STATEMENT OF CAROLYN CLANCY M.D., MACP
ASSISTANT UNDER SECRETARY FOR HEALTH, DISCOVERY, EDUCATION, AND AFFILIATE NETWORKS
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 11, 2024

Good afternoon, Madam Chair, Ranking Member Brownley, and other Members of the Subcommittee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today are Dr. Matthew Miller, Executive Director of the Office of Suicide Prevention, Dr. Ajit Pai, Executive Director for the Office of Rehabilitation and Prosthetic Services, and Mr. Ryan Heiman, Acting Director for Member Services.

VA does not have views on section 3(b) of H.R. 8562 or the draft bill that would require VA to carry out a pilot program to provide grants to outpatient mental health facilities. VA will provide these views to the Subcommittee in a letter after the hearing.

H.R. 6291 Have You Served Act

Section 2(a) would require VA to make grants to eligible entities for the purpose of carrying out the Ask the Question campaigns to encourage human services professionals, State and local governments, and community providers to ask consumers whether they or a loved one have served in the Armed Forces. Section 2(b) would require eligible entities that receive a grant use it to develop or expand an Ask the Question campaign and for associated program costs. Section 2(c) would define eligible entities to mean a State, Native American, or Alaska Native Tribe that develops a Governors Challenge Action plan (in the case of a State) or a Veteran suicide prevention plan (in the case of a Native American or Alaska Native tribe) and submits to VA a proposal for the implementation of such plans. Section 2(d) would require VA to provide technical assistance to eligible entities that receive grants. Section 2(e) would permit VA to make up to 25 grants for fiscal years (FY) 2024-and 2026, but each grant could not exceed $200,000. Section 2(f) would require eligible entities, as a condition of receiving a grant, to agree to submit to VA a report on the key performance indicators for the training provided using the grant funds. Section 2(f) would also require VA, no later than 1 year after enactment, to submit a report to Congress on the implementation of section 2, and for each fiscal year for which VA makes a grant under section 2, to submit a report to Congress on performance indicators for the training provided under such grants. Section 2(g) would require VA, in coordination with the Director of the Office of Management and Budget (OMB), to develop a plan to work with each Federal department and agency to implement Ask the Question campaigns, where appropriate,

through any social service or health care programs they operate. Section 2(h) would authorize $6 million each for fiscal years 2024 through 2028 to be appropriated to VA. Section 2(i) would define the term State to mean each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

VA supports this bill, subject to amendments and the availability of appropriations. VA generally supports the bill's intent to encourage human services professionals, State and local governments, and community providers to ask consumers whether they or a loved one have served in the Armed Forces. However, the bill requires additional technical and clarifying edits to ensure VA can carry out this grant program. The bill needs greater clarity in terms of the application process; requirements for applicants; the award of grants; the use of grant funds; and the administration of the grant program. VA also recommends modifying some of the requirements in the bill, such as the provision of technical assistance and the content of such assistance, to be more permissive to ensure that VA has the necessary flexibility to support the successful implementation by grantees. Additionally, we recommend the bill be updated to clarify the time period(s) in which VA would be authorized to make these grants. First, subsections (e) and (h) refer to FY 2024, which is nearly over. Also, if enacted, VA would need time to publish regulations and develop a grant program to implement this authority. Second, the 3-year authorization period in section 2(e) (for fiscal years 2024 through 2026) does not align with the 5-year authorization of appropriations period in section 2(h) (for fiscal years 2024 through 2028). Additionally, section 2(e) would provide VA with discretionary authority to make up to 25 grants in fiscal years 2024 through 2026 but would require that each such grant be in an amount up to $200,000. The bill is silent on any limits to the number and amount of such grants in the fiscal years after 2026.

VA further recommends the bill be amended to support a broader array of VA services and benefits, including peer support, transition needs, and local community engagement related to a range of efforts, including increasing access to health care and benefits, promoting food security, combatting homelessness, improving employment and education opportunities, and addressing transportation needs. VA also recommends expanding the scope of eligible entities that can apply for grants to consider community partnerships and collaborations engaged in the VetResources Community Network managed by VA's Veterans Experience Office, and Veteran community partnerships managed by the VHA National Center for Healthcare Advancement and Partnerships.

VA would be pleased to provide technical assistance to this legislation to address these recommendations.

VA estimates this bill would cost $3.1 million in the first fiscal year that it could implement this authority (likely FY 2026); $5.3 million in the second year; and $13.7 million over a 3-year period, as seems to be contemplated in section 2(e).

H.R. 6330 Veterans' Sentinel Act

Section 2(a) would require VA, within 90 days of the date of the enactment of this Act, to establish in the Office of Mental Health and Suicide Prevention (OMHSP) a pilot program for at least 2 years under which VA establishes a working group to collect and analyze data regarding on-campus suicides and attempted suicides. The working group would have to include staff from across VA and would report directly to the OMHSP Executive Director. The working group would have to use root cause analysis (RCA) to review all on-campus suicides and attempted suicides; conduct Behavioral Health Autopsy Program (BHAP) assessments document reasons for any deficiencies in the collected data with respect to on-campus suicides; and communicate every 90 days with VA medical centers (VAMC) and field offices to coordinate the collection and review actions of the working Group with review actions carried out by VAMCs and field offices. The working group would have to consider, and could implement for purposes of the pilot program, improvements to the process by which VA collects data on on-campus suicides and attempted suicides to unify the disparate sources of such data. VA would have to provide to Congress annual briefings on the progress and findings of the working group. Within 30 days of the completion of the pilot program, VA would have to submit to Congress a report detailing the effectiveness of the working group and any recommendations to enhance the data collection and management by VA with respect to on-campus suicides and attempted suicides.

VA supports section 2(a), subject to amendments. Annually, Veteran suicide deaths that occur on VA property represent less than 0.5% of the more than 6,000 Veteran suicides each year. Although on-campus suicides among Veterans represent a small fraction of overall Veteran suicide events, the impact is often widely felt among those who love, care for, and serve Veterans.

In 2020, the Government Accountability Office (GAO) issued a report, *Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides* (GAO 20-664),[1] which cited concerns with VA enterprise-wide processes for on-campus suicide surveillance. In response to GAO's recommendations, VA established an intra-agency workgroup; improved processes to accurately identify all on-campus Veteran deaths by suicide; and expanded analyses of on-campus Veteran suicides with annual reports of detailed findings that include information from RCAs and BHAP data. These efforts are in line with the general requirements of this section.

