if it has an adequate number of health care providers to meet veterans' needs;
- Effectively identifying and meeting the demand for mental health and other behavioral health services among veterans; and
- Ensuring timely implementation while addressing data quality issues as it works to modernize its electronic health record system.

Addressing each of these longstanding challenges requires sustained leadership and strong management and would help ensure veterans receive the care and benefits they deserve. Given the scope of VA's responsibility to serve veterans, effectively addressing its management challenges will require sustained commitment from VA leadership.

This legislation would require the VA Secretary to appoint a VA Medical Center director as acting director after detailing that director to a different position within the Department. The individual appointed as acting director would be afforded all of the authority and responsibilities of the detailed director. The VA Secretary would also be required to notify the House and Senate Veterans' Affairs Committees of such detail, including the location at which the director is detailed; the position title of the detail; the estimated time the director is expected to be absent from their duties at the medical center; and any other information as the Secretary may determine appropriate.

Last, this bill requires, not later than 180 days after such detail with limited exception, that the Secretary return the individual as director of the medical center or reassign the individual from the position as director of the medical center and begin the process of hiring a new director for such position.

This legislation would help improve accountability to sustain needed leadership to ensure the VA health care system runs seamlessly during a period of transition and that veterans' continuity of care and benefits are not disrupted.

DAV supports this legislation in accordance with DAV Resolution No. 056, which recognizes that staffing shortages and vacancies at every level of the VA health care system, especially for critical management positions, can impede the delivery of care for service-disabled veterans who rely on the VA to receive timely, high-quality, veteran-centric medical care.

### **H.R. 754, the Modernizing Veterans Health Care Eligibility Act**

This legislation would establish a Commission on Eligibility to examine policies guiding veterans' health care eligibility and make recommendations, if feasible and advisable, to change them. The Commission would be composed of 15 members appointed by the President; Senate Majority Leader; Senate Minority Leader; House Speaker and House Minority Leader (three each, at least one of whom would be a veteran). The President would designate the chair of the Commission and at least one member must be appointed from a veterans service organization; one member that has worked for a large private health care system; one representative with experience in a government health care system; and one individual familiar with the VHA, but not currently employed there.

The Commission would be required to hold its first meeting no later than 15 days after a majority of its members are appointed and issue a preliminary report with findings and recommendations no later than 90 days after its first meeting and a final report and recommendations no later than one year from its initial meeting. The President would then be required to submit a report to Congress on the advis-



ability and feasibility of each recommendation, along with the executive actions and legislation necessary to implement them. DAV believes these proposed timelines would not allow individuals selected for the Commission, who may have little familiarity with the VA, its mission, and the specialized programs it has created for the veterans it serves, enough time to undertake a comprehensive evaluation and assessment of the eligibility system and to understand the nuanced policy decisions Congress has legislated since the establishment of the VA health care system.

Additionally, we do have concern about previous efforts proposing to diminish the size and scope of the veterans' health care system, whether by proposing changes in eligibility to limit the number of veterans who may receive care or by pressing for privatization of VA medical services. Congress has made thoughtful decisions about assigned priority for care and eligibility for various groups of veterans outlined in this bill—including service-disabled veterans and most recently expanding eligibility for veterans exposed to combat and or toxic exposures or radiation, under the PACT Act and veterans in mental health crisis, under the Compact Act. These two pieces of bipartisan legislation that became law, are good examples of Congress maintaining an eligibility system that meets the needs of our Nation's veterans including our newest generation of wartime veterans. We appreciate Congress' oversight in providing VA the authority to exercise and implement new requirements of eligibility to veterans who have rightly earned access to VA health care.

Veterans' health care eligibility and VA's medical benefits package for enrolled veterans are clearly defined in title 38, United States Code, and accompanying Federal regulation and continue to be modified in accordance with the needs of veterans at Congress' and the Administration's discretion. Because Congress has full authority to modify eligibility requirements or VA's medical care benefits package through the legislative process, it is unclear why a special outside commission is necessary.

We prefer that Congress continue to make decisions in the best interests of veterans by conducting oversight of VA health care eligibility and legislating the changes it deems necessary.

#### **H.R. 808, the Veterans Patient Advocacy Act**

H.R. 808, the Veterans Patient Advocacy Act, would improve the assignment of patient advocates at VA medical facilities.

The Veterans Health Administration (VHA) has designated patient advocates at each VA medical center (VAMC) to receive and document feedback from veterans or their representatives, including requests for information, compliments, complaints and assist with clinical appeals. In recent years, the importance of a strong patient advocacy program has taken on new significance given concerns with VHA's ability to provide veterans timely access to health care, among other issues.

VHA provided limited guidance to VAMCs on the governance of patient advocacy programs and its guidance, a program handbook, has been outdated since 2010. VAMCs are still expected to follow the outdated handbook, which does not provide needed details on governance, such as specifying the VAMC department to which patient advocates should report. Officials from most of the VA facilities that the Government Accounting Office (GAO Report 18-356) reviewed noted that the department to which patient advocates report can have a direct effect on the ability of staff to resolve veterans' complaints. The lack of updated and complete guidance may impede the patient advocacy program from meeting its expectations, to receive and address complaints from veterans in a convenient and timely manner.

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

This legislation would direct VAMC directors to ensure there is no fewer than one patient advocate for every 13,500 veterans enrolled in the system. Additionally, it would also address the need for highly rural veterans to have access to the services of patient advocates assigned to rural community-based outpatient clinics.

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

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

#### **H.R. 1089, the VA Medical Center Facility Transparency Act**

H.R. 1089, the VA Medical Center Facility Transparency Act, would require the Secretary to ensure VA medical center directors submit an annual easy-to-read fact sheet to the Secretary, the House and Senate Veterans' Affairs Committees, and certain Members of Congress.

The fact sheet would be required to be made publicly available and provide statistics regarding:

- Number of veterans treated;
- Average wait time for veterans to receive treatment;
- Number of appointments conducted;
- Most common illness or conditions treated;
- Veterans' satisfaction rates;
- How veterans' satisfaction compares with other facilities; and
- Other matters the director determines appropriately.

The bill would also require that the fact sheet provide data and highlight special areas of emphasis or specialized care programs at each VA facility that are aimed at meeting the needs of women veterans, homeless veterans, suicide prevention and other mental health initiatives to include opioid abuse prevention and pain management services, or actions taken to improve the facility or quality of care.

Accurate and effective data collection is at the heart of assuring quality care. Without it, veterans, stakeholders and VA officials can be blindsided by crises that are otherwise difficult to identify, such as the access crisis in 2014, that led to major VA reforms under the Veterans Choice Act, and subsequently, the VA MISSION Act.

The Government Accounting Office (GAO Reports; 21-169, 22-103718, 22-105522, and 23-106665) has made a number of recommendations to improve this type of information to allow for greater program accountability and transparency in areas from assessing the quality of care provided to LGBTQ veterans, to understanding staffing needs for suicide prevention efforts and Vet Centers, to improving its electronic health record management system. Similarly, the Office of Inspector General (OIG Reports; 19-08658-153, 20-02186-78, 21-03020-168, and 21-00175-19) has made recommendations for improving data to ensure visibility into quality. Providing accurate, easily accessible, and up-to-date information to veterans will help to improve their care experience, as well as better inform policymakers overseeing the VA health care system. We suggest the Subcommittee consider adding a provision to the bill requiring VA to also provide comparable access and quality metrics for VHA providers and providers in VA's community care network.

DAV supports H.R. 1089, the VA Medical Center Facility Transparency Act, in accordance with DAV Resolution No. 121, which calls for greater attention and effort to be focused on developing and publicly sharing common access and quality metrics for both VA and non-VA providers participating in the VA's community care network. This information is essential for veterans to make fully informed decisions about their care.

#### **H.R. 1256, the Veterans Health Administration Leadership Transformation Act**

H.R. 1256, the Veterans Health Administration Leadership Transformation Act, would make certain changes to the laws pertaining to the appointment of the VA Under Secretary of Health (USH) and Assistant Under Secretaries of Health (AUSH).

Currently, Section 305 of title 38, United States Code (USC), states that in the VA, an Under Secretary for Health is appointed by the President, by and with the advice and consent of the Senate. Whenever a vacancy in the position of Under Secretary for Health occurs or is anticipated, the VA Secretary is required to establish a commission to recommend individuals to the President for appointment to the position.

This legislation would extend the term of appointment for the Under Secretary for Health to 5 years and remove restrictions for the number of Assistant Under Secretaries for Health that can be appointed (currently not to exceed eight). Last, the bill would eliminate the requirement that all but two AUSHs be physicians or dentists.

We understand the intent of this bill is to provide greater leadership stability at VHA and believe the proposed changes would help address identified governance challenges that have at times impeded oversight and accountability within the health care system. It would also empower the USH to more effectively manage and carry out their responsibilities to ensure veterans' health care needs are met. While DAV does not have a specific resolution that calls for changes to the laws relating to the appointment of these positions, we have no objection to the Subcommittee moving this bill forward.

This concludes my testimony on behalf of the DAV. I am pleased to answer any questions you or members of the Subcommittee may have.

