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BEFORE THE COMMITTEE ON VETERANS' AFFAIRS
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Chairwoman Miller-Meeks, Ranking Member Brownley, and other Members of the Subcommittee: thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is, Dr. Erica Scavella, Assistant Under Secretary for Health for Clinical Services.

Introduction

Before discussing each of the bills specifically, common threads among many of the bills is the proposed reduction in VA's role in furnishing and coordinating care and the bills' general misunderstanding of VA's current authorities and programs. VA disagrees with this purpose on a fundamental level; especially given that nearly all available scientific evidence shows that Veterans who receive care from VA have better outcomes and experiences than Veterans who do not receive VA care[1]. A few of VA's accomplishments include:

- Over the last year, multiple external reviews have shown that VA quality of care is extremely high. In this year's CMS Overall Hospital Quality Star Ratings, more than 58% of VA hospitals included received 4- or 5-star ratings compared to 40% of non-VA hospitals.[2] This is only the second year VA hospitals have been included in this review, and VA has outperformed non-VA health care in both years. VA also outperformed non-VA hospitals in the most recent CMS Hospital Consumer Assessment of Healthcare Providers and Systems star ratings, with 79% of VA facilities receiving a summary star rating of 4 or 5 stars compared to 40% of non-VA hospitals.[3]
- Veteran trust in VA outpatient care has reached a record high of 92%, based on a survey of more than 440,000 Veterans. An increase of 6% over 2018 (when the survey began). Additionally, overall Veteran trust in VA has reached an all-time high of 80.4% -- up 25% since 2016, according to the Veteran Trust in VA Survey. Additionally, these findings are consistent with a recent systematic

[1] https://www.hsrd.research.va.gov/publications/esp/quality-of-care-review.cfm
[2] https://news.va.gov/press-room/va-health-care-outperforms-non-va-care-in-two-independent-nationwide-quality-and-patient-satisfaction-reviews/
[3] https://news.va.gov/press-room/va-health-care-outperforms-non-va-care-in-two-independent-nationwide-quality-and-patient-satisfaction-reviews/

review that found that VA health care is consistently as good as — or better than — non-VA health care.[4]

- In fiscal year (FY) 2024, VA delivered more than 131 million health care appointments, representing a 9% increase over last year's record. During this fiscal year, wait times decreased, and VA health care outperformed non-VA care on independent reviews for patient satisfaction and care quality.
- Thanks to the largest outreach campaign in VA history under the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022, more than 840,000 Veterans have enrolled in VA health care since the PACT Act was signed into law — a 39% increase over the previous equivalent period; VA has received 4,414,334 claims for disability compensation benefits over the past two fiscal years — a 29.8% increase over the two years prior; and 954,189 Veterans have upgraded their priority groups, making them eligible for care with fewer copays.
- VA has screened 5.9 million Veterans for toxic exposures, a critical step to document Veteran exposure concerns, provide education, and connect Veterans to available medical care, registry, benefits, and other services, as indicated.
- In FY 2024, VA provided services, resources, and assistance to a record 88,095 Veteran family caregivers, representing an 18.6% increase over last year's record.

We also note that many of the bills seem to have been drafted from a misunderstanding of VA's existing authorities. VA's authority and responsibility to furnish health care to Veterans, particularly Veterans with service-connected disabilities, rest on a series of connected laws. Fundamentally, sections 1705 and 1710 of title 38, United States Code, establish the general requirements and authorities to furnish care. Section 1705 requires VA to establish and operate a system of annual patient enrollment "In managing the provision of hospital care and medical services under section 1710(a)." Section 1710(a), in turn, requires VA to furnish hospital care and medical services to Veterans under paragraphs (1) and (2) and permits VA to furnish care under paragraph (3) to other Veterans. The Veterans Community Care Program (VCCP) established under section 1703 defines when Veterans eligible for care under section 1710 can elect to receive that care from non-VA providers. Other statutes in chapter 17 and elsewhere further define how VA furnishes care, what care VA furnishes, or who can also receive care.

Providing consistent Veteran-centric care requires that all authorities are executed together, efforts to change a single provision of law without consideration of how that change affects the greater system are likely to produce unanticipated adverse results and costs for Veterans, including Veterans with significant service-connected conditions.

There also seems to be a misunderstanding of VA's current implementation mechanisms and practices. For example, several of the bills seem to assume that all

[4] https://news.va.gov/press-room/studies-va-health-care-better-equal-non-va/

care is authorized through third-party administrators (TPAs), when that is not the case. Further, some of the bills could potentially result in non-government actors binding the U.S. Government to certain transactions and obligating Federal resources, which would be contrary to current law and practice. Several bills reflect a lack of understanding of VA's current operations in terms of what VA staff do, how TPAs support VA's efforts, and how providers furnish care.

Additionally, several of the bills would expressly prohibit the appropriation of any additional funds to implement them. While this may result in a more favorable score from the Congressional Budget Office, we caution that such language would require VA to stretch resources to implement these authorities from its current funding. The only way to support these new efforts would be to divert resources from programs and benefits currently serving Veterans, which VA strongly opposes. Given that the costs of some of these bills could be significant, we believe the potential adverse effects on VA and (more importantly but directly as a result) on Veterans, who rely on and choose to receive care from VA, would be significant. While several of these bills are nominally intended to increase choice for Veterans, the likely result of these bills would be the reduction of choice by weakening the VA system to the point it may be unable to continue to function in its current form. That would remove the choice of millions of Veterans, many of whom were severely disabled in service to this country, to receive the specialized care they need from VA – benefits that these Veterans have earned and deserve.

VA is recognized as a world leader in the integrated treatment of complex mental health and medical care needs for conditions like traumatic brain injury and polytrauma, and all its mental health providers complete required training to ensure cultural competence in working with the Veteran population. Research has shown that understanding military culture is critical to the Veteran experience and allows VA clinicians to tailor clinical practices to address Veterans' specialized health care needs. While military cultural competency is highly encouraged in the community, there is no assurance that civilian health care providers are equally equipped. One example is VA's Spinal Cord Injuries and Disorders (SCI/D) System of Care that integrates vocational, psychological, and social services and addresses the changing needs of Veterans with SCI/D throughout their lives.

Veterans have unique health care needs based on their military service. Veterans experience military environmental exposures; face greater risk of catastrophic injuries such as traumatic brain injury,[5] SCI/D, and loss of limb;[6] and endure greater unique stress on their minds and spirits than civilians, to name just a few concerns. VA's

[5] Cornis-Pop M, Hinds SR 2nd, Picon LM, Tapia RN. Rehabilitation in the Department of Veterans Affairs Polytrauma System of Care: Historical Perspectives. Phys Med Rehabil Clin N Am. 2019 Feb;30(1):1-12. doi: 10.1016/j.pmr.2018.09.002. PMID: 30470415. See also Armstrong M, Champagne J, Mortimer DS. Department of Veterans Affairs Polytrauma Rehabilitation Centers: Inpatient Rehabilitation Management of Combat-Related Polytrauma. Phys Med Rehabil Clin N Am. 2019 Feb;30(1):13-27. doi: 10.1016/j.pmr.2018.08.013. Epub 2018 Oct 31. PMID: 30470417.

[6] Webster J, Scholten J, Young P, Randolph BJ. Ten-Year Outcomes of a Systems-Based Approach to Longitudinal Amputation Care in the US Department of Veteran Affairs. Fed Pract. 2020 Aug;37(8):360-367. doi: 10.12788/fp.0024. PMID: 32908343; PMCID: PMC7473733.

health care system is uniquely positioned to address these needs with specialized systems of care to ensure Veterans receive coordinated care from providers with expertise in treating these complex injuries. For example, the National Academies of Sciences, Engineering, and Medicine (NASEM) issued a consensus report in 2018 on the evaluation of VHA-provided, mental health services. The report found that VHA has "tremendous mental health care expertise, many and diverse care delivery assets, and substantial training and research capabilities."[7] Weakening VA's ability to support these core areas means that Veterans with service-connected disabilities are less likely to receive the best care possible that is informed by cutting-edge research performed by VA providers and scientists.

We encourage the Committees to take great care in considering any legislation that would undermine our Nation's ability to serve Veterans by weakening VA's ability to operate a full-service, nationally available health care system. VA health care serves four critical functions: (1) delivery of health care to Veterans and other beneficiaries; (2) performing research on Veterans' health care needs; (3) training health care providers; and (4) serving as a critical support system in emergency situations. Legislation that impedes VA's ability to fulfill its first mission of patient care will have cascading effects on VA's other three missions.

- If VA facilities do not have sufficient patient demand across a range of specialties, our ability to train the next generation of health care providers will diminish, and the entire country will suffer as a result.
- Similarly, VA facilities provide incredible research opportunities and support that would not otherwise be available within the U.S. health care system. These research opportunities are a valuable incentive for some of the best health care providers, researchers, and scientists to join VA, which directly contributes to improved patient care and outcomes. Weakening the VA system and reducing patient populations would harm Veterans, VA, and the country by limiting these research opportunities.
- Finally, a diminished VA health care system would be less able to meet the needs of the Nation in the event of a national emergency. VA facilities would have fewer providers and less specialized knowledge, which could prove to be a fatal deficit in such a scenario.

Several of the bills on the agenda would also expressly reverse VA's and Congress' efforts with the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, which sought to consolidate and simplify community care eligibility for covered Veterans. By creating distinct, separate programs, Congress would reintroduce the confusion and administrative problems the VA MISSION Act of 2018 and the Veterans Community Care Program (VCCP) was designed to solve.

[7] National Academies of Sciences, Engineering, and Medicine. 2018. Evaluation of the Department of Veterans Affairs Mental Health Services. Washington, DC: The National Academies Press. p. 326. https://doi.org/10.17226/24915.

Additionally, many of these bills, in addressing the same general issue (access to community care) but in different ways are very likely mutually exclusive. The Committee can choose among different alternatives or choose to strengthen the current VCCP through other means, but it likely cannot choose all the alternatives presented by these bills together; if it did, the overlapping changes would create even more confusion and problems with implementation than existed prior to the implementation of the VA MISSION Act of 2018.

Finally, many of the provisions in the bills on today's agenda overlap or potentially conflict with amendments Congress is looking to make through the Senate-passed Senator Elizabeth Dole 21st Century Veterans Healthcare and Benefits Improvement Act. These bills would require further amendments to reflect these pending statutory changes.