However, VA recommends some changes to section 2(a) to ensure resources can be used optimally to prevent Veteran suicide. Initially, it is important that the bill be amended to only impose requirements, such as using RCAs or BHAPs, when advisable. We recommend this for two reasons. First, BHAP family interviews are voluntary, and VA cannot mandate or require that family members complete an interview. Second, RCAs are extremely time- and resource-intensive, but they are not always necessary to determine how or why a suicide occurred. By extension, VA does not require RCAs for all suicide attempts or deaths by suicide that occur on a VA property. Similarly, BHAP

[1] https://www.gao.gov/products/gao-20-664

chart reviews are completed for all identified Veteran deaths by suicide, regardless of whether they are on-campus, but they are not completed for non-fatal suicide attempts, regardless of where they occur. If Congress were to require VA to conduct an RCA, in particular, for every suicide attempt on VA property, VA would require a significant increase in resources to support these efforts but would not expect to see sufficient value from this information to justify the investment. VA recommends that Congress not legislate a particular methodology or evaluation method, as this could also restrict VA's ability to develop and apply new and innovative solutions.

VA further recommends that references to OMHSP be removed (including in subsections (b) and (c) of section 2), because that Office no longer exists. We recommend against further specifying responsibilities for sub-organizations within VA; requiring the Secretary to take action is sufficient.

VA estimates section 2(a) would not result in any additional costs if it were amended as discussed above. If section 2(a) were enacted as written, while VA is unable to project a specific amount, it expects the costs would be significant.

VA supports section 2(b). Section 2(b) would amend section 1709B of title 38, United States Code to require VA, on an annual basis, to evaluate the statistical trends of suicides and attempted suicides by Veterans that occur on VA property and determine recommendations for preventing such suicides and attempted suicides. In its annual report to Congress under this section, VA would have to include the evaluation and recommendations and such other matters as determined appropriate.

The National Strategy for Preventing Veteran Suicide (2018-2028) underscores the importance of surveillance-related goals and objectives. Timely and useful surveillance efforts are needed to improve the ability to collect, analyze, and use information for action to bring an end to suicides among Veterans. Section 2(b) would support these efforts and ensure regular focus on these issues while ensuring that Congress would be informed of matters related to suicide prevention.

VA estimates section 2(b) would result in no additional costs.

VA defers to the Comptroller General regarding section 2(c). Section 2(c) would require the Comptroller General, within one year of the date of the enactment of this Act, to submit to Congress a report on the actions OMHSP has taken to meet VA's priority objective of preventing Veteran suicide, the challenges OMHSP has faced in making such actions, and recommendations for improvements.

H.R. 7504, Rural Veterans Transportation to Care Act.

Section 2(c) would require the Comptroller General, within one year of the date of the enactment of this Act, to submit to Congress a report on the actions OMHSP has

taken to meet VA's priority objective of preventing Veteran suicide, the challenges OMHSP has faced in making such actions, and recommendations for improvements.

This section would amend section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163; 38 U.S.C. § 1710, note), as amended, which requires VA to establish a grant program to provide innovative transportation options to Veterans in highly rural areas. The bill would amend this authority to include rural areas as well. It would also make tribal organizations eligible to be awarded a grant. It would amend the maximum amount of a grant under this section from $50,000 to $60,000 and would provide an exception to this threshold if the recipient is required to purchase a vehicle to comply with the requirements of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12101 et seq.), in which case the maximum grant amount would be $80,000. The bill would replace the current definition of highly rural in section 307 with definitions for the terms rural and highly rural, which would have the meanings given those terms under the Department of Agriculture Rural-Urban Commuting Areas coding system. It would also add a definition of the term tribal organization, which would have the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 5304). Finally, the bill would authorize to be appropriated such sums as may be necessary to carry out section 307 and remove the current language authorizing the appropriation of $3,000,000 each for fiscal years 2010 through 2022.

VA strongly supports this bill, subject to amendments and the availability of appropriations. This bill is very similar to a VA legislative proposal in the FY 2024 President's Budget request. We recommend the bill be amended to reflect VA's proposal more closely. Specifically, we recommend including county Veterans Service Organizations as eligible recipients and authorizing up to $140,000 for grantees needing to purchase a vehicle to comply with the ADA. We also recommend amending the definitions of the terms rural and highly rural in the bill to allow VA to use the Department of Agriculture Rural-Urban Continuum codes to define eligibility based on counties. Finally, we recommend including specific authority for VA to establish limitations regarding the purchase of new vehicles, including the frequency of vehicle purchasing and the number of vehicles that can be purchased by each grantee.

Lack of transportation in rural and highly rural areas is a well-known barrier to access to care. VA wants to ensure that Veterans living in rural and highly rural areas have access to transportation for their VA-authorized medical care and supports use of this grant program.

The current definition of highly rural in section 307 makes grants under this authority available only to applicants in 25 States. Expanding the scope of this grant to include rural, in addition to highly rural, areas and additional eligible recipients who serve Veterans in these areas would increase the impact of this program and would allow more eligible Veterans the opportunity to receive medical care that they may not otherwise receive.

VA's proposal matches H.R. 7504 in seeking an increase to the maximum amount of each grant from $50,000 to $60,000. Based on experiential data, an increase would help grantees avoid shortfalls caused by increasing costs in transportation. However, unlike H.R. 7504, which would authorize up to $80,000 if a grant recipient is required to purchase a vehicle to comply with the ADA, VA's proposal would make available up to an additional $80,000 to a grantee for whom the purchase of a vehicle is required to comply with the ADA, and use of an ADA-compliant vehicle ADA is required to implement or continue the grantee's transportation services under section 307. Currently, otherwise-eligible grantees who lack such vehicles may not apply or continue their program because of the high cost of purchasing vehicles needed to comply with the ADA.

VA would be pleased to provide additional technical assistance to this legislation to address these recommendations.

VA estimates this bill, as amended, would cost $24.3 million in FY 2025; $28.0 million in FY 2026; $147.4 million over 5 years, and $306.4 million over 10 years.

H.R. 8562 Parity for Native Hawaiian Veterans Act

Section 2 would amend 38 U.S.C. § 3765(3)(B), part of the Native American Direct Loan (NADL) statutes, to revise the definition of Native Hawaiian. This amendment would refer to the definition in section 801 of the Native American Housing Assistance and Self-Determination Act of 1996 (NAHASDA), 25 U.S.C. § 4221, rather than the definition in the Hawaiian Homes Commission Act (HHCA).

VA has no objection to this section. VA believes the substitution would not, on its face, have any effect on the use of the NADL Program. As such, VA has no objection to the amendments in section 2 of the bill.

VA's program authority under 38 U.S.C. §§ 3761 and 3765(1)(B) is limited to making direct housing loans to Native American Veterans residing on trust land, such as native Hawaiian Home Lands. It is VA's understanding that, even if this bill were enacted, the Department of Hawaiian Home Lands would continue to use the HHCA definition in determining who is a native Hawaiian eligible to lease Hawaiian Home Lands. If that is correct, then it would seem the number of Veterans using the NADL Program in Hawaii would, as now, be limited to those who meet the definition of native Hawaiian under the HHCA.

