LEGISLATIVE HEARING ON H.R. 3520; H.R. 1182; H.R. 1774; H.R. 2683; H.R. 2768; H.R. 2818; H.R. 3581; H.R. 1278; H.R. 1639; AND H.R. 1815

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

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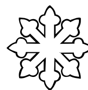

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LEGISLATIVE HEARING ON H.R. 3520; H.R. 1182; H.R. 1774; H.R. 2683; H.R. 2768; H.R. 2818; H.R. 3581; H.R. 1278; H.R. 1639; AND H.R. 1815

WEDNESDAY, JUNE 21, 2023

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

The subcommittee met, pursuant to notice, at 10:31 a.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meeks [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Murphy, Brownley, Landsman, and Budzinski.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. Good morning. This legislative hearing of the Subcommittee on Health will now come to order. I want to welcome all the members of the subcommittee and our witnesses for attending. Today we will be discussing 10 bills that would address issues impacting our veterans and that direct Veterans Administration (VA) to initiate fixes. These bills address issues raised in subcommittee oversight hearings to ensure veterans get timely access to substance use disorder treatment, and to help ease Veterans Health Administration (VHA staffing shortages. They also enhance peer support networks, explore a new long-term care option, boost suicide prevention efforts, and even provide flood mitigation solutions.

I would like to take this time now to speak on my bill, H.R. 3520, The Veterans Care Improvement Act of 2023. For several years, committee staff and many of the Veterans Service Organizations (VSOs) with us here today have heard accounts of the VA's unsatisfactory compliance with Mission Act's Community Care Guidelines. The partnering of VA care, along with community assets has had a demonstrable impact on the quality of medical care made available to veterans across the country. My bill would continue to make VA healthcare system more accessible and accountable to those in need of its services. It would codify current access standards, setting a baseline expectation for timeliness of care. It would establish a defined access standard for the provision of residential substance use disorder treatment, recognizing that when a veteran decides that help is needed, time is of the essence. It requires VA to be

more transparent with veterans when they are deciding their best options for care, whether in the VA or in the community. My bill also creates a pilot program through the Center for Innovation to incentivize how community providers interact with the VA, creating a more collaborative and value-based approach, and yes, working to improve several aspects of their performance as well.

The effective partnering of the VA care with community care results and more quality care overall. Veterans should have full transparency into their eligibility, their options for care, reasons for denial, and avenues for appeals. Knowledge is power, especially when it comes to making decisions critical to your health. I am grateful to our witnesses and those organizations that submitted statements for the record for their thoughtful feedback on my bill and the other bills on today's agenda. I look forward to learning more about each piece of legislation being considered today, their merits and their challenges, and the impact they could have on the VA operations, and most importantly, veterans' lives. Again, thank you all for being here. I now yield to Ranking Member Brownley, who is also sponsoring H.R. 1278, the Drive Act, for her opening remarks.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Chairwoman Miller-Meeks. I appreciate it and appreciate you for convening today's hearing. I look forward to our discussions of the 10 bills on today's agenda, including my bill, H.R. 1278, the Drive Act. This legislation will increase the mileage reimbursement rate for VA's Beneficiary Travel Program, which helps cover expenses for eligible veterans when they must travel to receive treatment for a service-connected condition. Specifically, my bill would make VA's rate 62.5 cents per mile, equal to the per mile reimbursement federal employees receive when driving personally owned vehicles for government business. VA's beneficiary travel reimbursement rate has not been increased since 2010, when it was set at 41 cents per mile. In the meantime, veterans' travels costs, including gasoline, vehicle maintenance, tolls, auto insurance, etc, have risen steadily.

I am pleased that VA and many of the organizations testifying or submitting statements for the record for today's hearing support my bill, which will help ensure veterans can travel to receive the care they need, whether it be at a VA facility or in the community. I am also pleased that we are considering Representative Slotkin's bill, and I know she wanted to be here today, H.R. 1815, the Expanding Veterans Options for Long Term Care Act. This bill would create a 3-year pilot program in six different locations where VA would assess the effectiveness of covering assisted living. Typically, assisted living is a less intensive and less costly care setting for individuals who may otherwise end up admitted to nursing homes.

Veterans' access to long term care has been a long-standing interest of mine, and this legislation would explore the feasibility and potential cost effectiveness of broadening options for veterans. I understand Representative Susie Lee will be here today to speak in support of her bill, H.R. 1639, the VA Zero Suicide Demonstration

Project Act. I will defer to her to tell the subcommittee more about it, but I wanted to express my support.

Turning to the other bills on today's agenda, I expect more robust discussions of many of the bills and almost all of them I am completely in support of. I do have, you know, some concerns over the chairwoman's bill, H.R. 3520, the Veterans Care Improvement Act of 2025.

First and foremost, in terms of concerns, I am concerned that the bill will lead to a far greater utilization of community care among veterans, driving them outside of VA's direct care system, where they will receive more costly, less timely, and oftentimes lower quality of care that they would otherwise receive at VA medical centers. Just last week, a national survey published by the Centers for Medicare and Medicaid Services found that veterans rated VA hospitals higher than private sector facilities in all 10 patient satisfaction care categories. At the same time, research shows that access to care in the community, particularly in rural areas, is actually shrinking and patients wait times are increasing.

I am concerned that H.R. 3520 would expand veterans' eligibility for community care so that there would seldom be a situation where a veteran would not be offered community care. For example, this bill would allow veterans to obtain community care referrals simply by expressing to the VA provider that it is their preference to be referred to the community for care. It would also bar VA from factoring in the availability of VA telehealth appointments when clinically appropriate, when making community care eligibility determinations, understanding that we are not doing that now, but in the event that we can get to a place where we can refer to telehealth appointments, I think is important.

We are, of course, still awaiting a Congress Budget Office (CBO) score for this legislation. However, if past experience is any indication, H.R. 3520 would drive up VA healthcare spending by tens of billions of dollars. Since implementing the Mission Act, more than 1/3 of VA's clinical encounters are happening in the community. Taxpayer spending on community care has far outpaced increases in VA's direct care system. I am concerned that this simply is not sustainable in the long run.

There is one very important area in which I hope we can work together to find some common ground. Under the chairwoman's bill, veterans needing residential substance use disorder treatments would become eligible for community care referrals when care at a VA facility is unavailable within 10 days of the veteran's request or within a 30-minute drive time of the veteran's home. Our subcommittee recently held a very good oversight hearing on this topic, and I was compelled by the testimony of many of the organizations that participated. I do think there are opportunities to clarify and streamline access standards for residential substance use disorder treatment. However, I think we need to think through what the drive time requirements should be. I want to work with the chairwoman to address this issue and to define access standards that we can all agree upon moving forward.

I hope today's hearing will provide an opportunity for a robust discussion of this and other bills on today's agenda. With that, Madam Chair, I will yield back.

Ms. MILLER-MEEKS. Thank you, Representative Brownley. We have a full agenda today, so I will be holding everyone to 3 minutes per bill so that we can get through them in a timely manner. I am honored to be joined this morning by one of our colleagues, and we also had colleagues who wanted to be here, but unfortunately have been delayed. Representative Kiggans wanted to speak on H.R. 3581, the Caregiver Outreach and Program Enhancement, or COPE Act, and Representative Lee sponsoring H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023. Their work and dedication to helping our veterans is very much appreciated. I would now like to recognize Representative Jennifer González-Colón. You are now recognized for 3 minutes.

STATEMENT OF JENNIFER GONZÁLEZ-COĹON

Ms. GONZÁLEZ-COLÓN. Thank you, Madam Chair. I am so happy to be back in this committee room. I was a part of this committee back when I was first elected to the House of Representatives in the 115th Congress. Chairwoman Miller-Meeks and Ranking Member Brownley, happy to be here with you. Thank you for the opportunity to testify on my bill, H.R. 1182, the Veterans Serving Veterans Act of 2023, and for including it in today's legislative hearing.

Maintaining adequate staff levels is essential to the quality of services our veterans seek and deserve when in need to care from the Department of Veterans Affairs. We have a single medical center and a network of clinics serving our veterans communities residing in Puerto Rico and in the U.S. Virgin Islands. Each of these facilities is important, just as the staff who go to work every day and provide direct service to the veterans. Yet, like the rest of the country, we see the challenges with hiring and retaining our VA staff.

H.R. 1182 seeks to support staffing levels at the VA by increasing the visibility of current vacancies and fostering the recruitment of former members of the military to fill these positions. The bill will authorize a single searchable data base for recruitment within the VA. The platform will include the military occupational specialty or skill that corresponds to a vacant position, as well as each qualified member of the armed services who elects to be listed in the data base and may be recruited to fill the position prior to being discharged and released from active duty. The Secretary may exercise expedited hiring as well as authorize a relocation bonus to a member of the armed services who has accepted a position and requires this assistance. Last, this bill will establish the Intermediate Care Technician Training Program to train and certify veterans who serve as basic health care technician while in the armed forces to work as an intermediate care technician in the VA.

I trust this bill could facilitate greater collaboration between the Department of Defense and the VA and will allow for veterans to use their skills and training to serve and work with other veterans. This is not the first time this bill has been considered. During the 115th Congress, it was passed unanimously by the committee as well as the House of Representatives. I look forward to receiving any feedback and welcome any suggestions from today's panel on

ways that we can move forward with this legislation. Thank you and I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Gonzàlez-Colòn for speaking and sponsoring H.R. 1182. As is our practice, we will forego a round of questioning for the members. You are now excused.

I will now invite our second panel to the table. Thank you very much. Joining us today from the Department of Veterans Affairs is Dr. Erica Scavella, who is the Assistant Undersecretary for Health and Clinical Services in the Veterans Health Administration. Accompanying Dr. Scavella today are Dr. Colleen Richardson, Executive Director of the Caregiver Support Program, Dr. Scotte Hartronft, excuse me, Executive Director of the Office of Geriatrics and Extended Care, and Dr. Mark Hausman, Executive Director for Integrated Access in the Integrated Veterans Care Office. Dr. Scavella, you are now recognized for 5 minutes to present the Department's testimony.

STATEMENT OF ERICA SCAVELLA

Ms. SCAVELLA. Thank you. Good morning, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee. VA apologizes for its written testimony being submitted late. Thank you for the opportunity to discuss the Department of Veterans Affairs views on pending legislation regarding veterans' health care benefits. I am accompanied today by Dr. Colleen Richardson, the Executive Director, Caregiver Support program, Dr. Scotte Hartronft, the Executive Director of the Office of Geriatrics and Extended Care, and Dr. Mark Hausman, Executive Director, Integrated Access.

My opening remarks will focus on three bills. My written statement provides more detailed information on the stated bills on today's agenda. The first bill, H.R. 1815, Expanding Veterans Options for Long Term Care Act, would require a VA beginning not later than 1 year after the date of enactment to carry out a 3-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans and their satisfaction with the pilot program. VA could extend the duration of this pilot program for an additional 3 years if VA determined it appropriate to do so based on the results of the pilot, which will be provided through annual reports to Congress and reviewed by the Office of Inspector General.

With amendments, VA supports this bill subject to the availability of appropriations. VA appreciates that the current version of this bill has addressed several technical concerns identified with similar legislation that has been proposed during the prior Congress. VA generally agrees that specific authority to furnish assisted living services, particularly through a pilot program to assess effectiveness and veteran satisfaction, would be a helpful addition to VA's options providing long term care services to help veterans and their families. It will provide VA with increased options to appropriately serve veterans and their family members in the appropriate care setting for their specific needs.

VA supports the protections this bill would include to ensure that veterans are receiving appropriate care for their needs. While VA

appreciates and fully supports the intent of this bill, there are recommended amendments that have been described in my full written statement.

I would direct the committee to my written statement regarding H.R. 3520, Veteran Care Improvement Act of 2023. VA is generally opposed to codification of access standards as it removes the ability of the Secretary to develop and publish such standards that provide veterans with options to access the right care at the right time based on their clinical needs. VA cannot support codification of residential treatment and rehabilitative services as proposed in this bill. While we generally support the establishing of a wait time standard of 10 or fewer days for the delivery of care, we have significant concerns with the 30-minute drive time standard for residential treatment program. At this time, it is inconsistent with industry standards and the accessible care that is available and could result in significantly greater financial costs to VA without any guarantee that veterans will receive care that is closer to home.

VA does not support specifically, Section 2 of H.R. 3581 Caregiver Outreach and Program Enhancement Act, or the COPE Act, which would authorize VA to award grants to carry out, coordinate, improve, and otherwise enhance mental health counseling, treatment, and support to the family caregivers of veterans participating in the Program of Comprehensive Assistance for Family Caregivers, or PCAFC. VA acknowledges and is grateful for the incredible work and sacrifices of family caregivers and the sacrifices that they make to take care of their loved ones. We have recently begun using regional clinical resource hubs, which are staffed by VA specialists that can provide direct mental health care to family caregivers using telehealth, which is an option for mental health support desired by the majority of the PCAFC caregiver respondents in previous surveys.

We believe these efforts will best address the intended goal of this section, and we agree that support is needed. As utilization of these services through VHA clinical resource hubs increases, VA will continue to assess and identify opportunities to resource and improve supportive services and meet the needs of our family caregivers for veterans. This section of the bill, as written, will require significant complexities and create significant complexities to administer and manage these grants as it is currently written.

This concludes my statement. We appreciate the committee's continued support of the programs that serve the Nation's veterans and look forward to working together to further enhance the delivery of benefits and services to veterans and their families.

[THE PREPARED STATEMENT OF ERICA SCAVELLA APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you for your testimony, Dr. Scavella. I now yield myself 5 minutes. Dr. Scavella, yes or no, are veterans ever required to utilize community care should that care or service be available at a facility when distance or time across standards are not met?

Ms. SCAVELLA. Thank you for the question, Chairwoman Miller-Meeks. Veterans are always given the choice of the care that they receive, and they have the opportunity to determine with informed decisions whether that care is received within the VA system or

within the community. There is no requirement that they go to the community, just as if we can provide the care within VA, we would hope that they would choose to take whatever type of care is best for them, whether it is in our system or in the community.

Ms. MILLER-MEEKS. I am just going to emphasize that. Should community care be available, it is not required even under this bill, it would not be required for a veteran, even if they met the requirements for community care, to obtain community care.

Ms. SCAVELLA. Correct.

Ms. MILLER-MEEKS. Codified access standards would only maintain what is currently available as a veteran's option, not changing the requirements.

Ms. SCAVELLA. Our concerns with codifying this particular piece of this legislation, we have concerns that in instances in rural America, it still may not allow them to receive care sooner. That is our concern with relations to particular issue.

Ms. MILLER-MEEKS. Well, certainly if there is not care even in rural America, since I live in rural America, then a veteran would not, you know, preferentially go there for care if there is not care available, whether it is codified or not. Yes or no, codifying access standards would make that determination one aspect of eligibility more transparent—by codifying, would it make it more transparent for veterans?

Ms. SCAVELLA. I think that is a complicated answer, Chairwoman Miller-Meeks. I do not think it is a universal yes or no answer.

Ms. MILLER-MEEKS. Okay. I will accept that. I think that that is probably a reflection of reality. Would we in general agree that more transparency for veterans for their options would be desirable?

Ms. SCAVELLA. Yes, I will agree that more transparency is desired and desirable.

Ms. MILLER-MEEKS. Thank you. Dr. Scavella, as several witnesses pointedly testified during our substance use disorder treatment oversight hearing, VA's determination that inpatient residential rehabilitation programs do not fall under the mission standards has resulted in delays and significant impact in providing access to veterans desperately seeking care. Some of the stories we heard were, in fact, heart wrenching, and we also know members of our committee have also experienced delays through getting care at the VA. In your testimony, you state that the VA generally supports establishing a wait time standard of 10 or fewer days, but not codifying. Can you explain that, please?

Ms. SCAVELLA. Yes, thank you for the question, Chairwoman Miller-Meeks. We obviously understand that when our veterans need to come in for a residential treatment program, we want to make sure that they have access. We are looking at those, at our current ability to meet the needs of our veterans, looking at trends from our veterans across this Nation to ensure that we understand what are the bottlenecks, what is slowing it down. We do have a platform of different forms of care that we can provide to include telehealth. In highly rural areas where there is not broadband access, telephone care is still possible as well.

We are looking at all of those things, but we do not want to lose the flexibilities in identifying how we provide this care to our veterans, realizing that we are committed to the same goal with getting them in as soon as possible for the care they need.

Ms. MILLER-MEEKS. As you have already stated, they are not required to receive care even in the community. I think for me, the standard is veterans getting care when they need it especially when it comes to mental health and substance use disorder treatment.

Dr. Scavella, your testimony indicates—I am going to ask you about H.R. 1182 in the short time I have left, Veterans Serving Veterans Act of 2023. Your testimony indicates that the VA already has a transitioning service member data base in use. Is that data base fully searchable? If so, how do veterans and potential VA employees access this data base?

Ms. SCAVELLA. Thank you very much for that question, Chairwoman Miller-Meeks. We do have a number of resources. The one I believe you were referring to that is in my written testimony is the Veterans Administration/Department of Defense (VA/DoD) Identity Repository, which does allow us to all, 100 percent of all service members, enter their information into that platform. We are able to use that information to search and to match people for employment.

We also have social media outreach, as well as the VA careers at VA.gov website to invite our service members to put their information there, as well as many other platforms. We do have a robust and diverse set of recruitment tools, and we are using those. The one that is 100 percent utilized is the VA/DoD Identity Repository.

Ms. MILLER-MEEKS. I apologize, since my time is finished, if you could in writing, submit to the subcommittee how veterans can access and the options that you just mentioned for VA employees and service members to access the data base, that would be appreciated. Thank you.

I now recognize Ranking Member Brownley for any questions she might. Thank you. Ranking Member Brownley, you now have 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair. As I said in my opening comments, I really do believe that we need to figure out what are the right standards for residential treatment. That piece of the bill after our hearing, I think is really important. I am wondering from the VA perspective, what you think the drive time should be for, you know, for using community care for residential treatment. You have stated that a 30-minute drive time is not really appropriate, but what do you think is appropriate?

Ms. SCAVELLA. Thank you. I will turn that question over to my colleague, Dr. Hausman for a response.

Mr. HAUSMAN. Thank you Ranking Member Brownley for the question. Our experience is that residential treatment facilities are just not available in every community. In fact, veterans that have accessed these services in the community, drive on average about 190 miles to do so. We do not have an exact suggestion for drive time standard, but we think 30 minutes is far too short just given

the reality of that these facilities are not located in every community. In fact, not in most communities.

Ms. BROWNLEY. Have you looked at, you know, commercial Insurers, TRICARE, or Medicaid plans to see if they have geographic network adequacy standards for this residential treatment care?

Mr. HAUSMAN. I will have to take that as a follow-up for the record. I expect that that work has been done through our external networks team within Integrated Veteran Care (IVC), and I will follow up with them and get that back.

Ms. BROWNLEY. Is that something that you would look at in terms of making recommendations for what the drive time would be?

Mr. HAUSMAN. Absolutely.

Ms. BROWNLEY. Okay. You know, I do not want to pick on this bill because I really do believe the residential treatment piece is important. As I said in my opening comments, I agree with some of the VA's concerns with regards to access standards. I really believe that the trajectory on cost and community care is going in, you know, an absolute upward direction. You know, I think if we just open up the access standards for anybody to just say this is what I want is to go to community care, that that trajectory is only going to increase and probably increase pretty substantially. I know I mentioned that the CBO has not scored it, but based on our experiences, do you have any sense of what the cost might be?

Mr. HAUSMAN. We do not have a cost estimate worked out yet, but as was informed in the testimony, approximately 38 percent of VA care is now purchased in the community. That trend has been increasing significantly in recent years and at significant cost. We will take a specific cost estimate for this as a follow-up for the record, please.

Ms. BROWNLEY. To what extent is VA currently able to inform veterans of their expected wait times for community care at the time they are deciding whether to opt for VA or community care?

Mr. HAUSMAN. Thank you for the question. I would say that is an important limitation that we have at present. Generally speaking, we are able to process a request for care, a referral, by first making sure that that request is clinically appropriate. From there, we determine veterans' eligibility for community care. Often they are asked to make a decision about whether they want to stay within VA or go to the community without being told the community wait time, what to expect, or where the community provider is located. That information is generally subsequently communicated at the point of community care scheduling. I think it is a limitation right now that we are working to resolve, but we are asking veterans to make a decision on where to get their care with incomplete information a lot of the time at present.

Ms. BROWNLEY. Thank you. I yield back, Mr. Chairman.

Mr. MURPHY. I practice at a medical center where literally there is a VA center not a mile away. They do not have admitting privileges at our institution, so I will tell you it is in very close proximity. One in seven of my constituents are veterans, so it is a big deal for us in eastern North Carolina. Thank you again, all for coming.

I have been made more aware really of the number of increasing incidences where VA has not been in compliance with the Mission Act requirements and not made aware of their eligibility for community care. I am an original cosponsor of Dr. Miller-Meek's bill and I believe this will correct and codify the current community care access standards.

I would like to dive down on this because when I was in private practice, we had an increasing issue with community care. As I said, there are a lot of veterans in my community and we were always happy to see them. However, we were always happy to see them, but we were always not happy to never be paid by the VA. I would like to get to dive down on that in the few minutes I have because in our community we have a lot of talented surgeons. For our guys, I live in a medical center which is halfway between Raleigh in Durham, where our other main medical center is, hospital, where most folks get referred. I am halfway between Durham and the coast. We have veterans that come 2 hours north, 2 hours south, and sometimes 5 hours east, just to come to Greenville, where I am, much less go on another 2 hours, 2–1/2 hours to Durham. Being admitted to Durham from 5, 6, 7, 8 hours away is just not a good thing for our veterans.

I would like to find out a little bit more about what your percentages for actually paying providers who deliver the care and what your backlog is. I will tell you guys, I hear from many folks who are trying to run practices, they want to see veterans patients, but you cannot see them for free. I would like to know about the process we have of actually paying our providers. Who can best speak to that?

Mr. HAUSMAN. Thank you for the question, sir. I can answer that one. You are absolutely right. This is a very critical issue, and if we do not get this right, veterans are often stuck with bills.

Mr. MURPHY. Caught in the middle.

Mr. HAUSMAN. Yes, caught in the middle of getting bills in the mail, which could be very stressful and have an impact to their health. We appreciate the importance of this. The data you are asking for is gettable, and I will take that as a follow-up for the record. I will say directionally, this is something we have been following very closely and we are doing better. We are not waiting for——

Mr. MURPHY. What does doing better mean? I am sorry, I am a surgeon, I am kind of dumb.

Mr. HAUSMAN. No, I will need to get that for you, sir. I know we are in—and I do not want to give you incorrect information, so I will take that as an action for the record, if you would permit me but——

Mr. MURPHY. Permit me, but you should have that on the top of your head because that is an exceedingly important statistic for caring for our veterans.

Mr. HAUSMAN. Yes, absolutely, completely agree. I want to say we are in the high 90 percent range. I will get you the specific information.

Mr. MURPHY. I want to know this, I want to know, one, are claims being paid? Two, how many denials, how many claims? In other words, how many times do I have to have somebody in my practice call back, go back, go back to the VA. It is worse some-

times than banish to say some of the insurance companies that love to deny, deny, deny.

You know, our purpose in providing care to veterans is to provide care to those who have sacrificed for our country and for us not to be able to do that, you have to pay staff, you have to pay the light bill, you have to pay the other things. At some point, it gets to be where we give out charity care every day. It cannot be charity care to our veterans. They do not want charity. They deserve to have their providers cared for so that they can do this.

This is a major item, and I would submit 90 percent is not near close from what I hear from our practice manager and from other practice managers in this vicinity. That is my main item. I am not going to beat on anything else. This is a big deal. We need to get the people who care for our veterans outside of the VA paid, period. Thank you. I will recognize Ms. Budzinski for 5 minutes.

Ms. BUDZINSKI. Thank you, Mr. Chairman, and thank you, Ranking Member Brownley. Thank you to the panelists for being here. My first question, Dr. Scavella, regarding H.R. 3520, the Veterans Health Care Improvement Act, can you elaborate a little bit more on the VA's opposition to this provision in the bill, Section 2, specifically, that would bar the VA from factoring in the availability of telehealth appointments when making community care eligibility determinations.

Ms. SCAVELLA. Thank you for that question. I will also refer that to Dr. Hausman.

Ms. BUDZINSKI. Okay.

Mr. HAUSMAN. Thank you for the question, ma'am. VA is proud of where we have come with telehealth. Last year, we did over 9 million appointments. We have between an 88 and 90 percent trust and satisfaction rate with veterans for telehealth appointments. Telehealth has become an important modality for healthcare delivery.

As the secretary mentioned back last fall in September, VA is looking at the possibility of incorporating available clinically appropriate telehealth appointments into access standards. The way we would do this would be through a rulemaking process, which would, of course, allow for visibility and time for public comment. An additional important point as we think about telehealth and veterans is we want to preserve a veteran's ability to choose their modality of care. In other words, if a veteran is not comfortable with telehealth, does not want telehealth, we do not want to force that modality. That is another component to how we are thinking about this.

Ms. BUDZINSKI. Thank you for that. I just wanted to elaborate on the district that I represent. I, too, come from a more rural part of the country. I represent central and southern Illinois. I have heard concerns around accessing care for too many veterans often have to travel long distances to access essential health care. I certainly understand the need to get our veterans care as soon as possible, including using community care when necessary.

I am concerned that this provision in H.R. 3520 would prevent our rural veterans from having that telehealth option that you just spoke about. According to the American Hospital Association report, there were over 130 rural hospital closures between 2010 and

2021, and the Pandemic has left hundreds of other healthcare facilities throughout the country at risk of closure. I support community care when needed, but I am worried potential closures of these hospitals and facilities may end up leading veterans to having to wait just as long or have to travel just as far to get to community care. Taking away telehealth health options may only really exacerbate that issue. That is my real core concern with this.

If I might follow up with you, Dr. Hausman, on another question. Do you believe this provision would hurt our rural veterans and or similarly severely limit the access to telehealth services and health care just in general?

Mr. HAUSMAN. Thank you for the question. I will say that we want to do everything we can to bring options to veterans, including telehealth, which, as I mentioned, is becoming an important, an increasingly important modality for care. As we are seeing ongoing pressure on rural markets and the loss of providers and potentially the loss of hospitals, we do believe that telehealth becomes that much more important as a way to fill that gap. Anything that would limit our ability to offer options to veterans, including telehealth, we would not be in favor of.

Ms. BUDZINSKI. Do you see this provision, though, as being something that would do potentially that?

Mr. HAUSMAN. I think it is a complicated question. I think, you know, with this provision in place, ideally, we would still offer the VA telehealth option along with the community option. I think in practice, in reality, once we determine a veteran is community care eligible, oftentimes we schedule in the community without taking a hard look at what VA resources are available. Now, that is a process that is on us to fix, and we are working on it, but I think that is the challenge there.

Ms. BUDZINSKI. Okay, thank you. I yield back my time.

Ms. MILLER-MEEKS. Thank you, Representative Budzinski. The chair now recognizes Mr. Landsman for 5 minutes.

Mr. LANDSMAN. Thank you, Madam Chair. Thank you all for being here and the work that you all do on behalf of veterans. The concern I have with the bill has to do with diverting resources from best practice care that we know veterans get from the VA. I am from Cincinnati, southwest Ohio. We have a phenomenal facility in Cincinnati. We know that the care is top notch. We do not have standards for these community options, so we do not know. It is questionable what kind of care our veterans are going to get. It is not questionable what kind of care they are going to get from the VA.

The idea that we would divert resources is challenging. Obviously, if this had been done in a bipartisan way, which I think most things ought to be done, if not everything should be done in a bipartisan way, because I think we could have gotten and maybe we will ultimately get to a better place in terms of ensuring that people have options but they are the highest standards, that we are not undermining VA benefits resources care.

You have cited concerns that the VA will no longer be the go-to caregiver for many veterans if this were to pass. In your view, what do you think that looks like? Why is it so important to keep care within the VA?

Mr. HAUSMAN. Thank you, sir, for that question. I do appreciate the statements you made about the quality of care that is provided within VA. We are very proud of that. We are very proud of our recent Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) results with better veteran satisfaction across 10 categories compared to the community, as well as numerous studies that have come out over the last 5 or so years that have shown VA is as good as and often better than the community care alternative.

You know, there are also challenges with community care. We had a hearing I think it was a couple of weeks ago, where challenges with care coordination have been discussed. You know, these are things, again, on us to fix. As things stand today, that is the reality. We do not get 100 percent of medical information back. We need to fix that. That results in challenges with care coordination. We know sometimes when veterans get their care in the community, it is likely not as high quality. Certainly, veteran centered care is what we can provide. We are passionate about providing health care to veterans. That is why we do what we do. That is what motivates us. It is really inspiring to see that, you know, we are doing a great job with veteran perception with our hospitals, as well as the quality that has been proven out in several studies.

Mr. LANDSMAN. Thank you. In your opinion, what would be, I mean, because there is an argument, right, that oftentimes in certain places, or just based on what a veteran may need, that a community provider may be closer, better positioned to provide that support. I do not want it to be too leading, but my sense is that if there were the same level of standards and that there were certain pieces of the agreement, that it could be, in fact, beneficial, but there would have to be real structure to those partnerships. Do you have an opinion about that or what that could look like?

Mr. HAUSMAN. Yes, sir. Completely agree with that assessment. I will share that as those items are being worked on, as we are looking at our next generation for our community care network, you know, specifically, how do we measure quality? How do we then communicate which providers are of highest quality to veterans that are community care eligible? How do we better facilitate the bidirectional exchange of medical information, thereby enhancing care coordination and clinical outcomes? All of these are very much in front of us and are being actively worked on as we are thinking about the next contract for our community care network.

Mr. LANDSMAN. Thank you so much, and I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Landsman. No one has challenged the quality of care provided at the VA, but you can have the best quality of care, but if you cannot access it and you commit suicide, you have had no care at all. I thank all of our witnesses for giving testimony and joining us today on behalf of the subcommittee. Thank you so much. You are now excused. We will wait a moment as the third panel comes to the witness table. Thank you.