Below we provide detailed feedback on each bill under consideration and again caution the Committee to more fully consider the potential cascading, negative impacts these provisions could have on veteran health care.

H.R. 214 Veterans' True Choice Act

Section 2(a)(1) would amend 10 U.S.C. § 1075(b)(1)(B), which defines the enrollment eligibility for the TRICARE Select program operated by the Department of Defense (DoD). Section 1075(b)(1) defines the beneficiary categories for purposes of eligibility to enroll in TRICARE Select and the cost-sharing requirements applicable to each category. The bill would amend subparagraph (B) to state that one of these categories is a "retired" category that consists of beneficiaries covered by 10 U.S.C. § 1086(c), other than Medicare-eligible beneficiaries described in 10 U.S.C. § 1086(d)(2) and, as would be added by the bill, "covered veteran beneficiaries under subsection (h), other than Medicare-eligible beneficiaries described in subsection (d)(2)." It would redesignate subsection (h) as subsection (i) and insert after subsection (g) a new subsection (h), which would state that, subject to 10 U.S.C. § 1086(d), a covered Veteran beneficiary may elect to enroll in TRICARE Select during the annual open enrollment season of the TRICARE program; additionally, the cost-sharing requirements under TRICARE Select for covered beneficiaries would be calculated pursuant to subsection (d)(1), regardless of the date of the original enlistment or appointment of the beneficiary in the uniformed services, and a dependent of a covered Veteran beneficiary may not enroll in the TRICARE program solely by reason of the covered beneficiary enrolling in the TRICARE program. Section 2(a)(2) would amend 10 U.S.C. § 1086(d), which generally limits eligibility for TRICARE by excluding individuals eligible for Medicare under 42 U.S.C. § 1395c et seq., by applying a similar exclusion for covered Veteran beneficiaries. Section 2(a)(3) would amend 10 U.S.C. § 1072, which establishes definitions for purposes of chapter 55 of title 10, by creating a new definition of "covered veteran beneficiary." This term would mean a Veteran who is eligible to enroll in VA health care under 38 U.S.C. § 1705(a)(1)-(3) and is eligible to enroll in the TRICARE program only pursuant to 10 U.S.C. § 1075(h) or section 1086(d) by reason of being an individual who would be covered in section 1075(h) but for being

a Medicare-eligible beneficiary covered by section 1086(d).[8] Section 2(a)(4) would amend 38 U.S.C. § 1705 by adding a new subsection (d), which would state that a covered Veteran beneficiary who enrolls in the TRICARE program could not be concurrently enrolled in VA health care under subsection (a), VA could not furnish medical care to the covered Veteran beneficiary under chapter 17 of title 38, United States Code, or other provision of law while the covered Veteran beneficiary is enrolled in the TRICARE program. The terms covered Veteran beneficiary and TRICARE program would have the same meaning given to those terms in 10 U.S.C. § 1072.

Section 2(b) would require VA and DoD to enter a memorandum of understanding under which VA would reimburse DoD for the costs of enrolling covered Veteran beneficiaries in the TRICARE program pursuant to the amendments made by section 2(a) of the bill, as jointly determined by the Departments.

Section 2(c)(1) would provide that the amendments made by this Act would take effect one year after the date of the enactment of this Act. Section 2(c)(2) would require VA and DoD to prescribe regulations to carry out the amendments made by this Act within a year of the date on which the amendments made by this section would take effect (which would be one year after enactment, per paragraph (1)). Section 2(c)(3) would provide a one-year phase-in period when VA and DoD would allow covered Veteran beneficiaries to enroll in the TRICARE program in accordance with its annual open enrollment season. Section 2(c)(4) would require VA to carry out this subsection through the Center for Innovation for Care and Payment (CICP).

Section 2(d) would require VA and DoD, on a quarterly basis during the 2-year period following the date of the enactment of this Act, to submit to Congress a report on the implementation of this Act and the amendments made by it. VA would also have to, not later than one year after the date on which the final quarterly report is required to be submitted and annually thereafter, submit to Congress a report on covered Veteran beneficiaries enrolled in the TRICARE program. Section 2(e) would define the terms “covered veteran beneficiary” and “TRICARE program” as having the meaning given those terms in 10 U.S.C. § 1072.

VA opposes enactment of H.R. 214. VA cites extensive concerns that the current would create significant uncertainty as to the bill’s effects, and because it would undermine VA’s position as the responsible Federal agency for Veterans’ health. The introduction to this testimony, incorporated here by reference, lists the concerns that would follow from this shift in responsibility.

[8] 38 U.S.C. § 1705(a)(1)-(3) refer to: (1) Veterans with service-connected disabilities rated 50 % or greater, Veterans awarded the Medal of Honor under certain authorities; (2) Veterans with service-connected disabilities rated 30 % or 40 %; and (3) Veterans who are former prisoners of war or who were awarded the Purple Heart, Veterans with service-connected disabilities rated 10 % or 20 %, and Veterans whose discharge or release from active military, naval, air, or space service was for a disability that was incurred or aggravated in the line of duty and Veterans who are in receipt of, or who, but for a suspension pursuant to 38 U.S.C. § 1151 (or both a suspension and the receipt of retired pay), would be entitled to disability compensation, under certain circumstances).

Assuming the intent is to make covered Veteran beneficiaries eligible for TRICARE Select, VA opposes this bill because it would increase out-of-pocket costs for participating covered Veteran beneficiaries, including for service-connected disabilities. The covered Veteran beneficiaries who would be eligible to enroll in TRICARE Select can receive VA care without copayments and without enrollment fees and may be eligible to receive care in many of the same locations and from the same providers. Further, section 2(b) would only require VA to reimburse DoD "for the costs of enrolling covered veteran beneficiaries in the TRICARE program." It would not require or authorize VA to reimburse covered Veteran beneficiaries for their costs for care, and it would not require or authorize VA to reimburse DoD for any costs of care (only the costs of enrolling Veterans in the TRICARE program). It is also unclear whether VA could use the Cost of War Toxic Exposures Fund to reimburse DoD for any toxic exposure-related care participating Veterans receive.

Beyond increasing out-of-pocket costs, covered Veteran beneficiaries would also likely experience a reduction in terms of care benefits. The proposed amendment to section 1705 would also seem to bar VA from furnishing care to covered Veteran beneficiaries, even if such Veterans are not otherwise required to enroll to receive care (principally for service-connected care) or where enrollment is not otherwise required. For example, under 38 U.S.C. § 1720J, VA provides emergent suicide care for Veterans, but participating in TRICARE Select would prohibit VA from furnishing this care under the bill's amendments to 38 U.S.C. § 1705. A reduction in the VA enrolled population would also, over time, affect VA's budget estimates, likely resulting in fewer resources appropriated to VA, which would potentially lead to a reduction in facilities, services, and programs that could easily spiral into a downward circle.

VA and DoD currently coordinate closely on care delivery for dual-eligible Veterans to ensure as seamless a transition as possible, but this bill would extend TRICARE eligibility to a cohort that is not currently dual-eligible.

This bill would also remove VA from its role as a care coordinator. Care coordination is critical to ensuring that patients receive appropriate, high quality, timely, and accessible care. Care coordination ensures Veterans are not subject to unnecessary procedures, duplicate tests, or additional costs; it also promotes patient safety by clearly sharing relevant information about treatment plans and the Veteran's health conditions with all relevant providers. Care coordination also supports the efficient delivery of care by reducing duplicate procedures and unnecessary care. Covered Veteran beneficiaries participating in this program would not have access to VA health care coordination and hence would be at greater risk. Further, by removing VA's pre-authorization requirements, VA would be unable to notify providers in advance of a covered Veteran beneficiary's care needs or provide access to critical medical records, which could undermine the quality and safety of care. Shifting covered Veteran beneficiaries' care to private providers may also adversely affect such Veterans' applications for disability benefits, as there could be delays in the receipt of medical records that could support a Veteran's claim for compensation.

VA does not believe the 2-year period from the date of enactment would be enough time to implement the changes, including data-sharing agreements, this bill would require. Beyond the need for regulations and coordination between two of the largest Departments in the Federal Government, we believe it would be critical to communicate clearly to all potentially eligible Veterans to inform them of these changes. As noted above, we believe the consequences for Veterans would be immense, so ensuring that Veterans understand how their benefits would change—particularly how their costs would increase—would be essential. Only providing two years to develop, implement, and communicate a program like this could invite failure.

VA opposes assigning responsibility for implementation to CICP; as we have previously noted in testimony to this Committee, language such as appears in section 2(c)(4) is ambiguous as to whether all the limitations in 38 U.S.C. § 1703E, establishing and governing the CICP, apply. To the extent they do, the costs of this pilot program alone could exceed the $50 million amount Congress has authorized the CICP to conduct all its work. We do note, however, that the reference in section 2(c)(4) may be unintentionally narrow, as it only refers to carrying out subsection (c), rather than the entirety of the changes this bill would make in subsections (a) and (b)—but even under that broader reading, we would not interpret the language to require the CICP to carry out expansion of the TRICARE program, which DoD administers.

VA also does not support the quarterly reporting requirements, which would be onerous and resource intensive.

Further, we note that the amendments to section 1075(b)(1)(B) are unclear. The added phrase regarding covered Veteran beneficiaries follows an exception, making it unclear if covered Veteran beneficiaries are another exception to beneficiaries covered by 10 U.S.C. § 1086(c). We recommend the Committee work with VA and DoD, as necessary, to resolve these ambiguities.

We note, as a technical matter, the bill would result in two subsections (i) in 10 U.S.C. § 1075.

Cost Estimate. VA is unable to provide a cost estimate for this bill, but anticipates that the costs could be significant. These costs impact both VA and DoD accounts and include both discretionary and mandatory costs. There could also be costs to other Federal payers like Medicare.

H.R. 3176 Veterans Health Care Freedom Act

Section 2(a) would require VA, acting through CICP, to carry out a pilot program to improve the ability of eligible Veterans to access hospital care, medical services, and extended care services through the covered care system by providing eligible Veterans the ability to choose health care providers. VA would have to select a minimum of four Veterans Integrated Service Networks (VISN) in which to carry out a pilot program, and

in making such selections, VA would have to ensure the pilot program would be carried out in varied geographic areas that include both rural and urban locations.