If the intent of the bill is simply to align VA's NADL definition with the one in NAHASDA, VA has no objection or technical recommendations. If, however, the intent is to provide more Veterans the opportunity to obtain NADL Program loans on Hawaiian home lands, we recommend consulting the Department of Justice, the Department of

Interior, and the Department of Hawaiian Home Lands for further technical assistance regarding the HHCA.

VA does not estimate any costs associated with section 2.

VA does not support section 3(a). Section 3(a) would add a new section 1703G to title 38 of the United States Code. Subsection (a) of this new statute would require VA to reimburse a Native Hawaiian health care system for the costs of care or services provided through such systems to Veterans eligible for such care or services from VA, regardless of whether such care or services are provided directly by VA, through purchased or referred care, or through a contract for travel. The phrase, Native Hawaiian health care system, would have the meaning given that phrase by section 12 of the Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11711).

VA appreciates that Native Hawaiians have a unique experience and history, but this legislation raises operational and equity concerns and includes unclear language that could frustrate efforts to implement it, if enacted.

Initially, it is not clear that the legislation is necessary. Native Hawaiian health care systems may already be eligible to join VA's Community Care Network (CCN) and be paid for services furnished through VA's Veterans Community Care Program (VCCP). All enrolled Veterans in Hawaii are eligible for the VCCP based on residing in a State without a full-service VAMC. To the extent the Native Hawaiian health care systems have entered into agreements to furnish care through VCCP, Veterans could elect to receive this care from them.

Operationally, VA does not support the establishment of a unique reimbursement program for Veterans who receive care through the Native Hawaiian health care systems to the extent the bill would require VA to do so. Congress and VA have sought to consolidate VA's community care programs, and this bill would represent a divergence from that effort.

The bill includes unclear language as well. For example, it refers to a contract for travel, without specifying what constitutes a contract for these purposes, or even, seemingly, limiting reimbursement to travel related to the provision of health care. Additionally, the term care or services is undefined and could potentially include care or services that are not covered by VA's medical benefits package.

VA does not have a cost estimate for section 3(a) of this bill.

H.R. 9146 Ensuring Continuity in Veterans Health Act

This bill would amend 38 U.S.C. § 1703(d)(2), which sets forth the criteria covered Veterans and their referring clinicians must consider when determining if it

would be in the best medical interest of the covered Veteran to receive care or services through a non-VA entity or provider, to include continuity of care as a criterion.

VA does not support this bill. VA fully supports the consideration of continuity of care as a factor in determining if furnishing care and services through a non-VA entity or provider would be in a covered Veteran's best medical interest under the VCCP. VA has already regulated this in 38 C.F.R. § 17.4010(a)(5)(v), which lists the potential for improved continuity of care as a factor. Because this has already been regulated, this bill is not necessary. VA believes this language would be redundant given current regulations and practice, and enacting a bill of this type could result in confusion in this area given the minor variations in phrasing between this bill and VA's existing regulation.

This draft bill would result in no additional cost because it would result in no change in policy.

H.R. 9301 New Mexico Rural Veterans Health Care Access Act

H.R. 9301 would require VA, within 180 days of the date of the enactment of this Act, to redraw the boundaries of the Veterans Integrated Service Networks (VISN) to include Otero County and Eddy County, New Mexico, in VISN 17.

VA does not support this bill. VA agrees with the interest in re-examining where the facilities in these two counties report, and efforts are already underway to examine whether shifting these counties from VISN 22 to VISN 17 is appropriate. VA is still examining the data, though, as it needs to ensure that referral patterns and support systems (such as transportation options) could be maintained or enhanced so that Veterans can continue accessing high quality care closer to home. We need to ensure that any change in operational alignment does not adversely affect Veterans' access to care and benefits. VA plans to brief the Committee and the local delegation on its decisions and efforts in this area by the end of this calendar year. We believe that the efforts already underway may obviate the need for this bill.

VA is concerned that legislating VISN boundaries could have adverse effects and consequences. VA has authority today to establish VISNs and adjust their boundaries as needed; if Congress legislates the boundaries in law, VA would be required to continue to adhere to those requirements. This could limit VA's ability to respond to new or evolving concerns, which could have adverse effects on patient outcomes and satisfaction. We note, however, that Veterans are not limited to receiving care only within one VISN. Many Veterans in Otero and Eddy Counties currently receive care through the VA El Paso Healthcare System in VISN 17. In fact, in FY 2024, more than 900 Veterans from these two counties received more than 9,000 encounters at the VA El Paso Healthcare System.

VA does not have a cost estimate for this bill.

H.R. 9324 Protecting Veteran Access to Telemedicine Services Act of 2024

Section 2 of the bill would add a new section 1730D to title 38 of the United States Code regarding the delivery, distribution, and dispensation of controlled medications through telemedicine. The proposed subsection (a) of this statute would state that, pursuant to 38 U.S.C. § 1730C and the requirements of title III of the Controlled Substances Act (CSA), 21 U.S.C. § 801 et seq, covered health care professionals could use telemedicine to deliver, distribute, or dispense to eligible patients a controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301 et seq, regardless of whether the professional has conducted an in-person medical examination under the following two circumstances.

First, if the covered health care professional is acting in the usual course of professional practice and is authorized to prescribe the basic class of such controlled substance under an active, current, full, and unrestricted State license, registration, or certification. Second, if the substance is delivered, distributed, or dispensed for a legitimate medical purpose. Proposed section 1730D(b) would require VA to establish in regulations guidelines and a process for the delivery, distribution, and dispensation of a controlled substance pursuant to subsection (a). Proposed section 1730D(c) would provide that nothing in this section could be construed to remove, limit, or otherwise affect any obligation of a covered health care professional under the CSA. Proposed section 1730D(d) would define the terms (controlled substance, deliver, dispense, and distribute) by reference to section 102 of the CSA. It would also define the term covered health care professional to mean a health care professional who is a VA employee appointed under 38 U.S.C. §§ 7306, 7401, 7405, 7406, or 7408; or under title 5; who is not a VA contractor; who is authorized by VA to provide health care under chapter 17; who is required to adhere to all standards for quality relating to the provision of health care in accordance with applicable policies of the Department; who has an active, current, full, and unrestricted license, registration, or certification or meets qualification standards set forth by VA within a specified time frame; and, with respect to health care professionals listed under 38 U.S.C. § 7402(b) (which includes physicians, dentists, nurses, and other providers), has the qualifications for such profession as set forth by VA. The term would also include health professions trainees appointed under 38 U.S.C. § 7405 who are under the clinical supervision of a health care professional described above.

VA strongly supports the bill, subject to amendments. VA currently faces two significant barriers to ensuring providers can furnish care, including prescribing controlled substances, to Veterans through telehealth: restrictions within the CSA, and the variability in State law regarding the use of telehealth. These barriers create significant access challenges for Veterans. This bill appears to be intended to address the first of these barriers. While VA strongly supports the goal of this bill, amendments would be required to ensure it addresses the first issue, and further amendments would be needed to address the second.