**Prepared Statement of Tiffany Ellett**



TESTIMONY  
OF  
TIFFANY ELLETT  
VETERANS AFFAIRS & REHABILITATION DIVISION DIRECTOR  
THE AMERICAN LEGION  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES

ON

"PENDING LEGISLATION"

MARCH 29, 2023

**EXECUTIVE SUMMARY**

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H.R. 41 – VA Same-Day Scheduling Act of 2023, <i>page 2</i>	<b>Support</b>
H.R. 366 – Korean American VALOR Act, <i>page 3</i>	<b>No Position</b>
H.R. 542 – Elizabeth Dole Home-and Community-Based Services for Veterans and Caregivers Act of 2023, <i>page 3</i>	<b>Support</b>
H.R. 562 – Improving Veterans Access to Congressional Services Act of 2023, <i>page 5</i>	<b>No Position</b>
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H.R. 1256 – Veterans Health Administration Leadership Transformation Act, <i>page 8</i>	<b>No Position</b>

STATEMENT OF  
TIFFANY ELLETT, DIRECTOR  
VETERANS AFFAIRS & REHABILITATION DIVISION  
THE AMERICAN LEGION  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
HOUSE COMMITTEE ON VETERANS' AFFAIRS  
ON  
"PENDING AND DRAFT LEGISLATION"

MARCH 29, 2023

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, on behalf of National Commander Vincent J. "Jim" Troiola and more than 1.6 million dues-paying members of The American Legion, we thank you for the opportunity to testify on pending legislation considered before this Subcommittee.

The American Legion is directed by active Legionnaires who dedicate their time and resources to serve veterans and their families. As a resolution-based organization, our positions are guided by more than 104 years of advocacy and resolutions that originate at the grassroots level of our organization. Every time The American Legion testifies, we offer a direct voice from the veteran community to Congress.

**H.R. 41 – VA Same-Day Scheduling Act of 2023**

*To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to ensure the timely scheduling of appointments for health care at medical facilities of the Department of Veterans Affairs, and for other purposes.*

Veterans using the Department of Veteran Affairs (VA) for their healthcare should receive that care in a timely manner. Appointment scheduling has often been a topic of contention in reference to improvements at VA. Medical centers have tried to make the process easier for veterans by allowing them to schedule appointments online through their secure system and by calling their specific facility.<sup>1</sup> However, the division of the VA system into 18 Veterans Integrated Services Networks (VISNs) allows for access to care, wait times, and appointments to vary.

VA has created other ways for veterans to schedule medical appointments to meet the wait time standard of 20 days or less. The most recent scheduling tool is the VA Online Scheduling portal which provides convenience to veterans by allowing them to schedule their appointments through a web browser.<sup>2</sup> Veterans are also able to schedule their appointments online through *My*

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<sup>1</sup> The Department of Veteran Affairs, "Scheduling and manage health appointments." <https://www.va.gov/health-care/schedule-view-va-appointments>. This and subsequent URLs cited have been accessed March 27, 2023.

<sup>2</sup> The Department of Veteran Affairs, "VAMobile." <https://mobile.va.gov/app/va-online-scheduling>.

*HealthVet*.<sup>3</sup> In regard to timely access to appointments, VA has also made efforts to be more transparent by giving veterans the ability to look up provider wait times through the [accessocare.va.gov](https://www.accessocare.va.gov) website.<sup>4</sup>

Some VISNs use call centers and others allow the medical facility or third-party administrators to handle scheduling, oftentimes a veteran would complete several phone conversations without successfully scheduling an appointment. The inability to schedule appointments in a timely manner cause veterans to seek healthcare through other avenues, such as private insurance and providers outside of the VA healthcare system, or the veteran may become discouraged and stop seeking care altogether.

The *VA Same-Day Scheduling Act of 2023* would ensure that a veteran enrolled in VA healthcare is able to schedule an appointment the same day they call the VA facility. Through Resolution No. 14: *Access to Care*,<sup>5</sup> The American Legion supports legislation and programs that will increase access to healthcare for veterans.

**The American Legion supports H.R. 41 as currently written.**

#### **H.R. 366 – Korean American VALOR Act**

*To amend title 38, United States Code, to treat certain individuals who served in Vietnam as a member of the armed forces of the Republic of Korea as a veteran of the Armed Forces of the United States for purposes of the provision of health care by the Department of Veterans Affairs.*

The provisions of this bill fall outside the scope of established resolutions of The American Legion. The American Legion is a resolution-based, grassroots organization that takes positions on legislation based on resolutions passed by the membership or in meetings of the National Executive Committee. The American Legion has no current position on the *Korean American VALOR Act*. However, The American Legion is currently researching this critical issue to include consulting with our membership to determine the best course of action which best serves veterans.

**The American Legion has no position on H.R. 366.**

#### **H.R. 542 – Elizabeth Dole Home-and Community-Based Services for Veterans and Caregivers Act of 2023**

*To amend title 38, United States Code, to improve certain programs of the Department of Veterans Affairs for home and community-based services for veterans, and for other purposes.*

<sup>3</sup> The Department of Veteran Affairs, "Manage your Appointments." <https://www.myhealth.va.gov/keeping-up-with-your-va-appointments>.

<sup>4</sup> The Department of Veteran Affairs, "Average wait times at individual facilities search." <https://www.accessocare.va.gov/PWT/SearchWaitTimes>.

<sup>5</sup> The American Legion Resolution No. 16 (2022): Access to Care. <https://archive.legion.org/node/14052>.

According to the Department of Veteran Affairs' (VA) Policy Analysis and Forecasting Office, the number of veterans eligible for nursing home care is estimated to expand from approximately two million in 2019 to more than four million by 2039.<sup>6</sup> Additionally, as of 2021, almost half of the 19.5 million veterans are 65 years or older and account for over 45 percent of VA emergency department visits, more than double the rate of the civilian counterpart population.<sup>7</sup>

The *Elizabeth Dole Home-and Community-Based Services for Veterans and Caregivers Act of 2023 (Elizabeth Dole Act)* aims to improve caregiver support at VA by establishing a publicly centralized access portal, expanding home-based community services nationwide, and providing greater access to resources and guidance on services supporting caregivers and their families. This legislation also covers a variety of improvements to home and community-based services and programs, such as expanding the Veteran Directed Care (VDC) program and respite care. The American Legion is pleased to see that respite care is addressed in this legislation as it is beneficial to caregivers and their families.

Veterans and caregivers have direct control of their long-term care through this legislation. They can identify and select the services they need. Additionally, VDC programs have a high satisfaction rating and have proven to be mutually advantageous by simultaneously lowering costs for VA. On average, supporting a veteran through a VDC program is \$144 less per day than the cost of a veteran living in a community nursing home. This amount of savings averages out to about \$52,800 per veteran per year.<sup>8</sup>

The *Elizabeth Dole Act* addresses The American Legion's long-held concerns regarding the VA recruitment and retention challenges by calling on the VA Secretary to establish procedures to identify staffing needs for the program and defining the roles and responsibilities of personnel at the national, Veterans Integrated Service Network, and facility levels. The American Legion is also pleased to see consideration given to caregivers by supporting services and education on possible benefits and agrees that successful transitions in care are critical to the overall well-being of both the caregiver and the veteran.

Through Resolution No. 20: *Home and Community-Based Services and Veteran Choice to Age in Place*,<sup>9</sup> Resolution No. 18: *Comprehensive Supports for Caregiver Support Program*,<sup>10</sup> and Resolution No. 24: *Caregiver Program*,<sup>11</sup> The American Legion supports improvements to community-based and home-based services in caring for our veterans.

<sup>6</sup> The Department of Veteran Affairs, "VA amplifies access to home, community-based services for eligible Veterans," Office of Public and Intergovernmental Affairs. <https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5757>.

<sup>7</sup> The John A. Hartford Foundation, "VA Launches Program to Improve Emergency Care for Nation's Older Veterans," September 9, 2021. <https://www.johnahartford.org/newsroom/view/va-launches-program-to-improve-emergency-care-for-nations-older-veterans>.

<sup>8</sup> Mary Lazare, "A Better Way to Care for Our Veterans?," Administration for Community Living, 2022. <https://acl.gov/news-and-events/acl-blog/better-way-care-our-veterans>.

<sup>9</sup> The American Legion Resolution No. 20 (2021): Home and Community-Based Services and Veteran Choice to Age In Place. <https://archive.legion.org/node/3579>.

<sup>10</sup> The American Legion Resolution No. 18 (2022): Comprehensive Supports for Caregiver Support Program. <https://archive.legion.org/node/7902>.

<sup>11</sup> The American Legion Resolution No. 24 (2017): Caregiver Program. <https://archive.legion.org/node/3411>.



**The American Legion supports H.R. 542 as currently written.**

**H.R. 562 – Improving Veterans Access to Congressional Services Act of 2023**

*To direct the Secretary of Veterans Affairs to permit Members of Congress to use facilities of the Department of Veterans Affairs for the purposes of meeting with constituents, and for other purposes.*

The provisions of this bill fall outside the scope of established resolutions of The American Legion. The American Legion is a resolution-based, grassroots organization that takes positions on legislation based on resolutions passed by the membership or in meetings of the National Executive Committee. The American Legion has no current position on the *Improving Veterans Access to Congressional Services Act of 2023*. However, The American Legion is currently researching this critical issue to include consulting with our membership to determine the best course of action which best serves veterans.