Welcome everyone and thank you for your participation today. On our third panel, we have Mr. John Retzer, Assistant National Legislative Director for Disabled American Veterans, Ms. Tiffany Ellett, Director, Veterans Affair and Rehabilitation Division for the

American Legion, and Mr. Cole Lyle, Executive Director of Mission Roll Call, a program of America's Warrior Partnership. 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 supports H.R. 1182, the Veterans Serving Veterans Act, which would require the VA to maintain a data base of vacant positions with corresponding military, occupational specialties, or skills to recruit qualified members to fill the position prior to discharge. VA must aggressively look at all means to successfully recruit highly trained, dedicated professionals to ensure and deliver sustainable, high-quality healthcare.

We support H.R. 1278, the Drive Act, which would require the VA to ensure beneficiary travel reimbursement rate is at least equal to the General Services Administration (GSA) reimbursement rate of federal employees. This will ensure VA's travel reimbursement rates keeps up with the cost of inflation and properly accounts for fluctuations in gas prices. Veterans should not have to choose between getting care they earned and deserve and the rising cost of travel to access their needed care.

Seventeen veterans take their own lives every day, twice the rate of nonveteran peers. We must work collectively until we get the number down to zero. Losing one service member or veteran to suicide is one too many. DAV supports H.R. 1639, the VA Zero Suicide Demonstration Project Act. This bipartisan legislation would bolster clinical training and resources to test the effectiveness of the pilot program and improve the quality of the mental healthcare services that our hero veterans deserve.

We support H.R. 1774, the VA Emergency Transportation Act, which would provide veterans reimbursement for the cost of emergency medical transportation regardless of provider or medical facilities.

DAV supports H.R. 1815, the Expanding Veterans' Option for Long Term Care, which would require the VA to carry out a program to determine the effectiveness of providing assisted living services to eligible veterans who are currently receiving nursing home care through the Department to meet the increasing demand of long-term care.

We support H.R. 2768, the Private First Class Joseph P. Dwyer Peer Support Program, which would require the VA to establish an advisory committee to create standards for grant recipients to carry out a program to hire veterans to serve as peer specialists to provide veterans nonclinical mental health support. Peer specialists would provide unique support to veterans by sharing their personal experiences to navigate veterans' recovery journey.

Home improvements and structural alterations rates have not changed since Congress last adjusted them in 2010. However, the cost of home modifications and labor have risen over 40 percent. DAV supports H.R. 2818, the Autonomy for Disabled Veterans Act.

This bipartisan legislation would increase amount of funding for VA grants for disabled veterans to make necessary modifications to their homes to fit their needs and would adjust amount to account for inflation.

We support H.R. 3581, the COPE Act, which would authorize the VA to provide grants to organizations that focus on increasing mental healthcare services and resources for caregivers. Finally, H.R. 3520, the Veterans Care Improvement Act. While DAV strongly supported the Mission Act and creation of the Veterans Community Care Program, we have questions and concerns about some sections of this legislation. We certainly agree that whenever and wherever VA is unable to provide timely, accessible, high-quality care to enrolled veterans, VA must provide other care treatment options. We believe it is critical to strengthen and sustain the VA healthcare system that millions of veterans choose and rely on for all or most of their healthcare. As studies continue to show, the care provided by VA is equal to or better than private care sector on average.

While we support the intention of improving the VA community care program, we believe it is essential that VA remain the primary provider and coordinator for veterans' medical care. Therefore, we ask the subcommittee to consider the concerns we outlined in our written statement and that we would be pleased to work with you to address them.

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

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

Ms. MILLER-MEEKS. Thank you, Mr. Retzer. Ms. Ellett, you are now recognized for 5 minutes.

STATEMENT OF TIFFANY ELLETT

Ms. ELLETT. Thank you. In April 2020, my friend Greg, a government employee on the verge of retiring, died by suicide via firearm. Exactly one year later, my friend Carl, a retired army veteran—excuse me—and county sheriff suffering from Post-Traumatic Stress Disorder (PTSD), died by means of self medication. Five months later, a boy like a second son to me named Cole, a 21-year-old college senior and son of a Marine veteran, died by suicide via firearm. This past February, my friend Bruce, an army veteran who served in a special unit in Panama, died by suicide via hanging.

Mental health and suicide does not just affect one community in one way. This is a complex problem that needs a multifaceted solution. We, as a society need to do better. Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, on behalf of our national commander, Vincent J. "Jim" Troiola, and our more than 1.6 million dues paying members, we thank you for inviting the American Legion to testify today.

According to the Substance Abuse and Mental Health Services Administration, in 2021, an estimated 12.3 million adults in the U.S. seriously considered suicide, 3.5 million planned an attempt, and 1.7 million attempted. Veterans Health Administration is the largest integrated healthcare network in the United States. If any organization has the ability to pull together the means to create a

multifaceted solution to the mental health epidemic plaguing the United States and its veterans' population its VA.

In 2021, the American Legion started its Be the One movement to destigmatize and encourage the discussion of mental health, suicide, and seeking help. This movement, in combination with our Buddy Check program, created in 2019 and adopted by VA through 2023 legislation, are examples of the American Legion's constant, vigorous support of peer-to-peer solutions for veterans' mental health complexities. The American Legion strongly supports the VA Zero Suicide Initiative pilot and the PFC Joseph P. Dwyer Peer Support Programs.

Mental health struggles or feelings of isolation can be exacerbated during transition from service through a veteran's perceived loss of identity or mission. One of the solutions for this empty space is to immediately provide a mission to the veteran. This is just one of the reasons we support the Veterans Serving Veterans Act of 2023, which assists in building a direct path for exiting service members to feed into the VA recruitment pool. Another reason we support this act is the direction to train and certify corpsmen or medics to become intermediate care technicians, ICTs, augmenting the VA medical workforce.

That being said, we would like to see the Department of Homeland Security added in this legislation so that Coast Guard health services technicians may be included in the recruitment data base. We think the VA ICT program is one that with increased use, could not only assist in amplifying personnel for our veterans, but could also provide much needed transition assistance to those exiting the service by giving them a mission to move directly into.

Separately, I would like to address legislation being considered to expand care for our veterans through improving long term care, home services, and living conditions, and community care. The American Legion believes that veterans and their families are best served when their long-term care needs are promptly met, while also honoring self-autonomy and giving them the choice to remain within their local communities. We support the introduced legislation that not only calls for an increase in funding to support housing improvements for disabled veterans so that they may retain self autonomy in the comfort of their own home, but also that which calls for codifying community care access standards to ensure veterans will receive timely, quality healthcare.

A final note to mention, the importance of our caregivers and their mental health. Often the caregivers of veterans, be they spouses, siblings, or even children, carry a burden that many of us do not see. They do such a good job of holding up the veteran that no one sees the cracks in the foundation. As a disabled veteran, the spouse of a disabled veteran, and an advocate for our veterans and their families, I have witnessed the demons that lay in wait in the dark for each of us. The American Legion calls on Congress to pass legislation such as those discussed today to assist in involving care and support for our Nation's veterans and their families.

I conclude by thanking Chairwoman Miller-Meeks, Ranking Member Brownley, and this subcommittee for your incredible leadership and for always putting veterans at the forefront of your mission. It is my privilege to represent the American Legion before the

subcommittee today, 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, and on behalf of the subcommittee, we are sorry for the loss of your fellow service members and friends. Mr. Lyle, you are now recognized for 5 minutes.

STATEMENT OF COLE LYLE

Mr. LYLE. Thank you. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of Mission Royal Call and the roughly 1.4 million veterans and supporters in our digital advocacy network, thank you for the opportunity to provide their feedback through our remarks on pending legislation. While all the proposed bills are worthy of discussion and will have impacts on the veteran community, I will focus the bulk of my time on the Chairwoman's bill, H.R. 3520.

Mission Roll Call strongly supports this legislation as a necessity to ensure veterans receive timely access to quality care. The Mission Act of 2018 streamlined a congealed process that existed via the Choice Act, and Congress's intent with Mission was clear, the VA must increase access to private doctors when the VHA cannot provide care in a reasonable time, distance, or if it was in the best medical interest of the veteran.

In 2021, reports surfaced that VA administrators were overruling decisions by VA doctors and patients to keep veterans in the system, in some cases cutting off care entirely. The article simply confirmed what many VSOs providing care coordination and casework already knew that to protect VA's parochial interest in some areas of the country, it was unnecessarily difficult for veterans to access care in the community when it was in their best medical interest. In 2022, 4 years after Mission was passed, Secretary McDonough testified community care now accounts for 1/3 of VA's healthcare budget. As a result, the Secretary said the VA would look at changing access standards and use telehealth availability to determine wait times.

Using the broad capabilities, we have available, Mission Roll Call conducted a poll question on the issue. With over 6,300 veteran responses across America, 81 percent said Congress should codify the access standards. Further, Mission Roll Call asked questions on the more general veteran experience accessing community care. With an average of 6,200 responses across seven unique polls, 60 percent of veterans said their providers do not make them aware of this option after a delay in care. Thirty-seven percent said they had experienced a delay or postponement of any healthcare appointment at a VA facility. Seventy-one percent said they were not referred to the community after a delay in mental health or other specialty care at a VA facility. Twenty-two percent experienced problems scheduling the care once referred. Fourteen percent said their providers referred them to the community, but the referral was later denied by the VA upon review. Last, 21 percent said their providers scheduled them a telehealth visit to access care when they preferred in-person visits.

This clearly indicates an issue simmering beneath the surface, but the problem can be found in more than just statistics. During Mission Roll Call's geographically diverse fact-finding tour last year, meeting with over 5,000 veterans individually in California, Texas, Florida, Alaska, Arizona, Idaho, Montana and elsewhere, these problems were borne out in personal testimonies of countless veterans. While those with good experiences at VA mitigated their healthcare issues and went on living their lives productively, those with negative experiences accessing healthcare in VA or being referred to the community, either gave up trying or were not shy telling other veterans to stay away from VA. The issues ranged from primary care appointments for things like allergies to significant mental health issues. A few stark responses from veterans said they had peers whose mental health spiralled after being frustratingly unable to access mental health care.

To the best of my knowledge, none of these examples ended in suicide. With less than 50 percent of the U.S. Census Bureau's estimated 17.4 million veterans in America enrolled in VA and even less using it on a regular basis, making it harder to access healthcare when needed is counterproductive to the VA's interest, regardless of where the care takes place.

As the VA is the largest healthcare system in the country and the second largest Federal agency behind DoD, it is understandable why officials sometimes make big decisions with respect to workforce recruitment and retention. However, Congress must ensure the Agency keeps the veteran, not Agency interests, as their North Star and not defer or be unduly influenced by workforce considerations when those decisions could negatively impact the individual veteran's ability to seek healthcare. After all, the VA's core mission is to care for those who have borne the battle.

Mission Roll Call has also supported a similar bill in the Senate, the Veterans Health Act. We hope the House and Senate pass both bills in a bipartisan manner to pass this urgently needed legislation to protect veteran access to timely health care, whether that is in a VA facility or not. Madam Chair, this concludes my testimony. Mission Roll Call would like to thank you and Ranking Member Brownley for the opportunity to testify on these important issues, and I am prepared to take any questions you or other subcommittee members may have.

[THE PREPARED STATEMENT OF COLE LYLE APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Lyle, and thanks to all of our witnesses today and for their thoughtful inputs. I now recognize myself for 5 minutes.

Mr. Lyle, and you may have answered this, but you listed seven unique polls that Mission Roll Call conducted on veterans accessing community care. Interestingly enough, they mirror what I experience when I talk with veterans within my district, and I am a fellow veteran, married to a fellow veteran. You also state in your testimony, the data clearly indicates that there is a problem simmering under the surface on this issue referring to community care. You may have addressed this, but could you again briefly expand on this problem?

Mr. LYLE. Thank you for the question, Madam Chair. You know, I think if we look at community care and the program since 2018, obviously it has expanded dramatically. By and large, the program is working well. I think people that work with veterans on the ground, talk to veterans, and get their learned experience can tell you that they or someone they know has experienced some sort of issue accessing care in the community. I myself use the VA full-time for my care, for everything, and I have experienced I mean, the vast majority of my care has been good, has been excellent, but I still have experienced the occasional problem accessing community care.

Ms. MILLER-MEEKS. Ms. Ellett, the quality of community care is often debated in Congress. In your opinion, can you provide an example of a veteran and how community care is safe, effective, and timely for veterans seeking to receive care in the community?

Ms. ELLETT. Thank you. Thank you, Madam Chair. I think that, you know, there are a couple of things that come to mind that did not have really good outcomes, because community care, there are good and there are bads in community care as well, just as well as VA. I know that I myself, I have to drive an hour and a half to Richmond to my medical center for some of my appointments, and the closest Community Based Outpatient Clinic (CBOC) that I have is 45 minutes away.

I was medically discharged from the army for my back issues. I do drive an hour and a half to work every day because I love it, but it takes a toll. Driving for another 45 minutes to a chiropractor is not very helpful for me. I do use my community care in that sense, and it is extremely helpful. It is only 10 minutes away. They seem to have a positive relationship between VA and the community care there, so that is kind of a success story, although we are aware that that is not always the case.

Ms. MILLER-MEEKS. I think I found that in both instances in community care and in VA care, and having been a provider in community care, I had excellent ratings as well.

Mr. Retzer, in your statement you mentioned the DAV supports a searchable data base consisting of existing military medical personnel for the purposes of recruitment. How confident are you in the VA's ability to, one, protect this information and maintain privacy, while also being able to connect service members to potential opportunities within the VA?

Mr. RETZER. Thank you for that question. I think as far as the confidence with electronic data bases that we are challenged right now with the VA, I think we can take some lead with the Department of Defense, being that this is going to be military occupational specialties and skills that are going to be listed in the record with individuals' information that have served and are serving. I think lessons can be learned as we navigate to make those data bases. I think some of the confidence levels of maintaining privacy is there because they do that with our veteran care information that we have as ourselves as veterans. I think they need to be a little bit more mindful of the fact that we are literally talking about service members putting their data bases into the system. I think as we navigate it, they can continue to learn from lessons learned in their developments.

Ms. MILLER-MEEKS. Ms. Ellett, as you know, the veteran population is aging with more senior veterans requiring long term care. You note the importance of providing veterans choice and care. Do you agree that H.R. 1815 will provide veterans with timely care to their long-term care needs while also remaining cost effective?

Ms. ELLETT. Yes, we support it, and we think that it will be a good supplement, and we are really just looking for something to assist VA in taking care of the expanding aging network of veterans.

Ms. MILLER-MEEKS. Thank you. I yield back. Ranking Member Brownley, you are now recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair. I wanted to ask a question really of all three of you and get individual answers from you. If we codified all of the access standards, including I just want to get community care, what do you believe that there would be any impact on VA's direct care system at all?

Mr. RETZER. Thank you for that question. Where DAV is concerned with regards to Section 2 of this bill is a codifying, is that we feel concerns with the limitation and flexibility that the VA would have to ensure that we as veterans who are getting the healthcare at the VA, would have that option of care for our individual needs. One of the things that we see is that the Mission Act already provides the guidance for the VA. We just need to ensure that VA is held accountable to the access standards and the quality of standards. That is the most important thing, is the quality of standards. We can have access and timely scheduling, but we have to make sure that we have that quality care provided to each individual veteran.

The other thing that we see is that, you know, if we limit that access for the VA, individual care out in the community, one of the things that they do not have are the same access standards or the quality standards. That is one thing that we do not have at this time to be able to measure what is really happening out there that would be beneficial for our safety and quality of our care. Let alone, I think, there is a second component there for us to look at is that when we look at community care, they do not have the wraparound services that veterans need. One of the things that we veterans deserve to have are the core values that VA is built on. If I can read them off for you, the strengths that they have is system wide clinical expertise regarding service-connected conditions and disorders. That is one of the things that we veterans walk into a community care and VA care system, is that we have multiple issues. As many of us suffer from musculoskeletal conditions, we also suffer from mental health. Even when we are trying to get those resources, we may be seen from medical for the mental health, but it is exasperated because of our chronic pains. The wraparound services are very important, and that direct care handoff, that warm handoff to different departments is important.

Ms. BROWNLEY. Thank you. Ms. Ellett.

Ms. ELLETT. Thank you for that question, Ranking Member Brownley. We never want community care to replace VA. I do not think that it will be detrimental. I think that it will expand or open doors to possibly veterans who are not willing to seek VA care. Giving them at least the option. Now, I have experienced good VA

care. I have also spoken to many veterans who have experienced poor VA care. Some of them will choose not to get care. That is the last thing that anybody wants. It is really just giving them that option, just that window of opportunity to get that assistance. We do not think that it is going to, you know, kind of privatize VA. We do not believe that that is what is going to happen.

One of the issues is you still have communities out there, like the LGBTQ community, who has a hard time going in and trusting VA facilities and VA staff. Just even opening up that branch to say, hey, if you come in and talk to VA, you get the option if you want to come here or go to community care. That might do a lot to build a bridge for that community or other under representative communities of veterans in order to build that trust back up.

Ms. BROWNLEY. Thank you. Mr. Lyle.

Mr. LYLE. Thank you, Ranking Member Brownley. I think my response would be if the veteran is getting the care they need when they need it, then that is not detrimental to anybody, including the VA, whose core mission is to take care of the individual veteran. If you give them a choice between VA care and community providers, if all the studies that VA touts about veterans preferring care at VA facilities and that VA care is demonstrably better, then why have we seen the explosion we have seen in the last 4 years? That is a question that the VA has got to answer. Why are they meeting so many of the access standards requirements currently? Let us look at the VA experience and see how we can improve that if the goal is to get the veteran the best care possible when they need it.

Ms. BROWNLEY. Very good. I mean, I agree, really with all of your answers and responses. I just still sort of maintain the concern that the trajectory of community health care, you know, is just continuing to rise. We do not have an endless bank account in some sense. I do not want to, you know, put a bank account against the care of our veterans by any stretch of the imagination. I think the data shows that the veterans prefer healthcare inside the VA, assuming it is good health care and they can have access to it and it is quality care. I just worry about losing resources to continue to, you know, to continually improve upon the VA healthcare services itself.

You know, I do not know where the sweet spot is and where it is a delicate balance, and I am not sure where it is, and we have got to figure that out. I do agree that the VA has to answer for why, you know, the demand on community care continues to go up. Oh, am I overtime already? I apologize. I yield back.

Ms. MILLER-MEEKS. Thank you, Ms. Brownley. The chair now recognizes Mr. Landsman for 5 minutes.

Mr. LANDSMAN. Thank you, Madam Chair. I have just a question about Congresswoman Lee could not be here, but in her bill, she calls for this VA Zero Suicide Demonstration Project, which creates a program that implements the curriculum of the Zero Suicide Institute of the Education Development Center. I just wanted to know if you guys were familiar with the curriculum, thoughts on the bill, or the need for that kind of support within the VA. Any of you can answer that. Just wanted to get your perspective.

Mr. LYLE. Thank you, sir, for the question. I think when we look at suicide, veteran suicide broadly, you know, I support any effort to improve training and care within VA facilities to try to expand outreach and prevention. Again, with less than 50 percent of veterans utilizing enrolled in VA care, VA has to do more. I think less than 1/10 of 1 percent of their annual budget goes to suicide prevention initiatives, and that includes Fox grants. It would be my opinion that a more far-reaching way to fight this problem would be to expand Fox grants for community providers that have touch points with veterans that the VA will just frankly, never have.

Mr. LANDSMAN. Yes, thank you. One of the things that we talked about with the administration were the partnerships with these community providers and getting to a point where there are agreements around sharing medical records, around the standard of care, and, you know, being able to increase those grants along with those partnerships. Without those partnerships, we could be sending folks into pretty questionable situations. Do you comment on that? Do you agree with that——

Mr. LYLE. I think——

Mr. LANDSMAN [continuing]. do you feel differently?

Mr. LYLE [continuing]. I mean, I think anytime that Congress mandates the VA enter partnerships with community providers, usually there is some prescription of rules guaranteeing, you know, certain ethical and programmatic standards that these programs have to adhere to. In many cases, with the Fox grants, the requirement to submit programmatic data back to VA requires a full-time employee. It is not a small job. I would just say that I do not think under current conditions for these types of programs, that that would be a huge issue.

Mr. LANDSMAN. Just and also a question for any of you or all of you. One of the issues that we have, so I am from Cincinnati, southwest Ohio, and we have a VA, a great VA. One big issue we have as I talk to veterans is those who are struggling, really struggling, obviously are isolated. Being able to connect with somebody is the biggest issue. Whether they get the care at the VA or somewhere else, it is getting connected. One of the, you know, issues or things I have been trying to understand better is what we do well in terms of outreach, where we could do outreach better. Let us just put aside the question of whether you get the care at the VA or a community provider. I still think there is this big question, I could be wrong, this big question as to whether or not we are really going out of our way, like going to meet veterans where they are? If so, what does that look like? What is best practice outreach so that we can get folks start to build those relationships and then get them the care that they need?

Mr. RETZER. I will share with my experience as almost 20 years of advocacy with the DAV advocating for our veterans' benefits and healthcare. DAV prides themselves on providing information seminars where we actually do these information seminars talking about VA benefits and navigating the healthcare system and partnering with the VA for the homeless programs and also with employment opportunities. It is one of these things that we use as peer specialists. Peer specialist concept with the DAV is not new because our national service officers are wartime service, injured,

and ill veterans who serve veterans to help veterans navigate VA system and to build that confidence.

I think that is one of the things that we as a panel has already expressed our experience with our service and what we do as advocates to be able to build that confidence and build the relationships with VA and our veteran community to have more reassurance that they are not alone in their journey, as I had stated earlier.

Mr. LANDSMAN. Thank you.

Ms. ELLETT. Just a quick comment, so——

Mr. LANDSMAN. My time is up.

Ms. ELLETT. Oh, Okay.

Mr. LANDSMAN. I apologize, but we will circle back afterwards. I apologize——

Ms. ELLETT. All right.

Mr. LANDSMAN [continuing]. Madam Chair.

Ms. ELLETT. Thank you.

Mr. LANDSMAN. I yield back, sorry.

Ms. MILLER-MEEKS. Thank you. I was waiting for you to yield back. Thank you very much. Ranking Member Brownley, would you like to make any closing remarks?

Ms. BROWNLEY. Not really. I appreciate you having this hearing and bringing these bills forward, and I look forward to the next steps in terms of markup and moving the bills along.

Ms. MILLER-MEEKS. Well, I just want to thank my colleagues on both sides of the aisle, the Department, our VSOs, members who presented to us today in addressing the issues that we discussed. I appreciate your feedback and we will look into that. As both a veteran, a doctor, and a former nurse married to a veteran who is a nurse, I think what is most important is that we take into consideration those veterans who are not receiving care in a timely fashion. It does not matter if you have the best quality care in the world if you cannot access that care by not getting an appointment. One of the first things that I did as a new Member of Congress when I was elected in 2020, in 2021, was to work in a bipartisan fashion to pass a bill because a service member from 60 miles away went to the VA in Iowa City for mental healthcare, was denied care, and 5 hours later committed suicide. It was the first bill I was on and was signed by President Biden.

That is why this is an important issue. Codifying community care and especially access to care in the community for substance use disorder or severe mental health disorder does not mandate that care has to be provided in the community. Codifying only means that the VA understands that it is their duty and their mission to make sure that care is accessed. No one wants to divert from best practices, and there are parameters that we can put in place. I am a staunch supporter of telehealth and had bills on telehealth immediately when I came into Congress to make the waiver permanent that had occurred.

Care coordination is at the behest of the VA. Yes, we did hear about care coordination. For those, you know, I was a nurse at Walter Reed taking care of spinal cord injury patients. Flipped a lot of strikers in my time, suctioned a lot of patients that were managing on ventilators. I know that care coordination is important, but that is at the behest of the VA to improve their practices.

I think for all of us here on the committee, what we are most concerned about is that veterans have access to care. Of course, we want it to be high quality care, and we want it to be timely. So, I look forward to working with all of you. The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and to include extraneous material. Hearing no objections, so ordered. I thank the members and the witnesses for their attendance and participation today. This hearing is now adjourned.

[Whereupon, at 11:53 p.m., the subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Witnesses

Prepared Statement of Erica Scavella

Good morning, Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee. I appreciate the opportunity to discuss the Department of Veterans Affairs' (VA) views on pending legislation regarding health care benefits. We are unable to provide views today on H.R. 2683, the VA Flood Preparedness Act. We will provide those views in a follow-up views letter. I am accompanied today by Dr. Colleen Richardson, Executive Director, Caregiver Support Program, Dr. Scotte Hartronft, Executive Director, Office of Geriatrics and Extended Care, and Dr. Mark Hausman, Executive Director, Integrated Access.

H.R. 1182 Veterans Serving Veterans Act of 2023

Section 2(a) of H.R. 1182 would amend section 208 of Public Law 115–46 in a number of ways. VA would be required to establish and maintain a single searchable data base (known as the Departments of Defense and Veterans Affairs Recruitment Data base) that also includes the military occupational specialty or skill that corresponds to each vacant position and each qualified member of the Armed Forces who may be recruited to fill the position before such qualified member has been discharged and released from active duty. VA would have to hire qualified members of the Armed Forces who apply for vacant positions without regard to the provisions of subchapter I of chapter 33 of title 5, United States Code (U.S.C.). VA could authorize a relocation bonus in an amount determined appropriate (subject to certain limitations) to any qualified member of the Armed Forces who has accepted a position listed in the data base. The term "qualified member of the Armed Forces" would mean a member of the Armed Forces described in 10 U.S.C. § 1142(a), who elects to be listed in the data base, and who VA has determined, in consultation with the Department of Defense (DoD) to have a military occupational specialty that corresponds to a vacant position described in section 208(a).

Section 3 of the bill would require VA to implement a program to train and certify covered Veterans to work in VA as intermediate care technicians (ICT). VA would have to establish centers at VA medical facilities selected by VA for the purposes of this program. The term "covered veteran" would mean a Veteran whom VA determines served as a basic health care technician while serving in the Armed Forces.

Section 4 would prohibit any additional funds from being appropriated to carry out these provisions.

Position: VA does not support

This bill duplicates multiple existing efforts already underway in VA to identify, engage, and recruit transitioning military personnel for employment at VA. Principally, section 5127 of the National Defense Authorization Act for Fiscal Year 2023 (the NDAA, Public Law 117–263), already addresses the elements of this bill.

Regarding section 2(a), several efforts are already underway to target transitioning military members for mission critical and difficult to fill positions by utilizing the occupational and personal contact data contained in the Veterans Affairs/Department of Defense Identity Repository (VADIR) data base. The VADIR data base includes information on all Service members projected to transition from the military. Using data from VADIR allows VA to target Service members for recruitment at a time prior to, during, or immediately upon their transition.

Additionally, the USA Jobs Agency Talent Portal (ATP) allows VA recruitment professionals to mine searchable job seekers who are eligible and well-suited for VA job opportunities. In addition, the Transitioning Military Program (TMP) marketing plan includes publishing a quarterly VA News blog and conducting outreach via VA Careers social media channels; these efforts combined yield more than half a million impressions per quarter.

Finally, section 5127(a) of the NDAA allows Veterans who served in a medical occupation while serving in the Armed Forces to provide a history of their medical experience and competencies to facilitate civilian medical credentialing and hiring

opportunities for Veterans seeking to respond to a national emergency. VA activated this portal on the VA Careers website May 1, 2023, and transitioning military personnel with relevant medical experiences can already self register.

Regarding section 3 of the bill, section 5127(b) of the NDAA requires VA to establish a program to train, certify, and employ covered Veterans as ICTs. The VA has already implemented a program to train, certify, and employ covered Veterans as ICTs. The VA ICT training program launched as a pilot in December 2012 and transitioned to an established national program in 2014.

H.R. 1278 Driver Reimbursement Increase for Veteran Equity Act (DRIVE Act)

H.R. 1278 would amend subsection (g) of 38 U.S.C. § 111 to require VA to ensure that the mileage rate paid under subsection (a) is equal to or greater than the mileage reimbursement rate established by the General Services Administration (GSA) for the use of privately owned vehicles by Government employees on official business when no Government vehicle is available. The bill would also remove the mileage rate in subsection (a), which is currently $0.415 per mile, and instead specify that the mileage rate would be determined in accordance with subsection (g).

Position: VA supports, subject to the availability of appropriations

The current GSA reimbursement rate is authorized if no Government-furnished vehicle is available and a privately owned vehicle is authorized; the rate is $0.655 per mile, which is greater than the current mileage reimbursement rate under VA's beneficiary travel program of $0.415 per mile. The current rate was established in law more than 13 years ago, and transportation costs have increased for Veterans since that time. VA sees benefit in ensuring that this rate is updated and continues to adjust in future years, as appropriate, to reflect rising costs for transportation.

Discretionary (for the Veterans Health Administration, or VHA) and mandatory costs (for the Veterans Benefits Administration, or VBA) would be associated with this section. The mandatory costs for VBA would increase by approximately $43.5 million in fiscal year (FY) 2024, $184.1 million over five years, and $349.1 million over 10 years. Additional mandatory costs would be associated with future rate increases published by GSA. VHA estimates that increased reimbursement rates at $0.655 per mile would result in an additional $337.7 million in FY 2024, $1.866 billion over 5 years, and $4.248 billion over 10 years. VA estimates a portion of the VHA costs would be allocated to the Cost of War Toxic Exposures Fund (TEF), consistent with the methodology used to develop the TEF request in the 2024 Budget.

H.R. 1639 VA Zero Suicide Demonstration Project Act of 2023

Section 2 of H.R. 1639 would require VA, not later than 180 days after the date of enactment, to establish a pilot program called the Zero Suicide Initiative (hereafter, the Program). The Program would have to implement the curriculum of the Zero Suicide Institute of the Education Development Center (the Institute) to improve safety and suicide care for Veterans. VA would develop the Program in consultation with the Secretary of the Department of Health and Human Services; the National Institutes of Health; public and private institutions of higher education; educators; experts in suicide assessment, treatment and management; Veterans Service Organizations; and professional associations VA determines relevant to the purposes of the Program.