As written, this bill appears to be intended to permanently extend Federal pandemic prescribing authorities (which have been continued on a temporary basis through rulemaking by the Drug Enforcement Administration (DEA) and the Department of Health and Human Services through December 2024) that have helped expand access since early 2020. These Federal pandemic authorities allowed qualified VA health care professionals to prescribe controlled substances following a telemedicine assessment, without a prior in-person medical evaluation,[2] when clinically appropriate. If those Federal pandemic authorities are made permanent for VA providers, this could mitigate the risk of access disruption for Veterans who continue to rely on VA telehealth services for critical aspects of their health care. It would further enable VA to more effectively leverage its national, integrated health care resources to Veterans regardless of their geographic location.

While the bill appears intended to address this concern, it does not address similar barriers in variable and fluctuating State laws, thereby limiting its effectiveness in protecting access to Veterans across State lines. The CSA generally prohibits providers from prescribing controlled substances in the absence of an in-person medical evaluation. See 21 U.S.C. § 829(e). Providers can prescribe controlled substances without having conducted a prior in-person medical evaluation if the provider is engaged in the practice of telemedicine (which is limited to seven specific scenarios) or if the provider is a covering practitioner. See 21 U.S.C. §§ 802(54) and 829(e). The practice of telemedicine as defined in the CSA generally requires compliance with applicable Federal and State laws.

These requirements concerning applicable State laws create ambiguity and legal concerns for VA health care professionals that could be subject to different State laws. Applicable State laws could be interpreted under the CSA as those in the provider's State of licensure; the provider's State of practice; the provider's State of registration with the DEA; the patient's State of residence; or the patient's location at the time of the clinical encounter. If one or more of these States' laws apply, a VA provider might be required to operationalize multiple practice standards; provide similar Veterans with different services; modify the treatment of a single Veteran based on the location at the time of a visit; or be prohibited from prescribing medically appropriate treatment at all.

VA has included a legislative proposal in the FY 2024 and FY 2025 President's Budget request to address the risk of variable State laws to Veteran access to care, while ensuring that providers remain subject to the CSA's requirements that prescriptions be for legitimate medical purposes and prescribed in the usual course of practice. Where these requirements are defined by State law, VA's proposal would authorize VA health care professionals to prescribe necessary controlled substances for

[2] As an example, a Veteran's local primary care provider may refer the Veteran for specialized mental health care. The mental health specialist needed is available but works in another State. The mental health assessment and ongoing treatment can be completed entirely through telemedicine. The Federal pandemic authority enabled the mental health specialist to treat the patient, including with controlled substances when necessary, based on their expertise.

their patients when adhering to national prescribing standards, regardless of a Veteran's location in the country and variable State laws.

Specifically, VA's proposal would require VA health care professionals to follow national telemedicine prescribing standards, as outlined in Federal law and regulations and supplemented by VA policy. In areas where a national standard had not been defined, VA health care professionals would follow the laws of their State of licensure.

Authorizing VA health care professionals to follow a single, understandable Federal framework for telehealth-controlled substance prescribing would enable VA to maximally leverage telehealth to expand access, reach vulnerable Veterans in rural communities, and deliver equitable services to all Veterans, wherever they are in the country.

Again, VA greatly appreciates the Committee's interest in addressing access risk for Veterans. VA would further appreciate the opportunity to discuss its proposal with the Committee to facilitate legislative action in this area and to ensure it fully achieves its goal of protecting Veterans' access to critical services by addressing both the Federal- and State-level barriers. We stand ready to provide technical assistance on this bill.

No costs are associated with VA's legislative proposal.

H.R. XXXX Service Dogs Assisting Veterans Act (SAVES Act)

Section 2 of this bill would require VA, not later than 24 months after the date of the enactment of this Act, to establish a 5-year pilot program under which VA would award grants, on a competitive basis, to nonprofit entities to provide service dogs to eligible Veterans. To receive a grant, nonprofit entities would have to submit to VA an application at such time, in such a manner, and containing such commitments and information as VA may require. Applications would have to include a proposal for the provision of service dogs to eligible Veterans, including how the entity would communicate with VA to ensure an increasing number of service dogs are provided to Veterans; a description of training and services provided by the entity; and documentation certifying the nonprofit entity is accredited by Assistance Dogs International or the International Guide Dog Federation, among other requirements.

VA would have to award a grant to each non-profit entity for which VA has approved an application. VA and the entity would have to enter into an agreement containing such terms, conditions, and limitations as VA determines appropriate. VA could establish a maximum amount to be awarded to each non-profit entity each FY under this section and would have to establish intervals of payment for the administration of each grant awarded under this section. Grantees would have to use the grant amounts to plan, develop, implement, or manage (or any combination thereof) one or more programs that provide service dogs to eligible Veterans. VA could establish

a maximum amount for each grant awarded under this section to cover administrative expenses. VA also could establish other conditions or limitations on the use of grant amounts.

Grantees would have to notify each Veteran that receives a service dog through the grant that the dog is being paid for, in whole or in part, by VA, and they would have to inform such Veterans of the benefits and services available from VA for the Veteran and service dog. Grantees could not charge a fee to a Veteran receiving a service dog through the grant.

Veterans with a mental health condition seeking a service dog from a grantee under this section would have to meet with a VA mental health provider. The mental health provider and the Veteran's care team would have to evaluate the Veteran and determine whether the Veteran has substantial mobility limitations, whether the mental health condition of the Veteran is the primary cause of such limitations, and whether a service dog would be the optimal intervention or treatment approach for the Veteran. If they determine a service dog would be the optimal intervention or treatment approach, the mental health provider and care team would have to request a service dog from a grantee on behalf of the Veteran through coordination with the Prosthetic and Sensory Aids Service of the local VAMC.

VA would have to provide to each Veteran who receives a service dog through a grant a commercially available veterinary insurance policy for the service dog, and, if VA provides such a veterinary insurance policy to a Veteran, VA would have to continue to provide the policy without regard to the continuation or termination of the pilot program.

VA could provide training and technical assistance to recipients of grants under this section. VA would have to establish oversight and monitoring requirements as appropriate to ensure grants are used appropriately, and VA could take actions as necessary to address any issues identified through the enforcement of such requirements. VA could require each grantee to provide reports or written answers to specific questions, surveys, or questionnaires as VA determines necessary.