**The American Legion has *no position* on H.R. 562.**

**H.R. 693 – Veterans Affairs Medical Center Absence and Notification Timeline Act**

*To limit the detailing of directors of medical centers of the Department of Veterans Affairs to different positions within the Department, and for other purposes.*

The American Legion has previously testified in support of the Department of Veterans Affairs' (VA) innovative recruitment and retention practices for the largest integrated healthcare system in the United States.<sup>12</sup> Recently, VA has presented several programs to improve recruitment efforts and foster a better working environment within this system. Though the American Legion recognizes the efforts, there continues to be concern over VA's leadership, physicians, and medical specialist staffing shortages within the Veterans Health Administration (VHA).

Since the inception of our System Worth Saving program in 2003, The American Legion has identified staffing shortages at every VA medical facility (VAMC) and reported these critical deficiencies to Congress, the VA Central Office (VACO), and the President of the United States. During the visits, on more than one occasion, VAMC staff have also expressed that the change of executive leadership caused a disruption in the workflow of the facility, in some cases lowering morale, hindering operational functions, fragmenting oversight, and weakening services for veterans.

Understanding that the movement and assigned detail of medical center directors are at times unavoidable, this legislation would force VA to establish and report a timeline for and reasoning behind the movement of a facility director. This reporting is in an effort to ensure appropriate

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<sup>12</sup> VA Choice and Quality Employment Act of 2017, Public Law No. 115-4, Congress. (2017). <https://www.congress.gov/bills/115th-congress/senate-bill/114/text>

leadership remains in charge of VA medical facilities in addition to permanently filling vacant key leadership positions without delay.

Through Resolution No. 115: *Department of Veterans Affairs Recruitment and Retention*,<sup>13</sup> The American Legion encourages legislation that addresses the recruitment and retention challenges at VA. Additionally, through Resolution No. 16: *Department of Veteran Affairs Accountability and Whistleblower Protections*,<sup>14</sup> The American Legion urges VA to maintain oversight and implement accountability on all methods of care provided through the VA healthcare system to ensure the needs of the veterans are met in a supportive, safe, and accepting environment.

**The American Legion supports H.R. 693 as currently written.**

#### **H.R. 754 – Modernizing Veterans’ Health Care Eligibility Act**

*To establish an advisory commission regarding eligibility for health care furnished by the Secretary of Veterans Affairs.*

Throughout American history, Congress has found commissions to be useful in the legislative process.<sup>15</sup> By establishing a commission, Congress can provide a highly visible forum for critical issues and assemble greater expertise than may be readily available within the legislature. Establishing an advisory commission to examine veterans’ eligibility for healthcare from the Department of Veterans Affairs (VA) would allow for the complex policy issues involved with veteran eligibility to be examined over a longer period and in greater depth. In addition, the nonpartisan or bipartisan character of the proposed commission would serve to minimize the politics of the issue, which has become charged in recent years. Finally, the changing healthcare landscape has been significantly impacted by the COVID-19 pandemic, and consideration of its impact and meaning for the Veteran Health Administration is needed.

Congress can and should exercise immediate action involving reforms to VA healthcare and eligibility when possible. Setting up a multimember, bipartisan, independent structure that incorporates participation from across the veteran stakeholder community would be welcomed in this instance. Through Resolution No. 74: *Amend the Eligibility Requirements and Extend the Eligibility Time Period for Service-Disabled Veterans Insurance*,<sup>16</sup> The American Legion strongly supports establishing a bipartisan advisory commission and would welcome the opportunity to work with and on it.

**The American Legion supports H.R. 754 as currently written.**

<sup>13</sup>The American Legion Resolution No. 115 (2016): Department of Veterans Affairs Recruitment and Retention. <https://archive.legion.org/node/342>.

<sup>14</sup> The American Legion Resolution No. 16 (2022): Department of Veterans Affairs Accountability and Whistleblower Protections. <https://archive.legion.org/node/7908>.

<sup>15</sup> CRS Report R40076, *Congressional Commissions: Overview, Structure, and Legislative Considerations*. <https://sgp.fas.org/crs/misc/R40076.pdf>.

<sup>16</sup> The American Legion Resolution No. 74 (2018): Amend the Eligibility Requirements and Extend the Eligibility Time Period for Service-Disabled Veterans Insurance. <https://archive.legion.org/node/576>.

**H.R. 808 – Veterans Patient Advocacy Act**

*To amend title 38, United States Code, to improve the assignment of patient advocates at medical facilities of the Department of Veterans Affairs.*

Patient advocates often function as the voice of a veteran who does not know where to turn when they are unable to find the proper connection between the Department of Veterans Affairs (VA) and their healthcare needs. Patients like Sergeant John Tedford, an American Legion member with a 90 percent service-connected disability rating, voiced his own story in an American Legion forum of how he waited over a year for a medical appointment after having several unsuccessful attempts.<sup>17</sup> Veterans like Sergeant Tedford offer their learned experiences by assisting other veterans to navigate through the VA healthcare system. This drive to help veterans was the catalyst for The American Legion to create the System Worth Saving (SWS) program, where The Legion conducts structured visits to VA facilities across the Nation in an effort to learn about the quality of care provided to veterans.

In March 2017, during an SWS visit to the Phoenix VA, in Arizona, The American Legion recommended that VA upgrade the patient advocate's position from a General Schedule (GS) 9 to a GS 11.<sup>18</sup> Currently, the patient advocate and patient representative positions are identified as GS 9-11 positions. During the 2022 SWS visits to the Bronx VA in New York, the Columbia VA in South Carolina, and the 2023 visit to Sacramento VA in California, The Legion saw that the patient advocates were managing a heavy workload, which could lead to burnout, inadvertently followed by loss of employees, slowed patient response times, and frustrated veterans. The availability of patient advocates is a priority of The American Legion, and will continue to be a focal point when speaking with veterans about their representation as a VA patient.<sup>19</sup>

This legislation would increase the success and decrease the chance of burnout for patient advocates by ensuring that there is at least one patient advocate for every 13,500 veterans enrolled in the VA medical center's catchment area. It could also expand support for veterans in rural areas, allowing them more access to advocates through community-based outpatient clinics. The American Legion believes that veterans should be able to receive timely healthcare regardless of their geographical location and that they have access to advocates that can help them access appropriate care. Through Resolution No. 75: *Department of Veterans Affairs Rural Health Care Program*<sup>20</sup> and Resolution No. 377: *Support for Veteran Quality of Life*,<sup>21</sup> The American Legion

<sup>17</sup> The American Legion. "Only hope for some." The American Legion. <https://www.legion.org/yourwords/personal-experiences/221152/only-hope-some>.

<sup>18</sup> The American Legion. "Phoenix VA Health Care System." The American Legion System Worth Saving. [https://www.legion.org/sites/legion.org/files/legion/publications/SWS\\_Report\\_2017\\_Phoenix.pdf](https://www.legion.org/sites/legion.org/files/legion/publications/SWS_Report_2017_Phoenix.pdf)

<sup>19</sup> The American Legion. "Veterans Healthcare System of the Ozarks (VHSO)." The American Legion System Worth Saving.

[https://www.legion.org/documents/legion/pdf/SWS\\_Report\\_Fayetteville\\_2019.pdf](https://www.legion.org/documents/legion/pdf/SWS_Report_Fayetteville_2019.pdf)[https://www.legion.org/document/s/legion/pdf/SWS\\_Report\\_Fayetteville\\_2019.pdf](https://www.legion.org/document/s/legion/pdf/SWS_Report_Fayetteville_2019.pdf).

<sup>20</sup> The American Legion Resolution No. 75 (2017): Department of Veterans Affairs Rural Health Care Program. <https://archive.legion.org/node/541>.

<sup>21</sup> The American Legion Resolution No. 377 (2016): Support for Veteran Quality of Life. <https://archive.legion.org/node/520>.

supports increased access to patient advocates for all veterans so they can receive the quality healthcare they deserve.

**The American Legion supports H.R. 808 as currently written.**

**H.R. 1089 – VA Medical Center Transparency Act**

*To require directors of medical centers of the Department of Veterans Affairs to submit annual fact sheets to the Secretary of Veterans Affairs on the status of such facilities, and for other purposes.*

The American Legion recognizes that parts of the Department of Veterans Affairs (VA) fall short of meeting the healthcare needs of veterans. We also recognize that the healthcare system is one worth saving, and we continue to work with VA to identify areas of improvement in addition to best practices that meet or exceed standards for veteran care. In 2021, Past National Commander, Paul E. Dillard, testified that The American Legion recommended congressional oversight on a variety of topics regarding VA programs and treatments for women veterans, medications, mental health services, traumatic brain injury, post-traumatic stress disorder, and the overall quality of life of veterans.

The American Legion supports the *VA Medical Center Transparency Act* as an avenue to create a transparent bridge of information that will highlight areas of need, improvement, and success in VA facilities. Furthermore, this information would facilitate actions by Congress and VA by creating and improving programs that will enhance the quality of life for veterans. The American Legion believes it is imperative for VA to maintain oversight and implement accountability on all methods of care provided through the VA healthcare system to ensure the needs of the veterans are met in a supportive, safe, and accepting environment. Through Resolution No. 16: *Department of Veterans Affairs Accountability and Whistleblowers Protections*,<sup>22</sup> The American Legion supports increased transparency in efforts to increase oversight and communication to provide better services for veterans.