The Program would generally terminate after 5 years, but VA could extend the Program for not more than 2 years if VA notified Congress.

Position: VA does not support the bill as written

VA does not support this current bill for clinical, fiscal, empirical, contractual, and technical, and empirical reasons which are elaborated in this following response.

Clinically, existing suicide prevention efforts and strategies are more robust than what would be required by this bill. VA's current efforts incorporate all foundations within the Institute's Program and offers surveillance, prevention and intervention strategies that exceed the Institute's Program. We welcome an opportunity to provide a briefing to the Committee comparing VA's comprehensive approach and programs within suicide prevention to that of the Institute's Program.

VA has made suicide prevention is a top clinical priority and is VA implements a implementing a comprehensive public health approach to with the goal of reaching all Veterans within and outside the healthcare system. This approach is in full alignment with the President's new White House Strategy for Reducing Military and Veteran Suicide, advancing a comprehensive, cross-sector, evidence-informed public health approach with focal areas in lethal means safety, crisis care and care transition enhancements, increased access to effective care (consistent with the VA/

DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide), addressing upstream risk and protective factors and enhanced research coordination, data sharing and program evaluation efforts. The FY 2023 Budget and the FY 2024 Budget request sufficiently supports VA's system of comprehensive treatments and services to meet the needs of each Veteran and the family members involved in the Veteran's care.

In August 2020, VA funded and completed a pilot, through the execution of a one-year contract awarded to the Education Development Center, for the development and implementation of a Zero Suicide Initiative at the Manchester (New Hampshire) VA Medical Center (VAMC). The Manchester VAMC, with the support of the New Hampshire State Suicide Prevention Council, engaged key community agencies across the State in a 9-month online community of practice (CoP). They also engaged in facility level organizational culture and performance related suicide prevention improvement efforts. A technical review of the Manchester VAMC pilot found that the facility did report qualitative improvements. However, when comparing suicide prevention outcomes and suicide prevention key performance indicators, there were no measurable improvements that could be directly attributed to the Zero Suicide processes (and some key performance indicators worsened). Therefore, further resource allocation to advance Zero Suicide was not supported at that time. This conclusion was drawn by both reviewing the performance across several suicide prevention domains and considering other performance improvement supports provided by VHA's public health approach.

Fiscally, the bill's requirements would come at unknown and unaccounted for cost to VA, which would likely require VA to divert resources from other suicide prevention programs and initiatives demonstrating solid, empirical evidence of progress. We welcome a conversation on the Institute's total costs of the Program to comply with the requirements in the bill prior to further action by the Committee. VA would then need adequate time to review and calculate indirect and opportunity costs associated with all phases of program implementation and with costs and cost parameters or assumptions provided by the Institute.

Contractually, the bill would direct VA to form a legally binding monetary agreement with a specific entity, seemingly violating Federal acquisition and procurement principles of open and fair competition. This could result in a greater cost to the Department than we might otherwise incur through full and open competition.

VA is concerned about legislating a specific model using specific entities when defining clinical operations. Suicide prevention is a dynamic field informed by evidence, and VA believes the best approach is to allow VA to continue to adopt a public health model based on proven clinical interventions, established business practices and equitable and transparent exchange of relevant data, rather than prescribing a single approach which predominantly focuses implementation within healthcare settings.

VA has several technical concerns regarding the bill. First, the stated goal of the implementation of the Institute's curriculum is to "improve safety and suicide care" for Veterans, but it is not clear how this would be defined, measured and reported, and over what course of time. Second, the eight metrics VA would have to use to compare the suicide-related outcomes at program sites and other VA medical centers would not be a methodologically valid or statistically valid study design. There are numerous and complex correlated, moderating, mediating, and confounding variables to include or statistically control if valid and reliable comparisons are going to be made isolating the impact of the Program. We could see value in a comparative study of different programs, but the evaluation would need to be carefully reviewed, constructed and implemented by appropriate data analytics and research design subject matter experts.

Finally, as written, the bill would require development and consultation with various stakeholders. This activity may invoke the Federal Advisory Committee Act and require VA to form multiple new Federal Advisory groups. VA recommends amending the bill's language to clarify that consultation activities are exempt from the Federal Advisory Committee Act. In the alternative, the consultation requirements could be removed, which would also address this concern. However, we again emphasize that even with these changes, VA would not support this bill.

VA does not know what the Institute would charge in terms of access to its materials and training resources or the direct and indirect costs to VA associated with implementation and training.

H.R. 1774 VA Emergency Transportation Act

H.R. 1774 would amend 38 U.S.C. § 1725 by replacing the term "emergency treatment" as used throughout the section with the term "emergency services" along with other conforming amendments. The bill would also define the term "emergency serv-

ices" to include both emergency treatment and emergency transportation. The term "emergency transportation" would be defined as transportation of a Veteran by ambulance or air ambulance by a non-VA provider to a facility for emergency treatment or from a non-Department facility where a Veteran received emergency treatment, to a VA or other Federal facility and subject to existing limitations on the duration of emergency treatment.

Position: VA supports, if amended, and subject to the availability of appropriations

This bill is intended to clarify VA's existing authority to pay for ambulance and air ambulance transportation to a facility that provides emergency treatment to an eligible Veteran; it also would require that VA pay or reimburse under 38 U.S.C. § 1725 for ambulance or air ambulance transportation from the non-VA facility where the eligible Veteran received emergency treatment to a VA or other Federal facility. VA already pays for ambulance or air ambulance transportation when payment or reimbursement is authorized under 38 U.S.C. § 1725 (or would have been in certain cases) for emergency treatment provided at a non-VA facility. VA would continue to do so under this bill; however, by defining emergency transportation to include ambulance and air ambulance transportation to a facility for "emergency treatment" in proposed section 1725(h)(2)(A), this bill could be interpreted to also authorize ambulance and air ambulance reimbursement so long as the purpose of the transportation was "for" emergency treatment, even if emergency treatment was not provided. While VA has interpreted current section 1725 to authorize payment for transportation when "emergency treatment" could not be provided due to the death of the patient, it is not clear if the bill is intended to cover the emergency transportation in other scenarios as well.

VA recommends several amendments to this bill. First, section 2(a)(8) of the bill would amend 38 U.S.C. § 1725(a)(2)(A) to replace the phrase "health care provider that furnished the treatment" with "provider that furnished such emergency services"; however, section 2(a)(5) would have already amended this provision to read "health care provider that furnished such emergency services", so the phrase that section 2(a)(8) would amend would not exist. VA recommends section 2(a)(8) strike the phrase "health care". Second, in section 2(a)(11)(B), the use of the phrase "was furnished", should instead be "were furnished".

VA recommends section 1725(h)(2)(B)(i), as well as redesignated (h)(3)(C), include non-Department facilities. VA may be able to interpret the phrase "to a Department...facility" to include a non-Department facility authorized to furnish services by VA, but we believe a clear statement by Congress would make this simpler. This amendment would address situations where, for example, a Veteran has reached the point of stability and no longer requires emergency treatment but needs continued care (e.g., inpatient care) or needs a higher level of care not available at the first facility. With this proposed change, if the Veteran is eligible to elect to receive such care through the Veterans Community Care Program and chooses to do so, under 38 U.S.C. § 1725, VA could reimburse for the Veteran's transport by ambulance or air ambulance from the non-Department facility that furnished emergency treatment to another non-Department facility that would furnish inpatient care, for example. The proposed change would clarify VA's authority to pay for emergency transportation under 38 U.S.C. § 1725 in the case of such a transfer.

We also note for awareness that this bill would not fill the gap in VA's authority to reimburse for transportation of a Veteran by ambulance or air ambulance to a VA facility for emergency treatment in cases where the Veteran is not eligible for such transportation under 38 U.S.C. § 111. The term "emergency transportation" would be defined to mean transport of a Veteran by ambulance or air ambulance by a non-VA provider "to a facility for emergency treatment" (proposed section 1725(h)(2)(A)). However, the term "emergency treatment" would be defined to only apply to "medical care or services furnished in a non-Department facility" (proposed section 1725(h)(3)). This would categorically exclude care or services furnished in a Department facility. If the Committee intended to ensure that Veterans' ambulance transportation costs to both VA and non-VA facilities are covered, further amendments would be needed to achieve that goal. VA can provide technical assistance if desired, to achieve this goal.

Forecasting costs for this section would require additional data gathering and analysis from VA's community care and beneficiary travel programs. VA is working to assemble the necessary data, but VA does not have a cost estimate for this bill at this time.

H.R. 1815 Expanding Veterans' Options for Long Term Care Act

This bill would require VA, beginning not later than 1 year after the date of enactment, to carry out a 3-year pilot program to assess the effectiveness of providing assisted living services to eligible Veterans (at their election) and the satisfaction with the pilot program of the Veterans participating in the program. VA could extend the duration of the pilot program for an additional 3 years if VA determined it was appropriate to do so based on the result of annual reports to Congress and a report by the IG on the pilot program.

In carrying out the pilot program, VA could enter into agreements for the provision of assisted living services on behalf of eligible Veterans with a provider participating under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.) or a State home recognized and certified under 38 C.F.R. part 51, subpart B. VA could not place, transfer, or admit a Veteran to any facility for assisted living services under the pilot program unless it determined that the facility met the standards for community residential care established in 38 C.F.R. §§ 17.61 – 17.72 and any additional standards of care VA may specify. State homes would have to meet such standards of care VA may specify. VA would pay to a State home a per diem for each Veteran participating in the pilot program at the State home at a rate agreed to by VA and the State home. In the case of a facility that is a community assisted living facility, VA would pay to the facility an amount that is less than the average rate paid by VA for placement in a community nursing home in the same VISN and would re-evaluate payment rates annually to account for current economic conditions and current costs of assisted living services. Upon termination of the pilot program, VA would have to provide to all Veterans participating in the pilot program at the time of the termination of the pilot program the option to continue to receive assisted living services at the site they were assigned, at VA expense, and for such Veterans who do not opt to continue to receive such services,

The term "assisted living services" would be defined to mean services of a facility in providing room, board, and personal care for and supervision of residents for the health, safety, and welfare. Eligible Veterans would be defined to mean Veterans who are already receiving nursing home level care paid for by VA, are eligible to receive nursing home level care paid for by VA pursuant to 38 U.S.C. § 1710A, or requires a higher level of care than domiciliary care provided by VA but does not meet the requirements for nursing home level care provided by VA, and are eligible for assisted living services, as determined by VA or meets such additional criteria for eligibility as VA may establish.

Position: VA supports, if amended, and subject to the availability of appropriations

We appreciate that the current version of this bill has addressed a number of the technical concerns we identified with similar legislation in the prior Congress. VA generally agrees that specific authority, particularly in the form of a pilot program, to furnish assisted living services would be a helpful addition to VA's options for long-term care. VA has encountered difficulties within its current authorities in appropriately placing Veterans who may only require assisted living services because these Veterans do not qualify for nursing home care. Moreover, due to shifts in the industry to an assisted living model of care, particularly for patients with dementia, Alzheimer's, or other memory deficits, VA's lack of authority to furnish assisted living services means they have no appropriate option. The pilot authority would allow VA to determine how best to develop a program to support these Veterans' needs. VA supports the protections this bill would include to ensure that Veterans are protected and receiving safe and appropriate care.

While VA supports the intent of this bill, VA recommends several amendments. First, the implementation timeline of 1 year from bill enactment is untenable. VA would need to issue regulations, hire staff, draft and enter into new agreements, and likely develop new systems or processes to support successful implementation. VA recommends providing 2 years from enactment and will require timely and sufficient resources to support the program.

Second, VA seeks clarification in the application of section 2(b)(2)(B). As written, it is unclear whether this section applies to the pilot program as a whole or to each participating VISN. VA cautions that requiring each VISN to meet the provisions of section 2(b)(2)(B) would severely complicate implementation and increase costs as well.

Third, the bill needs to clarify whether the other requirements in 38 U.S.C. §§ 1741 1745 and in VA regulations should apply if the payments to State homes are intended to be accomplished by a grant program. VA has been working to implement section 3007 of the Johnny Isakson and David P. Roe, M.D., Veterans Health Care and Benefits Improvement Act of 2020 (Public Law 116–315) related to per

diem payments for Veterans who do not meet all the requirements for per diem payments for domiciliary care in 38 CFR part 51; we recommend the bill be amended to allow for, but not require (at least not initially) participation of State homes to ensure that the existing efforts to comply with section 3007 are not delayed or interrupted by implementation of this new authority. We further note that selecting a State home for a location could present other issues, as VA does not manage or control State homes. Presumably, VA would need to establish standards and parameters for a program that a Sate home could then opt into or apply to furnish.

Fourth, VA recommends more specificity in section 2(d)(2)(B) in the definition and scope of benefits and participants under this program. As written, section 2(d)(2)(B) would require VA to "enroll" Veterans who no longer wish to participate in the pilot program in other extended care services based on their preference and best medical interest, but VA does not have an enrollment requirement for most VA extended care. It is unclear if the intent of this subparagraph is to require VA to enroll and pay for these Veterans' care in non-VA programs, to establish an enrollment requirement for VA extended care programs, or simply to provide VA care through other means.

Finally, VA seeks clarity regarding part of the definition of "eligible veteran" in section 2(i)(2)(B)(i). In this section, the term "eligible veteran" is defined to mean, in pertinent part, Veterans who are "eligible for assisted living services, as determined by the Secretary." The intent of this provision is unclear and could be interpreted various ways that could create significant and potentially costly implementation challenges. VA would appreciate the opportunity to discuss these technical issues in detail with the Committee.

VA estimates this bill would cost $60.309 million in FY 2024, $62.551 million in FY 2025, $188.195 million over 5 years, and $188.195 million over 10 years. The costs are the same for the 5 and 10-year estimates because this is only a 3-year pilot.

H.R. 2768 PFC Joseph P. Dwyer Peer Support Program Act

H.R. 2768 would require VA to establish a grant program, known as the PFC Joseph P. Dwyer Peer Support Program, under which VA would make grants to eligible entities for the purpose of establishing peer-to-peer mental health programs for Veterans. Eligible entities would be non-profit organizations that have historically served Veterans' mental health needs, congressionally chartered Veterans Service Organizations (VSO), and State, local, or Tribal Veterans service agencies, directors, or commissioners that submit an application to VA containing such information and assurances as VA may require. Grant recipients could receive a grant in an amount not to exceed $250,000. Grantees would be required to use funds to hire Veterans to serve as peer specialists to host group and individual meetings with Veterans seeking non-clinical support, provide mental health support to Veterans 24 hours a day, seven days a week, hire staff to support the program, and carry out a program that meets appropriate standards (including initial and continued training for Veteran peer volunteers, administrative staffing needs, and best practices for addressing the needs of each Veteran served) created by an advisory committee. VA could not require grantees to maintain records on Veterans seeking support or to report any personally identifiable information directly or indirectly to VA about such Veterans. The bill would authorize $25,000,000 to carry out this section during the 3-year period beginning on the date of enactment of this bill.

Position: VA opposes

While VA supports the broad goals of this bill, VA does not believe this bill is necessary and could prove problematic. VA already has the authority to appoint peer specialists at VA medical centers. As of May 2023, VA has more than 1,350 peer specialists working in mental health programs across the Nation, and VA also maintains peer support services through the Veterans Crisis Line that makes peer support services available to Veterans across the country. The proposed bill would place VA in competition with grantees in recruiting and retaining peer specialists and thus frustrate the purposes of already enacted statutory requirements.

VA is already working to comply with requirements under section 401 of the STRONG Veterans Act (Division V of Public Law 117–328) and section 5206 of the Deborah Sampson Act (Title V of Public Law 116–315) to increase staffing for VA peer specialists. In implementing section 506 of the VA MISSION Act of 2018 (P.L. 115–182), VA found that expanding peer specialist services in patient-aligned care teams benefited Veterans and was associated with increased participation and engagement in care. As stated in VA's final report to Congress on its implementation of section 506 of the VA MISSION Act of 2018, peer specialists were highly beneficial to Veterans.

In addition to the conflict this proposed bill would create, we oppose the provision that would prohibit grantees from maintaining records or sharing information with VA as it is contrary to efforts in a number of other grant programs, such as the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, which is designed to facilitate bringing Veterans into VA care. By prohibiting grantees from sharing information with VA, efforts to furnish VA care would be hindered, and such prohibitions would significantly impede any oversight and accountability efforts by VA to ensure the proper use of Federal funds.

VA believes this bill is overly prescriptive in some elements (establishing a cap on the amount of grant awards, defining narrowly the authorized uses of grant funds, requiring an advisory committee to establish standards, etc.) and very vague in others (the term "historically served veterans' mental health needs" is undefined, there are no requirements for grantees specifically enumerated, there is no requirement to provide data on the use of funds for oversight purposes, etc.). The bill is also unclear as to the duration of the program and other key parameters. We object to the unnecessary specificity included in the bill and would note that further detail would be needed to ensure VA could implement this consistent with Congressional intent. While the bill would authorize appropriations beginning on the date of enactment for a 3-year period, VA would be unable to implement this authority on such date, as it would need to engage in rulemaking (which can take approximately 24 months). Consequently, the authorization of appropriations under the bill would expire approximately 1 year after VA could begin implementing the program.

Finally, the bill would require VA to create an advisory committee subject to the Federal Advisory Committee Act, the National Records Act, the Privacy Act, the Freedom of Information Act, and the Government in the Sunshine Act. However, the bill does not provide sufficient guidance to VA to establish, manage, or terminate this committee. The bill would need to include an official name for the committee, the mission authority of the committee, the substantive objectives and scope for the committee, the size of the committee, the official to whom the committee would report, the reporting requirements for the committee, the meeting frequency of the committee, the qualifications for committee members, the types of committee members and their term limits, whether the committee is authorized to have subcommittees, the funding for the committee, and the record keeping requirements of the committee. Alternatively, the bill could strike the requirement to establish an advisory committee and avoid these issues altogether.

H.R. 2818 Autonomy for Disabled Veterans Act

Section 2(a) of H.R. 2818 would amend 38 U.S.C. § 1717 to increase the amount available to eligible Veterans for improvements and structural alterations furnished as part of home health services. In the case of medical services furnished under section 1710(a)(1) or for a disability described in section 1710(a)(2)(C), the amount available for improvements and structural alterations would be increased from $6,800 to $10,000.For all other enrolled Veterans, this amount would be increased from $2,000 to $5,000. Section 2(b) would make this change effective for Veterans who first apply for such benefits on or after the date of enactment. Section 2(c) would provide that a Veteran who exhausts his or her eligibility for benefits under section 1717(a)(2) before the date of enactment would not be entitled to additional benefits by reason of these amendments. Section 3 of the bill would further amend section 1717 to include a new subsection (a)(4) that would require VA to increase on an annual basis the dollar amount in effect under subsection (a)(2) by a percentage equal to the percentage by which the Consumer Price Index (CPI) for all urban consumers (United States city average) increased during the 12-month period ending with the last month for which the CPI data is available. In the event the CPI did not increase during such period, VA would maintain the dollar amount in effect during the previous fiscal year.

Position: VA supports, if amended, and subject to the availability of appropriations

VA recommends the bill remove the distinction between the levels of benefits available to Veterans with a service-connected disability and those without by making all eligible Veterans able to receive a lifetime benefit up to $9,000. The $9,000 amount is appropriate because the most common home improvement and structural alteration to accommodate a disability involves renovation of a bathroom, and the national average cost for a bathroom modification is $9,000. Further, VA recommends an index, such as one focused on construction costs, for determining cost index. VA further notes it is unclear how the adjustment for inflation that would occur as a result of section 3 would affect Veterans who have used but not exhausted their benefits as of the day before the date of enactment, as described in

section 2(c) of the proposed bill. VA recommends the bill include limitations on the number of times a Veteran could use this benefit to ensure appropriate administration of this program, proper use of Federal resources and to avoid disparate effects on similarly situated Veterans. While the benefit is a "lifetime" benefit, VA believes a limited number of disbursements would provide a more equitable program that would also be easier to administer. VA welcomes the opportunity to work with the Committee on language to address these concerns.

The cost for this bill, as written, is estimated to be $33.0 million in FY 2024 of which $4.3 million would be allocated to the TEF, $231.3 million over 5 years of which $40.7 million would be allocated to TEF, and $720.7 million over 10 years of which $40.7 million would be allocated to the TEF.

We estimate the bill, if amended, would costs $29.5 million in FY 2024 of which $3.8 million would be allocated to the TEF, $206.0 million over 5 years of which $36.3 million would be allocated to the TEF, and $640.3 million over 10 years of which $156 million would be allocated to the TEF. For all estimates, TEF allocations are consistent with the methodology used to develop the TEF request in the 2024 Budget.

H.R. 3520 Veteran Care Improvement Act of 2023

Section 2(a) of H.R. 3520 would amend 38 U.S.C. 1703B regarding VA's access standards to expand and codify VA's existing access standards established in regulation at 38 C.F.R. § 17.4040. Specifically, it would create a new section 1703B(a) that would provide that covered Veterans could receive hospital care, medical services, or extended care services under section 1703(d)(1)(D) (the eligibility criterion for the Veterans Community Care Program based on VA's designated access standards) if VA determined, with respect to primary care, mental health care, or extended care services, VA could not schedule an in-person appointment for the covered Veteran with a VA health care provider at a facility that is located less than a 30-minute drive time from the Veteran's residence or during the 20-day period after the date on which the Veteran requests such appointment. With respect to specialty care, covered Veterans could elect to receive community care if VA could not schedule an in-person appointment with a VA health care provider at a facility that is located less than a 60-minute drive from the Veteran's residence or during the 28-day period after the date on which the Veteran requests such appointment. With respect to residential treatment and rehabilitative services for alcohol or drug dependence, covered Veterans could elect to receive community care if VA could not schedule an in-person appointment with a VA health care provider at a facility that is located less than a 30-minute drive from the Veteran's residence or during the 10-day period after the date on which the Veteran requests such appointment. VA could prescribe regulations that establish a shorter drive or time period than those otherwise described above. Covered Veterans could consent to longer drive or time periods, but if they did, VA would have to document such consent in the Veteran's electronic health record and provide the Veteran a copy of that documentation in writing or electronically. In making determinations about scheduling appointments, VA could not consider a telehealth appointment or the cancellation of an appointment unless such cancellation was at the request of the Veteran.

Proposed section 1703B(b) would require VA to ensure that these access standards apply to all care and services (except nursing home care) within the medical benefits package to which a covered Veteran is eligible under section 1703 and to all covered Veterans.

Proposed section 1703B(c) would require VA to review, at least once every three years, the access standards established under the revised section 1703B(a) with Federal entities VA determines appropriate, other entities that are not part of the Federal Government, and entities and individuals in the private sector (including Veterans who receive VA care, VSOs, and health care providers participating in the Veterans Community Care Program (VCCP)). This subsection would also strike section 1703B(g), which allows VA to establish through regulation designated access standards for purposes of VCCP eligibility, as well as other conforming amendments.

Position: VA opposes Section 2

VA is opposed to codification of access standards. Removing the ability of the Secretary to develop and publish such standards for VA diminishes the Secretary's authority to ensure Veterans receive the right care, at the right time. This bill fails to consider other market forces that also impact access to care outside of VA and would not allow VA to consider and incorporate those forces to meet Veterans' needs for timely, high quality care. Moreover, VA cannot support codification of residential treatment and rehabilitative services as proposed in this bill. VA generally supports

establishing a wait-time standard of 10 or fewer days for the delivery of care, although we oppose codifying this in law.

We do, though, have significant concerns with and oppose the 30-minute drive time standard for residential treatment programs, which is inconsistent with industry standards in terms of accessible care. Although we do not have a cost estimate at this time, this standard could result in significantly greater financial costs to VA without any guarantee that Veterans would actually receive care that is closer to home. While Veterans are not eligible to elect to receive care in the community based on the designated access standards, they may be eligible on another basis (such as best medical interest, which can consider distance) and can elect to receive community care. When they do so, current data indicate that Veterans receiving community residential treatment care are traveling 189 miles on average to access such care.

Further, VA operates several different types of residential treatment programs beyond just alcohol and drug dependence (such as programs for posttraumatic stress disorder). It is unclear which, if any, standards established under this section would apply to these other residential treatment programs. Additionally, the exception to nursing home care under proposed subsection (b), which defines the applicability of the standards, creates confusion as to whether there are standards for nursing home care and they are simply not applicable or whether there is no requirement to establish standards for nursing home care. We are unclear as to the intended effect of this change but believe it could simply create more confusion for Veterans and staff alike.

The references to drive times refer only to drive times, not "average driving time", which is the current designated access standard in 38 C.F.R. § 17.4040. It is unclear whether this section is intended to retain that "average driving time" element or if it is intended to establish a requirement that VA calculate actual drive time. We caution that such an approach would be effectively impossible to implement, as actual drive times vary day-by-day and minute-by-minute, and VA must determine eligibility for community care now for an appointment in the future. It is unclear how VA would determine actual drive time in the future. This would represent a step backward for VA in terms of being responsive to Veterans' needs.

VA opposes the provision that, in making determinations about scheduling appointments, prohibits consideration of a telehealth appointment or the cancellation of an appointment unless such cancellation was at the request of the Veteran. VA will take into consideration a Veteran's preference for in-person care as it develops any .

Finally, VA notes that section 2 would require VA to engage in consultation with various stakeholders; this could invoke the Federal Advisory Committee Act and require VA to form multiple new Federal Advisory committees. VA recommends amending the bill's language to clarify that consultation activities are exempt from the Federal Advisory Committee Act. In the alternative, the consultation requirements could be removed, which would also address this concern.

Section 3 of the bill would amend 38 U.S.C. § 1703(a) by adding a new paragraph (5) that would require VA to notify a covered Veteran in writing of the eligibility of the Veteran for care or services under this section within two business days of the date on which the Veteran seeks care or services under chapter 17 and VA determines the Veteran is a covered Veteran. VA could provide covered Veterans with a periodic notification of Veterans' eligibility, and notice could be provided electronically.

Position: VA does not support Section 3

While VA agrees that timely eligibility notification is an integral component of VA's ability to provide Veterans quality care, a statutorily prescribed two-business day notification deadline would be administratively burdensome, especially in cases where notification by telephone or electronic communication is unavailable or in instances of walk-in emergency care. VA personnel would face administrative burdens if they were responsible for making notifications, which would come at additional cost to VA.

It is also unclear what is anticipated as the penalty for non-compliance in any situation where VA was unable to meet this requirement. VA welcomes the opportunity to work with the Committee to modify the process for notifying eligible Veterans to ensure they are notified in the timeliest fashion possible while avoiding some of the barriers that would be created by this section as written.

Section 4 of the bill would amend 38 U.S.C. § 1703(d)(2) by adding new subparagraphs (F) and (G). These amendments would require VA to ensure that criteria developed to determine whether it would be in the best medical interest of a covered Veteran to receive care in the community the preference of the Veteran regarding where, when, and how to seek care and services and whether the covered Veteran requests or requires the assistance of a caregiver or attendant when seeking care or services.

Position: VA does not support Section 4

While this section purports to include additional factors that would be considered by VA clinicians and Veterans when determining whether receiving care in the community is in the Veteran's best medical interest, the wording of these changes create ambiguity and may shift this decision-making from a joint decision to a unilateral one by the Veteran. Specifically, it is unclear whether the "preference of the covered veteran regarding where, when, and how to seek hospital care, medical services, or extended care services" would allow a Veteran unilaterally to determine his or her eligibility for community care if the Veteran stated a preference for community care. If the Veteran can choose to be seen in the community based on this preference, even if the provider did not agree, then by definition, the Veteran would be choosing to receive care that was not in the Veteran's best medical interest (in the judgment of the clinician). If, on the other hand, the Veteran's referring clinician only needed to "consider" the Veteran's preference, but the preference was not determinative, it is not clear that this would have any effect on operations or eligibility, and thus would seem unnecessary. Determinations regarding a Veteran's best medical interest already considers the distance between a provider and the Veteran, the nature of the care or services required, the frequency of the care or services, the timeliness of available appointments, the potential for improved continuity of care, the quality of care, and whether the Veteran would face an unusual or excessive burden in accessing VA facilities.

Further, by including "whether the covered veteran requests or requires the assistance of a caregiver or attendant" as a factor for determining whether it is in the Veteran's best medical interest to receive community, this similarly creates confusion as to how this factor would work in practice. VA agrees that a Veteran's need for an attendant or caregiver is relevant when making a determination as to whether receiving community care is in the best medical interest of the Veteran, and VA already considers this today (see 38 C.F.R. § 17.4010(a)(5)(vii)(E)). However, a Veteran's "request" for a caregiver or attendant does not establish need. The bill language would potentially allow Veterans who may not medically require a caregiver or attendant, but who request one for personal reasons, to qualify for community care.

Ultimately, we do not believe the proposed changes could be implemented as written without fundamentally altering the process for making determinations about Veterans' best medical interest.

Section 5 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (o) that would require VA, if a request for care or services under the VCCP is denied, to notify the Veteran in writing as soon as possible, but not later than two business days, after the denial is made of the reason for the denial and how to appeal such denial using VHA's clinical appeals process. If a denial were made because VA determined the access standards under section 1703B(a) were not met, the notice would have to include an explanation of the determination. Notice could be provided electronically.

Position: VA does not support Section 5

Similar to section 3, VA is concerned that a statutorily prescribed two-business day notification deadline would be administratively burdensome, especially in cases where notification by telephone or electronic communication is unavailable. It is also unclear what is anticipated as the penalty for non-compliance in any situation where VA was unable to meet this requirement. As written, section 5 includes a paradox, proposed 38 U.S.C. § 1703(o)(2) would State that if VA denied a request by a Veteran for care or services through the VCCP because the access standards are not met, VA would have to provide notice and an explanation of the determination. However, if VA was unable to schedule an appointment that met the designated access standards, then the Veteran would be eligible, so there would be no denial. We believe this was intended to apply when VA has determined that the access standards are met, and when a covered Veteran is ineligible for community care, rather than when the access standards are not met. We further note that the

language would only apply to eligibility determinations regarding the access standards and would not apply to determinations regarding any other eligibility criteria.