Eligible Veterans would be defined to mean Veterans enrolled in VA health care (or otherwise eligible for care) who have one or more of the following disabilities, conditions, or diagnoses: blindness or visual impairment; loss of use of a limb, paralysis, or other significant mobility issue, including mental health mobility; loss of hearing; posttraumatic stress disorder (PTSD); traumatic brain injury (TBI); or any other disability, condition, or diagnosis VA determines, based on medical judgment, that it is optimal for the Veteran to manage the disability, condition, or diagnosis and live independently through the assistance of a service dog. The term service dog would mean any dog that is individually trained to do work or perform tasks that are for the benefit of a Veteran with a disability, condition, or diagnosis described above and directly related to the disability, condition, or diagnosis of the Veteran. There would be authorized to be appropriated $10 million for each of the 5 consecutive fiscal years following the fiscal year in which the pilot program is established.

VA supports this bill, subject to amendments and the availability of appropriations. For more than 60 years, VA policy and regulations have recognized the value of service dogs for certain conditions and the benefits they can provide to Veterans. VA provides benefits for service dogs for eligible Veterans who have been diagnosed with a visual, hearing, or substantial mobility impairment (including mental health mobility) when the VA clinical team treating the Veteran for such impairment determines, based upon medical judgment, that it is optimal for the Veteran to manage the impairment and live independently through the assistance of a trained service dog. *See* 38 C.F.R. § 17.148(b). VA provides a commercially available veterinary insurance policy for service dogs, as well as payments for travel expenses associated with obtaining a dog if the Veteran is eligible for beneficiary travel under 38 U.S.C. § 111 and 38 C.F.R. part 70 and if pre-approved for such benefits.

While not involving the provision of service dogs, since February 2022, VA has been implementing the Puppies Assisting Wounded Servicemembers for Veterans Therapy Act (Public Law 117-37), which requires VA to conduct a pilot program to provide canine training to eligible Veterans diagnosed with PTSD as an element of a complementary and integrative health program for such Veterans. Service dogs provide essential support for many Veterans.

VA appreciates that this bill has addressed a number of technical concerns identified with an earlier companion draft of this legislation. VA still recommends this bill be amended to those address technical concerns.

We appreciate that the bill generally focuses on creating a more direct connection in the legislation between grant funds and the provision of service dogs to eligible Veterans, but we believe this could be clearer. Specifically, in section 2(d), the bill would require grantees to use funds to plan, develop, implement, or manage (or any combination thereof) one or more programs that provide service dogs to eligible Veterans. Allowing the use of funds to plan a program that provides service dogs, but which ultimately does not provide service dogs, is not an ideal use of funds. We recommend the bill simply state that grantees would use funds to provide service dogs to eligible Veterans. In VA's experience, Veterans can wait between 1 and 3 years between when a dog has been recommended by VA and when a Veteran has been fully paired with a service dog that has graduated training. VA believes the grants provided under this authority could help increase the supply of service dogs to reduce this delay. In any grant program, but particularly in the case of service dog training, it is essential to ensure that funds are properly used.

Several provisions in the bill raise concerns. First, VA recommends clearly aligning the definition of service dog under this section with VA's existing definition in regulations. Second, VA is concerned about the list of disabilities that was presented in the bill. Specifically, the inclusion of TBI, for which a Veteran may already otherwise qualify based on having a significant mobility issue, and PTSD, as there is no substantial evidence to date that service dogs provide improvements in functioning and

quality of life for Veterans with PTSD as compared to emotional support dogs. VA recommends striking these provisions and including other language that would ensure clear authority for the administration of a grant program. We note, similar to the discussion above regarding Veterans with TBI qualifying for a service dog when they have a significant mobility issue, Veterans with PTSD can receive a service dog on the same basis. We further recommend that subsection (f), which would establish a process for Veterans with mental health conditions, be removed. While it is an accurate statement of VA's current policy, the bill does not refer to other types of service dogs, which creates the impression that there would be a different process or expectation for other types of service dogs.

We also note that this proposal would likely require dedicated staff in a new office to administer this program.

VA estimates this bill would cost $0.3 million FY 2025, $0.3 million in FY 2026, $24.1 million over 5 years, and $51.1 million over 10 years.

H.R. XXXX Including Adaptive Prostheses and Terminal Devices for Sports and Other Recreational Activities in Medical Services

This draft bill would amend 38 U.S.C. § 1701(6), which defines the term medical services for purposes of chapter 17 of title 38 of the United States Code to specify that artificial limbs include adaptive prostheses and terminal devices for sports and other recreational activities.

VA does not support this bill. VA fully supports ensuring that eligible Veterans in need of adaptive recreation equipment, including adaptive prostheses and terminal devices for sports and other recreational activities, are able to access these items. However, VA has already included these items in its regulations at 38 C.F.R. § 17.3230(a)(1)(ii), which includes adaptive recreation equipment among the items and services VA will provide Veterans if VA determines that such items and services: (1) are needed to promote, preserve, or restore the health of the Veteran (under 38 C.F.R. § 17.38(b)); (2) serve as a direct and active component of the Veteran's medical treatment and rehabilitation; and (3) do not solely support the comfort or convenience of the Veteran. VA has defined adaptive recreation equipment at 38 C.F.R. § 17.3210 to mean an item that is designed to compensate for, or that by design compensates for, loss of physical, sensory, or cognitive function and is necessary for the Veteran to actively and regularly participate in a sport, recreation, or leisure activity to achieve the Veteran's rehabilitation goals as documented in the Veteran's medical record.

VA believes this language would be redundant given current regulations and practice. In addition, we express concern that enacting a bill of this type could result in confusion in this area. Such confusion could jeopardize or frustrate the delivery of benefits to Veterans because this language does not align exactly with VA's current

regulations. This could lead to an inference that the bill is intended to create benefits different from VA's current regulations and could lead to litigation.

VA providers currently evaluate each patient's needs and prescribe such equipment as clinically appropriate. VA can also prescribe and furnish these items as prosthetic devices as well under current regulations. VA currently provides Veterans with artificial limbs specifically designed for numerous activities like running, swimming, and climbing. VA also provides Veterans with a broad array of adaptive equipment to participate in their preferred recreational activities. Examples include adaptive hand cycles; wheelchair basketball equipment; adaptive ski and hockey equipment; and customized adaptations to participate in activities from hunting to kayaking.

Adaptive prostheses are designed to combine and amplify the range of movements a prosthesis can accomplish to help people feel as able-bodied and mobile as possible. A prosthetic terminal device is the part of a person's arm that interacts with the people and things around them. There are activity-specific terminal devices that are more like tools that allow people to tackle specific work tasks or hobbies. The adaptive recreation equipment VA providers prescribe and furnish include adaptive prostheses and terminal devices as explained above.

If any Members of the Committee are aware of issues or cases where Veterans have not received necessary equipment, we ask that you please let us know so we can assist.

This draft bill would result in no additional cost because it would result in no change in policy.