**The American Legion supports H.R. 1089 as currently written.**

**H.R. 1256 – Veterans Health Administration Leadership Transformation Act**

*To amend title 38, United States Code, to make certain improvements in the laws relating to the appointment of the Under Secretary of Health and Assistant Under Secretaries of Health of the Department of Veterans Affairs, and for other purposes.*

The provisions of this bill fall outside the scope of established resolutions of The American Legion. The American Legion is a resolution-based, grassroots organization that takes positions on legislation based on resolutions passed by the membership or in meetings of the National

<sup>22</sup> The American Legion Resolution No. 16 (2022): Department of Veterans Affairs Accountability and Whistleblower Protections. <https://archive.legion.org/node/7908>.

Executive Committee. The American Legion has no current position on the *Veterans Health Administration Leadership Transformation Act*. However, The American Legion is currently researching this critical issue to include consulting with our membership to determine the best course of action which best serves veterans.

**The American Legion has *no position* on H.R. 1256.**

**Conclusion**

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the committee; The American Legion thanks you for your leadership and for allowing us the opportunity to explain the positions of our 1.6 million members on the importance of these pieces of proposed legislation. Questions concerning this testimony can be directed to John Kamin at 202-263-5748, or [jkamin@legion.org](mailto:jkamin@legion.org).

### **Prepared Statement of Morgan Brown**

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to present our views on pending legislation impacting the Department of Veterans Affairs (VA) that is before the Subcommittee. No group of veterans understand the full scope of benefits and care provided by the VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). PVA provides comment on the following bills included in today’s hearing.

#### **H.R. 41, VA Same-Day Scheduling Act of 2023**

PVA supports the intent of the VA Same-Day Scheduling Act. This legislation would require the VA to ensure that when a veteran enrolled in the VA health care system contacts the VA by telephone to schedule an appointment for care or services at a VA facility, the appointment would be scheduled during that telephone call. Scheduling all appointments when requested by the veteran should be a key goal for the department and we believe most appointments are already being scheduled in this manner. However, it is unclear if the VA has the resources to fully comply with this mandate within the 120 days specified by this legislation. When an appointment slot at the VA is not available based on a physician’s request, the department might be limited in providing veterans with an appointment each time they contact the VA. It may also be difficult for some specialty clinics to comply if they control their own scheduling verses using the medical center’s patient service center. We recommend the language of this bill be adjusted to provide for circumstances like this, while ensuring compliance occurs whenever possible.

#### **H.R. 562, Improving Veterans Access to congressional Services Act of 2023**

The Improving Veterans Access to congressional Services Act directs the VA Secretary to permit Members of Congress to use VA facilities for the purposes of meeting with constituents. PVA does not have an official position on this bill but recognizes it may allow greater numbers of veterans to have better access to their elected officials. Therefore, we have no objection to the Subcommittee moving this bill forward.

#### **H.R. 808, Veterans Patient Advocacy Act**

The Veterans Patient Advocacy Act seeks to ensure there are an adequate number of patient advocates at VA medical facilities. Patient advocates are highly trained professionals who can help resolve veterans’ concerns about any aspect of their health care experience, particularly those concerns that cannot be resolved at the point of care. These advocates listen to any questions, problems, or special needs that a veteran has and works to resolve them. PVA supports H.R. 808, which directs VA medical center directors to ensure there is no fewer than one patient advocate for every 13,500 veterans enrolled annually in the system. Another provision ensures patient advocates are assigned to rural community-based outpatient clinics to ensure timely access to health care, and time to address requests for information, compliments, complaints, reimbursements, and assistance with clinical appeals. Although we support this legislation, we are concerned that the ratio of one advocate per 13,500 veterans seems rather high and believe it should be examined further to ensure that this number of advocates is adequate.

#### **S. 3304, the Patient Advocate Tracker Act**

PVA supports the Patient Advocate Tracker Act, which directs the VA to establish an information technology system that allows a veteran or their designated representative to electronically file a health care-related complaint and view its status. The system would include interim and final actions that the VA has taken to resolve the issue. This would be a tremendous improvement over the current system which oftentimes leaves veterans feeling like their concerns are being ignored.

#### **H.R. 754, Modernizing Veterans’ Health Care Eligibility Act**

This legislation would establish a 15-member, bipartisan commission to assess veterans’ eligibility for VA health care, and recommend ways to revise and simplify eligibility for consideration by the VA and Congress. These types of commissions are normally convened when outside subject matter expertise is needed and have a clearly defined purpose. As written, H.R. 754 lacks clarity on why an outside commission is needed to assess the current eligibility system. While it is true that considerable time has elapsed since overall eligibility for VA health care was last examined, we are unaware of any compelling reason that would make appointment of a commission to examine eligibility necessary. We also believe there is sufficient

knowledge and expertise between veterans' stakeholders, Congress, and veterans' health providers; thus, an expert commission is unnecessary. Recent efforts by some Members of Congress and outside organizations to reduce the number of veterans who are eligible to receive VA health care, limit the types of medical services provided, cut costs, and privatize VA health care have been repeatedly dismissed by Congress and outside experts alike. We believe Congress, particularly this Committee, should continue to exercise its exclusive authority to conduct oversight of VA health care programs to include eligibility, while ensuring that veterans receive timely access to the quality care they have earned and deserve.

**H.R. 693, Veterans Affairs Medical Center Absence and Notification Timeline (VACANT) Act**

The VACANT Act limits the detailing of medical centers directors to different positions within the VA and requires the department to notify Congress whenever these transfers take place. There is overwhelming evidence that an effective leader should be visible and available so they can work closely with their employees. PVA doesn't have a formal position on this legislation, but we have no objection to the Subcommittee moving this bill forward.

**H.R. 366, the Korean American VALOR Act**

PVA supports this bill which would give roughly 3,000 Korean veterans who are naturalized citizens of the United States access to VA health care. While they served under a different flag during the Vietnam War, they served with the same duty, honor, and valor as our United States service members. The Korean American VALOR Act bill simply extends to them the same recognition and benefits the country has given our U.S. European allies of World War I and World War II.

**H.R. 1089, VA Medical Center Transparency Act**

The VA Medical Center Transparency Act requires every director of a VA medical facility to publish an annual fact sheet that includes statistical information on the facility including average patient wait times and prevalent health concerns. The factsheet would also include what, if any, improvements have been made to patient care and service, and plans for future improvements. These fact sheets will be distributed to the VA Secretary, members of the House and Senate Veterans' Affairs Committees, and the Members of Congress who represent the facility. They would also be published on the facility's website and displayed in the facility. PVA supports efforts like this that make it easier for veterans to obtain the timely and accurate information they need.

**H.R. 542, Elizabeth Dole Home-and Community-Based Services for Veterans and Caregivers Act of 2023**

PVA gives its strongest support to this critically important legislation which would make urgently needed improvements to VA's Home and Community-Based Services (HCBS), including several that target our concerns about current program shortfalls.

In February 2020, the U.S. Government Accountability Office (GAO) released a report entitled, "Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand."<sup>1</sup> The report describes the use of and spending for VA long-term care, discusses the challenges the VA faces in meeting veterans' demand for long-term care, and examines the department's plans to address those challenges. From fiscal years 2014 through 2018, VA data shows that the number of veterans receiving long-term care in these programs increased 14 percent (from 464,071 to 530,327 veterans), and obligations for the programs increased 33 percent (from \$6.8 to \$9.1 billion). The VA projects the demand for long-term care will continue to increase, driven in part by growing numbers of aging veterans and veterans with service-connected disabilities. Expenditures for long-term care will increase as well and are projected to double by 2037. According to VA officials, the department plans to expand veterans' access to noninstitutional programs, when appropriate, to prevent or delay nursing home care and to reduce costs.

The VA has identified the need to provide additional SCI/D long-term care facilities and some of these requirements have been incorporated in a pair of ongoing construction projects but most of their plans have been languishing for years. Long-term care services are expensive, with institutional care costs exceeding costs for HCBS. Studies have shown that expanding HCBS entails a short-term increase in

<sup>1</sup> GAO-20-284, Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand

spending followed by a slower rate of institutional spending and overall long-term care cost containment.<sup>2</sup>

Reductions in cost can be achieved by transitioning and diverting veterans from nursing home care to HCBS, if they prefer it, and the care provided meets their needs. VA spending for institutional care doubled between 2016 and 2021; however, the number of veterans being cared for in this setting has remained relatively stable—partially attributed to expanding HCBS—indicating the cost of institutional care is rising. Despite doubling HCBS spending between 2016 and 2021, VA currently spends just over 30 percent of its long-term care budget on HCBS, which remains far less than Medicaid’s HCBS national spending average for these services among the states. The VA must continue its efforts to ensure veterans are able to live in their communities and remain with their families for as long as possible.