VA recommends modifying the process for notifying Veterans that VA has determined they are not eligible for community care to ensure they are notified in the timeliest fashion possible while avoiding some of the barriers that would be created by this section as written.

Section 6 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (p) that would require VA to ensure that Veterans were informed that they could elect to seek care or services via telehealth, either through a VA medical facility or through the VCCP, if a health care provider in the VCCP provides such care or services via telehealth and VA determined that telehealth was appropriate for the type of care or service the Veteran seeks.

Position: VA supports section 6, with amendments

As written, the bill would only require that "a" health care provider in the VCCP provide such care or services via telehealth, not necessarily that a provider who actually would furnish the care or services to the Veteran could do so via telehealth. We do not believe this result was the intended result, unless the language is specifically intended only to determine whether a Veteran would be willing to accept telehealth in general. It is unclear whether the bill is intended to ensure that a Veteran who, upon being informed of the option to receive care via telehealth declines to receive such care via telehealth, does not subsequently receive telehealth through the VCCP. If that is the case, that could result in additional costs to VA and could create network adequacy issues, as VA currently allows Veterans who decline VA-administered telehealth to receive telehealth from a community provider. VA welcomes the opportunity to discuss recommended amendments to this section with the Committee. We also would be happy to discuss the potential cost estimates with the Committee and others as needed.

Section 7 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (q) that would prohibit VA from overriding an agreement between covered Veterans and their referring providers regarding the best medical interest of the Veteran to receive care in the community unless VA notified the Veteran and the referring provider in writing that VA could not provide the care or services described in the agreement.

Position: VA does not support Section 7

Referring providers may not always have the specific information needed to know whether receiving community care is in the best medical interest of the Veteran. This section would prohibit reviews or corrections of erroneous use of the best medical interest criterion and would not be appropriate if there are clinical or other changes that might require changes to use of the best medical interest criterion. For example, a referring provider may be unaware of a Veteran's other conditions (such as when test results are pending or a referral with another is still pending) before agreeing that community care would be in the Veteran's best medical interest; other conditions may also arise during the course of treatment that would affect the best medical interest determination for a Veteran.

Moreover, this bill would prevent the reconsideration of a best medical interest determination once it has been made and could consequently negatively impact the course of treatment based on these other factors.

VA is concerned that this section could complicate determinations VA must make on whether the care is necessary and appropriate. This determination must occur prior to determining whether receiving care in the community would be in the Veteran's best medical interest. For example, VA currently requires that any Veteran that is potentially in need of a transplant be entered into the VA TRACER system for evaluation before a determination is made about the provision of the transplant. It is not clear whether this language would impact these determinations, but VA is concerned that it could be interpreted to prevent this type of clinical review.

Section 8 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (r) that would require VA to conduct outreach to inform Veterans of the conditions for care or services under section 1703(d) and (e), how to request such care or services, and how to appeal a denial of a request for such care or services using VHA's clinical appeals process. VA would have to inform Veterans upon their enrollment in VA care, and not less frequently than every two years thereafter, about this infor-

mation, and VA would have to ensure that this information is displayed publicly in each VA medical facility, prominently displayed on a VA website, and included in other outreach campaigns and activities conducted by VA. Section 8(b) would also amend 38 U.S.C. § 6320(a)(2)(A) would be amended to require VA, as part of the Solid Start program, to proactively reach out to newly separated Veterans to inform them of their eligibility for programs of and benefits provided by VA, including how to enroll in the system of annual patient enrollment under section 1705 and the ability to seek care and services under sections 1703 and 1710.

Position: VA does not support Section 8

The provisions of section 8 are already common practice in the VA enrollment process as enrollment prompts automated communications with information about the benefits available to them.

Under the VA Solid Start (VASS) program, VA conducts individualized conversations tailored to the needs of recently separated Service members to increase awareness and utilization of VA benefits and services. VASS calls are not scripted and are driven solely by the needs of the individual at the time of each interaction. Employees supporting VASS have the necessary training and resources to provide information about how to enroll in health care and seek community care for interested Veterans.

As VASS contacts all recently separated Service members, regardless of their character of discharge, some VASS-eligible individuals may not be eligible for VHA benefits, including VCCP. Requiring VASS to discuss these benefits with all

VASS-eligible individuals may create concern or frustration for those recently separated Service members who are not eligible for VHA benefits due to their character of discharge.

VBA must allocate resources to allow for the extended time it would take to discuss these services with each VASS-eligible individual, which may negatively impact the overall program's successful connection rate. VA would require additional funding to support implementation and maintenance of this section.

Section 9 of the bill would amend 38 U.S.C. § 1703(i)(5) to require VA to incorporate, to the extent practicable, the use of value-based reimbursement models to promote the provision of high-quality care. It would further require VA to negotiate with third party administrators (TPA) to establish the use of value-based reimbursement models under the VCCP.

Position: VA supports Section 9

VA currently has efforts underway to incorporate value-based care to improve outcomes and care coordination while lowering costs. However, generally speaking, any negotiations with TPAs or others who have existing contracts or agreements with VA would be subject to bilateral agreement on such terms. While VA may seek to incorporate such changes through negotiation, there is no guarantee that the non-VA party would agree to such terms.

VA does not have a cost estimate at this time because the specific terms and parameters surrounding value-based reimbursement are subject to contract negotiations, and VA cannot predict what reimbursement models would be adopted through such negotiations. We would be happy to discuss the potential cost estimates with the Committee and others as needed.

Section 10 of the bill would amend 38 U.S.C. § 1703D to extend from 180 days to one year the time period for health care entities and providers to submit claims to VA for payment for furnishing hospital care, medical services, or extended care services.

Position: VA does not support Section 10

VA's contracts for community care generally include a 180-day timely filing requirement. Providers are aware of the 180-day timely filing requirement when agreeing to the contracts. Additionally, section 142 of the recently enacted Cleland-Dole Act amended 38 U.S.C. § 1725 to require 180 days for timely filing, which is consistent with current section 1703D. VA believes the 180-day time limit is appropriate and ensures predictability and more accurate claims processing.

We note, though, at present, claims for service-connected emergency care under 38 U.S.C. § 1728 must be filed within two years of the date of service (see 38 C.F.R.§ 17.126), and claims under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) must be filed within one year of the

date of service (see 38 C.F.R. § 17.276). CHAMPVA claims are generally processed separately, and claims under section 1728 represent a relatively smaller number of claims processed by VA. Further, because claims under section 1728 are claims for service-connected care, a longer filing period helps ensure more Veterans receive benefits under this authority, which seems justified based on their service-connected disabilities.

In general, VA believes that a single, consistent filing timeline would make administration easier and more accurate and is concerned about the inconsistency this bill would create between sections 1703D and 1725.

Section 11 of the bill would amend 38 U.S.C. § 1720A to require VA to determine whether a Veteran who requests residential treatment and rehabilitative services for alcohol or drug dependence under section 1720A requires such services not later than 72 hours after receipt of such request.

Position: VA does not support Section 11

VA does not support a statutory requirement in this area. As written, the language is ambiguous as to whether a screening is required within 72-hours or whether care would need to be delivered within the 72-hour period. VA is already moving in the direction of conducting screening within 48-hours of a request of presentation of a need for care. We caution that a hard line in statute can prove difficult to administer in complicated cases (such as when a Veteran is known to need care but is not medically stable, as in the case of a recovering overdose), and the consequences of failure to meet the 72-hour standard are not defined. Further, it is not clear if this is intended to establish eligibility for community care, and if so, how this is reconcilable with the changes proposed to section 1703B under section 2 of this bill.

Section 12 would require VA, acting through the Center for Innovation for Care and Payment, to seek to develop and implement a plan with a TPA to provide incentives to a covered health care provider (defined as a health care provider under section 1703(c) that furnishes care or services under the VCCP and that is served by a TPA), pursuant to an agreement with such TPA, (1) to allow VA and the TPA to see the scheduling system of the provider, to assess the availability of (and to assist in scheduling appointments for) Veterans under the VCCP, including through synchronous, asynchronous, and asynchronous assisted digital scheduling; (2) to complete continuing professional education (CPE) training regarding Veteran cultural competency and other subjects determined appropriate by VA; (3) to improve the rate of the timely return to VA of medical record documentation for care or services provided under the VCCP; (4) to improve the timeliness and quality of the delivery of care and services to Veterans under such program; and (5) to achieve other objectives determined appropriate by VA in consultation with TPAs. The plan would also need to decrease the rate of no-show appointments under the VCCP and consider the feasibility and advisability of appropriately compensating such providers for no-show appointments under the VCCP, and it would need to, within each region in which the VCCP is carried out, to assess needed specialties and to provide incentives to community providers in such specialties to participate in the VCCP.

Position: VA does not support Section 12

VA does not support section 12 for several reasons. First, we do not believe it is necessary to specify the organization, the Center for Innovation for Care and Payment, that would carry out this effort. Second, and related, the Center for Innovation for Care and Payment was established pursuant to 38 U.S.C. § 1703E, which defines specific conditions and parameters associated with some of the work of the Center. Specifically, when the Center carries out a pilot program that requires a waiver approved by Congress, there are limitations in terms of the number of projects, the funding, and specific reporting requirements that attach to such an effort. It does not appear that section 12 would require a waiver proposal, but we believe clarifying this would be important.

Third, VA already has the authority to engage in efforts to support patient scheduling with community providers; indeed, sections 131–134 of the Cleland-Dole Act requires VA to commence a pilot program under which covered Veterans eligible for care through the VCCP may use a technology that has the capabilities specified in section 133(a) to schedule and confirm medical appointments with health care providers participating in the VCCP. Fourth, given the contractual requirements that would be necessary to implement this section, the timeline (submitting a plan with-

in 180 days) would be unrealistic. Fifth, we are concerned that the bill would prohibit VA from penalizing a health care provider or TPA for not carrying out any part of the plan; to the extent the plan is reflected in contract terms, this would seemingly preclude VA's ability to enforce contractual terms. Finally, VA is concerned with the way the specific parameters of this proposal could create contractual relationships between VA and VCCP providers who are part of a TPA's network. Currently, VA has contracts with TPAs, and the TPAs have contracts with individual providers. There is no privity of contract between VA and the TPA's providers, which means these providers are not subject to other requirements associated with Federal contractors. If the intent of the proposed changes is for VA to establish a direct contractual relationship with these providers, or if a relationship was imputed, this could change the obligations imposed upon these providers. There is also the potential that any contractual or other obligations between the provider and VA could conflict with requirements in the contract between the provider and the TPA. We recommend against creating a situation where providers could have conflicting requirements.

Finally, section 13 of the bill would require VA's Office of Inspector General (OIG), as OIG determines appropriate, to assess the performance of each VAMC in appropriately identifying Veterans eligible to elect to receive care through the VCCP; informing Veterans of their eligibility for care and services, including, if appropriate and applicable, the availability of such care and services via telehealth; delivering such care and services in a timely manner; and appropriately coordinating such care and services. OIG would have to commence the initial assessment within one year of enactment.

Position: VA has no objection, defers to OIG.

H.R. 3581 Caregiver Outreach and Program Enhancement Act (COPE Act)

Section 2 of the draft bill would create a new 38 U.S.C. § 1720K, which would authorize VA to award grants to carry out, coordinate, improve, or otherwise enhance mental health counseling, treatment, or support to the Family Caregivers of Veterans participating in the Program of Comprehensive Assistance for Family Caregivers (PCAFC). VA would have to seek to ensure that grants awarded under this section were equitably distributed among entities located in States with varying levels of urbanization. VA would have to prioritize awarding grants that would serve areas with high rates of Veterans enrolled in PCAFC, as well as areas with high rates of suicide among Veterans or referrals to the Veterans Crisis Line (VCL). Grants would have to be used to expand existing programs, activities and services; establish new or additional programs, activities, and services; or for travel and transportation to facilitate carrying out existing or new programs described above. Grant amounts awarded could not exceed 10 percent of amounts made available for grants under this section for the fiscal year in which the grant was awarded. Amounts necessary to support VA's activities under this section would have to be budgeted and appropriated through a separate appropriation account, and VA would have, in the budget justification materials submitted to Congress, have to include a separate statement of the amount requested to be appropriated for that fiscal year for this new separate account. There would be authorized to be appropriated $50 million for each of fiscal years 2023 through 2025 to carry out this section.

Position: VA does not support Section 2

This section, while discretionary, would, if implemented, require significant additional administrative staff and resources to implement and manage these grants. Further, VA has recently begun using clinical resource hubs to provide direct mental health support to Family Caregivers using telehealth (which was an option for mental health support desired by a majority of PCAFC caregiver respondents in previous surveys), and we believe these efforts will help address the intended goal of this section, which is the provision of mental health support to Family Caregivers participating in PCAFC. As utilization of these services through the clinical resource hubs increases, we will continue to identify opportunities to expand (either programmatically or geographically) to address those needs. Further, VA medical centers continue to offer mental health support to Family Caregivers. In the context of existing initiatives, the proposed section 1720K would authorize grants that would supplement existing efforts and would not create new benefits entirely.

VA has several technical concerns with the language in proposed section 1720K. The proposed distribution requirement, specifically requiring VA to "seek to ensure that grants awarded under this section are equitably distributed among entities located in States with varying levels of urbanization", is unclear and would be dif-

ficult to operationalize. Effectively every State has varying levels of urbanization as every State has both urban and rural areas, so the distribution requirement would seem to have no particular effect. If there is an intended outcome—other grant programs, for example, require VA to prioritize the award of grants to States with rural or highly rural populations or to territories or Tribal lands—we recommend this language be revised to State that intent clearly. Otherwise, we recommend its removal. The cap on grant amounts is also unclear, but seems intended to ensure that a single grant does not represent a disproportionate amount of the total grant funds awarded. VA has not had a similar issue with other grant programs and does not believe such a limitation is necessary. Also, the bill would set forth that activities would be budgeted and appropriated through a separate appropriation account. We note that no other VA grant program has a dedicated appropriations account, and it is unclear what would make this grant program unique in this regard. Additionally, the authorization of appropriations, as drafted, only applies to fiscal years 2023 through 2025, which would likely have elapsed by the time VA was ready to implement this authority. Finally, we recommend replacing the term "enrolled" in proposed section 1720K(d)(1) with the term "participating".

Section 3 would require the Comptroller General, within one year of enactment, to submit to Congress a report on the provision of mental health support to caregivers of Veterans. The report would have to include, for caregivers participating in VA's caregiver programs under 38 U.S.C. § 1720G(a) and (b), an assessment of the need for mental health support; an assessment of the options for mental health support in VA facilities and in the community; an assessment of the availability and accessibility of mental health support in VA facilities and in the community; an assessment of the awareness among caregivers of the availability of mental health support in VA facilities and in the community; and an assessment of barriers to mental health support in VA facilities and in the community.

Position: VA has no objection on Section 3, defers to the Comptroller General

While VA generally defers to the Comptroller General on this section, we do note, however, that it is unclear whether the Comptroller General would be able to gather and analyze information to conduct the assessments that would be required by this section. We believe that reframing the assessments to focus on when, where, and why Family Caregivers use mental health support would be more effective and produce more meaningful results.

Conclusion

This concludes my statement. We appreciate the Committee's continued support of programs that serve the Nation's Veterans and look forward to working together to further enhance the delivery of benefits and services to Veterans and their families.

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. 1182, the Veterans Serving Veterans Act of 2023

H.R. 1182, the Veterans Serving Veterans Act of 2023, would amend the Department of Veterans Affairs (VA) Choice and Quality Employment Act and direct the Secretary of Veterans Affairs to establish a vacancy and recruitment database to facilitate the recruitment of certain members of the Armed Forces to satisfy the occupational needs of the VA to establish and implement a training and certification program for intermediate care technicians within the Department.

Specifically, this legislation would amend Section 208 of the VA Choice and Quality Employment Act (Public Law 115–46; 38 U.S.C. 701 note); the VA Secretary shall establish and maintain a single searchable data base (to be known as the Departments of Defense and Veterans Affairs Recruitment Data base) and that with respect to each vacant position, the military occupational specialty or skill that cor-

responds to the position, as determined by the VA Secretary, in consultation with the Secretary of Defense; and each qualified member of the Armed Forces who may be recruited to fill the position before such qualified member of the Armed Forces has been discharged and released from active duty.

The database established regarding each qualified member of the Armed Forces would contain the following information:

- The name and contact information of the qualified member of the Armed Forces;
- The date on which the qualified member of the Armed Forces is expected to be discharged and released from active duty; and
- Each military occupational specialty currently or previously assigned to the qualified member of the Armed Forces.

Information in the data base shall be available to VA offices, officials, and employees to the extent the VA Secretary determines appropriate. The VA Secretary shall hire qualified members of the Armed Forces who apply for vacant positions listed in the database and may authorize a relocation bonus, in an amount determined appropriate by the VA Secretary to any qualified member of the Armed Forces who has accepted a position listed in the database.

The VA Secretary shall implement a program to train and certify covered veterans to work as intermediate care technicians in the department. The VA Secretary shall establish centers at medical facilities selected by the VA Secretary for carrying out the program.

The Veterans Health Administration (VHA) faces rising challenges to meet the needs of a rapidly growing and changing health care system, which is plagued with staffing shortages to provide much needed veteran-centric health care needs. For VHA, this data base and list of potential qualified candidates from the ranks of the Department of Defense would provide another selection pool of qualified and potentially peer support clinical specialists and providers. VHA must be able to not only retain their highly trained staff but aggressively look at all means to successfully recruit highly trained and dedicated professionals to ensure and deliver sustainable quality health care and continual performance improvement for the Nation's veterans.

DAV supports H.R. 1182, in accordance with DAV Resolution No. 056, as it supports a simple-to-administer alternative VHA personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that compete with the private sector and urges VA to consider campaigns to target service members in health care and other appropriate occupations separating from the military and develop systems for expedited hiring and credentialing to onboard them.

H.R. 1278, the DRIVE Act

H.R. 1278, the Driver Reimbursement Increase for Veteran Equity (DRIVE) Act, would increase the mileage reimbursement rate for veterans receiving health care from the Department of Veterans Affairs (VA).

Congress passed legislation in 2010 to set the mileage reimbursement rate at a minimum of $0.41 per mile, which was comparable at the time to rates federal employees were reimbursed for work-related travel. This law also gave the VA Secretary the authority to increase rates going forward to be consistent with the mileage rate for federal employees for the use of their private vehicles on official business, as established by the Administrator of the General Services Administration (GSA). Since the enactment of this law, the VA travel mileage reimbursement rate has not kept pace with increasing gas prices and costs of auto maintenance and insurance, which have significantly increased in the most recent years. Meanwhile, the GSA rate has increased over time to $0.655 per mile.

According to the U.S. Department of Energy (DOE), the average price for a gallon of regular gas during the week of March 1, 2010, when VA's mileage rate was last increased, was $2.671 per gallon. During the week of February 13, 2023, the average was $3.390 per gallon, and on the West Coast, it was $4.106 per gallon.

The DRIVE Act would require the VA to ensure the Beneficiary Travel reimbursement rate is at least equal to the GSA reimbursement rate for federal employees. This will ensure VA's reimbursement rates keep up with the cost of inflation and properly account for fluctuations in gas prices over time.

Veterans who are seeking care for service-connected conditions or veterans with service-connected conditions rated at least 30 percent are among veterans who are eligible for beneficiary travel pay—which may include reimbursement for mileage, tolls and additional expenses, such as meals or lodging.

Unfortunately, the current mileage rates for beneficiary travel do not always cover the actual expenses for gas and the associated costs of using a personal vehicle. The difference in the current mileage rate for reimbursement for veterans (41.5 cents) compared to federal employees using personal vehicles for business (65.5 cents) highlights the inadequacy of the rate for veterans' travel. Such expenses may serve as a barrier to care, especially when gas prices are high. However, the DRIVE Act would tie veterans' mileage reimbursement to the rate of government employees receive for using their personal vehicles for government business.

Veterans should not have to choose between getting the care they've earned and deserve, and the rising cost of travel to access their needed care. This legislation would provide much needed improvement by ensuring that veterans are not burdened with travel expenses, in particular low-income veterans and rural area veterans who heavily depend on VA's travel reimbursement program.

DAV supports H.R. 1278, the DRIVE Act, in accordance with Resolution No. 432, which calls for adopting the General Services Administration increased mileage rate for veterans' beneficiary travel.

H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023

H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023, would improve suicide and mental health care for veterans by launching the Zero Suicide Initiative Pilot Program at the Department of Veterans Affairs (VA).

In 2019, there was an average of more than 17 U.S. veterans dying from suicide per day at a rate 52.3 percent higher than non-veterans. 40 percent of veteran suicides were among active VA patients. For veterans who have served since September 11, 2001, the rate is even more alarming, with 30,117 active-duty service members and veterans dying by suicide, over four times the number of combat deaths over the past two decades. These statistics support the need to pilot alternative intervention methods at VA facilities to improve veteran care, diminish the risk of suicide, and help keep safe those who have sacrificed to serve our Nation.

Congress and the VA must do everything in their power and authority to address the epidemic of veteran suicide. Every day, 17 veterans take their own lives, and we must work collectively until we get that number down to zero. Our nation has an obligation to ensure that our veterans get the health care, including mental health care, they need.

This legislation would initiate pilot program to implement the Zero Suicide Institute curriculum to improve veteran safety and suicide care that stems from the Henry Ford Health Care System, built on the belief that all suicides are preventable through proper care, patient safety, and system-wide efforts. The model has delivered clear decreases in suicide rates through innovative care pathways to assess and diminish suicide risk for patients across care systems. In consultation with experts and veteran service organizations, the VA Secretary would select five medical centers to receive training and support under the pilot program to demonstrate the effectiveness of the Zero Suicide Framework to better combat suicides across the entire VA.

The VA Zero Suicide Demonstration Project Act would bolster clinical training, assessments, and resources to test the effectiveness of implementing the Zero Suicide Model at five VA centers. This model has proven successful in decreasing suicide rates in other health care settings through innovative care pathways, as noted in the Henry Ford Zero Suicide Prevention Guidelines.

Losing one service member or veteran to suicide is one too many. Our veterans have served our Nation, and they have earned the right to affordable, accessible and high-quality VA mental health care. This bipartisan legislation will take a positive step by establishing the Zero Suicide Initiative Pilot Program and bolstering the mental health care services that our hero veterans receive.

DAV supports H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023, in accordance with DAV Resolution No. 059, which calls for legislation to support program improvements, data collection and reporting on suicide rates among service members and veterans; improved outreach through general media for stigma reduction and suicide prevention; sufficient staffing to meet demand for mental health services; and enhanced resources for VA mental health programs.

H.R. 1774, the VA Emergency Transportation Act

H.R. 1774, VA Emergency Transportation Act, would reimburse veterans for the cost of emergency medical transportation to a federal facility.

The Veterans Transportation Service (VTS) provides safe and reliable transportation to veterans who require assistance traveling to and from VA health care fa-

cilities and authorized non-VA health care appointments. This program offers these services at little or no cost to eligible veterans.

VA's Beneficiary Travel (BT) program reimburses eligible veterans for costs incurred while traveling to and from VA health care facilities. The BT program may also provide pre-approved transportation solutions and arrange special mode transportation (SMT) at the request of VA. Veterans may be eligible for common carrier transportation (such as bus, taxi, airline or train) under certain conditions.

The Highly Rural Transportation Grants (HRTG) program provides grants to VSOs and State veteran service agencies. The grantees provide transportation services to veterans seeking VA and non-VA approved care in highly rural areas.

Since 1987, DAV has donated 3,665 vehicles to VA and Ford Motor Co. has donated 256 vehicles at a cost of more than $92 million. DAV operates a fleet of vehicles around the country to provide free transportation to VA medical facilities for injured and ill veterans. DAV stepped in to help veterans get the care they need when the federal government terminated its program that helped many of them pay for transportation to and from medical facilities. The vans are driven by volunteers, and the rides coordinated by more than 156 DAV Hospital Service Coordinators around the country.

However, none of the above transportation services address the needs during a medical emergency to seeking immediate medical attention that was reasonably expected to be hazardous to life and health.

This legislation would amend Section 1725 of title 38, United States Code by redefining emergency treatment as services and that such services include emergency treatment and emergency transportation. The bill would codify emergency transportation to mean transportation of a veteran by ambulance or air ambulance by a non-Department provider to a facility for emergency treatment; or from a non-Department facility where such veteran received emergency treatment to a Department or other federal facility, which would expand access and eligibility to much needed service for reimbursement of emergency care related to ambulance transportation.

DAV supports H.R. 1774, in accordance with DAV Resolution No. 148, which supports legislation to simplify the eligibility for urgent and emergency care services paid for by the VA and urges the Department to provide a more liberal and consistent interpretation of the law governing payment for urgent and emergency care and reimbursement to veterans who have received emergency care at non-VA facilities.

H.R. 1815, the Expanding Veterans' Options for Long Term Care Act

H.R. 1815, the Expanding Veterans' Options for Long Term Care Act, would require the Secretary of Veterans Affairs to carry out a pilot program to provide assisted living services to rapidly growing population of aging or disabled veterans who are not able to live at home.

This legislation would require the Secretary of Veterans Affairs to carry out a three-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans who are currently receiving nursing home care through the department in not fewer than six VA Veterans Integrated Service Networks.

Title 38, United States Code, subsection 1720C(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."

Over the next two decades, an aging veteran population, including a growing number of service-disabled veterans with specialized care needs, will require long-term care (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 VA the 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. 1815, in accordance with DAV Resolution No. 016, which supports legislation to improve the VA's program of long-term services and supports for service-connected disabled veterans irrespective of their disability ratings, and urges the Department to ensure each VA medical facility is able to provide service-connected disabled veterans timely access to both institutional and noninstitutional long-term services and supports.

H.R. 2683, the VA Flood Preparedness Act

H.R. 2683, the VA Flood Preparedness Act, would authorize the Secretary of Veterans Affairs to make certain contributions to local authorities to mitigate the risk of flooding on local property adjacent to VA medical facilities.

This legislation would amend Section 8108 of title 38, United States Code, by adding language to mitigate the risk of flooding, including the risk of flooding associated with rising sea levels adjacent to VA medical facilities.

The bill would require the VA Secretary to submit to the House and Senate Veterans' Affairs Committees a report that includes an assessment of the extent to which each medical facility is at risk of flooding, including the risk of flooding associated with rising sea levels; and whether additional resources are necessary to address the risk of flooding at each such facility.

DAV does not have a specific resolution to authorize the VA Secretary to make certain contributions to local authorities to mitigate the risk of flooding on local property adjacent to medical facilities of the VA as outlined in H.R. 2683 and takes no formal position on this bill.

H.R. 2768, the PFC Joseph P. Dwyer Peer Support Program Act

H.R. 2768, the PFC Joseph P. Dwyer Peer Support Program Act would require the Secretary of Veterans Affairs (VA) to establish a grant program to be known as the "PFC Joseph P. Dwyer Peer Support Program" under which the Department shall make grants to eligible nonprofit organization having historically served veterans' mental health needs, congressionally chartered veterans service organization and state, local, or tribal veteran service agency, director, or commissioner for the purpose of establishing peer-to-peer mental health programs for veterans.

The recipient of a grant would receive an amount that does not exceed $250,000 and would be required to carry out a program that meets the standards to hire veterans to serve as peer specialists to host group and individual meetings with veterans seeking nonclinical support; provide mental health support to veterans 24 hours each day, seven days each week; and hire staff to support the program.

The VA Secretary would be required to establish an advisory committee for the purpose of creating appropriate standards applicable to programs established using grants under this section. The standards would include initial and continued training for veteran peer volunteers, administrative staffing needs, and best practices for addressing the needs of each veteran served, with an authorized appropriation of $25,000,000 to carry out the program during the 3-year period.

Over a century of service, DAV's main goal has been to provide the best, most professional claims representation to all injured and ill veterans and their families and survivors. An integral part of that goal is fielding a knowledgeable, well-trained nationwide corps of national and transition service officers who can extend our advocacy and outreach to those who need our services not only as fellow veterans but also injured/ill veterans who have navigated and use the VA. This has provided an opportunity to build trust in not only the benefits claims/appeals process but also the confidence of the quality of care VHA provides to include mental health care, through our own personal experiences we share as veterans through our advocacy of being service officers. This relationship of veterans serving veterans has assisted in bridging the complexity and bureaucracy of the VA benefits and health care systems for fellow veterans to know they are not alone with their VA journey.

Expanding peer specialist support through to eligible nonprofit organization having historically served veterans' mental health needs, congressionally chartered veteran service organization and state, local, or tribal veteran service agency, director, or commissioner can be of great support to the veterans and to the VA.

Trained peer specialists can help veterans to reach identified personal goals for their recovery and wellness. Peer specialists serve as role models to veterans. And can share their personal recovery stories, model skills that help recovery, help with

personal goal setting and problem solving, help learn new coping strategies and improve their self-management over their mental health problems.

DAV supports H.R. 2768, in accordance with DAV Resolution No. 059, which calls for legislation to support mental health program improvements, data collection and reporting on suicide rates among service members and veterans.

H.R. 2818, the Autonomy for Disabled Veterans Act

H.R. 2818, the Autonomy for Disabled Veterans Act, would increase the amount of funding available to disabled veterans for improvements and structural alterations provided to them by the VA for home improvements related to their disability.

Veterans who need and receive Home Improvements and Structural Alterations (HISA) grants because of a service-connected disability receive up to $6,800 and those who are rated 50 percent service connected or greater may receive the same amount even if a modification is needed because of a nonservice-connected disability. Veterans who are not service connected but are enrolled in the VA health care system can receive up to $2,000 for needed home modification. These are the maximum amounts an eligible veteran can receive in their lifetime. HISA rates have not changed since Congress last adjusted them in 2010. However, the cost of home modifications and labor has risen more than 40 percent during the same timeframe.