H.R. XXXX No Wrong Door for Veterans Act

This draft bill would make several amendments to section 201 of the Commander John Scott Hannon Veterans Mental Health Care Improvement (Hannon) Act of 2019, P.L. 116-171, which authorized the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SPGP). First, it would change the requirement for the Secretary to consult with OMHSP in carrying out this program. The Secretary would instead be required to consult with the Assistant Under Secretary for Health (AUSH) for Clinical Services. Second, it would limit the use of grant funds to provide that not more than 5% of a grant could be spent on food and non-alcoholic beverages in a fiscal year. Third, it would require the Secretary to provide to the appropriate personnel of each VAMC within 100 miles of the primary location of a grantee a briefing, not less than once per calendar quarter, about the grant program to improve the coordination between a grantee and the VAMC personnel. Fourth, it would extend the authority to carry out this pilot program until September 30, 2027. Fifth, it would amend subsection (n), which requires VA to provide care to eligible individuals in certain situations, to state that if VA does not provide services to an eligible individual during the 72-hour period following a referral from a grantee, the eligible individual would be treated as eligible for

emergent suicide care under 38 U.S.C. § 1720J. Sixth, it would extend the authorization of $174 million to be appropriated from FY 2025 until FY 2027. Seventh, it would make a technical change to the definition of emergency treatment. Finally, it would state that the baseline mental health screening for grantees awarded a grant on or after the date of the enactment of this Act would be the Columbia-Suicide Severity Rating Scale (C-SSRS).

VA cannot support the bill as drafted, but could support this bill, subject to amendments and the availability of appropriations. VA supports two of the amendments this bill would make, specifically extending the duration of the pilot program through FY 2027 and the technical correction to the definition of emergency treatment which would have no substantive effect on benefits for eligible individuals. However, VA recommends the authority to conduct the program be extended further to operate for 8 years, or through FY 2030 because the amendment here would only authorize a little more than 2 additional years beyond the current authority).

VA has significant concerns with some of the changes this bill would make and seeks amendment to these provisions. The required quarterly briefings to VAMCs would likely require resources disproportionate to the value that would be realized from sharing this information. VA currently provides information to facilities and staff to support coordination, and we believe these efforts are sufficient. Also, VA is significantly concerned about codifying the use of the C-SSRS, which is currently a tool used by VA as one component of eligibility screening, in that it identifies individuals with suicidal thoughts and behaviors. Placing this in statute would prohibit VA from adopting another more effective tool should one be identified as more appropriate for the community-based setting. VA is invested in robust program evaluation to measure long term outcomes and ultimately identify and scale best practices for maximum benefit. It is essential that VA retains the ability to adjust the program, including the use of specific tools, in response to grantee feedback and early program evaluation outcomes, to include the eligibility scope and process, to best serve at-risk Veterans and their families. We note that VA has already stipulated in its regulations that the screening tool used by grantees must be a validated tool and will be announced in each notice of funding opportunity; this arrangement preserves VA's flexibility to ensure the best results for Veterans.

The change to treat eligible individuals who cannot receive care within 72 hours following a referral from a grantee as an eligible individual under 38 U.S.C. § 1720J also raises significant concerns over its potential inadvertent effects. The term eligible individual, for purposes of the SPGP, already overlaps significantly with eligibility under section 1720J(b), as Veterans (under 38 U.S.C. § 101) and individuals described in section 1720I(b) (referring generally to former Service members with other-than-honorable discharges) already qualify for both programs. Including the 72-hour limitation in section 201 of the Hannon Act could be read to infer that these individuals are not eligible under section 1720J until the 72-hour period has lapsed. The SPGP provides support and services to individuals who screen at low-, moderate-, and high-risk for

suicide, and participants are already referred to VA for routine mental health assessments and care.

Emergent suicide care under 38 U.S.C. § 1720J, by contrast, is available only for Veterans experiencing acute suicide risk. Given the overlapping authority, most SPGP participants are already eligible for emergent suicide care under section 1720J. The only potentially positive effect that could result from this provision would be the inclusion under section 1720J of members of the Armed Forces who are eligible for readjustment counseling services under 38 U.S.C. § 1712A(a)(1)(C)(i)-(iv). It is unclear, though, if this is the intent; if it is, it would seem simpler to amend section 1720J itself, or else only those individuals who are referred through the SPGP would be eligible. For Veterans or former Service members described in section 1720I(b), VA provides same-day care and assessments for mental health issues. In this context, current authority and programs seem to meet or exceed what the bill would provide.

Another concern is that the bill would extend the duration of the program, and it would extend the period of the authorization of appropriations, but it would not increase the amount of authorized appropriations. Without increasing the amount, VA would have no additional funds to carry out the program, which would frustrate the intent of VA and Congress. Consequently, VA recommends increasing the authorized amount of appropriations to reflect the extended time period in which the SPGP could operate. An increased authorization amount would also permit scaling the program to a nationwide effort.

Several of the amendments are not necessary, including the change to require the Secretary to consult with the AUSH for Clinical Services instead of OMHSP (as the Offices of Mental Health and Suicide Prevention report to the AUSH for Clinical Services). OMHSP has separated into two offices, the Office of Mental Health and the Office of Suicide Prevention. We recommend the bill strike any reference to a sub-component of VA, as this would avoid further confusion that might arise from reorganization or renaming of existing offices. The responsibility for implementation ultimately rests with the Secretary, so identifying further offices is neither necessary nor constructive. Also, VA does not view a limitation on the use of funds for food and non-alcoholic beverages as necessary within the pilot phase, where VA continues to gather data to inform the extent of this funding need and the justification for any such limitations. We do note that the limitation on non-alcoholic beverages implies there is no limitation on alcoholic beverages, which we do not believe would be appropriate.

VA also recommends including additional amendments to section 201 of the Hannon Act in this bill. Specifically, VA recommends removing the cap of $750,000 per grantee per fiscal year under section 201(c)(2)(A). This amount has not changed since the first grants were awarded in 2022, and if the program is extended in duration, this cap will mean that grantees will receive relatively less support each year due to inflation. Similarly, to address the issue noted above regarding the authorization of appropriations cap, we recommend authorizing such sums as may be necessary for FY 2021-FY 2030 (or through FY 2027, as the bill would permit). VA further recommends removing the

requirement to coordinate with the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide Task Force, as this Task Force is no longer operational.