#### Caps on Care

Section two of this bill raises the cap on how much the VA can pay for the cost of home care. Currently, the VA is prohibited from spending more than 65 percent of what it would cost to care for a veteran in a nursing home. When the VA reaches this cap, the department can either place the veteran into a VA or community care facility at a significantly higher cost or rely on the veteran’s caregivers who are often family members to bear the extra burden. Depending on the services available in their area, some veterans must turn to their state’s Medicaid program to receive the care they need, even for service-connected disabilities.

Amyotrophic lateral sclerosis (ALS) is presumptively related to military service and is rated by the VA at the 100 percent level. And yet, we are aware of many ALS veterans who are not receiving proper home care. One veteran with ALS who uses a gastrostomy tube, has a tracheostomy, and is ventilator dependent was only able to get a nurse to come to his home for 2-hour visits, two times per week to check his vitals. Unfortunately, these hours were not enough to care for his medical complexities and the VA was unable to provide additional services due to cost. Instead, the VA told him he could receive 24/7 skilled nursing at a facility. Another ALS veteran needs 120 hours of skilled care per week for him to be at home with his wife and family. Medicaid authorized 70 hours per week, but the VA was unable to approve the additional coverage due to the cost and instead the veteran is in a much costlier facility. And another ALS veteran lives with his wife who is responsible for around 130 hours of care a week on her own. She can no longer afford to pay out of pocket for additional care. The VA’s only option was to place the veteran in a facility due to cost.

It isn’t just ALS veterans who are impacted by this cap. A 39-year-old SCI veteran who is tracheostomy dependent has been in a facility since 2019 due to the cost of his care. He has a 10-year-old daughter that he has not been able to see since before COVID. Another veteran with a form of multiple sclerosis who has a gastrostomy tube, a tracheostomy, and is ventilator dependent is on the verge of ending up in a facility. His family needs 8 hours of care per day on the weekdays, but the VA is only able to approve 16 hours per week due to costs. Congress needs to allow the VA to cover the full cost of home-based care services for these veterans and others like them without exhausting their caregivers and leaving them struggling to cobble together the services and supports they need to stay home with their families.

On February 16, 2023, the Senate Veterans’ Affairs Committee advanced a similar version of this bill (S. 141) without the language raising VA’s cap on care primarily due to its cost. The Congressional Budget Office’s (CBO) score for this section is perplexing, because we believe that only a few hundred veterans are currently exceeding the 65 percent threshold. Some may need rates to be raised to the full cost of nursing home care, but the majority would not. The VA has committed to enhancing and maintaining the quality of life for all veterans but the current limitations due to the cap on services is contrary to this vision. Nothing in this legislation expands the number of veterans in this category and the number of them in this situation is relatively stable from year-to-year. We suggest this Subcommittee work with CBO and your Senate counterparts to review the current calculations to determine if they are accurate.

#### Veteran-Directed Care Program

PVA strongly believes that the VA and Congress must make HCBS more accessible to veterans and section four of this bill would require the VA to administer programs like Veteran-Directed Care (VDC) at all VA medical centers. The VDC program allows veterans to receive HCBS in a consumer-directed way and is de-

<sup>2</sup>Do noninstitutional long-term care services reduce Medicaid spending?



signed for veterans who need personal care services and help with their activities of daily living. Examples of the types of assistance they can receive include help with bathing, dressing, or fixing meals. VDC also offers support for veterans who are isolated, or whose caregiver is overburdened. Veterans are given a budget for services that is managed by the veteran or the veteran's representative.

Unfortunately, the VDC program is not available at all VA medical centers, and it currently has an enrollment of only about 6,000 veterans. Our members and other veterans are constantly asking for help in getting this program implemented at their VA health care facility. Milton, a PVA member in Ohio, is one of many veterans who have been waiting more than four years for the Cleveland VA to implement the program. Even if the program is available at a particular facility, veterans may not be aware of it or given the opportunity to enroll. The VDC program was available at our National President's VA medical center, but he was not made aware of it until last year. After several attempts to learn about accessing the program, he was told he had not been considered for it. Veterans should be given the choice to access this program where it is available.

Also, the need for a caregiver does not go away whenever veterans with catastrophic disabilities are hospitalized. Neither community hospitals nor VA medical centers are adequately staffed or trained to perform the tasks veterans with SCI/D need. Currently, veterans with high-level quadriplegia and other disabilities must pay out of pocket for their caregivers or caregivers donate their time, as veterans cannot receive caregiving assistance through VA programs while in an inpatient status. The bill addresses this need by allowing these veterans to retain their VDC payments to ensure that they can be properly cared for while hospitalized and timely discharged home.

Last year, the VA announced plans to expand the VDC program to 75 additional sites over a five-year period. We are pleased that VA's Under Secretary for Health recently directed the Veterans Health Administration (VHA) to accelerate the timeline and we urge Congress to provide the necessary funding so every VA medical center can offer a robust VDC program as quickly as possible.

#### Improve Coordination with VA Caregiver Program

Section five requires the VA to provide a personalized and coordinated handoff of veterans and caregivers denied or discharged from the Program of Comprehensive Assistance for Family Caregivers (PCAFC) into any other home care program for which they may be eligible. Veterans are routinely denied entry into the PCAFC, and the provisions in section five would ensure veterans are assessed for participation in other HCBS programs.

Additionally, veterans and their caregivers often express frustration trying to find information on HCBS. Information about HCBS is available through several websites and other sources which tends to lead to a lack of awareness about all the services that might be available. Section six would address this problem by establishing a "one-stop shop" webpage to centralize information about available programs for families and veterans.

#### Direct Care Workforce Shortages

Section seven would make it easier for veterans to find direct care workers or home health aides. Even when veterans have access to programs like VDC or Home-maker Home Health, it can be challenging to find home care workers. That is the experience of Ron, a PVA member from Minnesota who sustained a traumatic spinal cord injury in a vehicle accident in the spring of 2020. After spending four months in rehabilitation, he was released to an assisted living facility that did not meet his needs; so, he briefly lived with his mother while he and his family built an accessible home. In the fall of 2020, the VA authorized 24-hour care for him in his home and Ron was thrilled to have this option. His wife is very supportive but often feels sad and helpless because she is physically unable to care for him. He depends entirely on the home health staff for his daily care, health, and welfare. Unfortunately, because the VA did not have home care staff, he had to go through a community agency. Despite having many hours authorized, he has never found enough qualified people to fill them. He is fortunate when he has someone to get him out of bed and help him through the day. Oftentimes, he goes to bed at 7 p.m. because help isn't available at his usual bedtime of 9 or 10 p.m. He regularly spends weekends in bed because no staff is available to assist him and he is depressed and frustrated because he can't find the direct care workers he needs to assist him with daily activities.

The shortage of caregivers or direct care workers is not unique to the VA. Across the country, there is an increasing shortage of direct care workers, and a national effort is needed to expand and strengthen this workforce. We believe the pilot pro-

gram established in section seven would lessen the difficulty in finding direct care workers at the 10 sites the VA selects and may reveal additional ways the VA could alleviate this problem for veterans nationwide.

Again, this important bill addresses many pressing concerns for catastrophically disabled veterans, and we urge Congress to pass it this year.

**H.R. 1256, Veterans Health Administration Leadership Transformation Act**

The intent of the Veterans Health Administration Leadership Transformation Act is to ensure greater leadership stability at VHA, an issue that has become a concern in recent years. We appreciate the sentiment of this legislation but fear changes like fixing the term of appointment for the Under Secretary for Health at 5 years could present a new host of challenges to continuity. Therefore, we take no position on this bill at this time.

PVA would once again like to thank the Subcommittee for the opportunity to present our views on the legislation being considered today. We look forward to working with the Subcommittee on this legislation and would be happy to answer any questions.

**Information Required by Rule XI 2(g) of the House of Representatives**

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding Federal grants and contracts.

**Fiscal Year 2023**

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—\$479,000.

**Fiscal Year 2022**

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—\$ 437,745.

**Fiscal Year 2021**

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events—Grant to support rehabilitation sports activities—\$455,700.

**Disclosure of Foreign Payments**

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

## STATEMENTS FOR THE RECORD

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### **Prepared Statement of Veterans of Foreign Wars**

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on legislation pending before this subcommittee.

#### **H.R. 41, VA Same-Day Scheduling Act of 2023**

The VFW supports this legislation that would mandate the Secretary of Veterans Affairs (VA) to ensure veterans are able to schedule appointments for health care at VA medical facilities in a timely manner. The VFW understands that it is essential for veterans who need care to be able to schedule appointments via telephone, rather than have to wait for return calls from VA staff members. In practicality, appointments outside of referrals should be set up that same day to ensure high quality care is being delivered to veterans.

#### **H.R. 366, Korean American Vietnam Allies Long Overdue for Relief (VALOR) Act**

The VFW does not currently have a resolution supporting care and benefits for allied forces, therefore, we have no position on this legislation.

#### **H.R. 542, Elizabeth Dole Home Care Act of 2023**

As life expectancy continues to increase, so must life quality, and for many veterans that means having home health care as a choice. The VFW continues to advocate for long-term care options as stated in our legislative priority goals and resolution, which is why we support this proposal.

Home health care benefits the veteran, caregiver, and VA in many ways. Caregivers relieve VA of the necessity to place veterans in institutional long-term care. Even though veterans may require assistance with daily activities, being at home offers independence and familiarity, which is essential for veterans in the beginning stages of dementia. This freedom to remain in their homes needs to be supported by VA services and funding, while not financially stressing veterans and their families.