This bipartisan legislation would increase the amount of funding for VA grants for disabled veterans to make necessary modifications to their homes to fit their needs, including wheelchair ramps, structural changes, medical equipment, and would adjust the amount to account for inflation.

Veterans have made incredible sacrifices for our nation's freedom and bear the scars of their service every day. Therefore, it is only fitting that this Nation, Congress and VA keep the promise to ensuring that they are adequately provided for and to ensuring that they can all lead high quality lives.

DAV supports H.R. 2818, in accordance with DAV Resolution No. 326, which calls for a reasonable increase in HISA benefits for veterans.

H.R. 3520, the Veterans Care Improvement Act of 2023

H.R. 3520, the Veterans Care Improvement Act of 2023, would make numerous changes to the Veterans Community Care Program that offers veterans the option to use non-VA health care providers when VA is unable to provide medically necessary care in a timely or accessible manner.

Section 2 of the bill would codify current access standards that VA adopted via regulation as required by the VA MISSION Act of 2018. Current access standards for primary care, mental health care, and extended care are 20 days waiting time or 30 minutes driving time; access standards for specialty care are 28 days waiting time or 60 minutes driving time. As required by the VA MISSION Act, the department reviewed those access standards in 2021 and made no changes to them.

This section would add a new access standard for residential treatment and rehabilitative services for alcohol or drug dependence: 10 days waiting time or 30 minute driving time.

As history has shown, establishing arbitrary or unachievable access standards does not improve health outcomes. We are not convinced that codifying already existing access standards, and creating new ones for drug and alcohol treatment, while at the same time limiting future regulatory flexibility to adjust them, will lead to better health outcomes.

In addition, this section would remove the requirement that VA provide veterans with, "...relevant comparative information that is clear, useful, and timely, so that covered veterans can make informed decisions regarding their health care."

DAV believes that providing comparative information about the quality and timeliness of care is critical for veterans to make truly informed decisions about where to receive their care.

Section 3 would add a new requirement that VA provide written notification of community care eligibility to all veterans who seek care from VA or who VA determines are eligible for care from VA. We have concerns about the cost and administrative burden for this requirement.

Section 4 would add a new provision to require the VA to give consideration to the preference of each veteran seeking community care. It also requires VA to give consideration to whether a veteran has a caregiver when determining eligibility for community care. It is not clear how or why VA would consider a caregiver in determining community care eligibility.

Section 5 would require VA to provide formal notification in writing within 2 days of every determination that a veteran is not eligible for community care.

Section 6 would require VA to inform veterans eligible for community care of options for telehealth care, when considered medically appropriate, both from VA and from community care providers.

Section 7 would mandate that a "best medical interest" determination by a veteran and their referring physician to provide that veteran medical care through a community provider cannot be overridden by any VA official, unless VA is legally prohibited from providing that care.

Section 8 would create new outreach requirements for VA to notify all enrolled veterans of how to request community care and how to file clinical appeals if they are not found eligible for community care. Along with public outreach efforts, VA would have to repeat its direct outreach to all veterans every two years.

Section 9 would mandate that VA begin using value-based reimbursement models in the Veterans Community Care Program.

Section 10 would extend the length of time community providers are allowed to submit claims to VA for payment from six months to one year following the date they provided care to a veteran.

Section 11 would require that VA determinations about whether veterans requesting residential treatment or rehabilitative services for alcohol or drug dependence be made within 72 hours after receiving such a request.

Section 12 would create a pilot program to provide incentives to community care providers who commit to meeting certain objectives to increase their participation in the community care program. However, VA would be prohibited from penalizing a participating provider, or third party administrator overseeing the provider, if they fail to meet the objectives of the pilot program.

Section 13 would require an assessment by the VA Inspector General three years after enactment of the law to assess the performance of each VA medical center in identifying and informing veterans eligible for the community care program, including telehealth, as well as delivering and coordinating such care.

While DAV strongly supported the VA MISSION Act and the creation of the Veterans Community Care Program, we have questions and concerns about some sections of this legislation.

The new notification and outreach requirements in the bill could add significant administrative burden and expense to VA's health care providers and place additional strain on VA's health care budget absent new and dedicated resources for those purposes. We also have serious concerns about whether a value-based reimbursement model for community care would improve the quality of care; particularly since VA has never been able to establish quality standards for private sector health care providers.

We certainly agree that whenever and wherever VA is unable to provide timely, accessible, and high-quality care to enrolled veterans, VA must provide other health care treatment options. At the same time, we believe it is critical to strengthen and sustain the VA health care system that millions of veterans choose and rely on for all or most of their care. As numerous studies continue to show, the care provided by VA is equal to or better than private sector care on average. For this reason, VA must remain the primary provider and coordinator for enrolled veterans' medical care. While we support the intention of improving the VA community care program, we do not support moving this legislation forward at this time.

H.R. 3581, the Caregiver Outreach and Program Enhancement (COPE) Act

H.R. 3581, the Caregiver Outreach and Program Enhancement (COPE) Act, would increase mental health resources available to caregivers who care for our nation's veterans.

Currently, the VA Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) provide certifications and resources to veterans' caregivers.

Under PGCSS, general caregivers are defined as any person who provides personal care services to a veteran enrolled in VA health care who needs assistance with one or more activities of daily living and needs supervision or protection based on symptoms or residuals of neurological impairment or other impairment or injury.

General caregivers have access to training and support through online, in-person, and telehealth sessions; skills training focused on caregiving for a veteran's unique needs; individual counseling related to the care of the veteran; and respite care, giving caregivers short breaks.

The PFCAC program specifically targets family members or close friends who decide to take on caregiver responsibility for veterans. While its requirements are more stringent, the PFCAC provides stipends to caregivers that meet these requirements (in addition to the resources given to general caregivers).

The COPE Act would authorize the VA to provide grants to organizations whose mission is focused on the mental health care of participants in the PFCAC. This legislation would increase mental health resources available to caregivers through grant programs for entities that support caregiver mental health and well-being. Additionally, it requires that the VA must provide outreach to registered caregivers, as well as provide specific directives for meeting the needs of underserved populations.

DAV supports H.R. 3581, in accordance with DAV Resolution No.082, which calls for legislation to support mental health programs to provide psychological and mental health counseling services to family members of veterans suffering from post-deployment mental health challenges or other service-connected conditions.

This concludes my testimony on behalf of the DAV.

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 AND DRAFT LEGISLATION"

JUNE 21, 2023

EXECUTIVE SUMMARY

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H.R. 2768 – PFC Joseph P. Dwyer Peer Support Program Act, *pg 8*	**Support**
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TESTIMONY OF
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"PENDING AND DRAFT LEGISLATION"

JUNE 21, 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. 1182 – Veterans Serving Veterans Act of 2023

To amend the VA Choice and Quality Employment Act to direct the Secretary of Veterans Affairs to establish a vacancy and recruitment database to facilitate the recruitment of certain members of the Armed Forces to satisfy the occupational needs of the Department of Veterans Affairs, to establish and implement a training and certification program for intermediate care technicians in that Department, and for other purposes.

The Department of Veterans Affairs (VA) Intermediate Care Technician (ICT) program was established to address the growing demand for healthcare professionals in the VA system by leveraging our service branches frontline medical specialists: medics and Navy Corpsman. Created in 2012, the scope of practice for the role of an ICT is more advanced than a traditional VA Emergency Medical Technician (EMT). ICT requirements are configured for the medic and corpsmen skill set to provide a high-level clinical support to nurses and physicians. Additionally, the position was designed as an initial entry springboard for qualified veterans to explore further

career opportunities in healthcare.[1] Unfortunately, the program is continuing to be underutilized by veterans, with only 400 ICTs hired as of 2021.[2]

Reports from our Legionnaires who are involved in VA facilities at the state level suggest that the reason for this is not a lack of quality candidates, but rather process and pipeline barriers. For a Veterans Health Administration (VHA) facility to hire one person for a clinical position it can involve up to 18 steps — from getting approval for the job posting to running credential checks — and can take from four to eight months to complete. By that time, candidates have often accepted a job elsewhere.

The *Veterans Serving Veterans Act of 2023* would provide additional resources to this program, by mandating the Department of Defense and VA establish a recruitment database of available VA vacancies corresponding to military occupational specialties with relevant skillsets to the positions. Further, this legislation would reify the ICT program in statute, mandating the Secretary establish centers at VA medical facilities to train and certify veterans to work as ICTs.

The American Legion applauds Resident Commissioner González-Colón for this legislation; still, there is concern that it may exclude qualified Coast Guard Health Services Technicians. These Guardsmen are trained in providing emergency medical care similar to their sister branch servicemembers, however, they are a part of the Department of Homeland Security (DHS). Accordingly, The American Legion recommends amending this legislation to include DHS in federal collaboration to establish a recruiting database.

Through Resolution No. 338: *Support Licensure and Certification of Servicemembers, Veterans and Spouses*[3], The American Legion supports efforts to eliminate employment barriers that impede the timely and successful transfer of military job skills to the civilian labor market.

The American Legion supports H.R. 1182 *with amendments.*

H.R. 1278 – DRIVE Act

To amend title 38, United States Code, to improve the rate of payments provided by the Secretary of Veterans Affairs for beneficiary travel.

The Department of Veterans Affairs (VA) provides reimbursement for travel to health facilities to veterans that are at least 30% service-connected disabled, receiving VA pensions, or annual income below the maximum rate for VA pensions on a per mile basis. The reimbursement rate has been historically lower than the suggested rate set forth by the General Services Administration (GSA), having been modified less than 5 times since it was enacted in law. In 2010, a change was

[1] Snyder, C. "Pathways for Military Veterans to Enter Healthcare Careers." University of Washington Center for Workforce and Health Studies. May 5, 2016. https://depts.washington.edu/fammed/chws/wp-content/uploads/sites/5/2016/05/Pathways_for_Military_Veterans_FR_2016_May_Snyder.pdf. Unless otherwise noted, all links accessed June 15, 2023.

[2] "ICT Program Brief." Department of Veterans Affairs (2022). https://www.vaforvets.va.gov/vaforvets/docs/ICT-Program-Brief-PP0122.pdf

[3] The American Legion Resolution No. 338: *Support Licensure and Certification of Servicemembers, Veterans and Spouses* https://archive.legion.org/node/486

made to require this benefit to be maintained conforming to the minimum GSA rate for reimbursement. However, in the 15 years since this change, the rate has not been updated once. The current rate paid by the VA is $0.415 per mile[4], while the GSA has risen to $0.655 per mile as of January 2023.[5]

The American Legion believes this benefit is vital to ensure our nation's veterans can seek the care needed to ensure their whole health is a priority. A simple reimbursement can determine if the veteran can access the healthcare afforded to them to treat their service-connected disabilities without any additional hardship. The lack of a consistent and reliable mechanism to periodically adjust the per mile authorization for beneficiary travel creates an injustice and an unfair economic burden that will only grow in time. It is incumbent that Congress addresses this disparity sooner rather than later.

Through Resolution No. 62: *Veterans Transportation System and Benefits Travel,*[6] The American Legion supports periodically increasing the per mile reimbursement rate at a reasonable and acceptable level.

The American Legion supports H.R. 1278 *as currently written.*

H.R. 1639 – VA Zero Suicide Demonstration Act of 2023

To direct the Secretary of Veterans Affairs to establish the Zero Suicide Initiative pilot program of the Department of Veterans Affairs.

The issue of veteran suicide has persisted as a severe and growing crisis within our communities. In 2020, an alarming 6,146 veterans tragically ended their own lives. This statistic underscores the critical need to address this problem more effectively and urgently.[7] Traditional methods of mental health support and suicide prevention within the Department of Veterans Affairs (VA) have proven less than adequate, demonstrating a dire need for innovative, robust, and research-backed approaches to address this crisis.

The American Legion started the "Be the One" campaign to encourage mental health discussions without stigma, bolstering community resources and peer-to-peer support among veterans.[8] We stand firm in our commitment to mitigate this issue and support measures that facilitate quality mental health care and suicide prevention for veterans. The *VA Zero Suicide Demonstration Act of 2023* directs the establishment of the Zero Suicide Initiative pilot program, signifying a potential

[4] "Reimbursed VA travel expenses and mileage rate." Department of Veterans Affairs (2021). https://www.va.gov/resources/reimbursed-va-travel-expenses-and-mileage-rate/#mileage-reimbursement-rate
[5] "Privately Owned Vehicle (POV) Mileage Reimbursement Rates." General Services Administration (2021). https://www.gsa.gov/travel/plan-book/transportation-airfare-pov-etc/privately-owned-vehicle-mileage-rates
[6] The American Legion Resolution No. 62 (2016): *Veterans Transportation System and Benefits Travel* https://archive.legion.org/node/313
[7] "National Veteran Suicide Prevention Annual Report." Department of Veterans Affairs (2022). https://www.mentalhealth.va.gov/docs/data-sheets/2022/2022-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-508.pdf
[8] Be the One. American Legion (2023). https://www.legion.org/betheone/about

breakthrough in our collective efforts to curtail this grave issue. The program instructs the Secretary of Veterans Affairs to implement a curriculum developed by the Zero Suicide Institute of the Education Development Center. It lays out a comprehensive 10-week program that includes training at the Zero Suicide Academy, mandates data collection for continuous quality improvement, and focuses on enhancing the skills of the staff dealing with patients at risk of suicide. Furthermore, this initiative aims to be operational at five VA medical centers, extending its reach to veterans living in rural and remote areas.

The American Legion stands in strong support of this legislation. We recognize and affirm the bill's potential to deliver a robust, evidence-based, and comprehensive approach to suicide prevention. Our endorsement is founded on the program's promise to provide quality mental health services, enhance the competence of the workforce, and improve the quality of life for our veterans.

Through Resolution No. 20: *Suicide Prevention Program*, The American Legion supports legislation analyzing best practices in veteran suicide prevention not currently used by the Department of Defense or the Department of Veterans Affairs for the purpose of encouraging aforementioned government agencies to adopt them.[9]

The American Legion supports H.R. 1639 *as currently written.*

H.R. 1774 – VA Emergency Transportation Act of 2023

To amend title 38, United States Code, to reimburse veterans for the cost of emergency medical transportation to a Federal facility, and for other purposes

The passage of the MISSION Act gave eligible veterans greater access to healthcare in the community, to include covering the costs for episodes of authorizing emergency treatment under Title 38 Code of Federal Regulations (CFR) §17.4020(c). The American Legion supports the VA Emergency Transportation Act and has worked extensively with The Department of Veterans Affairs (VA) to amend its rules on medical emergency transportation, to include air emergency transportation, in the episode of care. Too often, veterans are being charged and billed for emergency transportation and services from private healthcare providers, now VA is finalizing a new rule, published February 22 and took effect April 24, 2023 that would cover those past costs and reimburse veterans going forward.[10]

The American Legion agrees VA should cover the costs of the episodes of medical emergency services, that also includes air and land transportation. The bill would amend title 38, United States Code, to reimburse veterans for the cost of emergency medical transportation by changing 'emergency transportation' to 'emergency services' so that the emergency transportation is all

[9] The American Legion Resolution No: 20 (2018): *Suicide Prevention Program* https://archive.legion.org/node/3455

[10] Miller, A. "Veterans' Emergency Room Bills Could Get Repaid by VA Thanks to Change." Military.com, March 1, 2023. https://www.military.com/daily-news/2023/03/01/veterans-emergency-room-bills-could-get-repaid-va-thanks-change.html

inclusive of the emergency services provided and The American Legion supports through Resolution No. 76: *Veterans Emergency Room or Urgent Care Facility Relief.*[11]

The American Legion supports H.R. 1774 *as currently written.*

H.R. 1815 – Expanding Veterans' Options for Long Term Care Act

To require the Secretary of Veterans Affairs to carry out a pilot program to provide assisted living services to eligible veterans, and for other purposes.

In 2019, The Government Affairs Accountability Office (GAO) testified that the number of qualifying service-connected veterans whom VA is required to cover for nursing home care is projected to double from 500,000 to 1 million between 2014 and 2024.[12] While VA is aware that the majority of veterans are not entitled to "mandatory nursing home eligibility" (i.e., 70 percent disability rating; plus around-the-clock 24-hour nursing care), VA does acknowledge that approximately 80 percent of the aging veteran population will need assistance in the form of long-term services and supports (LTSS), especially for those who were divorced, have no children, estranged from their families, or live great distances from their family.[13]

It is concerning that so many veterans will require LTSS. GAO reported that VA has extensive waiting lists and struggles to meet the ever-growing demand for its array of long-term services and supports due to systemic staffing shortages of VA nursing assistants, health technicians, and geriatric specialists.[14] It would be more compassionate and reasonable to allow VA to enter into purchased care agreements for veterans who exceed the requirements for domiciliary care yet are not debilitating enough to meet the requirements for nursing home placement. As it currently stands, VA is still restricted from covering "room and board fees" at State Veterans Homes or privately-owned Assisted Living Facilities "—a policy that precludes veterans from utilizing this long-term care option."

The *Expanding Veterans' Options for Long Term Care Act* will ensure that aging veterans in between tiers of care can be placed in a supportive assisted living setting, where they can safely remain and thrive before the transitional need of a higher, institutionalized care setting (i.e., nursing home facility).

The American Legion strongly believes that veterans, and their families, are best served when their long-term care needs are promptly met while also honoring their self-autonomy and giving them the choice to remain within their local communities. This is especially true when aging veterans get closer to needing end-of-life care.

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[11] The American Legion Resolution No. 76 (2017): Veterans Emergency Room or Urgent Care Facility Relief," American Legion, Aug. 22-24, 2017, https://archive.legion.org/node/623

[12] Silas, S. "VA Health Care: Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand." United States Government Accountability Office. February 1, 2020. https://www.gao.gov/assets/gao-20-284.pdf.

[13] "Elderly Veterans." Department of Veterans Affairs. February 1, 2020. https://www.benefits.va.gov/persona/veteran-elderly.asp#top.

[14] VA Faces Challenges in Meeting Demand for Long-Term Care." United States Government Accountability Office. GAO-20-463T. March 3, 2020. https://www.gao.gov/products/gao-20-463t

Through Resolution No. 20: *Home and Community-Based Services and Veteran Choice to Age in Place*, The American Legion supports legislation to address the needs of our ever-growing and aging veteran population if an approved and accredited agency provides the long-term services and support.[15]

The American Legion supports H.R. 1815 *as currently written.*

H.R. 2683 – VA Flood Preparedness Act

To amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to make certain contributions to local authorities to mitigate the risk of flooding on local property adjacent to medical facilities 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. As a large grassroots organization, The American Legion takes positions on legislation based on resolutions passed by the membership or in meetings of the National Executive Committee. With no resolutions addressing the provisions of the legislation, The American Legion is researching the subject and working with our membership to determine the course of action which best serves veterans.

The American Legion has no current position on H.R. 2683.

H.R. 2768 – PFC Joseph P. Dwyer Peer Support Program Act

To authorize the Secretary of Veterans Affairs to make grants to State and local entities to carry out peer-to-peer mental health programs.

Peer support is a well-established pathway to reduce vulnerability to stress and depression by emphasizing strengths and coping resilience to overcome trauma.[16] In March 2019, The American Legion launched our national "Buddy Check" program in which we ask our Legionnaires to conduct veteran outreach as part of their daily routine.[17]

After witnessing it's positive effects in its first year and potentially life-saving in 2020, through the COVID-19 pandemic and as winter months drew near, affecting the mental health and well-being of isolated veterans, we worked with both chambers of Congress to draft legislation to bring the "Buddy Check Week" concept to the Department of Veterans Affairs (VA), which was included in the Consolidated Appropriations Act for Fiscal 2023.[18]

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[15] 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

[16] Mercier, A. et al., (2023). Peer Support Activities for Veterans, Serving Members, and Their Families: Results of a Scoping Review. National Library of Medicine. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9964749/

[17] "Buddy Check." The American Legion. https://www.legion.org/buddycheck

[18] "American Legion welcomes 'victories for veterans' in budget agreement". American Legion. December 23, 2022. https://www.legion.org/legislative/257781/american-legion-welcomes-%E2%80%98victories-veterans%E2%80%99-budget-agreement

Just as the VA can utilize lessons from The American Legion, so to can it scale successes of smaller community programs. The PFC Joseph P. Dwyer Peer Support Program, which is currently funded by New York cities and townships, has been highly successful across the state, where the program has expanded to 11 counties.[19] One veteran who takes their own life is too many, and more must be done as a nation to make sure that no veteran feels alone when they return home. Our veterans deserve our unwavering support, and this program is an excellent step in the right direction to make sure our veterans receive the support they need.

The *PFC Joseph P. Dwyer Peer Support Program Act* will help thousands of veterans' transition by taking the best practices learned in New York and authorize the Secretary of Veterans Affairs to make grants to state and local entities to carry out their own peer-to-peer mental health programs.

Through Resolution No. 364: *Department of Veterans Affairs to Develop Outreach and Peer to Peer Programs for Rehabilitation,*[20] The American Legion supports efforts to develop a national program to provide peer-to-peer rehabilitation services based on the recovery model tailored to meet the specialized needs of current generation combat affected veterans.

The American Legion supports H.R. 2768 *as currently written.*

H.R. 2818 – Autonomy for Disabled Veterans Act

To amend title 38, United States Code, to increase the amount paid by the Secretary of Veterans Affairs to veterans for improvements and structural alterations furnished as part of home health services.

The Department of Veteran Affairs (VA) Home Improvement and Structural Alterations (HISA) grants are aimed at enhancing the independence of disabled veterans and servicemembers within their homes, facilitating medically necessary improvements and structural alterations. Regrettably, the current funding limitations constrain veterans' ability to achieve independence. For instance, veterans with service-connected and non-service-connected disabilities are eligible for only up to $6,800 and $2,000 respectively.[21] Upon exhaustion of these funds, they are left with unfinished home improvement projects, resulting in partially accessible residences.

With the last funding enhancement dating back to 2009, our economy has seen significant shifts, further exacerbated by the economic turbulence resulting from the COVID-19 pandemic. Therefore, the need to adjust the HISA grant maximums for inflation, in line with the Consumer Price Index, and increasing the cap for veterans with both service-connected and non-service-connected disabilities is more pressing than ever.

The Autonomy for Disabled Veterans Act seeks to address these issues directly. The Act is poised to elevate the HISA grant maximum amount to $10,000 for veterans with service-connected

[19] Joseph P. Dwyer Veterans Peer Support Project. http://mhaw.org/dwyer/about
[20] The American Legion Resolution No. 364 (2016): *Department of Veterans Affairs to Develop Outreach and Peer to Peer Program for Rehabilitation* https://archive.legion.org/node/511
[21] "Rehabilitation and Prosthetic Services." Department of Veterans Affairs (2022). https://www.prosthetics.va.gov/psas/HISA2.asp

disabilities, and to $5,000 for those with non-service-connected disabilities. This adjustment not only acknowledges the economic reality of our times but also underscores the critical intent of HISAs — to provide financial assistance that ensures more independence for all disabled veterans. The American Legion is resolute in its support for initiatives that aim to enhance home-based services and living conditions for veterans. This isn't merely about convenience; it's about affirming the dignity and respect of those who have selflessly served our nation.

Through Resolution No. 357: *Support Veterans Housing Repair and Modification Pilot Program*, The American Legion supports legislation seeking to modify or augment programs like the Specially Adaptive Housing Program, to allow veterans service organizations and housing nonprofits to combine their resources with other federal funding by applying for grants through the Department of Housing and Urban Development.[22]

The American Legion supports H.R. 2818 *as currently written.*

H.R. 3520 – Veteran Care Improvement Act

To improve the provision of care and services under the Veterans Community Care Program of the Department of Veterans Affairs, and for other purposes.

The Department of Veterans Affairs (VA) community care program allows veterans to receive timely and quality healthcare in the private sector. Initially, VA conducted this program with a piecemeal approach, but the system substantially expanded after Congress passed the *Veterans Access, Choice, and Accountability Act of 2014*.[23]

Since the program's inception, VA has experienced issues regarding timeliness of care. While VA maintains access standards for wait times, these standards are oftentimes not met, and Congress has no way of enforcing them. Long wait times are not only burdensome, but they are dangerous in high-risk situations where a veteran needs immediate care, such as substance abuse disorder treatment. Furthermore, VA employees must streamline the process by being informed on which veterans can access the program and under what circumstances.

The American Legion believes that VA's community care program should be standardized for both patients and providers to ensure quality care for veterans and appropriate compensation for providers. The *Veteran Care Improvement Act* would codify VA's access standards to ensure moderate wait times. It would also codify the access standard for veterans seeking residential abuse treatment and notify them of their eligibility within two business days, which is critically needed for veterans seeking help and who are confused about their access to treatment. Lastly, this legislation would further improve veteran notification regarding the care they are entitled to.

[22] The American Legion Resolution No: 357 (2016): *Support Veterans Housing Repair and Modification Pilot Program,* https://archive.legion.org/node/504

[23] Bass, Elizabeth. "The Veterans Community Care Program: Background and Early Effects." Congressional Budget Office. October 2021. https://www.cbo.gov/publication/57583

Through Resolution No. 363: *Consolidation of Department of Veterans Affairs Care*, The American Legion supports legislation that standardizes the Community Care program and ensures that veterans receive timely, quality health care.[24]

The American Legion supports H.R. 3520 *as currently written.*

H.R. 3581 – COPE Act

To amend title 38, United States Code, to modify the family caregiver program of the Department of Veterans Affairs to include services related to mental health and neurological disorders, and for other purposes.

The Department of Veterans Affairs (VA) Program of Comprehensive Assistance for Family Caregivers (PCAFC) is integral to the provision of care for veterans grappling with multifaceted medical or mental health conditions. In its current incarnation, this program often leaves those providing care — the caregivers themselves — wrestling with their own mental and physical hardships while they strive to maintain a strong front for the veterans they're caring for.

Regrettably, these caregivers, whilst navigating the mental toll of their duties, encounter their own struggles and constraints. They are eligible for limited support from the VA and, after this aid has been utilized, are often left in a state of psychological strain.[25] This challenging circumstance leaves our caregivers with partially fulfilled mental and physical health needs.

With a keen understanding of these realities, the Caregiver Outreach and Program Enhancement (COPE) Act seeks to remedy these issues in a comprehensive and efficient manner. This legislation aims to enhance the PCAFC by bolstering grants to organizations that support caregivers, ensuring they have access to mental health resources. It also stipulates that the VA must actively engage with caregivers, providing information about available resources and strategizing to improve care for underserved populations. Furthermore, this legislation calls for VA to work with the Government Accountability Office (GAO) to conduct a comprehensive evaluation of the caregiver program, measuring its impact on disabled veterans and their caregivers.

The American Legion is an adamant supporter of our nation's caregivers, advocating for legislation aimed at improving their mental and physical health. This commitment isn't just about offering support; it's about upholding the dignity and respect of those committed to caring for our nation's heroes.

Through Resolution No. 18: *Comprehensive Supports for Caregiver Support Program*, The American Legion supports legislation that provides more robust and available comprehensive

[24] The American Legion Resolution No. 363 (2016*): Consolidation of Department of Veterans Affairs Care in the Community Program* https://archive.legion.org/node/510
[25] Shepherd-Banigan et al. "Family Caregivers of Veterans Experience High Levels of Burden, Distress, and Financial Strain." National Institute of Health. November 2020. https://doi.org/10.1111/jgs.16767

home and community-based support to better alleviate the physical and mental strains of caregiving.[26]

The American Legion supports H.R. 3581 *as currently written.*

Conclusion

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee; 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.

[26] The American Legion Resolution No: 18 (2022): *Comprehensive Supports for Caregiver Support Program* https://archive.legion.org/node/7902

Prepared Statement of Cole Lyle

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, on behalf of Mission Roll Call, a non-partisan program of America's Warrior Partnership, and the roughly 1.4 million veterans and supporters who have opted-in to our digital advocacy network, thank you for the opportunity to provide their feedback through our remarks on pending legislation. While all the proposed bills are worthy of discussion and will have impacts on the veteran community, MRC's three main priorities are veteran suicide prevention, access to healthcare and benefits, and amplifying the voices of traditionally underserved populations. For this reason, in our testimony, MRC will focus on four specific bills on the docket for which we have polling data or learned in-person veteran experiences.

H.R. 3520, Veteran Care Improvement Act of 2023

MRC strongly supports this legislation as a necessity to ensure veterans receive timely access to quality care. The MISSION Act of 2018 was a bipartisan effort to improve accessibility to healthcare for veterans by streamlining the congealed process that existed via the CHOICE Act. Congress' intent with MISSION was clear: the VA must increase access to private doctors when the Veterans Health Administration couldn't provide care in a reasonable time and/or distance, or if access to an outside provider was in the best medical interest of the veteran.

In 2021, reports surfaced that VA administrators were overruling decisions by VA doctors and patients to keep veterans in the system, in some cases cutting off care entirely. The article confirmed what many veteran service organizations providing care coordination and casework already knew: that to protect VA's parochial interests, it was unnecessarily difficult for veterans to access care in the community when it was in their best medical interest. In 2022, 4 years after MISSION passed, Secretary McDonough testified community care now accounted for one-third of VA's healthcare budget. As a result, the Secretary said the VA would look at changing access standards and use telehealth availability to determine wait times. In response, MRC conducted a poll on the issue, and with over 6,300 veteran responses across America, 81 percent said Congress should codify the access standards.

- Further, MRC asked questions on the more general veteran experience accessing community care. With an average of 6,200 responses across 7 unique polls:

  60 percent of veterans said their providers don't make them aware of this option after a delay in care;
- 37 percent said they had experienced a delay or postponement of any healthcare appointment at a VA facility;
- 71 percent said they were not referred to the community after a delay in mental health or other specialty care at a VA facility;
- 22 percent experienced problems scheduling the care once referred; 14 percent said their providers referred them to the community but the referral was later denied by the VA upon review;
- 21 percent said their providers scheduled them a telehealth to access their healthcare when they preferred in-person visits.

This data clearly indicates there is a problem simmering under the surface on this issue.