VA also recommends amending the definition of eligible individual in section 201(q)(4)(C)) as it relates to individuals eligible for readjustment counseling services. This amendment would account for a statutory change that was made to section 1712A just days after enactment of the Hannon Act that appears to have unintentionally changed eligibility conditions under the SPGP. As originally enacted, the Hannon Act established as eligible individuals those persons described in clauses (i) through (iv) of 38 U.S.C. § 1712A(a)(1)(C). The Hannon Act was enacted on October 17, 2020. On October 20, 2020, the Vet Center Eligibility Expansion Act (Public Law 116-176) was signed into law. This law created new clauses (iv) and (v) in section 1712A and redesignated the existing clauses (iv) and (v) to be clauses (vi) and (vii). As a result of this, for 3 days during October 2020, well before VA could implement the SPGP, individuals who received counseling under section 1712A before the date of enactment of the National Defense Authorization Act for Fiscal Year 2013 were eligible for the SPGP but are not currently eligible unless they meet another condition of eligibility under section 201(q)(4) of the Hannon Act. While we anticipate this would affect only a small number of individuals, we believe amending the Hannon Act to include this population would be fair to them and more consistent with Congressional intent. It is unclear if the other category of persons included by P.L. 116-176, namely individuals who participated in a drug interdiction operation as a member of the Coast Guard, were intended to be included in the definition of eligible individuals under the SPGP.

We would be happy to provide technical assistance to the Committee, including specific line edits, to address these recommendations.

VA estimates the bill, if amended as described above, would cost an additional $0 in FY 2025, $115.5 million in FY 2026, and $613.2 million through FY 2030.

H.R. XXXX Directing VA to Carry Out a Pilot Program under which VA May Fill Vacant Shifts at VA Medical Facilities with Non-VA Health Care Providers

Sections 1(a) and (g) of the draft bill would require VA, not later than 1 year after the date of the enactment of this Act, to carry out a 3-year pilot program under which VA may fill a vacant shift at a VA medical facility with a non-VA health care provider. Section 1(b) would require VA to seek to enter into at least one agreement with an entity that employs or contracts with health care providers and VA would pay the entity a fixed rate for each shift filled by such entity under the pilot program. Section 1(c) would prohibit VA, under the pilot program, from filling a vacant shift at a VA medical facility with a non-VA health care provider unless the number of vacant shifts at the facility reaches a minimum number or percentage prescribed by VA. Section 1(d) would require VA to carry out the pilot program in medical facilities of not more than two VISNs. VA

would have to give preference to facilities located in a rural area or with a historically high rate of vacant shifts. Section 1(e) would require VA to restrict access of non-VA providers to only the medical records of Veterans whom the provider furnishes hospital care or medical services. Section 1(f) would require VA to submit to Congress a report on the pilot program by not later than 21 months after the date on which VA begins the pilot program and 90 days after the date on which the pilot program ends.

VA does not support this bill. VA fully agrees with the desire to ensure that Veterans can retain access to care, but we believe critical elements of this draft bill are undefined and could result in worse patient experiences. Also, we do not believe this draft bill is necessary given other efforts VA is undertaking and VA's existing authority.

Initially, there are key pieces of this draft bill that are not clearly defined. It is unclear what is intended by the term vacant shift. For example, whether this is intended to refer to day-to-day absences (such as unexpected sick leave or travel), or if this is intended to refer to longer duration absences (such as the period following the departure of an employee before a replacement can be hired). VA has developed several options to provide short- to medium-term support when needed based on employee absences or departures. For example, VA has developed VISN-based Clinical Resource Hubs (CRH) to fill short-term, often unexpected absences of employees – particularly providers. CRHs also expand access to care by providing more resources when local facilities experience gaps in care or service capabilities. While the CRHs originally started with a focus on furnishing primary care and mental health, they now provide support for additional specialties. Further, VA awarded a multi-year contract for the Integrated Critical Staffing Program (ICSP) in January 2024. VA has been using the ICSP principally to ensure that qualified staff (often clinicians, but not always) are able to fill positions on a temporary basis while efforts are underway to fill vacancies. We would welcome the opportunity to discuss this program with the Committee, as it may already address many of the concerns that were the basis for this bill. We also have authority under 5 C.F.R. § 300.503 to hire temporary employees via contract for short-term vacancies, and, under 5 C.F.R. § 300.504, we can contract with temporary help service firms for an initial 120 workdays and may extend this to 240 workdays if needed.

Similarly, the draft bill does not define the term provider. Together, these omissions make it impossible to determine whether the bill would raise labor-management concerns. Depending upon the structure of the pilot program and the terms of the contract, this bill could affect our collective bargaining agreements regarding the terms and conditions of employment for our bargaining unit employees. It is also unclear whether this bill would result in issues regarding compliance with OMB Circular A-76, which establishes Federal policy regarding the performance of commercial activities and whether they should be performed under contract with commercial sources or in-house using Government facilities and personnel.

We also have concerns with some of the specific provisions in the draft bill. For example, subsection (b) would require VA to pay the entity a fixed rate for each shift

filled by such entity under the pilot program. VA does not believe that legislating contract terms is an ideal way to ensure that VA is able to obtain favorable terms. A fixed-rate payment structure may be advisable, but it may not be, and without market analysis, this draft bill would force VA to adopt a single approach, regardless of its utility. VA typically does not contract for work paying a fixed rate for each shift. VA normally contracts for full time employees or equivalents with a built-in reduction for hours not actually worked to avoid overpayment. This subsection also raises the question of whether this language would give VA sole source authority to enter into a contract with an entity without regard to competition or set aside requirements under VA's Vets First Contracting Program. This language would also seem to prohibit VA from contracting directly with providers, as it refers to VA seeking to enter into an agreement with an entity that contracts or employs providers. This could also frustrate VA's efforts to fill vacancies with qualified providers if those providers are unwilling to contract with or work for another agency. The draft bill is also silent regarding tort liability, so VA's agreements would need to clarify this.

Additionally, subsection (c) would prohibit VA from filling a vacant shift unless the number of vacant shifts at the facility reached a minimum number or percentage prescribed by VA. It is unclear how VA would determine such a minimum number or percentage. Further, to the extent the facility is at or around this number or percentage, the facility's ability to fill a vacant shift might vary day-by-day (or even hour-by-hour). VA would likely need to develop very specific operational requirements and monitoring systems to ensure compliance with this, which would result in significant additional overhead and administrative costs with little associated value in terms of Veterans' access to care. Subsection (e) would require VA to restrict access to medical records, but this would be technologically difficult to implement. VA currently restricts access to records on a need-to-know basis, but it does not have the means to completely bar access to records to providers with access to the system, as the bill seems to contemplate. Developing systems that are able to restrict this access could result in barriers to care, particularly when unexpected conditions arise among patients being treated by these providers, that might jeopardize patient care. Personal identity Verification (PIV) credentialing is also required to access VA systems, but it is not clear if or how this could be accomplished, in part because it is unclear how many days each provider would work for VA in a given year (which has an impact on PIV credentialing).

VA is also concerned that the pilot program contemplated in the draft bill might result in inconsistent Veteran experiences. VA has rigorous training requirements for its providers – and many of these were established in law by Congress – and it is not clear that these short-term contracted providers would be able to meet such standards. This could result in differences in experience and qualification for these contracted providers relative to VA employees or significant additional cost to VA if they are able to comply with these requirements.

VA does not have a cost estimate for this bill.