Section 2(b) would require VA to furnish hospital care, medical services, and extended care services to eligible Veterans through the pilot program through the covered care system as follows: at VA medical facilities, regardless of whether the facility is in the same VISN as the VISN in which the Veteran resides or at non-VA facilities pursuant to 38 U.S.C. § 1703, without regard to the requirements specified in subsection (d) (concerning eligibility for covered Veterans to elect to receive community care) or 38 U.S.C. § 1703A (governing Veterans Care Agreements (VCA)), without regard to the limitations on the use of VCAs in section 1703A(a)(1)(C).

Section 2(c) would provide that eligible Veterans participating in the pilot program could elect to receive hospital care, medical services, and extended care services at any provider in the covered care system.

Section 2(d) would require each participating eligible Veteran to select a primary care provider in the covered care system. The primary care provider would coordinate the hospital care, medical services, and extended care services furnished to the Veteran under the pilot program with VA and other health care providers and refer the Veteran to specialty care providers in the covered care system, as clinically necessary. VA would have to establish systems, as appropriate, to ensure that a primary care provider can effectively coordinate the hospital care, medical services, and extended care services furnished to a Veteran under the pilot program.

Section 2(e) would allow participating eligible Veterans, subject to the referral process described above, to select any specialty care provider in the covered care system from which to receive specialty care. VA could designate a specialty care provider as a primary care provider of an eligible participating Veteran if VA determined that such designation was in the health interests of the Veteran.

Section 2(f) would allow participating eligible Veterans to select a mental health care provider in the covered care system from which to receive mental health care.

Section 2(g) would require VA, in carrying out the pilot program, to furnish to eligible Veterans the information on eligibility, cost sharing, treatments, and providers required for Veterans to make informed decisions with respect to selecting primary care providers and specialty care providers and available treatments.

Section 2(h) would require VA to carry out the pilot program during the 3year period beginning on the date that is one year after the date of the enactment of this Act. It would also amend 38 U.S.C. § 1703(d) by amending paragraph (1) to state that, except as provided for in a new paragraph (4), VA would furnish hospital care, medical services, and extended care services, subject to the availability of appropriations, to covered Veterans through health care providers if any of five conditions were met (reflecting the five current eligibility criteria for VCCP). It also would add a new

paragraph (4) stating that paragraphs (1)-(3) of section 1703(d) (defining eligibility and the conditions under which eligible Veterans can elect to receive care) would not apply, beginning on the date that is four years after the date of the enactment of this Act, with respect to furnishing hospital care, medical services, and extended care services to covered Veterans.

It would further require VA to furnish such care and services to a covered Veteran under section 1703 with the same conditions on the ability of the Veteran to choose health care providers as specified in the pilot program required by this Act. Section 2(h) would make similar amendments to 38 U.S.C. § 1703A by amending subsection (a)(1) to provide exceptions under subparagraph (C) to recognize a new subparagraph (E), which would also, beginning on the date that is four years after the date of the enactment of this Act, provide that subparagraph (C) would not apply with respect to furnishing hospital care, medical services, and extended care services to covered Veterans; it would also require VA to furnish such care and services to covered Veterans under this section with the same conditions on the ability of the Veteran to choose health care providers as specified in the pilot program described in section 2 of this Act. Finally, section 2(h) would require VISNs, beginning on the date that is four years after the date of the enactment of this Act, to furnish hospital care, medical services, and extended care services to Veterans under chapter 17 at VA medical facilities, regardless of whether the facility is in the same VISN as the VISN in which the Veteran resides.

Section 2(i) would require VA, on a quarterly basis during the 2-year period beginning on the date of the enactment of this Act, to submit a report to Congress on the implementation of the pilot program. One such report would contain a description of the final design of the pilot program. On an annual basis, beginning on the date that is one year after the date of the final quarterly report, and ending on the date of the conclusion of the pilot program, VA would have to submit to Congress a report on the results of the pilot program.

Section 2(j) would authorize VA, in consultation with Congress, to prescribe regulations to carry out this section.

Section 2(k) would state that no additional funds would be authorized to be appropriated to carry out this section, and that this section would be carried out using amounts otherwise made available to VHA.

Section 2(l) would define the term “covered care system” to mean each VA medical facility, health care provider under the VCCP, and eligible entity or provider that has entered a VCA. The term “eligible veteran” would mean enrolled Veterans, and the term “non-Department facility” would have the meaning given that term in 38 U.S.C. § 1701, which defines that term as “facilities other than Department facilities”.

VA opposes this bill. As currently drafted, the bill would remove VA from serving as a coordinator of care, at least in cases where a non-VA provider is selected

as the primary care provider. Because it would increase administrative costs to VA at the direct expense of other clinical programs, it would jeopardize all Veterans' access to timely and quality care. The introduction to this testimony, incorporated here by reference, lists the concerns that would follow from this shift in responsibility and the consequences that would have on Veteran outcomes.

Specific provisions in this bill also present unique problems. First, the bill purports to require a pilot program in four VISNs, but then it also includes language that would make the pilot permanent. This approach does not make sense methodologically or practically. The purpose of a pilot program is to determine whether a certain effort or program works, and then to determine, if it works, whether it should be expanded. This Committee, in at least dozens of situations, has expressly embraced this model – develop a pilot program, survey its results, and report back to Congress with recommendations. This bill instead would require VA to develop a program, survey its results, and expand it regardless of those results, unless a future Congress acts to undo the amendments this bill would make. It is also unclear whether the language stating the pilot program would operate in four VISNs, but Veterans could choose to receive care outside their home VISN, means that Veterans in the pilot program could choose to receive care from areas outside the four participating VISNs.

Similar to H.R. 214, this bill would also remove VA from its role as a care coordinator when a Veteran selects a non-VA provider. Care coordination is critical to ensuring that patients receive appropriate, high quality, timely, and accessible care[9]. Care coordination ensures Veterans are not subject to unnecessary procedures, duplicate tests, or additional costs; it also promotes patient safety by clearly sharing relevant information about treatment plans and the Veteran's health conditions with all relevant providers. For example, VA has an integrated suicide prevention framework across services that improves care coordination for those at risk for suicide. A recent review of national suicide prevention program frameworks found VA has the most comprehensive framework and approach because the organization developed, integrated, and standardized Nationwide plans for implementation across medical centers in a way other approaches or agencies have been unable to achieve on a national scale.[10] The 2024 VA National Veteran Suicide Prevention Annual Report notes Veteran deaths by suicide are lower among Veterans who receive VHA care compared to both Veterans who receive only VA-funded community care and Veterans receiving a mix of VHA care and VA-funded community care. Rates of death by suicide among Veterans receiving VHA-care have dramatically improved across many of the diagnoses most closely associated with unique drivers of Veteran suicide risk. Specifically, from

[9] Sathyanarayanan S, Zhou B, Maxey M. Reducing Frequency of Emergency Department and Inpatient Visits Through Focused Case Management. Prof Case Manag. 2021 Jan/Feb;26(1):19-26. doi: 10.1097/NCM.0000000000000426. PMID: 33214508.

[10] DeBeer, B.R., Mignogna, J., Talbot, M., Villarreal, E., Mohatt, N., Borah, E., Russell, P.D., Bryan, C.J., Monteith, L.L., Bongiovanni, K., Hoffmire, C.A., Peterson, A., Heise, J., Baack, S., Weinberg, K., Polk, M., & Benzer, J.K. (2024). Suicide Prevention Programming: Comparing Four Prominent Frameworks. *Psychiatric services*, appips20230173. https://doi.org/10.1176/appi.ps.20230173

2001 to 2022, suicide rates fell for Veterans in VHA care with diagnoses of Anxiety, Depression, Posttraumatic Stress Disorder (PTSD), and Alcohol Use Disorder.

Care coordination also supports the efficient delivery of care by reducing duplicate procedures and unnecessary care. Veterans participating in this program would not have access to VA health care coordination and hence would be at greater risk. This bill, unlike H.R. 214, would establish a role of a care coordinator, but the individuals responsible for care coordination would be unlikely to have access to the information and resources that VA can bring for enrolled Veterans. This creates specific risks for disruption in care. While the bill would nominally require VA to establish systems to ensure effective care coordination, this would likely face significant logistical and practical challenges, and VA would have very limited means of monitoring and enforcing this requirement. Further, by removing pre-authorization requirements, VA would be unable to notify providers in advance of a Veteran's care needs or provide access to critical medical records, which could undermine the quality and safety of care.

Additionally, the bill appears to misunderstand how VA furnishes care today, as it attempts to require VA to furnish care to Veterans regardless of VISN boundaries, but that is already the case today. As VA explained in testimony to this Subcommittee just three months ago regarding H.R. 9301, the New Mexico Rural Veterans Health Care Access Act, Veterans are not limited to receiving care only within one VISN. In this respect, at least some of the changes this bill would make are unnecessary. It also misunderstands 38 U.S.C. § 1703A. Section 1703A allows VA to enter VCAs as a procurement vehicle to furnish care through non-VA providers to Veterans and other VA beneficiaries. Section 1703A is not an independent authority under which Veterans can qualify to receive care from non-VA providers. Section 1703, which established the VCCP, which generally defines when enrolled Veterans receive care from non-VA providers. In this regard, the references in this bill to section 1703A are largely inapplicable or should also be accompanied by references to 38 U.S.C. § 8153 (sharing of health care resources), which VA has relied upon for many of its procurement efforts for community care (including the Community Care Network (CCN) contracts) and other statutes that authorize VA to procure goods and services.

VA opposes assigning responsibility for implementation to CICP; as we have previously noted in testimony to this Committee, language such as appears in section 2(a)(1) is ambiguous as to whether all the limitations in 38 U.S.C. § 1703E, establishing and governing the CICP, apply. To the extent they do, the costs of this pilot program alone could exceed the $50 million amount Congress has authorized the CICP to conduct all its work.

VA also does not support the quarterly reporting requirements, which would be onerous and resource intensive.