A Kaiser Family Foundation report released in February 2022 states that almost twenty-five percent of individuals who died from COVID-19 lived in long-term care settings. People living in nursing homes most often cohabitate with two beds per room separated by a curtain, and share a bathroom, increasing the likelihood of becoming ill or dying. By residing at home, a veteran's risk of exposure to infectious diseases decreases.

This bill contains many ways VA would expand home and community services for veterans and their caregivers. VA would be required to partner with a state's Program of All-Inclusive Care for the Elderly to ensure veteran care is coordinated. All medical centers would have the programs of Veteran Directed Care, Home Maker and Home Health Aide, Home-Based Primary Care, and Purchased Skilled Home Care to support and provide veterans a non-institutional care setting. Caregivers would receive a warm handoff to home and community service programs if they are denied or discharged from the Program of Comprehensive Assistance for Family Caregivers. By closing the gap, caregivers would be more aware of other VA programs that provide caregiver support. VA would pilot a program to address locations with home health aide shortages. Offering both medical and financial support would make the decision to keep veterans at home easier.

#### **H.R. 562, Improving Veterans Access to congressional Services Act of 2023**

The VFW supports this legislation that would require VA to provide space at VA facilities for congressional offices to provide constituent assistance. As a Veterans Service Organization that for more than one hundred years has been assisting veterans with filing claims to obtain their earned benefits, the VFW understands the

value and need for constituent services at VA facilities. We have heard positive feedback and believe VA should continue to provide space where available, as long as it does not conflict with patient care.

**H.R. 693, Veterans Affairs Medical Center Absence and Notification Timeline (VACANT) Act**

The VFW supports this proposal to provide transparency regarding VA officials being detailed for other positions. We understand there are times when VA calls on its best staff, which includes directors of VA Medical Centers (VAMCs) for essential detail coverage. However, in-house leadership at those facilities is crucial for staff morale, the mission of caring for America's veterans, and ensuring that the VAMC meets production deadlines. When a director is utilized for detail, it must be clearly communicated in appropriate time so a qualified replacement can fill in if needed.

**H.R. 754, Modernizing Veterans' Health Care Eligibility Act**

The VFW cannot support this proposal at this time. While we agree VA's eligibility standards may not be perfect and could be improved or streamlined, we do not think a complete overhaul of the system is called for at this point. We also do not think a proposed commission is the way to accomplish that goal. Commissions like the one described in this proposal are needed when subject matter experts are required for an issue and an outside commission is established. The VFW feels if changes are needed for eligibility, there is more than enough knowledge and expertise between veterans' stakeholders, Congress, and veteran health care providers that an expert commission is unnecessary.

Additionally, a major issue we have with the proposed goal is it is too vague. Typically, we would like to see a proposal have a specific directive, examples such as diminished or expanded eligibility, or to consolidate priority groups. We think the mission of the proposed commission is not narrowly defined, which could lead to creating solutions for problems that do not exist. The VFW welcomes the discussion to improve care and access to care by modifying existing eligibility requirements, especially for emergency situations, but does not think the entire system needs an overhaul.

**H.R. 808, Veterans Patient Advocacy Act**

For the past nine years, the VFW has partnered with Student Veterans of America (SVA) to select student veterans from across the country to research and advocate for improving an issue that is important to veterans. VFW-SVA Fellow and Grand Valley State University graduate Cameron Zbikowski focused his semester-long research proposal on enhancing VA's patient advocate program. Cameron called for the improvement of the program by making sure there is an adequate amount of patient advocates at each facility.

The VFW supports this bill that would ensure there is no less than one patient advocate for every 13 thousand five hundred veterans enrolled in the local VA system. It would also provide highly rural veterans with better access to the services of patient advocates.

**H.R. 1089, VA Medical Center Facility Transparency Act**

The VFW supports this bill to require VAMC directors to submit to VA and Congress an annual fact sheet containing specified information about their facilities. This would allow for standardized reporting to identify specific health care needs and services provided at each location. This data would be informative when discussing the health conditions that are prevalent in the veterans' community. Improvement to VAMCs is vital for access and quality of care. Giving executive teams the opportunity to review and understand areas of progress and areas still in need of improvement would help develop better approaches, and quarterly reports would allow VA, Congress, and the VAMCs to determine what is and is not working. The VFW believes an improvement for this proposal would be to include data on efforts focused on the needs of underserved veterans, suicide prevention and other mental health initiatives, pain management and opioid abuse prevention, and combating veteran homelessness.

**H.R. 1256, Veterans Health Administration Leadership Transformation Act**

The VFW cannot support this bill at this time. We understand that this proposal seeks to provide stability within the Veterans Health Administration by ensuring the Under Secretary of Health and Assistant Under Secretaries of Health positions will not be vacant. This could be helpful in maintaining consistency. On the other hand, we respect every administration's position to choose appointees who align with their command message. Since Presidential terms are for four years at a time,

appointing certain positions for five-year terms could cause some of these appointments to bridge different administrations and impact the delivery of care if VA leadership is not fully aligned. For these reasons, we cannot offer support at this time.

Chairwoman Miller-Meeks, this concludes my testimony. Again, the VFW thanks you and Ranking Member Brownley for the opportunity to provide remarks on these important issues pending before this subcommittee.

#### **Information Required by Rule XI2(g)(4) of the House of Representatives**

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any Federal grants in Fiscal Year 2023, nor has it received any Federal grants in the two previous Fiscal Years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

#### **Prepared Statement of Student Veterans of America**

Chair Miller-Meeks, Ranking Member Brownley, and Esteemed Members of the Subcommittee, thank you for inviting Student Veterans of America (SVA) to submit a Statement for the Record on legislation before you today.

With a mission focused on empowering student veterans, SVA is committed to providing an educational experience that goes beyond the classroom. Through a dedicated and expansive network of on-campus chapters across the country, SVA aims to inspire yesterday's warriors by connecting student veterans with a community of like-minded chapter leaders.

Every day these passionate leaders work to provide the necessary resources, network support, and advocacy to ensure student veterans can effectively connect, expand their skills, and ultimately achieve their greatest potential.

#### **H.R. 808 – The Veterans Patient Advocacy Act**

SVA fully supports the Veterans Patient Advocacy Act (H.R. 808), which represents a crucial step toward improving the quality of customer service and care for our Nation's veterans. This bill would require the Department of Veterans Affairs (VA) to ensure that no fewer than one Patient Advocate is available for every 13,500 veterans enrolled in the system of annual patient enrollment. This increase in staffing would allow VA to better assist veterans with their complaints, resulting in reduced frustration, improved accountability, and a higher quality experience.

Patient Advocates play a vital role in helping veterans, including student veterans, express concerns about their treatment and resolve any problems with their care providers. However, well-documented issues, including staffing and workload challenges, have limited the effectiveness and ability of Patient Advocates to adequately serve veterans in need. According to the VA, there are currently only 550 Patient Advocates nationwide, with at least one full-time position per VA Medical Center in accordance with the current VHA Directive 1003.04.<sup>1</sup> The national average caseload for a Patient Advocate is around 1,025 inquiries annually.

The Government Accountability Office (GAO) documented many concerns with the Patient Advocate program, including staffing and workload issues, in an April 2018 report.<sup>2</sup> According to the report, there was near universal concern among the VA Medical Center officials interviewed by GAO about program staff workload.<sup>3</sup> The report details how backlogs have resulted in basic administrative tasks, among other things, going unaddressed. Consider this particularly concerning excerpt from the report.

Officials from one VAMC [GAO] spoke with in July 2017 stated that due to workload demands and not enough patient advocacy program staff at their VAMC, they had roughly 300 unanswered phone calls at that time from veterans who wanted to provide feedback to a patient advocate. Officials from several VSOs we spoke with stated that there is not enough patient advocate staff, adding that veterans reported that their calls to patient advocates were not an-

<sup>1</sup> E-mail from congressional staff to author concerning current program staffing levels provided by VA in response congressional inquiry on file with author (March 24, 2023) (on file with author).

<sup>2</sup> See generally U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-18-356, VA HEALTH CARE: IMPROVED GUIDANCE AND OVERSIGHT NEEDED FOR THE PATIENT ADVOCACY PROGRAM (2018).

<sup>3</sup> *Id.* at 13.

swered, they were unable to reach an advocate, or their calls were not responded to in a timely manner.<sup>4</sup>

This bill would help solve the staffing issues in the Patient Advocate program by requiring VA to hire an additional 78 Patient Advocates, with the expectation that 35 of them placed at Community-Based Outpatient Clinics where there was no physical presence of a Patient Advocate previously. SVA urges the Subcommittee to support and pass the Veterans Patient Advocacy Act, which is an excellent next step toward addressing the challenges faced by veterans using the Patient Advocate program.

The continued success of veterans in higher education in the Post-9/11 era is no mistake or coincidence. In our Nation's history, educated veterans have always been the best of a generation and the key to solving our most complex challenges. This is the legacy we know today's student veterans carry.

We thank the Chair, Ranking Member, and the Subcommittee Members for your time, attention, and devotion to the cause of veterans in higher education.