But this problem can be found in more than just statistics. During MRC's geographically and demographically diverse fact-finding tour last year, meeting with over 5,000 veterans individually in California, Texas, Florida, Alaska, Arizona, Idaho, Montana, and elsewhere, these problems were borne out in more than just statistics. While veterans who had good experiences at the VA mitigated their issues and went on living their lives productively, those with negative experiences accessing healthcare at VA facilities or with referrals to community care either gave up trying or were not shy to tell other veterans they should stay away from VA. These issues ranged from simple primary care appointments for things like allergies, to significant mental health issues. A few stark responses from veterans said they knew peers whose mental health spiraled after being frustratingly unable to access mental healthcare when and where they needed it. To the best of my knowledge, luckily none of these examples ended with a suicide attempt. But with less than 50 percent of the U.S. Census Bureau's estimated 17.4 million veterans in America enrolled in VA, and even less using it on a regular basis, making it harder to access healthcare when needed is counterproductive to the VA's interest, regardless where the care takes place.

As the VA is the largest health care system in the country and the second-largest Federal agency behind the Department of Defense, it's understandable why officials

sometimes make big decisions with respect to workforce recruitment and retention. However, Congress must ensure the agency keeps the veteran, not agency interests, as their North Star, and not defer or be unduly influenced by workforce considerations when those decisions could negatively impact the individual veterans' ability to seek healthcare. After all, the VA's core mission is to care for those who have borne the battle.

MRC is a successful program of America's Warrior Partnership, which has also supported a similar bill in the Senate, the Veteran's HEALTH Act. We hope the House and Senate can pass both bills and come together on a bipartisan basis to pass this urgently needed legislation to protect veteran access to timely healthcare, whether that is in a VA facility or not.

H.R. 2768, PFC Joseph P. Dwyer Peer Support Program

MRC supports this legislation that would require the Secretary to establish a grant program to benefit eligible entities for the purposes of establishing peer-to-peer mental health programs for veterans.

Recently, MRC conducted a poll that asked if former service members with mental health challenges should be able to access the provider of their choice, regardless of whether the care was in a VA facility or in the community. With 7,200 responses, 94 percent said yes. With less than 50 percent of the estimated 17.4 million U.S. veterans enrolled in VA care, the Department must expand its use of grant funding to local organizations with touchpoints in the veteran community the VA simply does not have. Integrating local, non-governmental resources into a web of connectivity for veteran care is crucial in our fight against veteran suicide.

Successful peer-to-peer programs, whether through VA facilities like Vet Centers, community programs of America's Warrior Partnership across the country, resources like the Vets4Warriors line, or Boulder Crest Foundation events, show remarkable results where evidenced-based treatments fail. No one can better understand the struggles a veteran may be going through than another veteran. These resources provide confidential and free support through programs, case coordination, and conversations which help veterans in crisis or dealing with a non-crisis issue that may or may not be mental health related.

However, given the short window of applications for a similar grant program which negatively affected smaller organizations the program was intended to assist, MRC has concerns that if VA is not given a mandate to provide a reasonable window of time, history will repeat itself. The organizations on the ground doing this work must be laser-focused on programmatic activity and may not have a full-time employee whose job is to apply for grants and follow-up on government reporting requirements.

H.R. 1639, VA Zero Suicide Demonstration Project Act of 2023

MRC supports this legislation that would require the Secretary to establish a pilot program to institute the "Zero Suicide Initiative," which seeks to improve safety and suicide care for veterans at select VA facilities.

VA providers, generally, understand the unique traumas of veterans in crisis. However, according to the VA's treatment decision guide for mental health issues, the effectiveness of evidenced-based treatments—talk therapy and pharmacology—have variable success rates of 53 percent and 40 percent, respectively. Providing VA clinicians with another resource to improve their ability to handle veterans in crisis and refer them for "comprehensive assessment of suicidality" would bolster the VA's ability to refer and treat veterans with the appropriate resource they require, whether that is evidenced-based treatment or a more holistic approach to suicide prevention.

The VA is not going to counsel or prescribe its way out of a mental health crisis. Every veteran is different and needs a holistic approach.

H.R. 1774, VA Emergency Transportation Act

Under current law, VA only covers emergency travel to hospitals within their network. If a veteran seeks care for an emergent health issue at a non-VA facility, reimbursed by VA under current law and regulation, that veteran could still be hit with an expensive, surprise bill for ambulatory care. Given that acute financial stress is a major driver of suicide, MRC supports this legislation that would require the Secretary to reimburse veterans for the cost of emergency medical transportation to a healthcare facility. If a veteran requires care that the VA provides, either at a VA facility or community provider, it makes sense that the VA should cover the cost of that entire episode of care, from the moment a veteran requires assistance to complete convalescence.

Chairwoman Miller-Meeks, this concludes my testimony. Mission Roll Call would like to thank you and Ranking Member Brownley for the opportunity to testify on these important issues before this subcommittee. I am prepared to take any questions you or the subcommittee members may have.

STATEMENTS FOR THE RECORD

Prepared Statement of Wounded Warrior Project

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health – thank you for the opportunity to submit Wounded Warrior Project's views on pending legislation.

Wounded Warrior Project (WWP) was founded to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing more than 20 life-changing programs and services to more than 190,000 registered post-9/11 warriors and 48,000 of their family support members, continually engaging with those we serve, and capturing an informed assessment of the challenges this community faces. We are pleased to share that perspective for this hearing on pending legislation that would likely have a direct impact on many we serve.

H.R. 3520, the Veterans Care Improvement Act

Opioid and substance use disorders (SUDs) continue to rank as one of the top self—reported – and objectively verified – health challenges faced by those who complete WWP's Annual Warrior Survey. In our 2022 report [1], more than two in five responding warriors screened positive for potentially hazardous drinking or alcohol use disorders (43.5 percent) and over 6 percent showed a moderate to severe level of problems related to drug abuse. VA estimates that among veterans that served in Iraq and Afghanistan, about 1 in 10 have a problem with alcohol or drugs. Unfortunately, many of these veterans face difficulties when attempting to get treatment for substance use issues.

Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) represent the most intensive level of care for veterans with SUDs and other conditions, like PTSD, military sexual trauma (MST) and serious mental illness (SMI) at the Department of Veterans Affairs (VA). The *VA MISSION Act* (P.L. 115–182 § 104) required VA to establish access standards for community care and in 2019, VA announced those access standards for primary care, mental health, specialty care, and non-institutional extended care services. However, VA did not include a specific access standard for residential care. Instead, VA relies on VHA Directive 1162.02 to establish when a veteran is eligible for residential treatment in the community. The Directive states that veterans requiring priority admission must be admitted within 72 hours. For all other veterans, they must be admitted as soon as possible after a decision has been made. If they cannot be admitted within 30 days, they must be offered treatment at a residential program within the community.

Unfortunately, this is often not the reality on the ground. WWP has frequently ran into issues when trying to place veterans into suitable residential care programs outside VA when local VA facilities have reached their capacity. These issues are similar to experiences in a recent report from the VA's Office of Inspector General (OIG) that found that staff at VA North Texas placed patients on waitlists for two to three months, while failing to offer referrals for community based residential care in 2020 and 2021.[2] This type of experience can have devastating consequences for veterans that are reaching out for help. Extended wait times for treatment increase the risk of losing contact with a veteran or the veteran changing their willingness to enter treatment or further engage with VA.

H.R. 3520 seeks to address this issue and others by:

[1] *Our Annual Warrior Survey* reference corresponds to the thirteenth edition of the survey, which was published in 2023 and reflects data gathered in 2022. To learn more, please visit https://www.woundedwarriorproject.org/mission/annual-warrior-survey.

[2] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, NONCOMPLIANCE WITH COMMUNITY CARE REFERRALS FOR SUBSTANCE ABUSE RESIDENTIAL TREATMENT AT THE VA NORTH TEXAS HEALTH CARE SYSTEM (Jan. 2023).

- Codifying current community care access standards and giving the Secretary the option to shorten the distance or time access standards through regulation.
- Establishing an access standard for the provision of residential treatment and rehabilitative services for alcohol or drug dependency.
- Requiring that veterans seeking residential treatment for alcohol or drug dependence are evaluated no later than 72 hours after VA receives the request.
- Ensuring that access standards apply to all VA care, except for nursing home care.
- Prohibiting VA from considering the availability of a telehealth appointment as satisfying the access standards.
- Requiring that the calculation of a veteran's wait time for the purposes of determining community care eligibility starts on the date of request for the appointment, in the case that a veteran's appointment is canceled by VA.
- Requiring VA to inform veterans of their eligibility for community care.
- Requiring VA to take into consideration a veteran's preference for when, where, and how to seek care, as well as their need or desire for a caregiver, when determining if it is in the best medical interest of a veteran to receive care in the community.
- Requiring VA to provide a veteran with the reason for their denial for community care and instructions for how to appeal the decision.
- Requiring that a determination for eligibility for community care not be overturned without notification in writing to the veteran and their provider.
- Requiring outreach from VA to inform veterans of their ability to seek community care, how to request community care, and how to appeal a denial of a request for community care.
- Requiring VA to conduct public outreach regarding care and services under Veterans Community Care Program, including through the Solid Start Program and on VA's webpages.
- Requiring VA to develop a pilot program to improve administration of care under the Veterans Community Care Program through the Center for Innovation for Care and Payment, including by providing incentives to community care network providers to allow visibility into their scheduling systems, improving the rate of timely medical documentation return and improving the timeliness and quality of care in the community.
- Requiring the VA OIG to assess the implementation of the Veterans Community Care Program at each VA Medical Center on a regular basis.
- Requiring VA to incorporate the use of value-based reimbursement models and report to Congress on these efforts.

Veterans in need of inpatient residential care must be able to access it in a timely and efficient manner. With an established access standard for MH RRTPs, veterans will receive more consistent, quality, and timely care. For these reasons, Wounded Warrior Project supports H.R. 3520 but would respectfully ask the Committee to consider expanding the terms in Section 2 to include other varieties of RRTP care, including its specialty tracks for PTSD, MST, and SMI. We would like to thank Chairwoman Miller-Meeks for her introduction of this legislation and her attention to this issue.

H.R. 1182, the Veterans Serving Veterans Act

Despite sustained efforts, VA continues to face a workforce shortage and high turnover rates, resulting in longer wait times and disjointed care for veterans. According to its own June 2022 report[3], VA experienced a 20-year high in its VHA staff turnover rate (9.9 percent) in FY 2021 partly due to higher wages and bonuses offered by private health care systems, COVID–19 pressures, and burnout. These shortages can be aggravated by a slow and complicated hiring process used by the Veterans Health Administration (VHA).[4] Furthermore, thousands of former military health care providers from all branches of the Armed Services separate from the

[3] U.S. DEP'T OF VET. AFFAIRS, ANNUAL REPORT ON THE STEPS TAKEN TO ACHIEVE FULL STAFFING CAPACITY 3 (June 2022), *available at* https://www.va.gov/EMPLOYEE/docs/Section–505-Annual-Report–2022.pdf.

[4] U.S. GOV'T ACCOUNTABILITY OFF., STAFFING CHALLENGES PERSIST FOR FULLY INTEGRATING MENTAL HEALTH AND PRIMARY CARE SERVICES (Dec. 2022).

military and, despite their training and experience, do not possess a civilian certificate allowing them to continue in the occupations for which they were trained.

Congress has given VA tools to address these issues. The *RAISE Act* (P.L. 117–103, Div. S § 102) increased the pay limitation on salaries for nurses, advanced practice registered nurses, and physician assistants within VA. The *STRONG Veterans Act* (P.L. 117–328, Div. V) includes provisions that will expand the Vet Center workforce (§ 102), create more paid trainee positions in mental health disciplines (§ 103), and offer more scholarship and loan repayment opportunities for those pursuing degrees or training in mental health fields (§ 104). Clearly, however, more can be done.

The *Veterans Serving Veterans Act* would serve a dual purpose of increasing veteran employment and addressing VA health workforce shortages by requiring VA to identify the health care related military occupation specialties (MOS) that relate to similar job openings within VA. VA would accomplish this by establishing a vacancy and recruitment data base that would be used to identify VA's occupational needs and transitioning Service members (job candidates) to fill those needs. VA would also deploy direct hiring and appointment systems for vacant data base positions and may approve relocation bonuses. Finally, the bill requires VA to train and certify veterans who worked as basic health care technicians in the U.S. military to function as VA intermediate care technicians.

In addition, WWP believes veterans may be better served by fellow veterans who understand their needs and concerns. WWP supports this legislation because it is a welcomed initiative to address the workforce shortage VA is currently facing and can provide economic opportunities for our warriors. We thank Resident Commissioner Jenniffer Gonzalez-Colon (R-PR-At Large) for introducing this legislation.

H.R. 1774, the VA Emergency Transportation Act

The Department of Veterans Affairs currently reimburses veterans for ambulance transportation to non-VA facilities during an emergency. However, if these veteran patients require ambulance transportation to a VA medical facility for further treatment, the agency is not required to pay for that subsequent transportation, leading to significant ambulance bills for veterans.

The VA *Emergency Transportation Act* would amend 38 U.S.C. § 1727 to address reimbursement rates for emergency medical transportation to a federal facility. Specifically, VA would be required to reimburse a veteran for transportation by a non-VA provider (1) to a facility for emergency treatment, or (2) from a non-VA facility where the veteran was treated to a VA or other federal facility for additional care.

This legislation would help ensure veterans are not paying out-of-pocket for necessary emergency transportation to facilities outside of VA's network and are not limited in their ability to receive high quality treatment. WWP is pleased to support the VA *Emergency Transportation Act*. We thank Rep. Mark Alford (R-MO–04) for introducing this bill, and we urge Congress to pass this legislation to help address transportation costs for veterans in need of emergency medical care.

H.R. 2683, the VA Flood Preparedness Act

Currently law is unclear about whether VA can support flood mitigation projects that decrease the possibility of washed-out streets or other flooded infrastructure impeding access to its facilities. Under this legislation, 38 U.S.C. § 8108 would be amended to clarify that VA can contribute funding to assist local authorities mitigate the risk of flooding on properties neighboring VA medical facilities. Additionally, this bill would require VA to present a report to Congress detailing the extent to which VA medical facilities are at risk of flooding. This report must also inform on whether additional resources are needed to mitigate the risk of flooding at said facilities.

Wounded Warrior Project supports this legislation because it would empower VA to work directly with local authorities on flood mitigation initiatives that ensure safe and reliable access to essential care facilities. We thank Rep. Nancy Mace (R-SC–01) for introducing this legislation.

H.R. 2768, the PFC Joseph P. Dwyer Peer Support Program Act

Peer support is a critical tool for many veterans facing stress, emotional challenges, and mental health concerns. WWP's most recent Annual Warrior Survey showed that 18.5 percent of responding warriors have used support groups, including peer-to-peer counseling, to help them face these challenges. Over 30 percent of responding warriors have had difficulty getting physical health care, put off getting physical health care, or did not get the physical health care they thought they needed because no peer support was available. To help address this need, one of the programs that WWP offers is our Veteran Peer Support Groups, held monthly at loca-

tions across the country. Last year, WWP facilitated over 1,200 Peer Support Groups, giving us firsthand insight into the life changing impacts of peer support. These Peer Support Groups are small, Warrior-led groups that allow veterans to connect with each other, discuss shared challenges, and support one another in their communities.

The Joseph P. Dwyer Veteran Peer Support Program is a peer-to-peer program for veterans facing challenges related to post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI) in New York State. Established in 2012, its focus on addressing loneliness and creating communities of healing appears prescient in 2023 after U.S. Surgeon General Vivek Murthy's recent advisory about the epidemic of loneliness and isolation in our country. This bill would create a grant program for state and local entities to receive up to $250,000 to establish similar peer-to-peer mental health programs for veterans. These state and local entities would include nonprofit organizations that have historically served veterans' mental health needs, congressionally chartered veteran service organizations, or a state, local, or tribal veteran service agencies.

As an organization that embraces the power of peer support, WWP supports this legislation. The expansion of peer support programs like the Joseph P. Dwyer Peer Support Program will give more veterans the opportunity to use peer connection to address their challenges and embark on their path to healing. We urge Congress to pass this legislation and would like to thank Rep. Nick LaLota (NY–01) for its introduction.

H.R. 2818, the Autonomy for Disabled Veterans Act

Wounded Warrior Project's 2022 Annual Warrior Survey reported that nearly half of responding warriors indicate that they live paycheck-to-paycheck and 43.2 percent say they have little to no confidence that they could find the money to cover a $1,000 emergency expense. Many of these veterans, either due to their service-connected disabilities or other medical conditions, find themselves needing special home alterations and adaptations for them to live comfortably in their own home.

The VA Home Improvements and Structural Alterations (HISA) benefit helps disabled veterans by providing a grant to offset the cost associated with making medically necessary improvements and structural alterations to a veteran's primary residence. However, the lifetime benefit is only $6,800 for veterans with a service-connected disability and $2,000 for those with disabilities that are not service-connected. As prices and inflation have risen over the last few years, the amount that disabled veterans are eligible for has not.

The *Autonomy for Disabled Veterans Act* increases the amount available to disabled veterans for improvements and structural alterations to their homes related to their disability, through the HISA grant program. The bill increases the amount to $10,000 for veterans with a service-connected disability and $5,000 for those with disabilities that are not service-connected. The bill also requires VA to increase the amount of the grant in accordance with inflation as determined by the Consumer Price Index.

Wounded Warrior Project supports this bill that would help disabled veterans fund modifications and alterations that are medically necessary to update their homes. We believe that these alterations are crucial to a warrior's quality of life and should be increased periodically to keep up with inflation. We thank Rep. Don Bacon (R-NE–2) and Rep. Chris Pappas (D-NH–1) for introducing this legislation.

H.R. 3581, the Caregiver Outreach and Program Enhancement (COPE) Act

Caregivers of post-9/11 veterans tend to be younger than those of other generations. The number of post-9/11 military veteran caregivers who were aged 30 years or younger (37 percent) is higher than pre-9/11 military veteran caregivers (11 percent) or civilian caregivers (16 percent).[5] Therefore, post-9/11 veteran caregivers may serve as caregivers for a greater period of time. For example, 30 percent of veteran caregivers reported they had been caregiving for 10 years or more compared to 15 percent of civilian caregivers.[6] Military caregivers were also found to have greater levels of caregiver burden and stress compared to nonmilitary caregivers.

Over time, the stress of caring for another person can lead to "compassion fatigue." This is a common condition that can make caregivers feel irritable, isolated, depressed, angry, or anxious. Additional symptoms include exhaustion, impaired

[5] RAJEEV RAMCHAND ET AL., HIDDEN HEROES: AMERICA'S MILITARY CAREGIVERS 81 (RAND Corp., 2014), *available at* https://www.rand.org/pubs/research__reports/RR499.html.

[6] NAT'L ALLIANCE FOR CAREGIVING, CAREGIVERS OF VETERANS – SERVING ON THE HOMEFRONT (Nov. 2010), *available at* https://www.unitedhealthgroup.com/content/dam/UHG/PDF/uhf/caregivers-of-veterans-study.pdf.

judgment, decreased sense of accomplishment, and sleep disturbances. Military and veteran caregivers may require increased access to mental health care because many of these stressors can contribute to the development of conditions, such as depression, anxiety, or substance use disorders.

The *COPE Act* would authorize VA to award grants to carry out, coordinate, improve, or otherwise enhance mental health counseling, treatment, and support for caregivers in VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC) program. To apply for a grant, entities must submit an application with a detailed plan for the use of the grant and, if selected, must meet outcome measures developed by VA. At least once a year, VA would review the performance of entities who have received a grant to ensure that they are meeting outcome measures; those who are not would be required to submit a remediation plan and will not be eligible for a subsequent grant until the remediation plan is approved.

This legislation would authorize $50 million for a three-year period and would require that funding be distributed equitably among states. Grant selection would prioritize areas with high rates of veterans enrolled in PCAFC, high rates of suicide among veterans, or high rates of referrals to the Veterans Crisis Line. Finally, the *COPE Act* requires VA and the Government Accountability Office (GAO) to conduct studies to report to Congress on the program and its outcomes.

As an organization committed to supporting veteran caregivers, WWP supports the intent of the *COPE Act* and thanks Rep. Jennifer Kiggans (R-VA–02) for introducing this bill. While we appreciate the description of the application process that would be involved for grant selection, we would invite the Committee to consider amending this legislation to include a definition of the word "entity" to further clarify who is eligible for such a grant (i.e., state government, local government, tribal governments, nonprofit organizations, etc.) and whether there would be any limitations on such groups to be eligible for application.

H.R. 1278, the DRIVE Act

According to our latest *Annual Warrior Survey*, a total of 15.6 percent of responding warriors cited distance from the VA as a significant barrier to accessing VA care. While there are other factors aside from fuel costs associated with these long commutes, the VA Travel Beneficiary Program provides reimbursement for mileage and other expenses incurred while traveling to and from their VA health care appointments to help alleviate some of the financial burden. Under the current policy (which was enacted in 2010), reimbursements are calculated based on a mileage rate of 41.5 cents per mile and have not been adjusted to reflect the rising cost of fuel and other expenses impacted by inflation. These costs negatively impact warriors who live further from VA medical facilities, especially those who must travel from rural areas.

The *DRIVE Act* would allow for an increase in reimbursement rates for health care related travel by striking the rate of 41.5 cents per mile and adjusting the rate to be equal or greater than the mileage reimbursement rate for government employees who use private vehicles for official purposes, which is currently 65.5 cents per mile.[7] In addition, this bill would require VA to ensure the Beneficiary Travel reimbursement rate is equal to the General Services Administration reimbursement rate for federal employees moving forward. This will ensure that these rates keep up with the cost of inflation and properly account for fluctuations in gas prices over time.

Wounded Warrior Project supports this legislation that would help ease the financial burden of medically necessary travel expenses and make health care and benefits more accessible to the veterans who need them, and we thank Rep. Julia Brownley (D-CA–26) for introducing this legislation.

H.R. 1639, the VA Zero Suicide Demonstration Project Act

Tragically, veteran suicide continues to be a national public health crisis that requires coordinated action from all levels of government, as well as public-private partnerships. In 2020, there were 6,166 veteran deaths by suicide according to VA's *2022 National Veteran Suicide Prevention Annual Report*. Our Annual Warrior Survey data found that nearly one in five responding warriors reported an attempted suicide at some point in their lives, and nearly 30 percent have had suicidal thoughts in the past 12 months. Thankfully, some progress has been made on this front in recent years. Fewer veterans died by suicide in 2020 than the year before and 2020 had the lowest number of veteran suicides since 2006. However, there is

[7] U.S. GOV'T SERVS. ADMIN., PRIVATELY OWNED VEHICLE (POV) MILEAGE REIMBURSEMENT RATES, *available at* https://www.gsa.gov/travel/plan-book/transportation-airfare-pov-etc/privately owned-vehicle-mileage-rates.

still significant work that must be done to address this crisis and prevent veteran suicide.

This legislation would establish a five-year Zero Suicide Initiative pilot program at five VA medical centers across the country, including one that must serve primarily veterans who live in rural areas. The pilot program would implement the curriculum of the Zero Suicide Institute of the Education Development Center to improve safety and suicide care for veterans and reduce veteran suicide. The bill requires VA to submit an annual report to Congress that includes a comparison of suicide-related outcomes at program sites and those of other VA medical centers. The report would also assess whether the policies and procedures implemented at each site align with the standards of the Zero Suicide Institute in several areas, including suicide screening, lethal means counseling, and outreach to high-risk patients. VA may choose to extend the pilot program for up to two additional years.

While we agree with the unobjectionable intent of ending veteran suicide, WWP is concerned about the collateral impact of this legislation. Currently, suicide prevention is VA's top priority and they have implemented a comprehensive public health approach to address the issue that extends beyond what is required by this legislation. Implementing this new pilot program would require VA to redirect an unknown number of resources that are currently being used for suicide prevention efforts that have shown signs of progress over recent years. Additionally, the legislation requires VA to enter into a legally binding financial agreement with a specified non-profit organization to implement their curriculum. We agree with VA's assessment[8] that they should have the ability to evolve and adapt their suicide prevention efforts based on proven clinical interventions, established business practices, and an exchange of relevant data, as opposed to legislation requiring them to adapt a single model. While we support the intent of this bill, WWP has concerns with the current legislative language, but looks forward to working with the Committee and VA to continue our shared goal of preventing veteran suicide.

H.R. 1815, the Expanding Veterans' Options for Long Term Care Act

A September 2021 report to Congress by VA found that the percent of veterans who are 85 or older that are eligible for nursing home care will increase 61,000 to 387,000 over the next 20 years, a nearly 535 percent increase. However, of the veterans currently living in Community Nursing Homes (CNHs) at VA's expense, approximately five percent do not require the daily skilled nursing interventions provided and would be better served by assisted living, which would allow them to live more independently. In fiscal year (FY) 2020, the annual cost of a CNH placement was $120,701, while the annual cost of an Assisted Living Placement was $51,600.[9]

Currently, VA can refer veterans to assisted living facilities but is restricted from paying room and board fees; this policy precludes many veterans from utilizing this long-term care option because they cannot afford it. The *Expanding Veterans' Options for Long Term Care Act* would create a pilot program for eligible veterans to receive assisted living care paid for by VA. The 3-year pilot program would be conducted at six Veterans Integrated Services Networks (VISNs) nationwide, including at least two program sites located in rural or highly rural areas and two State Veterans Homes. Veterans may be eligible for this program if they are already receiving nursing home level care paid for by VA; are eligible to receive nursing home level care paid for by VA; or require a higher level of care than the domiciliary care provided by VA but do not meet the requirements for nursing home level care. To qualify, veterans must also be eligible for assisted living services or meet additional eligibility criteria that may be established.

Establishing a pilot program for veterans to receive assisted living care paid for by VA would not only allow aging veterans to live more independently but would also help save taxpayer dollars. This bill would provide veterans whose conditions do not rise to the level of requiring nursing home care with more appropriate long-term care options based on their preferences and in their best medical interests. In particular, the focus on rural veterans would help those who face greater challenges

[8] Legislative Hearing on: H.R. 291, the COST SAVINGS Enhancement Act; H.R. 345, the Reproductive Health Information for Veterans Act; H.R. 1216, the Modernizing Veterans' Health Care Eligibility Act; H.R. 1957, the Veterans Infertility Treatment Act of 2021; H.R. 6273, the VA Zero Suicide Demonstration Project Act of 2021; H.R. 7589, the REMOVE Copays Act before the House Committee on Veterans Affairs Subcommittee on Health, 117th Congress. 9–12, 2022 (statement of Matthew A. Miller, Ph.D., MPH, Executive Director, Suicide Prevention Program, Office of Mental Health and Suicide Prevention, Veterans Health Administration (VHA), Department of Veterans Affairs (VA).

[9] Letter from the American Seniors Housing Association et al., to U.S. Senators Jon Tester, Jerry Moran, and Patty Murray (June 13, 2022) (available at https://www.argentum.org/wp-content/uploads/2022/06/FinalVAcoaltionltrSENATESponsors.pdf).

accessing Veterans Homes in their states. Further, for each veteran who is placed in an assisted living community for their supportive care services, VA would realize a potential nursing home savings of approximately $69,101 per placement per year. An annual report on the pilot program would study several factors, including aggregated feedback from participants in the pilot program and an analysis of cost savings by VA.

Traditionally, VA programming does not provide veterans with housing. One notable exception was VA's pilot program, the Assisted Living for Veterans with Traumatic Brain Injury (AL-TBI) Program, which demonstrated a demand for providing increased housing options for younger veterans with difficulty with independent living. This program provided residential care and neurobehavioral rehabilitation to eligible veterans with traumatic brain injuries to enhance their quality of life and community integration. Veterans were eligible for VA's AL-TBI pilot program if they were enrolled in VA's patient enrollment system; had received VA hospital care or medical services for a TBI; were unable to manage routine activities of daily living without supervision and assistance; and could reasonably be expected to receive ongoing services after the end of the pilot program under another Federal program or through other means. (P.L. 110–181 Sec. 1705.) Through VA's AL-TBI program, veterans received care and support in specialized assisted living facilities; these facilities provided assistance with activities of daily living, including meal preparation, bathing, dressing, grooming, and medication management. Although this pilot lasted for nearly a decade before sunsetting in 2018, its utility has not been replicated despite ongoing need.

Expanding veterans' access to assisted living services is a WWP priority. The *Expanding Veterans' Options for Long Term Care Act* would help VA provide access to a greater range of long-term care options and prepare to care for the ever-increasing population of aging veterans. WWP urges Congress to pass this legislation, and we appreciate Rep. Elissa Slotkin (D-MI–08) for its introduction. We would recommend that the Committee broaden the eligibility criteria by incorporating eligibility criteria – similar to that used for the expired AL-TBI pilot – that would accommodate veterans with TBI symptoms that challenge their ability to live without supervision. The need for residential support and services remains while access to appropriate facilities covered by VA is limited mostly to nursing homes where aging populations often are a poor fit for a younger person with TBI or other long-term care needs.

CONCLUSION

Wounded Warrior Project once again extends our thanks to the Subcommittee on Health for its continued dedication to our Nation's veterans. We are honored to contribute our voice to your discussion about pending legislation, and we are proud to support many of the initiatives under consideration that would enhance veterans' access to care and support. As your partner in advocating for these and other critical issues, we stand ready to assist and look forward to our continued collaboration.

Prepared Statement of The Independence Fund

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

Thank you for your kind invitation to The Independence Fund and me to testify before today's legislative hearing.

The Independence Fund (TIF) serves catastrophically wounded Veterans and their Caregivers so much of the legislation before the Subcommittee holds particular relevance for our community.