H.R. XXXX Including a Representative of the National Association of State Veterans Homes on the VA Geriatrics and Gerontology Advisory Committee

This bill would amend 38 U.S.C. § 7315(a) to require the Secretary's appointment of members of the Geriatrics and Gerontology Advisory Committee (the Advisory Committee), upon the recommendation of the Under Secretary for Health, to occur in consultation with the President of the National Association of State Veterans Homes (NASVH) with respect to matters concerning such association. It would further require the Advisory Committee to include one representative of NASVH who holds a professional license in nursing home administration.

VA does not support this bill. VA fully supports the participation of a NASVH representative on the Advisory Committee, but we do not believe this bill is necessary because VA is working to appoint a member of NASVH to the Advisory Committee.

We caution that legislating membership of the Advisory Committee could restrain VA's ability to adapt to evolving circumstances in the future. We also have concerns with the language that would apparently subject the appointment of all members of the Advisory Committee, at least with respect to matters concerning NASVH, to the consultation requirements of the NASVH President. While the term consultation is not defined, this could constrain the Secretary's authority to appoint members and would be inconsistent with other laws regarding Federal Advisory Committees.

VA does not believe this bill would result in any appreciable costs.

H.R. XXXX Enhancing Faith-Based Support for Veterans Act of 2024

This bill would add a new section 1730D to title 38 of the United States Code. Under the proposed subsection (a) a VA chaplain, with respect to a patient on whom the chaplain has conducted a spiritual assessment, could transmit the contact information of the patient to a non-VA religious or faith-based organization specified by the patient and upon the election of the patient. The proposed subsection (b) would define the term spiritual assessment to mean an evaluation of a patient entitled to receive medical treatment under chapter 17 by a chaplain employed by VA to gather spiritual information about the patient and inform the medical treatment plan of the patient, if applicable.

VA does not support this bill. VA agrees that Veterans should be able to access spiritual support services from any organization of their choice, but this bill does not provide any new authority and could produce confusion. For example, VA is concerned that the phrase at the election of the patient is too vague, since it does not specifically refer to the patient's authorization required by the Privacy Act or the HIPAA Privacy Rule for the Department to share information as described or provide an exception under those provisions to the general prohibition against disclosure without an authorization. Even if the bill were enacted as drafted, VA would be barred from providing religious or faith-based organizations with patients' contact information unless

the patient signed a completed release of information form. In that context, this is no different than current practice.

There is also some concern that sharing this information could produce conflicts regarding confidential information the patient has shared with the chaplain. The bill also does not define what is a non-Department religious or faith-based organization. The current VA practice involves review and vetting of organizations providing sacramental services to ensure they are appropriate and will support Veterans and not take advantage of them. Without a proper vetting system, Veterans could be abused financially, emotionally, mentally, and spiritually. We believe Congress would need to expressly delegate to VA authority to establish such a system to protect our Veterans if this bill were to become law; there are currently some parameters in place under other programs, such as those administered by the Centers for Medicare and Medicaid Services, that might also be helpful in this regard.

Finally, the definition of spiritual assessment in the bill differs from VA's current use of the term, as VA incorporates ongoing assessments, rather than a single assessment, in evaluating patients and supporting their spiritual needs.

VA does not have a cost estimate for this bill.

H.R. XXXX Requiring Non-Citizen Appointees to Positions in the Veterans Health Administration to be Subject to Background Investigations Prior to Employment

This draft bill would add a new paragraph to 38 U.S.C. § 7407(a), which authorizes VA, in certain situations, to appoint an individual who is not a citizen of the United States to certain positions in VHA. The new paragraph would prohibit VA from making such an appointment unless the person has been subjected to a background investigation.

VA supports this bill, subject to amendments and the availability of appropriations. VA generally supports ensuring that employees have received a background investigation, including non-U.S. citizens, prior to employment. However, the draft legislation does not define what type of background investigation would be required. The Defense Counterintelligence and Security Agency (DCSA) is VA's Investigative Service Provider. DCSA lists five different investigative tiers, ranging from Tier 1 for Low-Risk investigations through Tier 5 for critical-sensitive (national security). The overwhelming majority of VA's employees receive the Tier 1 level investigation, which is based on a low-risk position designation. Background investigation levels are based on a review of the position description to determine the position designation. Therefore, any legislation should state that background investigations are commensurate with the position designation.

Due to limitations in the ability to collect background investigative data outside of the U.S., Tier 1 background investigations on non-U.S. citizens who have not resided in the U.S. or its territories for 3 years or more cannot be completed. This limitation is set forth in the Office of Personnel Management, December 15, 2020, Credentialling Standards Procedures for Issuing Personal Identity Verification Cards under HSPD-12 and New Requirement for Suspension or Revocation of Eligibility for Personal Identity Verification Credentials. As a result, VA began an initiative to review all non-U.S. nationals using another Federal vetting system. On June 13, 2024, VA issued a Department-wide memorandum outlining VA's Enhancement of Security Posture. When the policy is finalized, this initiative will require, among other things, that all non-U.S. nationals undergo a Federal database check utilizing a national vetting system sponsored by the Office of the Director of National Intelligence. The vetting system is a web-based platform that enables United States Government security mission partners to efficiently screen, assess, and track foreign nationals requesting access to Federal Government facilities, personnel, or systems.

VA estimates this bill, as amended, would cost $1.2 million in FY 2025; $1.3 million in FY 2026; $6.7 million over 5 years, and $14.3 million over 10 years.

H.R. XXXX Making Improvements Relating to Conflicts of Interest for Certain VA Employees

This bill would amend 38 U.S.C. §§ 7302 and 7303, which identify functions for health care personnel education and training programs and research programs, respectively. The amendments to section 7302 would allow certain VA employees with dual appointments at the academic affiliate to participate in activities, oversight, supervision, and educational relationships related to formal education and training in a health care profession without regard to the criminal conflict of interest law regarding personal financial interests at 18 U.S.C. § 208 under certain conditions. It would also permit VA employees who serve in a health professions education role at an affiliated entity to communicate with VA regarding such matters without regard to the criminal conflict of interest law regarding claims and other matters affecting the Government at 18 U.S.C. §§ 205 and 203 under certain conditions. The amendments to section 7303 would be similar to those described above but would apply for researchers including those with appointments at the VA affiliated non-profit corporations established under 38 U.S.C. § 7361.

VA does not support the bill as currently drafted. VA supports the intent of this bill, which would resolve conflicts of interest for educators and researchers. We recommend the bill exempt the provisions of 18 U.S.C. §§ 203, 205, 208, and 209 (specifically for the educators and non-research clinicians), as applicable. VA would be ready to provide technical assistance to ensure the text reflects this broader goal, and to discuss VA's concerns with the Committee.

VA estimates the bill would not result in any additional costs and could produce some savings by eliminating administrative burdens.

Conclusion

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