### Prepared Statement of Elizabeth Dole Foundation

Chairman Bost, Ranking Member Takano, and Members of the Committee, thank you for the opportunity to provide a written statement for today's hearing. Today's docket consists of a series of legislation for your consideration, and we would like to focus our attention on one: *The Elizabeth Dole Home Care Act*.

As you may know, the Elizabeth Dole Foundation is the preeminent organization empowering, supporting, and honoring our Nation's military caregivers; the spouses, parents, family members and friends who care for America's wounded, ill or injured veterans. The Foundation was born out of Senator Elizabeth Dole's conversations with caregivers while Senator Bob Dole was receiving care at Walter Reed Medical Center, and she realized that not enough was being done for military and veteran caregivers. Senator Elizabeth has since made the transition from caregiver to survivor after the passing of Senator Bob in 2021, but she remains steadfast and fervent in her advocacy on behalf of caregivers.

*The Elizabeth Dole Home Care Act* is critically important to military and veteran caregivers across the Nation. This legislation was first introduced in both the House and Senate during the 117th Congress. It received bipartisan support and endorsed by a diverse coalition of organizations, including Paralyzed Veterans of America, The American Legion, AARP, Disabled American Veterans, Wounded Warrior Project, Veterans of Foreign Wars, National PACE Association, National Council on Urban Indian Health, and the National Association of Counties.

This bill is an investment in resources that help veterans age in place and could not come at a more appropriate time. In 2014, research conducted by RAND and commissioned by the Elizabeth Dole Foundation found that there are approximately 5.5 million military and veteran caregivers in the United States that provide \$14 billion annually in unpaid labor, caring at home for their veteran loved ones. With inflation, this equates to approximately \$20 billion today. Experts predict that by 2050, there will be an estimated 1.5 billion people aged 65+ worldwide, which is a sharp increase from 703 million in 2019. Not only are people living longer, but they are more likely to have chronic health conditions that require regular care. A study conducted by AARP found that 76 percent of people aged 50 or older would prefer to remain in their current home for as long as possible. These trends all point to the ever-growing need to invest in home and community-based services and the caregivers who step into this role.

The version of *The Elizabeth Dole Home Care Act* as introduced during the 117th Congress included the following provisions:

- Increase the non-institutional expenditure cap from 65 percent to 100 percent.
- Expedite and expand access to the Department of Veterans Affairs (VA) Home and Community-Based Services (HCBS) to all Medical Centers, including those in the U.S. territories, in 2 years. Services include:
  - The Veteran Directed Care Program – Provides veterans a flexible budget to hire friends, family, and neighbors to help with activities of daily living.
  - The Home Maker Home Health Aide Program – Allows VA to contract with a community partner that employs home health aides to care for veterans in their homes.

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<sup>4</sup>*Id.*

- The Home-Based Primary Care Program – For a veteran who has difficulty traveling, is isolated, or whose caregiver is burdened, a VA physician will supervise healthcare in the veteran’s home.
- The Purchased Skilled Home Care Program – For veterans who have higher levels of need the VA will contract with a community agency to provide skilled nursing care in a veteran’s home.
- Require VA to continue working with caregivers if they are denied from a program to find an alternative. VA must inform caregivers of other services they can access and ensure they are connected to appropriate resources.
- Expand access to respite care for family caregivers of veterans enrolled in home care programs.
- Establish a “one stop shop” webpage to centralize information for families and veterans on all programs and includes an informational eligibility assessment tool.
- Mandate stronger coordination between the Program of Comprehensive Assistance for Family Caregivers (PCAFC) and VA’s other services. If a veteran is denied or discharged from PCAFC, the veteran must be assessed for participation in all other HCBS programs.
- Establish a three-year pilot program to address shortages of home health aides. VA will directly hire or repurpose current nursing assistants to be home health aides for veterans.

Last winter, the Congressional Budget Office (CBO) published their cost estimate for *The Elizabeth Dole Home Care Act*. They projected that the bill would cost \$16.1 billion in discretionary spending and \$8.5 billion in mandatory spending, totaling \$24.6 billion over 10 years. CBO estimated that the section raising the non-institutional expenditure cap would cost \$24.5 billion over this timeframe. Due to this provision contributing to the vast majority of the cost, it has become the subject of debate and has been consequently removed from the Senate version of the bill.

#### **Addressing the Cost:**

The non-institutional care expenditure cap is VA’s ability to pay providers of in-home health care services up to 65 percent of the total cost to the VA if it had provided care within a VA facility (38 U.S.C. § 1720C(d) (1997)). When veterans—those of whom usually have complex care needs—reach this limit, their families and caregivers are required to bear the other 35 percent of the costs or must place their veteran in institutional care.

Not only is in-home care essential to our community’s well-being, but we are concerned that the CBO score does not properly reflect the true costs of implementing this provision, especially when considering more complex care facilities. It is the opinion of our experts, as well as a coalition of military and veteran-serving organizations, that the projected cost estimate is unintentionally inflated. At the high end, approximately 500 veterans have reached the 65 percent cap and not all of them need it increased to 100 percent. Because the share of veterans reaching the cap is so low, it is improbable that adding funding for this small group will cost \$24.5 billion over 10 years. We strongly encourage the respective House and Senate Committees on Veterans Affairs to challenge the CBO score and ensure that this was calculated properly.

In addition to reevaluating the cost, it is important to acknowledge the money that is saved on a continued basis by veteran caregivers across the country. In order to put the value of family caregiving into perspective, CBO should also calculate how much it would cost if every veteran who qualified for institutional care at the VA elected to utilize it. We are confident that cost over 10 years would be far greater than the projected cost of raising the non-institutional expenditure cap, especially as AARP recently reported that civilian family caregivers nationwide contribute over \$600 billion in unpaid labor each year.

#### **The Non-Institutional Expenditure Cap’s Impact:**

In addressing this issue, it is crucial to go beyond the numbers and consider how it operates in practice. For caregivers, raising the non-institutional expenditure cap would be a much-needed relief for their families. Caregivers like Karee, Jim, Mary, and Lara know this struggle all too well.

In North Carolina, Karee and Jim are impacted every day by this cap. Karee and Jim are both Army veterans and they have nine children, many of whom have followed in their parents’ footsteps and become Army officers too. One of those children was Kimmy, who at 25-years-old following a deployment to Afghanistan, suffered a Traumatic Brain Injury (TBI) while stationed in Italy. Karee and Jim now care for

a 34-year-old Kimmy. Kimmy requires 24-hour care as well as tube feeding, frequent pulmonary care, support with all activities of daily living (ADLs,) and additional therapies.

Despite living just outside of Raleigh, a city home to exceptional healthcare facilities and North Carolina's State capital, no facility would accept Kimmy within 40 minutes of her parents' house. Kimmy receives her care at home and is enrolled in Veteran-Directed Care (VDC), which pays for a small portion of her healthcare costs. Kimmy's pension from the Army funds the rest, including income for professional caregivers to assist with her 24/7 care. Together this costs upwards of \$200,000 annually and leaves little for additional expenses.

Theoretically, Kimmy could receive care in an institution for the rest of her life. Despite the potential benefits, her parents are willing to take on these responsibilities in order to ensure that their daughter has the best quality of life possible. If placed in institutional care, Kimmy would suffer immeasurably and miss the interactions with her eight brothers and sisters, going to family events, and her vast community of friends who regularly have her over in their homes. Karee and Jim would be unable to see Kimmy regularly and would be an hour away should anything happen. Despite all of the current challenges that come with caring for Kimmy at home, Karee and Jim do it anyway because it is the best option for their daughter.

Two hours south of Raleigh, another family is experiencing similar struggles. Mary cares for her husband, Tom, who is 68 years old. He served in the Marine Corps from 1972 to 1975. In 2010, he was diagnosed with service-connected Amyotrophic Lateral Sclerosis (ALS). He has been living with ALS for nearly 13 years. Mary is 63 years old and retired several years ago to become his full-time caregiver. He has specifically requested that he remain in the home through the end of his life, rather than be cared for in a facility. Mary is fully supportive of this decision and can see no other way for him to live out his days than at home surrounded by family, pets, music, and his paintings. Mary currently does not have outside help to care for Tom, but likely will require it in the near future. Because of the expenditure cap, she will care for Tom at home without the appropriate amount of care and it will come at a great expense, both financially and physically. When asked what keeps her up at night, she replied, "that the disease will consume me from exhaustion, and I will die before him."

This experience is not isolated to the East Coast. In Texas, caregivers are facing similar challenges caused by the non-institutional expenditure cap. Lara was the wife and caregiver to her husband Tom, a US Air Force veteran. Tom was diagnosed with service-connected ALS in 2016, received a tracheostomy and became ventilator dependent in 2019, and passed away from the disease on July 15, 2022.

For the last three years of his life, he was paralyzed, received nutrition and medication through a feeding tube, required a tracheostomy and ventilator to breathe, and communicated using eye gaze technology. Tom's care was considered high acuity, meaning not only did he need help with all aspects of Activities of Daily Living, but he also required the support of his ventilator and circuits, feeding tube, and constant evaluation for skin breakdown. His care was like the care received in a hospital-level ICU. Lara was able to keep Tom in their home, where he wanted to be in the last years of his life, surrounded by family, friends, and his loyal service dog, Lou. Lara was not a trained medical professional, but she cared for Tom to the best of her ability, despite her fear and uncertainty.