As we outlined in our testimony at the April 18, 2023 Subcommittee on Health hearing, "Combating a Crisis: Providing Veterans Access to Life-saving Substance Abuse Disorder Treatment," too many Veterans are being denied the critical, often life-saving treatment they require because of an unclear, poorly implemented policy for Mental Health Residential Rehabilitation Treatment Programs (MH RRTP). Our Caseworkers have uncovered a seemingly widespread access to care and care coordination problem within the Veterans Health Administration (VHA) and it is particularly acute with Substance Use Disorder (SUD) treatment. TIF supports efforts to codify and expand access standards to include all extended care services including MH RRTP. We also support ensuring that the calculation of wait times is consistent and clearly communicated to VHA clinical and administrative staff, as well as Veterans, and allowing the Secretary of the Department of Veterans Affairs (VA) the flexibility to reduce wait and drive times. Veterans who need residential support should not be forced to wait beyond 30 days or more and not be offered or denied

Care in the Community (CITC). These Veterans who require immediate care for SUD or risk suicidality do not have 30 days to wait. For substance abusers, time is the enemy. The longer a Veteran waits, the less likely he/she will follow through with treatment. Studies show there is a 48-hour window which substance users must receive treatment before they return to using.

Further, industry standards for SUD detoxification and treatment include residential, inpatient care immediately following (bed-to-bed transfer) detoxification, however VA practices often do not align with those standards. Many VA facilities refer SUD Veteran patients to a community provider for "detox" then send them home without critical follow-up residential care or put Veterans in an intensive outpatient program (IOP) which is against the standards set by industry professionals. This gap in residential services sets Veterans up for failure as they are forced to return to unhealthy or enabling environments leading them back to substance use and causing Veterans to repeat the cycle of "detox" with no rehabilitation. Veterans are being discharged from "detox" with no indication of when treatment will start or referred to an outpatient program which has little chance of success. This pattern of providing a lower level of care following "detox" is harming our Veterans and is contrary to best practices for providing appropriate clinical care. Legislation is needed to ensure Veterans' access to residential care is based on a defined set of standards to be applied at all Veteran Affairs Medical Centers (VAMCs).

We have seen too often the stalemate that occurs when a provider and Veteran believe it is in the best medical interest of the Veteran to be referred to CITC, however the CITC team denies the referral without taking the wishes and best interests of the Veteran into consideration as a determining factor. TIF believes the preference and interest of the Veteran must be a priority when making such decisions and supports expanding the decision to include the Veteran's preference.

Ensuring timely information about CITC approval and denial, and how to appeal a denial, is critically important for Veterans. Establishing a standard for notification will provide clear direction and eliminate ambiguity in whether a Veteran can access a CITC provider. However, we question the ability for the VA to reasonably implement a two-day, written response given staff shortages and other limitations. We also question when the clock starts on the two-days.

Telehealth has been a game-changer for many Veterans. It is useful for Veterans in rural areas without close access to a VAMC for many appointments such as primary care. But telehealth is no substitute for intensive, in-patient treatment for SUD or other mental conditions. We support excluding the availability of telehealth as acceptably meeting the access standards and allowing Veterans to choose CITC and support the availability of telehealth to Veterans to choose for their care.

As previously stated, once a Veteran presents themselves for SUD assessment, the window of time is short to identify and provide the care they seek. A 72-hour timeframe to assess alcohol or drug dependence from the time the VA receives the request is appropriate in our opinion, however we would expand the 72-hour rule to include other, urgent mental health conditions.

We support strengthening accountability for CITC and would advocate for additional measures as outlined in Title II, Sections 205 and 206 of S. 1315, the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023.

TIF supports the codification and expansion of access standards, inclusion of a Veteran's preference in CITC, timely disclosure of CITC information and 72-hour turnaround for SUD and other mental condition assessment. While not addressed in this hearing, we also recommend ensuring the transition from "detox" to residential treatment is a seamless one, without harmful gaps or delays.

TIF supports the intent behind H.R. 3520, however we are disappointed there is not yet bipartisan support for the measure, and we encourage both sides of the Committee to work together to ensure that our veterans receive the high quality and timely care they need.

H.R. 1182, the Veterans Serving Veterans Act of 2023

In recent years, the VA has experienced significant labor shortages. H.R. 1182, Veterans Serving Veterans Act of 2023 would create a pipeline between the Department of Defense (DoD) and VA to create a data base of prospective workers to fill empty VA positions and expedite hiring for qualified members of the Armed Forces. The legislation would also implement a program to train and certify covered veterans to work as intermediate care technicians in VAMCs. TIF supports this bill.

H.R. 2768, the PFC Joseph P. Dwyer Peer Support Program Act

Roughly nine percent of TIF's casework in 2023 has been mental health related. This is the highest concentration behind benefits, housing, and income. Our Case-

work Team remains largely effective in serving over 900 constituents with complex and challenging issues due to the rapport built on peer support. Named to honor the memory of an Iraq war hero, the Joseph P. Dwyer Veteran Peer Support Project is a peer-to-peer program for Veterans facing the challenges of Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). H.R. 2768, PFC Joseph P. Dwyer Peer Support Program Act would expand a successful, local pilot partnership by establishing a grant program to create peer-to-peer mental health programs for veterans. TIF would like to note the important role that many non-congressionally chartered Veteran Service Organizations (VSOs) play in executing programs such as these. We support the intent of this legislation but recommend H.R. 2768 be amended to allow non-congressionally Chartered VSOs to participate in this grant program.

H.R. 2818, the Autonomy for Disabled Veterans Act

TIF's original mission was to support catastrophically wounded post-9/11 Veterans gain the mobility and freedom to have a meaningful quality of life. We have donated over 2,500 all-terrain track chairs to Veterans of all eras and know these devices are life changing. H.R. 2818, the Autonomy for Disabled Veterans Act, provides a much-needed raise in the Home Improvements and Structural Alterations (HISA) grant by increasing the maximum amount authorized from $6,800 to $10,000 for veterans with a service-connected disability and $2,000 to $5,000 for those with disabilities that are not service-connected. These grants allow Veterans the opportunity to improve or enhance their homes to make the necessary accommodations for daily living. We support our disabled Veterans and support H.R. 2818.

H.R. 3581, the Caregiver Outreach and Program Enhancement Act or COPE Act

As a VSO with Caregivers as the CEO and on staff, we understand the toll caregiving can have on the mental health of the Caregiver. We have helped over 2,000 Caregivers through our Caregiver Retreats and continue to support them and their children today. Caregivers sacrifice so much to care for their Veterans and often ignore or dismiss their own mental health needs. H.R. 3581, the Caregiver Outreach and Program Enhancement Act" or "COPE Act" would provide grant funding to organizations to provide much-needed mental health services to Caregivers without the fear they are taking away VA benefits from their Veterans. We fully support our Nation's Caregivers and support H.R. 3581.

H.R. 1278, the Driver Reimbursement Increase for Veteran Equity Act or DRIVE Act

Transportation costs are up. From gas to insurance, our Veterans are paying more to travel to their VAMC appointments. Additionally, the Beneficiary Travel mileage reimbursement rate, which pays eligible Veterans and caregivers back for mileage and other travel expenses to and from approved health care appointments, has not been adjusted in over a decade. H.R. 1278 will update the Beneficiary Travel mileage reimbursement rate as well as ensure VA's mileage reimbursement rates keep up with current prices. It is long overdue to make these changes to ease the financial burden of Veterans and Caregivers traveling to and from their VAMC appointments. TIF supports this bill.

H.R. 1639, VA Zero Suicide Demonstration Project Act of 2023

Veteran suicide is an epidemic facing our country. For Post–9/11 Veterans, this epidemic is even more acute and devastating. Some reports say about 17 Veterans die by suicide a day, however others indicate the number is even higher. Several factors are known to increase suicidality in Veterans including feelings of loneliness, isolation, and stress. The Zero Suicide Initiative was developed by Henry Ford Behavioral Health who was the first to pioneer and conceptualize "zero suicides" as a goal and develop a care pathway to assess and modify suicide risk for patients with depression. This approach proved groundbreaking in terms of suicide-prevention. The Zero Suicide pilot program would build on the VA's suicide prevention efforts by implementing more comprehensive, systems focused Zero Suicide efforts in five VAMCs, including one that serves Veterans in rural or remote areas. As a VSO which engages in suicide-prevention initiatives with Post–9/11 combat Veterans, TIF supports H.R. 1639 and will closely monitor the progress of the chosen VAMCs to observe the success and learn from other suicide-prevention modalities.

H.R. 1815, Expanding Veterans' Options for Long Term Care Act

Long-term care projections outlined in a September 2021 report from the VA to Congress indicated veterans over age 85 were the fastest growing veteran popu-

lation in VA's health care system. Over the next 20 years, the number of veterans in that age group eligible for nursing home care will increase from 61,000 to 387,000, nearly a 535 percent jump. While this statistic is alarming, not all senior Veterans require or desire the comprehensive care provided by nursing homes. Assisted living may be an appropriate alternative which would allow Veterans to live independently. However, the VA is prohibited from covering costs associated with assisted living facilities. H.R. 1815, the Expanding Veterans' Options for Long Term Care Act creates a three-year pilot program for eligible veterans to receive assisted living care paid for by the VA which would help senior Veterans to live more self-sufficiently while reducing costs for the VA. Nursing home fees average nearly $121,000 per year, while assisted living facilities cost only a little more than $51,000 per year. For example, from TIFs case files, Vietnam Combat Veteran "T.K" from Knoxville, TN currently desires assisted living services and is unable to use a Veterans home due to not needing a "skilled-care" level. If eligible for this program, Veterans like him who need a moderate level of support could receive services. TIF Supports this legislation which will help thousands of senior Veterans.

On behalf of The Independence Fund, we thank you again for the opportunity to provide testimony in response to the above legislation. Each bill moves us closer to fully meeting the obligation our Nation carries to support and care for our heroes when they return home. Our Veterans deserve what they were promised when they put on the uniform to serve our country, and our Caregivers deserve the support necessary to care for their Veterans. Please contact our team if you have any questions about this testimony or other that we can work together to assist our community.

Prepared Statement of Concerned Veterans for America

Statement of Russ Duerstine
Deputy Director, Concerned Veterans for America

On

H.R. 3520: The Veteran Care Improvement Act

House Veterans' Affairs Subcommittee on Health
Legislative Hearing

June 21st, 2023

Thank you to Chairwoman Miller-Meeks, Ranking Member Brownley, and the Members of the Subcommittee for the opportunity to submit this statement on behalf of Concerned Veterans for America (CVA). CVA is a grassroots network of thousands of veterans, family members, and patriotic citizens that advocates for and defends policies to preserve freedom and prosperity for all Americans. Our organization is driven to organize and amplify the American veteran's unique perspective to both the American people and our leaders in Washington.

CVA's History in Veterans' Health Care Reform

As a leading advocate for reform and accountability at the Department of Veterans Affairs and for increased health care choices for our veterans since 2012, CVA appreciates the opportunity to support key legislation before the subcommittee today. Throughout our ten-year history, CVA has been on the front lines working to improve veterans' health care outcomes, contributing to bringing three major pieces of veterans' health care legislation across the finish line.

CVA was a key supporter of the passage of the VA MISSION Act in 2018, which passed with overwhelming bipartisan support. This legislation incorporated many of the recommendations of the 2015 Fixing Veterans' Health Care Task Force convened by CVA, namely by creating the Veterans Community Care Program (VCCP). By consolidating existing choice programs and simplifying access standards, the VA MISSION Act offered greater health care choice to millions of veterans, enabling far more to access care where and when they needed it.

Ensuring the full implementation of the VA MISSION Act and holding the VA accountable for failures to do so have been consistent priorities of CVA's since the legislation passed. During the height of the COVID-19 pandemic, the VA admitted to cancelling or delaying 20 million appointments, often without follow-up.[1] This failure makes access to alternative treatment options to VHA care essential.

Unfortunately, the VA's reluctance to honor its regulatory and statutory obligations since the VA MISSION Act's passage has limited millions of veterans' health care choices, too often resulting in

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[1] "Secretary McDonough's remarks to Veterans Service Organizations regarding the American Rescue Plan," VA News, *Department of Veterans Affairs*. February 12, 2021. https://news.va.gov/84721/secretary-mcdonoughs-remarks-veterans-service-organizations-regarding-american-rescue-plan/?utm_source=facebook&utm_medium=social&utm_campaign=&utm_term=&utm_content=

delayed and denied care. After the passage of the PACT Act last year, VA has new treatment obligations to millions of veterans, and ensuring the VA MISSION Act is fully implemented as intended will be essential to helping the VA keep its promises to new and existing beneficiaries alike.

Community care remains under threat and needs further statutory protection. Last summer, Secretary McDonough suggested interest in reducing veterans' health care choices even further by tightening the regulatory access standards for community care.[2] The VA's apparent reluctance to facilitate access to community care was also made clear when it quietly shut down MissionAct.va.gov in 2021, the dedicated website educating veterans on community care options. To address this educational gap, CVA's sister organization, Concerned Veterans for America Foundation, created vamissionact.com, replicating the previous community care resources for the fifth anniversary of the MISSION Act's passage.[3] It should not be necessary for civil society to provide the resources the VA should be offering to veterans to begin with.

In light of the VA's failures to effectively implement and educate veterans about the VCCP, the time has come to codify community care access standards and require greater accountability for the MISSION Act's successful implementation.

H.R. 3520: The Veteran Care Improvement Act
CVA strongly supports H.R. 3520, the Veteran Care Improvement Act (VCIA), brought by Rep. Miller-Meeks. The VCIA directly addresses several ongoing failures of the VA to fully implement the MISSION Act.

Codifying Access Standards
Most importantly, the VCIA codifies the community care access standards created under MISSION Act. Given the VA's refusal to follow these implementing regulations it developed in 2019, codifying them is a vital step. While still providing for a process of regular review and recommended statutory updates to access standards should future changes be necessary, codification through the VCIA provides veterans longer-term certainty about their care options.

Codified access standards are necessary because the VA has refused to implement its own regulations for years. Documents obtained through a Freedom of Information Act lawsuit by the Americans for Prosperity Foundation (AFPF)[4] show that the VA has manipulated wait time data for determining community care eligibility, artificially reducing the length of public wait times. This practice cuts veterans off from community care they are legally entitled to.[5] By continuing to rely on outdated scheduling guidance, the VA uses the metric of "patient indicated date" (PID) rather than a veteran's actual "date of request" for an appointment as directed in the community care access standards.[6] The VCIA requires that wait times must be calculated from a veteran's date of

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[2] Patricia Kime, "VA Weighs Limiting Access to Outside Doctors to Curb Rising Costs," *Military.com*, June 15, 2022. https://www.military.com/daily-news/2022/06/15/va-weighs-limiting-access-outside-doctors-curb-rising-costs.html.
[3] "Increasing Veterans' Access to Health Care: The VA MISSION Act," *Concerned Veterans for America Foundation*, June 2023. VAMISSIONAct.com.
[4] Records confirm VA's use of inaccurate wait time numbers." *Americans for Prosperity Foundation*, October 1, 2021. https://americansforprosperity.org/records-confirm-va-inaccurate-wait-time-numbers/
[5] For a detailed explanation of VA wait time manipulation practices, see: "Delayed and Denied Care: Transparency and Oversight Needed for VA Wait Times," *Concerned Veterans for America*, 2022. https://cv4a.org/wp-content/uploads/2022/02/22_298900_VAPolicyBriefingHandout.pdf.
[6] "Veterans Community Care Program," Department of Veterans Affairs, *Code of Federal Regulations*, title 38 (2019): 26278. https://www.federalregister.gov/documents/2019/06/05/2019-11575/veterans-community-care-program.

request to the date of their appointment, bringing this VA practice that subverts the will of Congress as expressed in the MISSION Act to an end.

Community Care Outreach and Scheduling

The VCIA addresses the issue of the VA routinely failing to educate veterans about their community care options and the access standards for eligibility. At every CVA event around the country, our staff encounter veterans who were previously unaware that community care existed because they were never informed by the VA that it was an option. Veterans who do request community care regularly find themselves having to cite MISSION Act access standards to VA schedulers in order to have their legal right to community care recognized. AFPF's FOIA suit further revealed that internal VA guidance directs schedulers to attempt to persuade veterans to use VHA facilities instead when they request community care access.[7]

Members of this committee are all too familiar with the VA's resistance to offering community care. For example, Chairman Bost, an original co-sponsor of the VCIA, wrote Secretary McDonough last week expressing frustration with the VHA's attempts to deny his constituent access to urgently needed cancer treatment in his community.[8] This veteran legally qualified for community care under the MISSION Act's access standards. Nevertheless, the VA subjected this veteran to four-months of delays and denials, first ignoring requests for updates on the status of their referral and then referencing outdated rules to claim that the veteran did not qualify for community care and would need to drive over 50 miles to a VHA facility for treatment. It took Chairman Bost's staff directly intervening with the VHA central office and reiterating the community care access standards to their staff for the VA to finally relent and approve the veteran's request for community care.

It should not need intervention from a Member of Congress to move the VA to follow its own rules and allow veterans to receive the care they have earned. Unfortunately, veterans like Chairman Bost's constituent deal with these problems every day in every Congressional district and will continue to until the VA is forced to change.

The VCIA addresses these staggering failures by requiring the VA to inform veterans about their community care options and incorporate preferences for this option during scheduling. The VCIA requires the VA to inform veterans of community care eligibility within two business days of determining eligibility internally and periodically reach out with information about the access standards thereafter. If veterans' referral requests are denied, the bill requires the VA to inform them in writing of the reason for the denial and how to appeal. In response to reports of VA administrators overturning clinicians' recommendations that veterans pursue community care, the VCIA makes these agreements final.

Access Standards for Substance Use Treatment:

The VCIA also streamlines community care access for substance use treatment. The legislation adds access standards for residential treatment and rehabilitative services, recognizing the importance of timely treatment. These substance use access standards offer community care eligibility for these services if the VHA cannot provide treatment at a facility within a 10 day wait-time or 30-minute drive from a veteran's home.

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[7] "Standard Mission Act Guidance: Patient Eligibility and Scheduling Sheet," *Department of Veterans Affairs*, October 28, 2020. https://americansforprosperity.org/wp-content/uploads/2021/09/03-Mission-Act-Guidance-Oct.-2020.pdf

[8] Kathleen McCarthy, "Chairman Bost Fights For Veteran Community Care Access, Pushes Back on Biden Administration," *House Committee on Veterans' Affairs*, June 12, 2023. https://veterans.house.gov/news/documentsingle.aspx?DocumentID=6198

Proper Incorporation of Telehealth:
The ongoing importance of embracing innovative, cost-reducing health care options such as telehealth was clearer than ever over the course of the COVID-19 pandemic. The VCIA requires the VA to discuss telehealth options with veterans during scheduling, should that be the right option for their needs.

Crucially, however, the VCIA works to ensure that telehealth is used appropriately, where a virtual appointment makes sense, rather than replacing in-person treatment. Specifically, the VCIA clarifies that telehealth cannot be used by the VA to satisfy wait time targets under the access standards. This provision prevents telehealth availability from being abused by the VA to deny veterans community care access.

Accountability:
The VCIA adds accountability for its implementation as well. The legislation requires the VA Inspector General to assess every VHA medical center's performance at identifying veterans eligible for community care, informing them of this treatment option, and delivering VCCP referrals in a timely fashion, well-coordinated with community providers.

Conclusion:
The VA's failures to fully implement the MISSION Act are well-known and affect millions of veterans in every Congressional district around the country. The VCIA takes necessary steps to protect community care options by codifying current access standards. It adds further protections to community care scheduling to thwart bureaucratic restrictions on veterans' access to the full range of care they have earned. For these reasons, I strongly urge the subcommittee to support H.R. 3520, the Veteran Care Improvement Act.

Respectfully Submitted,

Russ Duerstine
Executive Director
Concerned Veterans for America

Prepared Statement of American Federation of Government Employees

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Eric Bunn Sr. *National Secretary-Treasurer*

Dr. Everett B. Kelley *National President*

Jeremy A. Lannan *NVP for Women & Fair Practices*

June 16, 2023

The Honorable Mariannette Miller-Meeks
1034 Longworth Building
Washington, DC 20515

The Honorable Julia Brownley
2262 Rayburn Building
Washington DC 20515

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

The American Federation of Government Employees, AFL-CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to provide comments on H.R. 3520, the "Veteran Care Improvement Act of 2023," pending before the Subcommittee on Health, House Committee on Veterans' Affairs during the June 21 legislative hearing. AFGE represents more than 750,000 federal and District of Columbia government employees, 291,000 of whom are proud, dedicated Department of Veterans Affairs (VA) employees.

H.R. 3520 would codify community care access standards that require the VA to authorize patients' use of community care providers when the VA cannot provide in-person care within:

- 30 minutes of a veteran's home and 20 days of the veteran's request for primary care, mental health care, or extended care services;
- 60 minutes of a veteran's home and 28 days of the veteran's request for primary care service; or
- a 30-minute drive from the veteran's home and 10 days of veteran's request for residential treatment and rehabilitative services for alcohol or drug dependence.

The bill does not apply these standards to community care providers who would supplant the VA's care. In fact, a recent study found that VA wait times were lower than those for community-based clinicians in many areas.[1] H.R. 3520 would authorize the Secretary to prescribe an even shorter drive-time standard for VA while applying no such standard to community care providers. H.R.3520 would also prevent the Secretary from correcting the current bias in the access standards for telehealth. VA providers cannot satisfy access standards using telehealth while community care providers can. As a result, veterans can be referred to community care because VA cannot meet the access standard for in-person care only to be sent to a community care provider for a telehealth visit.

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[1] Feymany, Y, Asfaw, AA, Griffith, KN. Geographic Variation in Appointment Wait Times for US Military Veterans. *JAMA Network Open*, 2022;5(8):e2228783. doi:10.1001/jamanetworkopen.2022.28783

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Further, H.R. 3520 would undermine VA's power to properly manage community care requests by allowing access to community care when veterans indicate their "preference" to their provider for "where, when, and how to obtain private sector health care." The preference provision superficially offers the veteran the choice between VA and community care services, but over time it would further erode the VA by accelerating the already alarming trend toward privatization.

More than a third of care is now provided by community care. According to the Congressional Budget Office, the percent of VA spending on community care nearly doubled from 2014 to 2021, a trend Secretary McDonough has publicly admitted is unsustainable. H.R. 3520 would further erode the ability of VA to appropriately manage community care by disallowing the VA from overriding inappropriate referrals to community care by third-party administrators.

H.R. 3520 is one-sided and would convert the VA from a provider of care to a payer for private care. This is an effort to dismantle the VA hidden behind the disingenuous language of choice. If enacted, this would deplete the VA of an adequate patient population to operate and eventually lead to facility closures. Academic studies have shown that the VA's in-house care is less expensive and produces health outcomes (as measured by reduced mortality) compared to community care[2]. Bills that recklessly promote community care will unfortunately increase patient waiting times, increase taxpayer costs, and in some cases worsen veterans' health and indeed shorten their lives.

AFGE urges Congress to reject transparent backdoor attempts to dismantle the VA and instead focus on improving it by addressing the workforce shortage, providing adequate funding, undoing the harmful effects of HR modernization and reforming access standards so that they are applied to community care providers as well as VA.

Sincerely,

Julie N. Tippens
Director, Legislative Department

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[2] Chan, DC, Danesh, K, Costanini, S. Mortality among US veterans after emergency visits to Veterans Affairs and other hospitals: retrospective cohort study. *BMJ* 2022; 376 doi: https://doi.org/10.1136/bmj-2021-068099 (Published 16 February 2022)

Prepared Statement of All Points North

We are grateful for the opportunity to submit written testimony about the need to expand access to community care under the MISSION Act for Veterans and their loved-ones suffering with mental health and substance use disorders.

It is estimated that since 2008, more than 70,000 veterans have died by suicide – more than the total number of deaths from combat during the Vietnam War and the Global War on Terrorism combined. Risk of suicide is significantly higher among Veterans who have a mental health and/or substance use disorder.[1] More than 18 percent of all Veterans say they experience high levels of difficulty when transitioning to civilian life. Amongst combat Veterans, over 45 percent describe a difficult transition.[2] After service, many Veterans describe a sense of loss of the camaraderie, honor, duty, and service that inspired them for years or even decades, leaving them alone and without purpose. This serves as a stark reminder that many of America's warriors need mental health and addiction treatment on this side of the uniform.

Approved, in-network community care providers have immediate capacity, expertise, experience, and resources to rapidly and effectively provide medical and clinical care for anxiety, depression, substance misuse, and other known drivers of suicide among Veterans.

For example, All Points North (APN) is an approved substance misuse and behavioral health treatment provider for Veterans with TriWest. With 77 residential beds, APN combines innovative neurotechnology and interventional psychiatry – such as Hyperbaric Oxygen Therapy (HBOT), Deep Transcranial Magnetic Stimulation (dTMS), Stellate Ganglion Block (SGB), Neurofeedback, and Ketamine-assisted treatment – with proven talk and experiential PTSD treatment modalities, extensive group therapy, individual therapy, and medically assisted treatment for substance use disorders, anxiety, and depression. APN's specific Veterans' treatment track creates a safe and specialized environment for Veterans with significant mental health, trauma and substance use disorders. To further support Veterans in an acute condition, APN also has walk-in detox and behavioral health assessment and stabilization facilities in Colorado and California with more facilities opening soon in Texas and Florida.

Because APN focuses on outcomes and transparency, it participates in the ACORN collaboration, a large data base of psychotherapy treatment outcomes. ACORN measures APN's client outcomes against 3,000 other providers and 3 million other patients. APN is in the top 5 percent of provider outcomes, with six-times better client engagement and only 7.3 percent of clients returning for additional care post-treatment. ACORN categorizes APN's Change in Patient Condition as "Significantly Improved".

APN is the only community care provider of its kind for the approximately one million Veterans who live in the VA Rocky Mountain Network (VISN 19), a 10-state region covering Montana, Wyoming, Utah, Colorado, Oklahoma, and portions of North Dakota, Nebraska, Kansas, Nevada, and Idaho.

Despite its innovative services and excellent outcomes, the VA has rarely referred a Veteran to APN for community care under the MISSION Act. Instead, the VA consistently delays approval for Veterans who meet the Eligibility Standards for Access to Community Care under the MISSION Act and ask to be treated at APN. Instead of efficiently and quickly approving a Veteran for life-saving community care, the VA makes them wait for authorization, leaving them to languish in a dangerous "VA decision-limbo" for many weeks and even months without treatment.

To further delay a Veteran's access to community care, the VA often rejects the diagnosis and level of care recommended for a Veteran by a non-VA licensed clinical or medical professional. Instead of accepting the assessment and recommended treatment plan of a licensed clinical or medical professional, who is a specialist trained to diagnose and treat mental health and substance use disorders, Veterans are instead required by VA policy to first see a Primary Care Physician (PCP). This step alone oftentimes and tragically results in the Veteran giving up seeking treatment altogether, putting the Veteran at high risk of suicide or overdose.

Rather than turn them away, APN has consistently admitted and treated any Veteran at risk of suicide or overdose and provided anywhere from thirty to sixty days of intensive, residential care, free of charge. Currently, seven combat Veterans are receiving care at APN's residential facility. Their diagnoses range from severe

[1] Tanielian, Terri, et al. Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans. RAND Corporation, 2008.

[2] Parker, Kim, et al. The American Veteran Experience and the Post–9/11 Generation. Pew Research Center, 10 Sept. 2019.

PTSD and opioid dependence to anxiety and depressive disorders. Less than half of the seven at APN have currently been approved by the VA for community care under the MISSION Act.

Changing the culture of resistance to community care within the VA ranks remains the largest and most time-sensitive challenge to ending Veteran suicide and overdose. A hand-in-hand partnership with its in-network community care providers is something Congress has encouraged, authorized, and advocated through multiple statutory and budget approvals. After nearly a decade of efforts, starting with the Veterans Choice Program, the tools are in place for the VA to engage community care providers as a much-needed extension of mental health and addiction treatment in the life-saving care of Veterans and their families.

Community Care Under the MISSION Act of 2018

Under the MISSION Act of 2018, Veterans may request, and are eligible for, community care when they meet one or more of the MISSION Act Eligibility Standards for Access to Community Care. These eligibility standards were intentionally designed by Congress to accelerate care for Veterans whose condition would otherwise worsen unless treated quickly, and when a Veteran needs a service not available at a nearby VA medical center; a Veteran lives more than a 30 minute drive to their nearest VA medical center; a VA medical center cannot schedule an appointment for the Veteran within 20 days; a Veteran determines that community care is in their best interest; or a Veteran does not feel they are receiving the best care they need at the VA.

For Veterans seeking treatment for a mental health and/or substance use disorder, these access standards rightly prioritize the urgent conditions under which community care treatment services are needed to prevent another Veteran suicide or overdose.

Considering the shocking reality that we are now in our 20th consecutive year with 6,000 or more Veteran suicides per year, there is no rational or humane justification to delay or deny an eligible Veteran efficient and effective mental health and substance use disorder treatment by an approved community care provider.

Community care under the 2018 MISSION Act should be a seamless alternative for Veterans who can't quickly or easily access care at a VA medical center. Unfortunately, there are currently significant obstacles to overcome in order to ensure Veterans can access community care under the law.

The VA's Own Guidance Has Dissuaded Veterans from Community Care Options.

The Americans for Prosperity Foundation (AFPF) has reported extensively on documents obtained under the Freedom of Information Act about the VA's willingness and efficiency in approving Veterans for community care. According to the AFPF, the VA regularly fails to refer, while delaying and denying eligible Veterans for community care under the MISSION Act and its own regulatory requirements.[3]

According to AFPF, the VA Veterans Health Administration's own Referral Coordination Initiative Implementation Guidebook (Updated: October 28, 2021) describes the VA's strategy to reduce utilization of community care because of "more Veterans being referred to the community than expected."[4] The VA's solution to the higher-than-expected access to community care among Veterans was to shift the responsibility of referring to community care from health care providers to "dedicated clinical and administrative staff" who the VA calls "Referral Coordination Teams." This additional process of decision-making was implemented in part because "Veteran feedback suggests many Veterans prefer to receive internal/direct VA care."[5] The AFPF also uncovered a VA training document that creates an additional barrier for a Veteran already eligible for community care. It states, "After eligibility has been confirmed, clinical review is performed to determine if the requested services are clinically appropriate to be authorized for delivery in the community." This extra step is not required in the MISSION Act or implementing regulations, but it could lead to longer wait times or denial of community care.[6]

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[3] "More Evidence the VA Is Improperly Delaying or Denying Community Care to Eligible Veterans." Americans for Prosperity, AFPF, 28 Jan. 2022.