VA also has concerns with section 2(j), which would permit VA, "in consultation with the Committees on Veterans' Affairs of the House of Representatives and the Senate", to prescribe regulations to carry out this section. VA agrees that regulations

would be critical to implementing an authority like this, but we object to the language permitting VA to develop these regulations in consultation with Congress. It is unclear exactly what the scope of this consultation would be, and it is unclear whether this language would prohibit VA from developing regulations without such consultation. We would interpret this provision to not limit VA's ability to regulate as it normally does, meaning that, in carrying out its responsibilities to the execute the law, VA would develop and consider pre-decisional material as part of the deliberative process. While VA wants to and will be as transparent as possible with Congress and the public, the deliberative process allows for unfiltered discussion among those responsible for implementing policies. If VA were required to report to Congress every element of its efforts to develop regulations, this could stifle the free flow of ideas and result in a worse rule and program. Congress and the public would have the opportunity to comment on VA's regulations under the Administrative Procedure Act, and Congress could always enact new legislation to address any concerns raised in VA's rulemaking.

The bill also suffers from various technical issues. For example, the bill would result in two paragraphs (4) in 38 U.S.C. § 1703(d). VA can provide technical assistance to attempt to address these more limited concerns, but we emphasize that no technical fixes would address VA's more fundamental concerns with the bill as described above.

Cost Estimate. VA is unable to provide a cost estimate for this bill, but anticipates that enactment of the bill would result in significant costs, both discretionary and mandatory.

H.R. 5287 Veterans Access to Direct Primary Care Act

Section 2(a) would require VA, beginning one year after the date of the enactment of this Act, to carry out a 5-year pilot program under which VA must provide eligible Veterans with the option to choose to receive primary care services furnished by a non-VA health care provider under a direct primary care service arrangement using certain Veteran health savings accounts. This pilot program would be conducted under the CICP under 38 U.S.C. § 1703E.

Section 2(b) would provide that eligible Veterans would be those enrolled in VA health care.

Section 2(c) would require VA to provide to eligible Veterans participating in the pilot program a Veterans health savings account that could be used to purchase primary care services furnished through a non-VA direct primary care service arrangement. The health savings account could also be used for associated costs, including periodic fees paid to a physician for a defined set of medical services or for the right to receive medical services on an as-needed basis; amounts paid or prepaid for medical services designed to screen for, diagnose, cure, mitigate, treat, or prevent disease and promote wellness; and prescription or non-prescription medicines or drugs.

Section 2(d) would provide that participating Veterans could not receive medical care furnished by VA that is included in the direct primary care service arrangement during the period the Veteran participated in the pilot program.

Section 2(e) would require VA to establish a mechanism to prevent fraudulent activity in connection with payments made under this section and to ensure participating Veterans use health savings accounts only as authorized under this section.

Section 2(f) would require VA to determine the annual amount to be deposited in a Veterans health savings account using calculations conducted by VA and in consultation with an actuarial service and ensure that each participating Veteran received such amount on an annual basis during the period the Veteran participates in the pilot program.

Section 2(g) would define the term “direct primary care service arrangement” to mean an arrangement under which a defined set of medical services are provided to a patient by a physician for fixed periodic fees.

Section 2(h) would require VA, for each calendar quarter during the 2-year period beginning on the date of the enactment of this Act, to submit to Congress a report on the implementation of this section. One report would have to include a description of the final design of the pilot program. Not later than one year after the date on which the final implementation report is submitted, VA would have to submit to Congress a report on the results of the pilot program.

Section 2(i) would state that amounts required to carry out this section would have to be made available from amounts otherwise authorized to be appropriated for VHA.

Section 2(j) would provide that VA’s authority to deposit funds in a Veteran health savings account under this section would terminate on the date that is five years after the date of the enactment of this Act.

VA opposes this bill. Enactment of this bill would result in fragmentation of care by removing VA as a care coordinator, which would harm patient safety and care, and because it would be immensely difficult to monitor and enforce to ensure financial accountability. The introduction to this testimony, incorporated here by reference, lists the concerns that would follow from this shift in responsibility. VA is also concerned that the requirement to establish a new program, deposit funds, and monitor usage would result in significant additional administrative costs that could not be funded through additional appropriations. There is also an open question as to whether the bill itself – by prohibiting Veterans from receiving care that is paid for by VA – is internally inconsistent, as even under this pilot program, the funds Veterans would use to receive care pursuant to a direct primary care service arrangement would be provided by VA originally.

The bill would require VA to deposit funds in Veterans' health savings accounts and ensure that participating Veterans receive such amount on an annual basis during the pilot program. VA has no experience in determining the proper amounts to deposit and would have no means to ensure that funds were only used for these purposes, at least not without significant paperwork and documentation from Veterans and providers. VA would also need to hire additional staff, such as accountants and potentially tax experts, to monitor the usage of these funds and the administration of this program. To ensure that funds were only used for appropriate purposes—and the bill only speaks to preventing fraud in the most general of ways with no clear enforcement or recovery functions articulated—would require significant additional administrative oversight and management, along with new personnel to execute these functions. These overhead costs would come expressly at the cost of other resources Congress provides for VHA, pursuant to section 2(i) of the bill. Another, but related point, is that it is unclear what happens to funds deposited in the Veterans health savings accounts at the end of the pilot program; while VA could not deposit funds after the 5-year period has lapsed, the funds that had already been deposited would presumably remain available for use. To the extent there were still available funds at the end of the pilot program, VA would presumably still need to monitor the use of those funds over time or else allow those funds to be left for unauthorized uses potentially years after the termination of the program.

The bill also would prohibit VA from furnishing care "that is included in the direct primary care service arrangement" to participating Veterans. This would also require significant administrative oversight to implement correctly and would further result in the fragmentation of care. This could result in more travel and inconvenience for Veterans when they come to VA or the direct primary care service arrangement; it could also adversely affect the Veteran's health if records are not shared reliably between VA and the participating non-VA providers. Additionally, it is unclear that a discrete list of primary care services could be established and defined for purposes of this program. VA's medical benefits package is set forth in 38 C.F.R. § 17.38, but it is not exhaustive. New services that fit within the categories articulated in paragraph (a) of that regulation can be furnished under VA's authority so long as they otherwise comply with paragraphs (b) and (c) of that regulation. It seems unlikely that VA could define a similarly expansive list of services without requiring extensive communications between non-VA providers and VA administrators. Veterans might also be subject to higher out-of-pocket costs under this bill than under VA care today; for example, they may have to pay fees up front before they can be reimbursed through the health savings account, or the amounts deposited in the health savings account may be inadequate to address all their needs. VA also would need additional administrative steps and processes in place to ensure that it could identify participating Veterans and then determine which forms of treatment could not be furnished based on the terms of the direct primary care service arrangement.

VA opposes assigning responsibility for implementation to CICP; as we have previously noted in testimony to this Committee, language such as appears in section 2(a) is ambiguous as to whether all the limitations in 38 U.S.C. § 1703E,

establishing and governing the CICP, apply. To the extent they do, the costs of this pilot program alone could exceed the $50 million amount Congress has authorized the CICP to conduct all its work.

VA also does not support the quarterly reporting requirements, which would be onerous and resource intensive.

The bill also suffers from various technical issues. VA can provide technical assistance to attempt to address these more limited concerns, but we emphasize that no technical fixes would address VA's more fundamental concerns with the bill as described above.

Cost Estimate. VA is unable to provide a cost estimate for this bill, but anticipates that enactment of the bill would results in significant discretionary and mandatory costs.

H.R. 6333 Veterans Emergency Care Reimbursement Act

Section 2(a) of H.R. 6333 would amend 38 U.S.C. § 1725(c)(4)(D) to remove the phrase "or similar payment" and insert "of less than $100." This change would prohibit VA from reimbursing the cost of emergency treatment at a non-VA facility to a Veteran under this section for any copayment of less than $100 that the Veteran owes the third party or for which the Veteran is responsible under a health-plan contract. It also would define the term "copayment" to mean a fixed amount paid by an individual for a covered health service received by the individual and would not include any amount paid for a deductible or coinsurance. Section 2(b) would provide that the amendments made by section 2(a) would apply with respect to any reimbursement claim under 38 U.S.C. § 1725 submitted to VA for emergency treatment furnished on or after February 1, 2010, including any such claim submitted by a member of the certified class seeking relief in *Wolfe* v. *McDonough* (No. 18-6091 (U.S. Vet. App.)). Section 2(c) would define the terms "emergency treatment" and "health-plan contract" to have the same meanings as given in 38 U.S.C. § 1725(f). Section 2(c) also would define the term "reimbursement claim" to include any claim by a Veteran for reimbursement of a copayment, deductible, coinsurance, or any other type of cost share for emergency treatment furnished to the Veteran in a non-Department facility and made by a Veteran who had coverage under a health-plan contract, including any claim for the reasonable value of emergency treatment that was rejected or denied by VA, whether the rejection or denial was final or not.

VA does not support H.R. 6333. The Department is deeply interested in ensuring that Veterans who have received emergency treatment are reimbursed appropriately for those costs. We would welcome the opportunity to discuss this bill further with the Committee to clarify its intent and to ensure that any legislation in this area clearly identifies its intended goals. However, we do not support H.R. 6333 because of ambiguities in the proposed legislation and several technical concerns with the bill, as written. We note that the reference to, "any such claim submitted by a

member of the certified class seeking relief in Wolfe v. McDonough, No. 18–6091 (U.S. Vet. App.)[,]" is potentially ambiguous. On March 17, 2022, the United States Court of Appeals for the Federal Circuit granted VA's appeal to the Wolfe ruling, and in doing so determined that the United States Court of Appeals for Veterans Claims lacked jurisdiction over the claim, and therefore, the ruling that created the class was overturned. The class does not currently exist and should not have ever existed per the court's ruling. Relying on this "class" as a means of identifying eligible claims may lead to confusion about what claims are included.

