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

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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. Scotte 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% of the cost that would have been incurred by the Department during that fiscal year if the Veteran had instead been furnishing nursing home care under section 1710 to 100% of that cost. Further, it would authorize VA to exceed 100% of the cost that would have been incurred under section 1710 if the Secretary determines, 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% 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 proposed 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% of the Veterans served in the program have short-term, post-acute needs. The remaining 25% of Veterans require care for a longer period for conditions such as non-healing wounds, long-term catheter management,

medication management and ventilator care. VA purchases skilled home care services from approximately 4,000 agencies, mostly through CCN contracts. In FY 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 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 one 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 one 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 increased 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. Lastly, 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 impact continuity 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 one 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 Congress 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% 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 one 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 two 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 five-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.