[4] "Veterans Health Administration: Referral Coordination Initiative Implementation Guidebook." U.S. Department of Veterans Affairs, 28 Oct. 2021, pp. 92.

[5] Veterans Health Administration: Referral Coordination Initiative Implementation Guidebook." U.S. Department of Veterans Affairs, 28 Oct. 2021, pp. 90.

[6] "More Evidence the VA Is Improperly Delaying or Denying Community Care to Eligible Veterans." Americans for Prosperity, AFPF, 28 Jan. 2022.

Sadly, some may think that these VA cost-saving measures are justified for fiscal reasons. However, in the face of a two-decades-long suicide crisis, these decision delays leave Veterans languishing in “VA decision-limbo”, putting them a grave risk of suicide and overdose. Delaying an eligible Veteran from receiving community care for mental health and/or addiction treatment it’s nothing short of inhumane, not to mention, unlawful.

Delays to Access Community Care

Long delays veterans face when attempting to access life-saving mental or behavioral health care through the Veterans Administration (VA) betrays America’s Promise by Abraham Lincoln *“To care for him who shall have borne the battle, and for this widow and his orphan.”* According to the VA’s own internal data, veterans waited an average of 41.9 days for an appointment, starting from the time he or she requested an appointment until the date they actually were seen by the VA.

Outside audits of appointment delays at the VA are far more damning. On July 24, 2019, Debra Draper, Director of Health Care at the United States Government Accountability Office (GAO), delivered shocking testimony before the House Committee on Veterans’ Affairs. When considering all factors, veterans are typically waiting up to 70 days for an appointment for care at the VA.

This limbo period, between when a veteran in a mental health or behavioral health crisis first asks for help, and the moment they access care, has become a “Valley of Death.” Consequently, many veterans lose hope, give up, and tragically take their own lives or suffer a lethal overdose.

It is acutely problematic when a veteran seeks non-VA “Community Care” under the MISSION Act of 2018. There are two primary VA policies that create delays which can contribute to suicides for veterans seeking Community Care.

First, veterans are required by VA policy to first see a VA Primary Care Physician (PCP) prior to accessing community care. If and when the veteran finally sees their PCP, many weeks or months later, and secures a referral for Community Care, the VA often overturns the PCP referral and requires the veteran to be treated within the VA’s own health care system. More appointments are then required, and the process starts all over again.

Second, the VA often rejects the diagnosis and level of care recommended for a Veteran by a non-VA licensed clinical or medical professional. Instead of accepting the psychiatric assessment, diagnosis, and recommended treatment plan from a licensed clinical or medical professional, who is a specialist trained to diagnose and treat mental health and substance use disorders, the VA requires the veteran to be assessed by their physician.

These steps and delays don’t make clinical or economic sense for someone with any other life-threating condition such as cancer, heart disease, or a severe allergy. Why then is it acceptable to slow-play and disregard veterans who need immediate intervention and treatment for depression, anxiety, post-traumatic stress, or addiction? Have we not learned anything from the now two-decade-long veteran suicide crisis where we have lost over 6,000 Veterans year over year? The solution is simple. Veterans must have the same rights and access to life-saving mental health and behavioral health care that every other insured American is afforded.

Mental and Behavioral Health Treatment for Non-Veterans

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2018 (a.k.a., mental health parity law or Federal parity law) requires any insurance company to treat mental and behavioral health and substance use disorder coverage equal to, or better than medical/surgical coverage. The law also requires that insurers treat financial requirements equally and lift all limits on the number of mental health visits allowed by an insurance company per year.

The federal parity law applies to all employer-sponsored health coverage, for companies with 50 or more employees, coverage purchased through health insurance. It also applies to exchanges that were created under the Affordable Care Act, the Children’s Health Insurance Program (CHIP), and most Medicaid programs.

Unlike the delays a Veteran has to endure with VA care, under commercial PPO health insurance coverage in the United States, an individual can walk into any in- or out-of-network provider and receive treatment for a mental or behavioral health disorder. Under even the most basic HMO plan, the policy-holder can typically get an appointment and referral from their PCP in less than a week. In the case of a mental or behavioral health referral, approvals are oftentimes expedited due to the emergent nature of the diagnosis and the liability the PCP shoulders if they delay getting their patient into the proper level of care.

Furthermore, under commercial insurance plans, the insurer accepts the psychiatric assessment and diagnosis, performed by the patient's chosen healthcare provider.

Policy Recommendations

Therefore, to eliminate delays in life-saving services and to reduce Veteran suicide and overdose:

1) Congress should ensure that all Veterans who meet one or more of the MISSION Act Eligibility Standards for Access to Community Care should be afforded both the same choice of when and where they receive treatment that is given under the Urgent Care exception in the MISSION Act and the same choice afforded to every American under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

2) Congress should ensure that all Veterans who self-refer to Community Care, and who meet one or more of the MISSION Act Eligibility Standards for Access to Community Care, are quickly assessed by a licensed clinical or medical Community Care professional, and promptly approved for the indicated level of care by the VA, without the requirement that a Veteran must first see their Primary Care Physician. Congress should consider imposing a 7-day maximum waiting period for mental health care attendant to a finding of suicidal crisis/ideation or any assessment that is deemed life-threatening.

3) Congress should ensure that diagnostic assessments conducted by any licensed clinical or medical professional (whether at the VA or in the community) are the standard for diagnosis and level of care placement for Veterans.

4) Congress should pass H.R. 3520 the Veteran Care Improvement Act of 2023 as it addresses barriers that are preventing access to mental health care via Community Care for veterans in crisis and recognizes the difficulties that veterans and clinicians are facing in rapidly providing assessment and care to prevent suicide.

5) Congress should pass H.R. 3554, the Protecting Veteran Community Care Act as it provides much needed reforms to the Community Care program at VA specific to mental health and can make a measurable difference in preventing veteran suicide.

About the Author

West Huddleston has been advocating for and helping Veterans who have substance misuse and/or behavioral health treatment needs for 30 years. As the former CEO of the Washington, DC-based National Association of Drug Court Professionals (NADCP) and founder and Executive Director of Justice For Vets, he led the only national organization dedicated to transforming the way the justice system identifies, assesses, and treats justice-involved Veterans. Due in part to his effort, there are now over 700 Veterans Treatment Courts across the United States, significant federal and State funding, as well as engagement by the VA, national and state Veteran Service Organizations, and a vast network of volunteer Veteran Mentors. West is on the Advisory Boards of the Harvard Medical School CHA Division on Addiction and All Points North (APN). He is the former Vice Chairman of the Board of The Independence Fund, granting mobility to our Nation's catastrophically wounded combat Veterans and the proud dad of an Active-Duty son in the United States Armed Forces.

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 these important pieces of legislation pending before this subcommittee.

H.R. 1182, Veterans Serving Veterans Act of 2023

The VFW supports this legislation that would amend the *VA Choice and Quality Employment Act of 2017* (P.L. 115–46) to direct the Secretary of Veterans Affairs (VA) to establish a vacancy data base to facilitate the recruitment of certain members of the armed forces to satisfy the occupational needs of VA, and to establish

and implement a training and certification program for intermediate care technicians. The VFW recognizes the skill sets that veterans obtain from their time in service and the need for those skills in our workforce. Providing training and certifications would help veterans obtain employment, and also aid VA with hiring the qualified employees it desperately needs to fill its vacancies. This would be beneficial to both transitioning service members and to veterans receiving care at VA facilities.

H.R. 1278, DRIVE Act

The VFW supports this legislation that would increase the rate of reimbursement payments provided by VA for beneficiary travel. The VFW agrees that beneficiary travel rates should be at least equal to those for government employees. The inflation of automotive fuel cost has made it more financially difficult for veterans to travel to their appointments. Prices have risen but the travel beneficiary has remained the same, causing hardship for some veterans. This proposed increase would equalize VA with all other government agencies. Veterans should receive reimbursement payments at a rate that enables them to afford the cost of travel to health care appointments.

H.R. 1639, VA Zero Suicide Demonstration Project Act of 2023

The VFW supports this legislation that would establish the Zero Suicide Initiative pilot program of VA. Reducing the number of service members and veterans who die by suicide has been a priority for the VFW and will remain so until it is no longer needed. This multi-layered approach consists of continuous suicide screening at all health care touchpoints, creating a crisis plan, and maintaining consistent communication with veterans. Removing the stigma of discussing suicide and fostering healthy conversation will help in reaching the goal of zero suicides. The Veterans Health Administration has the opportunity to support all VA providers with the tools and knowledge to screen their patients for suicide at every appointment.

H.R. 1774, VA Emergency Transportation Act

The VFW supports this legislation to reimburse a veteran for the reasonable cost of emergency medical transportation by a non-VA provider to a facility for emergency treatment, or from a non-VA facility to a VA or other federal facility for additional care. A veteran should not be burdened with the transportation cost component of receiving critical medical attention.

H.R. 1815, Expanding Veterans' Options for Long Term Care Act

The VFW supports this legislation that would require VA to carry out a three-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans. Assisted living facilities are needed when a veteran does not require nursing home care but cannot live alone. This program would allow veterans to receive needed services without being financially responsible for the cost, thereby reducing or eliminating the burden on family members who may not be able to provide round-the-clock care. This option for long-term care has great potential for veterans to still have some independence while being cared for at facilities that are authorized and inspected by VA.

H.R. 2683, VA Flood Preparedness Act

The VFW knows this proposal has a worthy goal, but cannot support it at this time. The Ralph H. Johnson VA Medical Center is located in a highly flood-prone area that can cause life-threatening conditions for patients during flood emergencies, which of course is a major concern. However, VA's current authority to make contributions to local authorities was meant to help patients safely ingress and egress facilities. We believe making contributions to local authorities for major infrastructure work would be outside of the intent of Section 8108, Title 38, United States Code. Additionally, the VFW believes VA infrastructure is already underfunded and does not have sufficient personnel to oversee its own backlog of necessary infrastructure work. Rather than routing VA funds to local communities to combat the effects of rising sea levels, we recommend adding funds for the U.S. Army Corps of Engineers to incorporate this problem or to prioritize it in existing projects.

H.R. 2768, PFC Joseph P. Dwyer Peer Support Program Act

The VFW supports this legislation that would make grants to State and local entities to carry out peer-to-peer mental health programs. The VFW recognizes that all veterans do not utilize VA facilities to obtain mental health services or the support of peer-to-peer specialists. This grant would enable eligible entities to establish

peer-to-peer mental health programs for veterans. We understand there is a demand for more mental health services, and would particularly like to see additional services in rural areas.

H.R. 2818, Autonomy for Disabled Veterans Act

The VFW supports this legislation that would increase the amount paid by VA to veterans for medically necessary improvements and structural alterations furnished as part of home health services. As veterans age their mobility may decrease, which may make navigating their surroundings and accomplishing daily tasks increasingly difficult. Having a resource for improvements or alterations creates more accessible, safer homes, and better quality of life for these veterans.

H.R. 3520, Veteran Care Improvement Act of 2023

The VFW supports this legislation that would improve the provision of care and services under the Veterans Community Care Program of VA. We understand this program is essential as it provides services for veterans who live too far from a VA facility or in the event a requested appointment is not available in an acceptable timeframe. VA's focus should remain on how veterans can receive the care they need, whether it is inside or outside of its facilities.

Adapting a value-based health care model allows for a patient-centered system that aligns with VA's whole health care approach. Value-based care programs focus on prevention efforts to reduce illnesses and suicide, which is a top priority of VA. The VFW also supports the continuation of the Electronic Health Record Modernization program as it is needed to work in conjunction with the value-based program.

The VFW agrees the ability to access the scheduling system would help improve the timeliness of appointments and/or allow veterans to obtain care at non-VA facilities. Medical record documentation needs a timely return to allow VA providers to access treatments received and determine if additional follow-up would be appropriate. The VFW understands the need for VA to explore a value-based reimbursement plan to determine and implement a more holistic system.

There are two parts of this proposal we believe should be clarified. Section 4 may provide contradictory guidance to patients or clinicians regarding a veteran's preference for care. Currently, if a veteran and the veteran's referring clinician agree that receiving care and services through a non-VA entity or provider would be in the best medical interests of the veteran, then the veteran is referred to community care. We are concerned this proposed section has the potential to allow for conflicts with the veteran's preference and the best medical interest of the veteran. We would like to see this clarified.

Additionally, the VFW questions if the telehealth provisions in Section 2 and Section 6 are in conflict with each other. Telehealth is a critical tool for VA to deliver care for veterans. Veterans should not have telehealth appointments scheduled for them if that is not their request or preference. However, we do believe they should be an option if appropriate to patients' wants and needs. We look forward to working with the committee to ensure the best outcomes are available for veterans.

H.R. 3581, Caregiver Outreach and Program Enhancement (COPE) Act

The VFW supports this legislation that would modify the family caregiver program of VA to include services related to mental health and neurological disorders. However, we would like clarification on the neurological disorders referred to in this bill. Caring for our nation's veterans is not an easy task. The diverse and often complex issues our veterans face require the care and support of well-trained caregivers. Balancing everyday life with the health care needs of a veteran can cause mental, emotional, and physical distress for the caregiver. The VFW believes that caregivers need support to ensure they are healthy enough to be of service.

Chairwoman Miller-Meeks, Ranking Member Brownley, this concludes my testimony. I am prepared to answer any questions you or the subcommittee members may have.

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 Paralyzed Veterans of America

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit 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 VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). Several of these bills will help to ensure veterans receive much needed aid and support. PVA provides comment on the following bills included in today's hearing.

H.R. 3520, the Veteran Care Improvement Act of 2023

PVA has concerns about how this bill would affect care for veterans with the greatest support needs. First, care in the community should only be offered when it is unavailable at VA facilities, or when it is based on sound medical judgment in the best interest of the veteran. Section 4 expands the criteria VA must consider when authorizing community care, and the additional variables could eventually cause VA to circumvent these important tenants of the community care program and eventually harm VA's ability to provide the care. Second, Section 9 allows VA to negotiate with third party administrators to establish the use of value-based reimbursement models under the Veterans Community Care Program. Value-based models were designed for the "for profit" healthcare sector and are often not suitable for the management of complex medical conditions. We have concerns about how VA might implement such a model.

H.R. 3581, the Cope Act

The Cope Act seeks to help veterans' caregivers by authorizing the VA to provide grants to organizations whose mission is focused on the mental healthcare of participants in its Program of Comprehensive Assistance for Family Caregivers. It also requires the Department to provide outreach to registered caregivers. Veterans' caregivers are often isolated, forced to give up careers or lifestyles to provide around-the-clock medical and emotional support for their loved one. They are normally so focused on the needs of their veterans that they will put their own well-being on the backburner. PVA supports this bill, which would help caregivers meet their emotional needs, so they can continue to support their veterans.

H.R. 1182, the Veterans Serving Veterans Act

The Veterans Service Veterans Act establishes a vacancy and recruitment data base to facilitate the recruitment of soon to separate members of the Armed Forces in order to fill vacant positions at VA. To do so, it requires DOD to provide the names and contact information of every member of the Armed Forces whose military occupational specialty or skill corresponds to an employment vacancy at the VA. We are unconvinced the current employment data bases are so insufficient that it justifies this degree of interagency investment and upkeep. Most concerning, this data base of DOD information, to be maintained by VA, would automatically submit service members' information and require one to opt-out, rather than opt-in, in writing. PVA commends the intent of this legislation, to fill vacancies and provide suitable employment to newly separated service members, but we recommend the privacy and efficiency concerns be addressed.

H.R. 1278, the Drive Act

The Drive Act increases the mileage reimbursement rate available to beneficiaries for travel to or from VA facilities in connection with vocational rehabilitation; required counseling; or for the purpose of examination, treatment, or care. Specifically, the bill makes the reimbursement rate for such travel equal to or greater than the mileage reimbursement rate for government employees using private vehicles when no government vehicle is available. Government employees travel rates are adjusted annually but reimbursement rates for veterans are not. Under current regulations, VA reimburses veterans when traveling for a VA health care appointment at a rate of 41.5 cents per mile, which is far less than what government employees receive. PVA endorses this bill, because veterans should not be subject to a lower reimbursement rate.

H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023

PVA supports this measure, which directs the VA to establish the Zero Suicide Initiative pilot program at five VA medical centers across the country. This proposed pilot program would help the VA identify gaps in care and create a multi-layered approach with evidence-based interventions to ensure veterans at risk of suicide do

not slip through the cracks and transform the culture around suicide prevention. The pilot program would require the VA to consult with several outside stakeholders and agencies such as the National Institutes of Health, the Department of Health and Human Services, and different offices within the VA.

According to a recent VA Office of Inspector General report, approximately 163,000 veterans were referred to a Suicide Prevention Coordinator between March 2019 and June 2020.[1] This statistic paints a stark picture for veterans. The current system needs strengthening. The Zero Suicide Institute has seen impressive results from its quality improvement model, transforming system-wide suicide prevention and care to save lives. They report a reduction in suicide deaths and hospitalizations, an increase in quality and continuity of care, improvements in post-discharge follow-up visits, and improvements in screening rates.[2] Implementing a similar project through the VA could reduce veteran suicides and should be pursued.

H.R. 1774, the VA Emergency Transportation Act

PVA supports this bill, which requires the VA to properly reimburse veterans for the cost of emergency transportation by a non-VA provider to a facility for emergency treatment, or from a non-VA facility where the veteran was being treated to a VA or other federal facility for additional care. We feel this commonsense legislation will decrease veterans' worries about the cost of emergency transportation by eliminating this financial burden.

H.R. 1815, the Expanding Veterans' Options for Long Term Care Act

Currently, the VA can refer veterans to assisted living facilities, but it cannot directly pay for that care. PVA strongly supports the Expanding Veterans' Options for Long Term Care Act, which would create a three-year pilot program at six VISNs, including at least two program sites in rural areas and two in state veterans homes to test the benefit of having VA pay for this care. Veterans eligible for the pilot would include those already receiving nursing home-level care paid for by the VA and those who are eligible to receive assisted living services or nursing home care. At the conclusion of the pilot program, participating veterans will be given the option to continue receiving assisted living services at their assigned site, paid for by the VA. We believe this would help veterans and the VA alike by giving greater access to assisted living and reducing costs for long-term care, allowing more veterans to receive needed assistance.

H.R. 2818, the Autonomy for Disabled Veterans Act

Improvements are long overdue for VA's Home Improvements and Structural Alterations (HISA) grant program. As the name suggests, HISA grants help fund improvements and changes to an eligible veteran's home. Examples of qualifying improvements include improving the entrance or exit from their homes, restoring access to the kitchen or bathroom by lowering counters and sinks, and making necessary repairs or upgrades to plumbing or electrical systems due to installation of home medical equipment.

A lifetime HISA benefit is worth up to $6,800 for veterans who need a housing modification due to a service-connected condition. Veterans who rate 50 percent service-connected may receive the same amount even if a modification is needed due to a non-service-connected disability. Veterans who are not service-connected but are enrolled in the VA healthcare system can receive up to $2,000. These rates have not changed since 2010 even though the cost of home modifications and labor has risen at least 50 percent during the same timeframe. As a result, the latter figure has become so insufficient it barely covers the cost of installing safety bars inside a veteran's bathroom.

In the past, our service officers reported having veterans who had used the HISA grant more than once because the remainder of the one-time amount would cover at least part of a second project. Today, they rarely have veterans with remaining balances because veterans' entire allowance coupled with their own money is needed to complete one project. This should not be happening.

PVA strongly supports this legislation, but believes it could be made even better by adjusting the text so it offers a single rate of $10,000 for all veterans and ties future increases to the same index VA uses for its other home modification programs. The most commonly requested HISA grant alteration is to renovate a bathroom. Nationwide, it costs about $10,000 to modify an average size bathroom.

[1] VAOIG Report 20–02186–78, Suicide Prevention Coordinators Need Improved Training, Guidance, and Oversight

[2] Zero Suicide Results; the Zero Suicide Institute

Increasing the grant amount to $10,000 for all enrolled veterans would allow for this critical modification. We also believe the relevance of the grant program would be better sustained if it used a formula like the Turner Building Index which calculates the actual costs of home modifications. HISA grants were intended to serve injured and aging veterans at a time in their lives when they need it the most, and we appreciate the effort to restore this grant program to its originally intended strength.

PVA would once again like to thank the Subcommittee for the opportunity to submit our views on some of the bills being considered today. We look forward to working with the Subcommittee on this legislation and would be happy to take any questions for the record.

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.

Prepared Statement of Argentum

June 21, 2023

The Honorable Mariannette Miller-Meeks
Chairwoman
House Committee on Veterans' Affairs
Subcommittee on Health
364 Cannon House Office Building
Washington, D.C. 20003

The Honorable Julia Brownley
House Committee on Veterans' Affairs
Subcommittee on Health
364 Cannon House Office Building
Washington, D.C. 20003

Dear Chairwoman Miller-Meeks and Ranking Member Brownley:

On behalf of Argentum, the leading national association representing senior living communities and the older adults and families they serve, I appreciate your holding today's hearing on pending legislation, including H.R. 1815, the Expanding Veterans' Options for Long-Term Care Act.

The members of Argentum operate senior living communities offering assisted living, independent living, continuing care, and memory care services. Along with its state partners, Argentum's membership represents approximately 75 percent of the professionally managed communities in the senior living industry—an industry with a national economic impact of nearly a quarter of a trillion dollars and responsible for providing more than 1.6 million jobs. These communities are home to nearly two million vulnerable seniors, offering choice, dignity, security, and comfort in the final years of life.

Our veteran population is aging rapidly, and so are their long-term care needs. According to the U.S. Department of Veterans Affairs, roughly half of the 9 million veterans currently enrolled in veterans' health care programs are 65 or older. Over the next decade, the number of veterans over 75 is expected to approach 3 million. The number of veterans aged 85 or older receiving care from VA health services is expected to grow approximately 535 percent over the next 20 years.

Federal data shows that someone turning age 65 today has a 70 percent chance of needing some type of long-term care in their lifetime. However, the Department of Veterans' Affairs predicts that approximately 80 percent of veterans will develop the need for long-term services.

Argentum, its members, and its state partner organizations strongly support H.R. 1815, a commonsense approach to expand veterans' access to assisted living services at a time that the aging population is creating growing demand by older Americans and veterans for assisted living and other long-term care options. Many veterans eligible for nursing home care may not need skilled nursing or other institutional settings and may prefer a more home-like setting that promotes independence such as assisted living when appropriate.

In her prepared remarks, Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services at the Department of Veterans Affairs, indicated that the VA supports H.R. 1815, with some technical amendments and subject to the availability of appropriations. We welcome the VA's support of this important legislation.

In a 2021 report to Congress, the VA outlined federal savings that could be achieved if veterans were given the option of assisted living care. Approximately 5 percent of veterans residing in federally funded Community Nursing Homes (CNHs) could be appropriately housed in assisted living. In FY2020 the annual cost of a CNH placement was $120,701 compared with $51,600 for assisted living. By utilizing assisted living for individuals who meet the relevant criteria at the time of admission, the VA would realize a potential cost of avoidance of $69,101 per placement per year.

Assisted living communities are home to two million seniors, of which 42% are veterans or their spouses. However, the current VA prohibition on paying for assisted living room and board fees means many low-income veterans who participate in federal assistance programs have had to pay for almost all assisted living costs out of pocket. H.R. 1815 is the first step in addressing this issue by helping VA provide access to a greater range of long-term care options, and prepare to care for the ever-increasing population of aging veterans.

Argentum and its members look forward to working with members of the Veterans Affairs Committee to pass H.R. 1815, and to identify bipartisan legislative solutions to increase veterans' access to assisted living. Please contact me with any questions or requests for additional information.

Sincerely,

James Balda
President & CEO
Argentum

Prepared Statement of The Honorable Mark Alford (MO-04)

Chairwoman Mariannette Miller-Meeks and Ranking Member Julia Brownley, thank you for the opportunity to submit a statement as the Subcommittee considers H.R. 1774, the VA Emergency Transportation Act.

H.R. 1774 replaces the term “emergency treatment” with “emergency services” and defines “emergency services” to include both emergency treatment and transportation. If enacted, this bill would cover emergency transportation to a non-Veterans’ Affairs (VA) facility for treatment.

Under current law, the VA only covers emergency transportation within the VA network. While veterans can always file a claim with the VA for reimbursement, there is no guarantee their costs for emergency transportation outside the VA network will be covered.

What is a veteran to do if they experience an emergency and require emergency transportation outside of the VA network? This is not a concern men and women who selflessly gave everything to serve this country should have to deal with.

Missouri’s Fourth congressional District is proudly home to two prestigious military installations, Whiteman Air Force Base and Fort Leonard Wood. These bases generate a significant military population to our district, including a substantial number of veterans. Our veterans made the decision to put their life on the line to defend our country and it is our duty to support their health and prosperity in civilian life.

Once again, I would like to thank the Veterans’ Affairs Subcommittee on Health, Chairwoman Mariannette Miller-Meeks, and Ranking Member Julia Brownley for this opportunity. I appreciate the committee holding this important hearing and hope this bill passes with overwhelming support.

Prepared Statement of The Honorable Susie Lee (NV-03)

Chair Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee, thank you for this opportunity to share my strong support for passage of a bipartisan bill I introduced earlier this year, H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023.

As members of the House Committee on Veterans Affairs, you are far too familiar with the fact that suicide is a serious, devastating issue in the United States, especially for our veterans and their families.

The suicide rate for veterans is one and a half times higher than that of the general population, with an average of 17 veterans dying by suicide each day. Many veterans in southern Nevada have told me they think the number is even higher. Of those 17 veterans a day, 40 percent of them are actively seen at the VA, which means we lose approximately seven veterans a day to suicide who receive VA care. These numbers are simply unacceptable.

Given the unique stressors and risk factors we know veterans face, Congress needs to do more to ensure those who served our country are effectively, consistently supported through their worst moments.

We need to do more to advance suicide prevention efforts among veterans across our communities—keeping in mind the truth that even one suicide is too many. We need to change our mindset and do everything in our power to bring the number of veteran suicides to zero.

That’s why I reintroduced the VA Zero Suicide Demonstration Project Act in March 2023, alongside my colleague, Representative Tony Gonzales. Building on VA’s existing suicide prevention efforts, this bipartisan, bicameral bill would stand up a Zero Suicide Initiative pilot program at the VA.

Developed in Michigan’s Henry Ford Health Care System, this program is rooted in the belief that all suicides are preventable through proper care, patient safety, and system-wide planning. This model trains and empowers clinicians to assess for suicide risks at every encounter with patients, identifying risk factors as well as interventions, self-management tools, and other effective suicide prevention techniques.

This Zero Suicide approach has delivered statistically significant results across diverse health system, including a notable 18-month period without a single suicide. We owe it to veterans to ensure they have access to this proven approach to suicide prevention.

This bill will ensure veterans have the care and support they deserve, by implementing a pilot program across five VA medical centers and offering them Zero Suicide Initiative training and support. It’s all about changing mindsets and rearranging priorities with a commitment to getting to zero suicides a day.

The bill does not authorize any new spending, and it has been endorsed by many leading VSOs and national mental health organizations—some of which have submitted letters of support for this hearing.

Last Congress, this bill saw robust bipartisan support through a successful legislative hearing and passage by voice vote through this committee. While the bill did not come up for vote before the full House during the 117th, I am glad to return to the committee and to urge my colleagues to do all we can to see it through this Congress. Thank you for the committee's attention to and support for this critical piece of legislation. I look forward to working with you all to pass the VA Zero Suicide Demonstration Project Act into law, and to take a critical step in preventing veteran suicide.

Prepared Statement of The Honorable Denis McDonough

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

October 3, 2023

The Honorable Mike Bost
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Chairman Bost:

Enclosed for the Committee's consideration are the Department of Veterans Affairs (VA) views on H.R. 2683, the VA Flood Preparedness Act, which was a topic on the agenda for the Subcommittee on Health's June 21, 2023, legislative hearing.

VA is committed to flood preparedness. Having experienced roadway flooding that restricted access to our medical facilities, we understand how mitigating flooding assists with delivering timely, world-class care and services to the Nation's Veterans, their families, caregivers, and survivors. We welcome the opportunity to work with you and your staff to further our shared goal of continuing to strengthen our properties for current and future generations of Veterans.

Thank you for your continued support of our mission.

Sincerely,

Denis McDonough

Enclosure

Enclosure

H.R. 2683 VA Flood Preparedness Act

H.R. 2683 would amend 38 U.S.C. § 8108, which authorizes VA to make contributions to local authorities toward, or for, the construction of traffic controls, road improvements, or other devices adjacent to a medical facility if considered necessary for safe ingress or egress. Specifically, this bill would authorize VA to make such contributions to mitigate the risk of flooding, including the risk of flooding associated with rising sea levels. The bill also would require VA to submit to Congress a report, not later than 2 years after the date of enactment, that includes an assessment of the extent to which each medical facility (as defined in 38 U.S.C. § 8101(3), which includes any facility or part thereof over which VA has jurisdiction for the provision of health care services, including any necessary buildings and auxiliary structures, garages, parking facilities, mechanical equipment, trackage facilities leading thereto, abutting sidewalks, accommodations for attending personnel, and recreation facilities associated therewith) is at risk of flooding, including the risk of flooding associated with rising sea levels, and whether any additional resources are necessary to address the risk of flooding at each such facility.

Position: VA does not support.

VA does not support the use of discretionary resources for the expanded purposes identified in Flood Preparedness Act TM-118-37.

VA has concluded that it can accomplish nearly all proposed scenarios within existing statutory authority. For the limited scenarios that are not authorized by existing statute, VA does not support this expanded authority allowing the expense of discretionary resources for these purposes.