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

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

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

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

We also are concerned that due to system limitations, VA may be unable to re-adjudicate on its own initiative all claims submitted on or after February 1, 2010; any adjudicative provision should provide flexibility to allow VA to request that claimants re-submit their claims. In addition, VA has updated its systems since 2010, which has made accessing data from the legacy system difficult. The bill also does not address what action should be taken if the Veteran is deceased or if supporting documentation is no longer available. In the Wolfe case, prior to VA's appeal being granted, VA was ordered to re-adjudicate claims that were previously denied because the amount was

attributable to a coinsurance or deductible liability. For the reasons listed above, this proved to be extremely difficult and resource intensive. Based on this experience, we are concerned that additional re-adjudication of claims based on the enactment of this bill would create significant resource requirements without any guarantee of improved benefits for Veterans. This result would certainly be the case given the "application of amendment" language in section 2(b), which would make these changes retroactively applicable to February 1, 2010. If Congress were to establish such a retroactive effect, we strongly encourage Congress to require individuals to resubmit new claims and to limit the period under which such claims could be resubmitted (e.g., for up to one year from the bill's enactment).

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

VA would welcome the opportunity to work with the Committee to address other issues in section 1725, particularly subsections (f) and (g), that were created as a result of amendments made by section 142 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act (Cleland-Dole Act). VA is concerned that the intended results of the earlier amendments (to hold Veterans harmless and to clarify VA's payment responsibilities) cannot be achieved with the language currently in the statute. VA can provide technical assistance to address this concern.

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

H.R. 8347 Improving Menopause Care for Veterans Act of 2024

Section 2(a) would require the Comptroller General to carry out a study on the medical services furnished by VA under 38 U.S.C. §§ 1703 and 1710 for Veterans

experiencing perimenopause, genitourinary syndrome of menopause, and menopause stages.

Section 2(b) would require the Comptroller General to make publicly available a report on this study not later than 18 months after the date of the enactment of this Act.

Section 2(c) would require, not later than six months after the date on which the Comptroller General makes this report publicly available, VA to submit to Congress a strategic plan to implement the recommendations contained in the report, improve the quality of menopause care furnished under sections 1703 and 1710, and improve the access of Veterans to menopause care.

VA has no objection to enactment of H.R. 8347, and generally defers to the Comptroller General. While VA generally defers to the Comptroller General regarding the study required by section 2(a), we note that the Government Accountability Office (GAO) recently began conducting a study on menopause care furnished by VA, and this bill may duplicate those efforts. We recommend the Committee consult with GAO to determine if another review, as outlined in this bill, would yield new information or if it would simply duplicate the current review.

Additionally, the bill distinguishes between care furnished by VA under section 1703 and 1710. We note for clarity that care furnished through section 1703 is care that VA is authorized (or required) to furnish under section 1710, so in this sense, the language is redundant. We believe the bill could be clearer by simply referring to medical services provided by VA, including through VCCP, assuming the intent is to only analyze care furnished to Veterans. Menopause care could be furnished to non-Veterans by VA through other programs, such as the Civilian Health and Medical Program of VA (CHAMPVA).

VA has no objection to providing responses to the Comptroller General's recommendations and often does so for reports issued by the Comptroller General.

Cost Estimate. VA has no cost estimate for this bill.

H.R. 8481 Emergency Community Care Notification Time Adjustment Act

Section 2(a) of this bill would amend 38 U.S.C. § 1703(a)(3), which generally limits VA to furnishing care or services under VCCP to care or services authorized by the Secretary, to add a new subparagraph (B). The new subparagraph (B) would state that, in the case of an emergency which existed at the time of admission of a covered Veteran to a VCCP health care provider, VA would have to deem any care or services received by the Veteran during the period beginning at the time of such admission and ending at the time of discharge from the facility at which such care or services were furnished to be authorized under subparagraph (A) if the covered Veteran (or an individual acting on the Veteran's behalf) submits an application for such authorization

by a deadline that VA determines appropriate, except that such deadline may not be less than 72 hours following such discharge. Section 2(b) of this bill would provide that the amendments made by subsection (a) would apply with respect to admissions occurring on or after the date of the enactment of this Act.

VA does not support enactment of H.R. 8481. VA currently authorizes emergency care furnished by an authorized entity or provider if VA is notified within 72 hours of the start of such care for covered Veterans. As VA has previously advised this Committee, VA has been reviewing the existing "72-hour rule" under 38 C.F.R. § 17.4020(c) to determine whether changes are appropriate, including whether reliance on other statutory authorities (such as 38 U.S.C. §§ 1725 and 1728) might be more appropriate. VA would welcome the opportunity to discuss potentially broader reforms regarding eligibility for and administration of emergency care benefits to simplify the process for Veterans and VA.

Initially, the bill suffers from several technical ambiguities, particularly regarding procedural elements of this benefit, that we believe Congress would need to address before VA could implement this authority. First, it is unclear if the bill is intended to override VA's discretionary authority under the 72-hour rule; however, given that Congress would be speaking directly to the same subject as an existing regulation but doing so in a different way, this would appear to supersede VA's regulation at 38 C.F.R. 17.4020(c). Second, the bill would provide that VA "shall deem any care or services…to be authorized"; however, under VA's contracts and agreements, VA must authorize such care to pay for it. This intermediate step of "deeming" care to be authorized seems unnecessary given the contractual requirement to authorize, and so it raises questions as to its actual effect. Third, the bill would require VA to deem care or services to be authorized "if the covered veteran (or an individual acting on behalf of the covered veteran) submits an application for such authorization by a deadline that the Secretary determines appropriate." The bill does not technically require that the application be received by VA, be in a proper format or contain sufficient information, or include any review of whether the care can even be furnished by VA in the first place; all that is required for VA to deem the care or services to be authorized is that an application is submitted in the case of an emergency that existed at the time of admission.

Beyond these procedural concerns, the bill would, in several respects, expand VA's current 72-hour rule, which allows VA to authorize under the VCCP emergency care or services when VA is notified of such care within 72 hours of that care beginning. This expansion would undermine VA's ability to coordinate care, which is required by 38 U.S.C. § 1703(a)(2) and would increase VA's financial costs without any apparent improvement in patient care. Current regulations provide that notice must be provided "within 72 hours of the beginning of such treatment," while the bill would begin the 72-hour period "following such discharge" from a facility. As VA explained in its rulemaking to establish the 72-hour rule under the VCCP, we believe that 72 hours from the beginning of treatment provides Veterans and other parties (principally VA's contractors) sufficient time to notify VA. Additionally, the termination point of care would differ in this bill from VA's current 72-hour rule, as any care "ending at the time of discharge" would be included within the bill, but VA's regulations (given the definition of

"emergency treatment in 38 U.S.C. § 1725) only permit payment to the point of stability unless a Federal facility is unable to accept transfer of the patient. Veterans may reach the point of stability well before they are discharged. Thus, the bill could increase VA's liability for community care when such care may be more appropriately furnished in a VA facility (as is required under the definition of "emergency treatment" in section 1725).

The bill would also expand the scope of services VA would have to authorize relative to the current 72-hour rule. Currently, VA only authorizes "emergency treatment," as that term is defined at 38 U.S.C. § 1725; generally, this includes medical care or services rendered in a medical emergency and until the point of stability, as noted earlier. However, the bill would require VA to "deem any care or services received by the veteran…to be authorized." Under VA's emergency treatment authorities, only care necessary to treat the medical emergency is covered, while under this language, non-emergent care, and care not included in VA's medical benefits package under 38 C.F.R. § 17.38, would also be covered because it would include "any" care or service. This, again, would frustrate VA's efforts to coordinate care on behalf of Veterans to improve patient outcomes and would increase VA's financial liabilities for care.

Additionally, the bill could narrow VA's current 72-hour rule in several ways. First, we note that the phrase "In the case of an emergency which existed at the time of admission" would only apply in situations where "an emergency…existed." The bill does not define "emergency," and it is not clear whether VA's existing "prudent layperson" standard would apply or if a more objective standard would control. If the prudent layperson test of medical emergency would not apply, then a covered Veteran who reasonably believed that emergency treatment was needed (for example, due to severe chest pain), but who did not actually experience a medical emergency (the chest pain was only caused by indigestion, nothing life-threatening) would not be covered. Second, the language is specific to emergencies that existed "at the time of admission," but if a covered Veteran is not admitted (because the facility can provide treatment and release the Veteran safely), then this language would not apply, and thus VA could not authorize the care under this language. Again, VA's current 72-hour rule does not require admission; the rule permits VA to authorize care if notified "within 72 hours of the beginning of such treatment." *See* 38 C.F.R. 17.4020(c). Consequently, VA may be unable to authorize certain care for covered Veterans, which could leave them financially liable for the receipt of this care.

Although section 2(b) of the bill would make the amendments applicable with respect to admissions occurring on or after the date of the enactment of this bill. VA would need to update its regulations to reflect this change (which would normally take more than a year to complete), making this timeline unrealistic. Separately, but related, VA would need different contractual terms than are currently in place to give effect to this change; that would either require a modification of current contracts or inclusion of these terms in future contracts. VA's efforts to develop the next generation of CCN contracts are already underway, so attempting to modify current contracts would likely not be feasible or advisable. If VA attempted to include this in the next generation

contracts, this could delay the award of such contracts, and if these delays resulted in a gap between the expiration of the existing contracts and the award of the next contract, this gap could have significant consequences in terms of Veterans' access to community care.

Cost Estimate. VA does not have a cost estimate for this bill.

H.R. 9924 What Works for Preventing Veteran Suicide Act

Section 2(a) would amend 38 U.S.C. § 527 to create a new subsection (b) that would require VA to prescribe regulations to establish standard practices that, unless otherwise prohibited by law, would have to apply to a grant program or pilot program relating to suicide prevention or mental health carried out through VHA. The practices would have to include (1) the establishment of clear and measurable objectives, (2) the development of a methodology and plan to evaluate the program, (3) the communication of program objectives, assessment methodology, and evaluation plan with relevant entities, (4) program evaluation at the conclusion of a program, and (5) the sharing of program results and best practices with relevant entities. Section 2(b) would require VA, not later than 180 days after the date of the enactment of this Act, to prescribe regulations under the new 38 U.S.C. § 527(b). Section 2(c) would provide that the standard practices would apply to a grant or pilot program without regard to when such program was established.

VA does not support this bill because ambiguities within the language make the scope of this proposal unclear and because we believe the general intent is already being met through current efforts. To the extent the bill would impose new requirements, VA is also concerned about the potential for this bill to disrupt current programs and service delivery that could harm Veterans and communities.