Tom's care was 24 hours, 7 days a week. Tom's ventilator had to be monitored at all times and provide the required suctioning, as well as ensure that he was regularly adjusted to avoid skin deterioration. Tom required the use of a Hoyer lift to be moved out of the bed for toileting, showering, or to be placed in his wheelchair. It took Lara over a year of advocating to the Central Texas VA to have skilled nursing approved to provide much-needed skilled help in the home. Her VA found a path forward to getting the care she needed in the home, but her experience is very much an exception and not the rule.

Solitary caregiving, like what Lara provided to Tom prior to receiving skilled care, led to extreme physical and mental exhaustion. The cumulative exhaustion felt by Lara was not only unhealthy for her as the caregiver, but also for the care recipient—the husband she adored. On several occasions, Lara's exhaustion did lead to her making errors in Tom's care; from minor ones like forgetting to restart the feeding pump after toileting to more serious ones of inadvertently turning the ventilator off. The lack of in-home nursing support, sleep deprivation, and grief took a toll on Lara's mental and physical health, and Lara began experiencing suicidal ideations.

For high acuity veterans and their caregivers, having skilled care in the home is so much more than just a break in care responsibilities or respite for the caregiver. It is essential for the health of the caregiver. In Lara's case, having skilled care in



the home enabled her to get more than 2–3 hours of sleep most nights. Skilled care also allowed for moments that would allow her to give her attention to their teenage son, Trey, and gave her space to step away to allow herself to grieve her husband and the life they shared before ALS entered it.

Keeping the 65 percent cap on care services the VA offers, especially for high-acuity veterans, is detrimental to the caregiver's physical and mental well-being, which ultimately reduces the quality of care for the veteran. Caring for high-acuity veterans in the home is possible with services offered by the Veterans Health Administration, especially when the veteran is adamant about living their life in their home.

Providing a path forward for these high-acuity veterans and their families and removing the 65 percent cap is vital for the well-being of military families.

The unfortunate reality is that there are so many other families who are just like Karee, Jim, Mary, and Lara. They are parents who will never stop caring for their children and spouses who are taking on more than they ever expected. Not only are veterans lucky to have them by their side, but our Nation should feel lucky too.

**Conclusion:**

Senator Elizabeth Dole was honored to lend her name to legislation that is uniquely focused on improving caregiver resources and supporting care within the home. Congress has an opportunity to invest in this population and an obligation to ensure that veterans receive the treatment that they want and deserve. It is critical to include provisions that address the non-institutional expenditure gap and continue to provide solutions for those wanting to receive care at home.

Passing this legislation helps veterans and their caregivers get the services they need now while also building the infrastructure needed to serve veterans into the future. Caregivers cannot afford to wait any longer. Thank you for considering this critical issue, and we look forward to the *Elizabeth Dole Home Care Act* becoming law.

**Prepared Statement of The American Association of Retired Persons**

April 3<sup>rd</sup>, 2023

The Honorable Mariannette Miller-Meeks  
 Chairwoman  
 Subcommittee on Health  
 Committee on Veterans' Affairs  
 U.S. House of Representatives  
 3460 O'Neill House Office Building  
 Washington, DC 20515

The Honorable Julia Brownley  
 Ranking Member  
 Subcommittee on Health  
 Committee on Veterans' Affairs  
 U.S. House of Representatives  
 2262 Rayburn House Office Building  
 Washington, DC 20515

Dear Chairwoman Miller-Meeks and Ranking Member Brownley:

AARP, on behalf of our nearly 38 million members and all older Americans nationwide, appreciates the opportunity to submit a written statement for the record to the Subcommittee on Health of the Committee on Veterans' Affairs for the legislative hearing concerning the "Elizabeth Dole Home and Community Based Services for Veterans and Caregivers Act of 2023." AARP supports passage of this important piece of bipartisan legislation to expand access to current VA programs that provide care at home, and thanks Representative Brownley (D-CA) and Representative Jack Bergman (R-MI) for their leadership.

**Increasing Access to Home- and Community-Based Services (HCBS) and Supporting the Direct Care Workforce**

For most older adults, their strong preference is to receive care they may need as they age in their own homes and communities, rather than in a nursing home. In a [2021 AARP survey](#), three-fourths of adults age 50+ told us they wish to remain in their current homes and communities as long as possible. That's why AARP has made it a priority to ensure people age 50+ are able to find the care they and their family members need, when they want it and in the setting of their choice. AARP has long advocated at the federal and state level for enabling older adults to live in their homes and communities. The COVID-19 pandemic has clearly shown the dangers too often faced by older Americans in institutional care. Greater investments in home- and community-based services will allow more veterans to age in their homes and communities, where they want to be, while alleviating some of the challenges facing our nation's State Veterans homes.

After their service, hard work, and contributions to our society, America's veterans deserve to live with independence, security, and dignity. AARP is fighting for individuals to have high-quality, affordable options when it comes to long-term care—especially care at home.

Investments in the workforce that provides these important services are also critical. Direct care workers provide the bulk of paid long-term care, but there is already a shortage of direct care workers that will only grow as the population ages. A shortage of skilled workers makes life difficult for individuals and families searching for quality care, and there is an urgent need to

develop an adequate workforce to care for older adults and provide long-term services and supports. AARP encourages Congress to take action to help attract and retain direct care workers through increased pay and benefits, paid leave, improved training, career pathways, and other job improvement initiatives. It will require bipartisan work at the local, state, and federal levels and in both the public and private sectors to make sure that our nation's veterans with service-connected disabilities have access to the quality, affordable supportive services and care they need.

### **Supporting Family Caregivers**

Family caregivers—broadly defined as including relatives, partners, friends, or neighbors—are the backbone of the care system in this country, and there should be no discussion of caregiving or the care economy that leaves out the 48 million Americans who are providing care to loved ones. They help make it possible for older adults, people with disabilities, and veterans to live independently in their homes and communities. Family caregivers are all ages, races, and ethnicities and cut across all generations and segments of our population. This is physically, emotionally, and financially challenging work family members and others are providing, usually without pay.

[Family caregivers are providing about \\$600 billion annually in unpaid care to loved ones.](#) Each year, [\\$14 billion](#) in uncompensated care is provided by 5.5 million veteran and military caregivers. On this point, AARP wishes to be crystal clear: if families were not shouldering these caregiving responsibilities, taxpayers would be on the hook for much more costly nursing home care and unnecessary hospital stays.

Every day, family caregivers help loved ones with tasks such as eating, dressing, bathing, transportation, arranging, directing, and coordinating care among multiple providers and settings (including post-discharge), performing medical/nursing tasks such as wound care, managing multiple complex medications, managing finances, and paying for services to help their loved ones. [Six in ten family caregivers are women, four in ten caregivers represent diverse populations, and six in ten caregivers are working, either full- or part-time.](#)

Family caregivers often take on physical, emotional, and financial challenges. For example, military veteran caregivers consistently experience worse health outcomes, greater strains in family relationships, and more workplace problems than non-caregivers – with caregivers of pre-9/11 veterans being two times more at risk. Veteran and military caregiving respondents report higher levels of need for immediate financial assistance when compared to their non caregiving peers, according to research by Blue Star Families.

An [AARP report](#) found that family caregivers are spending, on average, 26 percent of their income on routine caregiving expenses annually, or \$7,242 every year. Hispanic/Latino and African American caregivers also reported greater financial strain than White or Asian American caregivers. Hispanic/Latino caregivers spent, on average, 47% of their household income on caregiving, and expenses for African American caregivers totaled, on average, 34% of income.

**H.R. 542, “The Elizabeth Dole Home and Community-Based Services for Veterans and Caregivers Act of 2023.”**

AARP supports the passage of the “Elizabeth Dole Home and Community-Based Services for Veterans and Caregivers Act of 2023” introduced by Representative Julia Brownley (D-CA) and Representative Jack Bergman (R-MI). This important piece of legislation expands access to current VA programs that provide care at home through coordination with Medicare’s well-established and successful PACE program. The bill raises the expenditure limit for non-institutional care alternatives to match the reimbursement rate of nursing homes to better allow veterans who require complex and round-the-clock care to remain at home with their friends and loved ones. HCBS programs at the VA such as the Veteran Directed Care Program, the Home Health Aide Program, the Home-Based Primary Care Program, and the Skilled Home Health Care Program need more support in order to provide vital home-health care to our nation’s veterans, and this legislation helps shore up those critically important programs.

The bill will also improve transitions for veterans and their caregivers upon denial or discharge from the VA Program of Comprehensive Assistance for Family Caregivers. The legislation would also create a central online resource to help families and veterans find information on available programs, increase access to respite care to give caregivers a temporary break from caregiving responsibilities, and review access to services, caregiver support, and other issues to lay the groundwork for further improvements.

AARP appreciates your efforts to better support our veterans, and their caregivers, to get the care and support they need to remain in their homes. If you have any questions, please feel free to contact me or have your staff contact Emily Hetherington on our Government Affairs team at [ehetherington@aarp.org](mailto:ehetherington@aarp.org).

Sincerely,



Bill Sweeney  
Senior Vice President  
Government Affairs