The scope of this bill is unclear. As written, it is not apparent whether the standard practices would apply to all grant programs, and to pilot programs relating to suicide prevention or mental health and carried out by VHA, or if it applies only to grant programs and pilot programs relating to suicide prevention or mental health and carried out by VHA. In other words, it is not clear if the phrases "relating to suicide prevention or mental health" and "carried out through [VHA]" would apply just to pilot programs or also to grant programs. The range of programs that would be included would vary considerably between these two interpretations. There could be other variations in meaning – for example, does the phrase "carried out through the Veterans Health Administration" only qualify pilot programs relating to mental health, or does it also qualify pilot programs relating to suicide prevention? Absent further Congressional clarification, VA would interpret this to apply narrowly to only grant or pilot programs relating to suicide prevention or mental health and carried out by VHA; in other words, grant or pilot programs operated by VHA that are not related to suicide prevention or mental health, and any programs or grants administered by any organizational component other than VHA, would not be subject to these requirements.

Even given a narrower interpretation, the exact definition of which grant or pilot programs are "relating to suicide prevention or mental health" is unclear. Many of VA's

homeless program grants, for example, provide mental health support in some form or fashion, but it is unclear if those programs are intended to be included. As another example, Congress has required VA to carry out a pilot program to provide beneficiary travel for eligible Veterans to access Vet Centers; while Vet Centers provide readjustment counseling services that can support mental health and suicide prevention, the pilot program involves the delivery of transportation benefits. In the absence of further Congressional clarification, VA would interpret programs like these to be beyond the scope of this legislation, as they do not primarily relate to suicide prevention or mental health.

There also is no definition of what a pilot program is. VA experiments within its current authorities in many ways that could be considered a pilot program. The initiatives have established operation procedures that guide robust evaluation, funding, and implementation. This ability to innovate is critical to ensuring that Veterans and other beneficiaries receive the best care possible, and that VA operates as efficiently as possible, and we are concerned that applying the requirements in this bill to those initiatives could frustrate those efforts by delaying implementation of new ideas. Consequently, absent further Congressional clarification, VA would interpret the bill language to apply narrowly to only pilot programs formally authorized by Congress through law; this would include pilots authorized by Congress under the CICP.

Beyond these ambiguities, VA already maintains robust program evaluation efforts for grant programs and pilot programs, many of which were statutorily established and are publicly available. Creating additional regulations for grant or pilot program evaluation could create potential conflicts of law for future and existing grant programs or pilot programs. To that end, it is unclear how this legislation would result in any improvement of services or outcomes beyond existing law that would justify the potential conflicts described. It also is not clear how VA would develop practices for the conclusion of certain programs, like grant programs, that do not have a specific end date noted within their statutory authority (or that routinely receive extensions of authority).

VA also has concerns with section 2(b) and (c). Regarding subsection (b), VA does not believe it is realistic to promulgate regulations within 180 days of enactment given the timelines associated with the rulemaking process. It is also not clear that regulations are even necessary in this context, so VA recommends striking this subsection altogether. Regarding subsection (c), to the extent this bill does impose new requirements, applying them to existing programs could result in disruptions of those programs that could delay the award of grants or the provision of benefits through pilot programs. We recommend amending subsection (c) to direct VA to ensure that existing programs are brought into compliance with these standard practices as soon as practicable to allow each program to be updated without disruption.

As a technical matter, if this bill is intended to apply only to grant and pilot programs carried out through VHA, we recommend that any amendments like this be made in chapter 17, such as in section 1709B, instead of 38 U.S.C. § 527. Notably, section 1709B already requires VA to conduct an evaluation of mental health care and suicide prevention programs carried out by VA.

Cost Estimate. VA does not have a cost estimate for this bill.

H.R. 10012 Including Eyeglass Lens Fittings in the Category of Medical Services Authorized to be Furnished to Veterans under the Veterans Community Care Program

Section 1(a) would amend 38 U.S.C. § 1701(6)(C), which defines the term "medical services" for purposes of chapter 17 to include optometric and podiatric services, to also include fittings for eyeglass lenses within this definition. Section 1(b) would require VA to establish policies and procedures and prescribe regulations to carry out the amendments made by subsection (a). Under these regulations, VA would have to ensure that a Veteran eligible to receive medical services from a non-VA provider under the VCCP can schedule an appointment for a fitting for eyeglass lenses at such provider in geographic proximity to the Veteran. Section 1(c) would require VA, not later than 180 days after the date of the enactment of this Act, to submit to Congress a report that includes a statement of the status of the implementation of the amendment made by subsection (a), a summary of any challenges faced with respect to such implementation, a strategy to mitigate such challenges (if applicable), and an assessment of the benefits for Veterans resulting from such amendment.

VA does not support this bill. The proposed amendments are not necessary for the intended outcome, which is already being pursued through other means. We understand the concerns regarding payment for eyeglass fitting, but VA is already working to address these under current authority.

Section 1(a) of the bill would amend the definition of medical services to include fittings for eyeglass lenses; however, VA already includes fittings for eyeglass lenses among optometric services under the medical benefits package. VA has experienced issues where covered Veterans under the VCCP were unable to receive eyeglass fittings, or providers who furnished such fittings were unable to be paid, but this was not because the definition of medical services for purposes of chapter 17 was insufficient. The issue with the VCCP was that VA's contracts did not include fittings for eyeglass lenses among the authorized services for which VA would provide payment. VA is already working to ensure Veterans receive the services they need and that providers are paid appropriately.

Section 1(b) would require VA to establish policies and procedures and prescribe regulations to carry out these amendments, but VA does not believe further regulation is necessary (either under current law or under the proposed text). As noted earlier, the underlying issue currently is a contractual one, not a regulatory one. Section 1(c) would require VA to submit to Congress a report within 180 days of enactment on the status of implementation and other factors, but to the extent VA was required to engage in rulemaking, VA would likely have nothing to report within 180 days of enactment because it would still be engaged in the rulemaking process, which could easily take two years or longer to complete.

As a technical matter, section 1(b) would require VA to ensure that eligible Veterans "can schedule an appointment for a fitting for eyeglass lenses at such a provider in geographic proximity to the veteran." The phrase "at such a provider" does not clearly refer to eligible providers under the VCCP. In the absence of further Congressional clarification, VA would interpret this requirement to refer only to eligible providers under the VCCP.

Also, the phrase "geographic proximity" is undefined and appears to create a separate and distinct standard from the access standards applicable to community provider under 38 U.S.C. § 1703B. In the absence of further Congressional clarification, VA would interpret this requirement to refer to the applicable access standards VA established under section 1703B.

Cost Estimate VA does not have a cost estimate for this bill.

H.R. XXXX Supporting Medical Students and VA Workforce Act

Section 2 of the bill would amend chapter 76 of title 38, United States Code, to add a new subchapter establishing the VA-Public Health Service (PHS) Joint Scholarship Program. Under this scholarship program, VA would pay for the medical education of a PHS-commissioned officer at the Uniformed Services University (USU) in return for a period of obligated service by such officer at a VA medical facility.

VA supports enactment of this draft bill, subject to the availability of appropriations. This bill would give VA the authority to expand its Health Professions Scholarship Program (HPSP) program and fund the education of medical students enrolled in the F. Edward Hébert School of Medicine at the USU as commissioned junior PHS officers who would ultimately serve as VA physicians to fulfill their 10-year PHS service obligation.

VA has an urgent need to recruit high-performing physicians and clinical leaders. USU graduates are a particularly high-quality pool of physicians with military competencies, Veteran-centricity, and mission focus. The USU serves as the leadership academy for the military health system and the PHS. It is the only medical school wholly funded by the U.S. Government and is dedicated to training physicians for national service in the U.S. Army, Navy, Air Force, or PHS. By providing positions for medical students committed to future service in VA, this scholarship program would continue the tradition of creating physician leaders in the Federal health care system. Several other benefits include its military-focused education, the lengthy service obligation, and the unique nature of USU-trained physicians.

In addition to receiving an exceptional medical education, all USU medical students receive more than 650 hours of additional military-specific instruction in operational medicine, health protection, and leadership. This military-specific curriculum

and its valuable military cultural competencies is unique in US medical education and makes USU students ideally suited to care for Veteran patients and to become the next generation of VA physician leaders.

After graduation and completion of residency, all PHS-supported physicians would be obligated to serve a minimum 10-year period of post-residency national service. This is longer than the 7 years incurred for Army, Navy, or Air Force USU students and the 4-6 years for other VA HPSP medical students.

Provisions in the VA MISSION Act of 2018 (P.L. 115-182) gave VA the authority to expand the HPSP to medical and dental students, increase the Education Debt Reduction Program (EDRP) cap, provide loan repayment to physician residents in training, and expand the HPSP to Veteran medical and dental student enrollees. All these programs result in service obligation to VA and are all important tools to expand the physician workforce in VA. However, acquiring physicians through USU would provide a corps of physicians who, by the nature of their USU training in military culture and tradition, are uniquely prepared to serve as providers and leaders for VA, and satisfy Veteran patients' need for culturally competent providers. In addition, these physicians would be fully deployable to sites of need in VA (e.g., rural or other underserved areas).

At the end of their 10-year service obligation, these physicians may a) choose to continue serving in VA as a PHS officer; b) continue to serve as a PHS officer but request transfer to another Federal agency; c) separate from the PHS and work for VA as a civilian; or d) separate from the PHS. Based on the prior track record of USU graduates, it can be expected that 75% will make a career-long commitment to Federal service. Also, given that these providers will already have compiled nearly two decades of Government service at the end of their service obligation, it is highly likely that they will choose to continue to work for VA to continue their Federal service employment ("time in service") longevity to accrue retirement benefits, even if they leave the PHS. Thus, we expect this program to drastically diminish recruitment and retention costs for highly qualified physician leaders through their required service obligation.

VA has a national physician shortage of over 1,000 physicians. Physicians are always at or near the top of shortage occupations as assessed by VHA Workforce Management and Consulting Office's succession planning initiatives as well as the Office of Inspector General annual assessment. Limitations on aggregate salary for Federal physicians limits VA's competitiveness. Scholarship programs such as this one would enable VA to recoup service obligations to staff its health care system. After 10 years of operation, this program would satisfy approximately one-third of VA's physician deficit and supply VA with an extremely high-caliber physician workforce who will have retirement incentives to continue their careers as Federal workers.

Currently, there are no existing authorities available to VA to execute this unique scholarship program. The current VA HPSP, authorized by 38 U.S.C. §§ 7601-7619 and 7631-7636, is primarily a tuition and fees reimbursement program, and thus is not

applicable to the tuition-free USU medical school. This limits VA's access to USU's talented pool of future physicians. In addition, the mechanisms for reimbursement of both PHS and DoD for the costs of educating these students requires specific statutory authority.

Cost Estimate. VA estimates this bill would cost $0.3 million in FY 2027, $1.1 million in FY 2028, $12.2 million over five years, and $67.5 million over 10 years.

H.R. XXXX Complete the MISSION Act of 2024

This bill contains two titles; title I contains seven sections, and title II contains five sections.

VA cites a number of substantive and procedural concerns throughout.

Title I. Section 101 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 would be eligible to elect to receive non-VA hospital care, medical services, or extended care services, excluding nursing home care, under section 1703(d)(1)(D) (the eligibility criterion for VCCP based on VA's designated access standards) if VA determined, with respect to primary care, mental health care, or extended care services (excluding nursing home care), VA could not schedule an in-person appointment for the covered Veteran with a VA health care provider who could provide the needed service at a facility that is located within 30 minutes average driving time from the Veteran's residence (unless a longer average driving time has been agreed to by the Veteran in consultation with a health care provider of the Veteran) and within 20 days of the date of the request for such an appointment (unless a later date has been agreed to by the Veteran in consultation with a health care provider of the Veteran).

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 within 60-minutes average driving time from the Veteran's residence (with a similar exception for Veteran consent to a longer average driving time) and within 28 days of the date of request for such appointment unless a later date has been agreed to by the Veteran in consultation with a health care provider. The availability of telehealth appointments from VA would not be taken into consideration when determining VA's ability to furnish such care or services in a manner that complies with the access standards. VA could prescribe regulations that establish a shorter average drive time or period than those otherwise described above. Covered Veterans could consent to longer average drive time or later date, 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. If a Veteran had an appointment cancelled by VA for a reason other than the request of the

Veteran, VA would have to calculate the wait time from the date of the request for the original, canceled appointment.

Proposed section 1703B(b) would require VA to ensure that these access standards apply to all care and services within the VA medical benefits package to which a covered Veteran is eligible under section 1703 (except nursing home care) and to all covered Veterans, regardless of whether they are new or established patients.

Proposed section 1703B(c) would require not later than three years after the date of enactment of the Act and not less frequently than once every three years thereafter, VA to review the eligibility access standards established under the revised section 1703B(a) in consultation with such 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, Veterans Service Organizations, and health care providers participating in the VCCP). It would also require VA to submit to Congress a report on its findings with respect to the review and such recommendations as VA may have with respect to eligibility access standards. Section 101 would also strike section 1703B(g), which allows VA to establish through regulation designated access standards for purposes of VCCP eligibility and would make other conforming amendments.

VA opposes enactment of section 101. VA is opposed to codification of access standards. Limiting the Secretary's ability 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.

VA also opposes the provision that would, in making determinations about scheduling appointments, prohibit consideration of a telehealth appointment or the cancellation of an appointment (unless such cancellation was at the request of the Veteran). VA is evaluating how best to consider telehealth regarding its access standards, including determining how to best prioritize the Veteran's preference. If a Veteran agrees to the use of telehealth, and telehealth is clinically appropriate, VA believes a telehealth appointment should satisfy the access standards and meet the Veteran's need for health care services.

Decades of rigorous research consistently supports that mental health services, including psychotherapy and psychiatry, delivered over telehealth are as clinically effective as traditional in-person care for treating a range of mental health conditions in Veterans.[11] Patient and provider satisfaction, therapeutic alliance, and retention have

[11] Morland LA, Wells SY, Glassman LH, Greene CJ, Hoffman JE, Rosen CS. Advances in PTSD Treatment Delivery: Review of Findings and Clinical Considerations for the Use of Telehealth Interventions for PTSD. Curr Treat Options Psychiatry. 2020;7(3):221-241. doi: 10.1007/s40501-020-00215-x. Epub 2020 May 30. PMID: 32837831; PMCID: PMC7261035. See also, Morland LA, Greene CJ, Rosen CS, Foy D, Reilly P, Shore J, He Q, Frueh BC. Telemedicine for anger management therapy in a rural population of combat veterans with posttraumatic stress

also been demonstrated. We also know that many Veterans prefer and appreciate the convenience of video visits; Veteran experience data consistently indicate that after Veterans complete a mental health video-to-home visit and are asked about their preferences, most of them prefer video to other modalities (including in-person care).

Finally, VA notes that section 101 would require VA to engage in consultation with various stakeholders; this could invoke the Federal Advisory Committee Act (FACA) 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 FACA. In the alternative, the consultation requirements could be removed, which would also address this concern.

Rather than amending 38 U.S.C. § 1703B as proposed by section 101, we recommend instead amending section 1703B(f), which generally requires VA to apply its access standards to providers to all VCCP providers. Section 1703B(f) includes a waiver process for providers furnishing care pursuant to CCN contracts, but it includes no similar waiver process for providers furnishing care outside of the CCN contracts. These non-CCN providers are typically small facilities or single providers who do not have the capacity or flexibility to comply with VA's access standards, particularly the average driving time element of VA's access standards. VA would be happy to work with the Committee to address this concern through technical assistance.

Cost Estimate. VA does not have a cost estimate for section 101.

Section 102 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 as soon as possible, but not later than two business days, after the date on which the Veteran is seeking care or services and is eligible for such care or services under section 1703. VA would have to provide such Veterans periodic reminders, as it determines appropriate, of their ongoing eligibility under section 1703(d). VA could provide covered Veterans notice electronically.

VA does not support section 102. While VA agrees that timely eligibility notification is an integral component of VA's ability to provide Veterans quality care, a statutorily prescribed 2-business day notification deadline would make universal implementation of this standard extremely challenging, especially in cases where notification by electronic communication is unavailable or in instances of walk-in emergency care. VA personnel would face operational and administrative burdens if they were responsible for making notifications, which would come at additional cost to VA.

Under the proposed section 1703(a)(5)(B), VA would be required to provide periodic reminders of VCCP eligibility to Veterans eligible under 38 U.S.C. § 1703(d).

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disorder: a randomized noninferiority trial. J Clin Psychiatry. 2010 Jul;71(7):855-63. doi: 10.4088/JCP.09m05604blu. Epub 2010 Jan 26. PMID: 20122374.

However, three of the five eligibility factors in section 1703(d) may only confer eligibility for a single episode of care for a specific service required at that time by the Veteran. Eligibility determinations in general are highly dependent on short-term, situational circumstances of which VA cannot make periodic anticipatory assessments and notifications.

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 meet the intent of this section more feasibly.

Cost Estimate. VA does not have a cost estimate for section 102.

Section 103 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 include 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.

VA does not support section 103. The wording in this section creates ambiguity and may shift this decision making regarding the best medical interest of the Veteran 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, 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 consider 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.

To include "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 care, would create confusion in practice. VA agrees that a Veteran's need for an attendant or caregiver is relevant and already considered consistent with 38 C.F.R. § 17.4010(a)(5)(vii)(E)). A Veteran's "request" for

a caregiver or attendant does not establish need, but this section would qualify a requesting Veteran for community care irrespective of need.

VA believes that the proposed changes could not be implemented as written without fundamentally altering the process for making determinations about Veterans' best medical interest.

Cost Estimate. VA does not have a cost estimate for section 103.

Section 104 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 was 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.

VA does not support section 104. VA is concerned that a statutorily prescribed two-business day notification deadline would be operationally impractical and burdensome, especially in cases where notification by electronic communication is unavailable. It is also unclear the penalty for non-compliance in a situation where VA was unable to meet this requirement. Section 104 is ambiguous, as it refers to a Veteran not meeting the eligibility access standards; however, VA must be able to schedule an appointment that meets the eligibility access standards, and if it cannot, then the Veteran is eligible. 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. 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 is working to modify 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. We do not believe legislation is needed in this regard.

Cost Estimate. VA does not have a cost estimate for this section.

Section 105 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 telehealth is available to the Veteran, is appropriate for the type of care or service the Veteran seeks, and is acceptable to the Veteran.

VA supports section 105, if amended. While VA supports this section, it is unclear whether the bill is intended to establish that a Veteran's preference to not

receive care via telehealth would also be binding on how they receive care 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 and cost implications of this section.

Cost Estimate. VA does not have a cost estimate for this section.

Section 106 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 TPAs to establish the use of value-based reimbursement models under the VCCP. It would also impose additional reporting requirements associated with these efforts. It would define Third Party Administrator as an entity that manages a provider network and performs administrative services related to such network under section 1703.

VA supports section 106. VA currently has efforts underway to incorporate value-based care to improve outcomes and care coordination while lowering costs. However, 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.

Cost Estimate. VA does not have a cost estimate for this section.

Section 107 of the bill would amend 38 U.S.C. § 1703D to extend from 180 days to one year, the period of time for health care entities and providers to submit claims to VA for payment for furnishing hospital care, medical services, or extended care services.

VA does not support section 107. VA would welcome the opportunity to discuss other potential amendments to section 1703D to clarify the scope of the applicability of this requirement as well as enhancing the provisions regarding fraudulent claims to provide VA enhanced authority to combat waste, fraud, and abuse.

Currently, 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 their contracts with the TPAs. 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.

Cost Estimate. VA does not have a cost estimate for this section.

Title II

Section 201 would require VA, working with TPAs and acting through the CICP, to develop and implement a plan to establish an interactive, online self-service module: (A) that would allow Veterans to request appointments, track referrals for care, and receive appointment reminders; (B) to allow Veterans to appeal and track decisions relating to denials of requests for care and services under VCCP and denials of requests for care and services at VA facilities; and (C) implement such other matters as determined appropriate by VA in consultation with TPAs. Within 180 days of enactment, VA would have to submit to Congress this plan. Following submittal of the plan, VA would have to submit to Congress quarterly reports for two years containing any updates on the implementation of the plan. This section could not be construed to be a pilot program subject to the requirements of 38 U.S.C. § 1703E. It would define TPA as an entity that manages a provider network and performs administrative services related to such network under 1703.

VA does not support section 201. VA objects to a statutory requirement to work with the TPAs, as this could narrow the Secretary's authority and flexibility to design systems and processes that are responsive to the needs of Veterans. Additionally, not all providers who furnish care through the VCCP have an agreement with a TPA; some providers have direct contracts or agreements with VA. VA is working to implement many of the functions described in this section, such as by allowing Veterans to request and schedule appointments on their own and by allowing Veterans to appeal and track decisions. However, a single, consolidated module that would perform all these functions would likely be very difficult to build and operate. We also do not support requiring the CICP to implement this program as it is not clear that the CICP would have the resources or expertise to manage an information technology platform like this. The Secretary should have the discretion to determine which offices would be best to implement this authority.

Cost Estimate: VA does not have a cost estimate for section 201.

Section 202 would create a new 38 U.S.C. § 1703G that would require VA to publish online the average wait time for a Veteran to schedule an appointment at each VA medical center for the receipt of primary care, specialty care, and mental health care measured from the date of request for the appointment to the date on which the care was provided. VA would have to update these wait times not less frequently than monthly.

VA supports section 202, if amended. VA currently provides this information pursuant to section 206 of the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act, 38 U.S.C. § 1701, note), but this section would not rescind that authority. We recommend repealing section 206 of the Choice Act if Congress intends to codify a permanent requirement like this.

Cost Estimate: VA does not anticipate any additional costs would result from section 202.

Section 203(a) would amend the CICP's authority in 38 U.S.C. § 1703E in ten ways.

VA does not support section 203. First, moving the CICP to the Office of the Secretary could lead to operational disruptions, cause work output delays, and create confusion through this reorganization.

Additionally, the apparently expanded scope of the Center's authority would still be constrained by the current statutory focus on testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by VA. It seems unlikely that VA could test payment and service delivery models to determine whether these models (1) improve access, quality, timeliness, and satisfaction of care, (2) create cost savings for VA, and (3) increase productivity,

Further, the proposed amendments to CICP's waiver authority under § 1703E(f) create some ambiguity. The amendments to paragraph (1) would allow VA, subject to Congressional approval, to waive any requirements in title 38, U.S.C. (rather than only subchapters I-III of chapter 17), any requirement in title 38, C.F.R., and any handbooks, directives, or policy documents, but the amendments to paragraph (2) refer only to waiving "any provision of this title" (title 38, U.S.C.), leaving open the question of whether waivers of regulatory authority in title 38, C.F.R. or waivers of VA policies would not require a waiver approved by Congress. Given the importance and novelty of this authority, we recommend Congress be explicitly clear as to the limits of this authority.

Also, the bill would require VA to carry out a minimum of three pilot programs concurrently. VA has defined the term "pilot program" through regulation at 38 C.F.R. § 17.450(b) to mean pilot programs conducted under that section (and thus under § 1703E). These pilot programs are subject to Congressional approval, as noted earlier. To the extent Congress did not approve at least three pilot programs concurrently, VA would be in violation of this requirement (although the penalties for non-compliance are not clear). Additionally, the limitations imposed by § 1703E would still apply (such as the limitation on the total amount VA could expend in any FY), so the requirement to carry out at least three pilot programs could narrow the scope of programs the CICP could pursue given these other constraints. It is possible the drafters only intended the CICP to operate three programs concurrently, whether they were "pilot programs" that required Congressional approval or not; if that was the intent, we recommend revising the language to reflect that.

Finally, we note that, if the CICP is moved to the Office of the Secretary, the specific line item the bill would require for the CICP would need to be funded by the same account as the Office of the Secretary. This would either require a proportional increase to the budget for the Office of the Secretary or would require significant cuts to the existing Office infrastructure. We are also unsure how the shift from the Medical Services account to the General Administration account would affect the Center's ability to support the delivery of health care. We would appreciate the opportunity to discuss this and other issues further with the Committee.

Section 203(b) would require the Comptroller General, within 18 months of enactment, to submit to Congress a report on the efforts of the CICP in fulfilling the objectives and requirements under 38 U.S.C. § 1703E and containing such recommendations as the Comptroller General considers appropriate.

Section 203(c) would require the CICP, not later than one year from enactment, to establish a three-year pilot program in not fewer than five locations to allow enrolled Veterans to access outpatient mental health and substance use services through the VCCP without referral or preauthorization.

VA has no objection to section 203(b); VA opposes section 203(c). VA has no objections to section 203(b) and defers to the Comptroller General on this provision.

Concerning section 203(c), we know there are several Veterans being recruited to participate in treatment programs, but VA has no means to verify that the care being provided is high quality, economical, or appropriate. Treatment plans are designed to address the unique needs of Veterans, who may need a more structured environment and schedule to succeed in their path to recovery. This raises concerns about the delivery of care to Veterans, and whether participation in some such programs might deter Veterans from seeking other, evidence-based care. A recent study demonstrated the efficacy of VA's integrated system, particularly for patients with mental health needs, but this type of program would impede our ability to furnish this integrated care. VA has significant concerns with section 203(c) for several reasons.

First, section 203(c)would seemingly conflict with § 1703(a)(3), which requires that covered Veterans only receive care through the VCCP "upon the authorization of such care or services by the Secretary". If Veterans could self-refer for care, unless VA were to issue a blanket authorization (and it is not clear that doing so would satisfy the requirements of 38 C.F.R. § 17.38(b), that VA determines the care is necessary to promote, preserve, or restore the health of the Veteran), it would still need to authorize this care individually. Further, VA's contracts are structured to rely upon an authorization from VA for care (other than walk-in care under § 1725A) and would require contract modifications to effectuate this under the CCN contracts. If this section is intended to establish a program separate from the VCCP, the MISSION Act was enacted to consolidate and simplify community care eligibility; this proposal would be a step back toward what the MISSION Act was intended to fix.

Second, the bill would require VA to have a care coordination system in place, though it is not clear that such a system would be nearly as effective as VA's current efforts. Participating health information exchange providers can already obtain VA health information, but not all VCCP providers participate in health information exchanges. In these situations, it is not clear how VA could coordinate the care of such Veterans, or even if VA would know that such care was being sought until after it was received. It is similarly unclear whether this pilot program would be intended to cover the full range of services – walk-in, regularly scheduled, emergent care – and how the

pilot program would interact with or supersede other statutory authorities in these areas. It seems very likely that in at least many cases, VA would only be able to monitor patient safety and outcomes retroactively, which would make implementation of a value-based model even more difficult.

Third, VA has concerns with the required metrics, as it is unclear whether community providers could report the metrics VA would use for its own programs or other metrics adopted within the industry (such as standards developed by the Centers for Medicare & Medicaid Services (CMS)).

Finally, section 203(c) would require the CICP to carry out a pilot program under § 1703E, but it is not clear whether this supersedes the waiver process required by § 1703E(f) or not.

Cost Estimate. VA does not have a cost estimate for this section.

Section 204(a) would require VA, not later than one year after the date of the enactment of this Act, to establish a standardized screening process to determine, based on clinical need, whether a covered Veteran satisfies criteria for priority or routine admission to a covered treatment program.

Section 204(b)(1) would provide that, under the standardized screening process, a covered Veteran would be eligible for priority admission to a covered treatment program if the covered Veteran meets criteria including, but not limited to, certain identified symptoms or risk factors. In deciding under paragraph (1), VA would have to consider any referral of a health care provider of a covered Veteran for admission to a covered treatment program.

Section 204(c) would require VA, under the standardized screening process, to ensure a covered Veteran is screened not later than 48 hours after the date on which the covered Veteran (or a relevant health care provider) makes a request for the covered Veteran to be admitted to a covered treatment program. VA would also have to ensure a covered Veteran determined eligible for priority admission to a covered treatment program is admitted to such program not later than 48 hours after the determination.

Section 204(d) would require VA to include the standardized screening process in the wait time access standards for eligibility for mental health care under section 1703(d).

Section 204(e) is an incomplete statement, but it generally refers to situations where VA determines a covered Veteran to be eligible for either priority or routine admission to a covered treatment program pursuant to the standardized screening process and VA is unable to admit the Veteran to a clinically necessary covered treatment program at a VA facility that is within 30 minutes average driving time (or a shorter period as VA may prescribe) of the Veteran's residence and within 20 days (or

such shorter period as VA may prescribe) for routine admission, or within 48 hours (or such shorter period as VA may prescribe for Veterans deemed eligible for priority admission.

Section 204(f) would define the term "covered treatment program" to mean a VA mental health residential rehabilitation treatment program (MH RRTP); a VA program for residential care for mental health and substance abuse disorders; includes current programs or future MH RRTPs; and does not include VA's Compensated Work Therapy Transition Residence programs. Section 205(f) would also define the term "covered veteran" consistent with the definition for the VCCP under 38 U.S.C. § 1703.

VA does not support section 204. VA agrees with many of the intended outcomes of this section, and has already established policies that would satisfy several of the requirements of this section. In addition, many of the timelines and procedural requirements are consistent with current practice and proposed changes to policy (except for the language in subsection (e), which is incomplete, but appears to be intended to apply the 30-minute average driving time and 20-day wait time elements of the access standards to MH RRTP care. Similar to section 101 of this bill, VA cannot support codification of residential treatment and rehabilitative services as appears to be proposed in this bill; specifically, VA cannot support the application of the 30-minute average driving time element of the access standards. Residential treatment is specialized, intensive treatment that is typically not available in every community. Veterans who receive such care from programs in the community typically travel on average two to three hours to access residential treatment services, and they may travel even further for very specialized services.

VA cites concerns with several provisions in this section. First, this section refers to Veterans requesting MH RRTP care. MH RRTP is a form of domiciliary care, and domiciliary care includes additional requirements that must be met to receive such care (see, e.g., 38 U.S.C. § 1710(b); 38 C.F.R. § 17.47). While Veterans can unofficially self-refer for MH RRTP, verification of their eligibility occurs during the screening process. If this language is not modified, VA would interpret this phrase considering these requirements. Further, VA is concerned with language codifying criteria for priority admission, which is a clinical decision. As written, the criteria would include general considerations for residential admission that would establish an access standard of 48 hours for most, if not all, Veterans requiring residential treatment.

VA recommends that if these requirements will continue to govern MH RRTP care (as appears to be the case) that this be codified in title 38, U.S.C., to allow for easier reference and amendment in the future. VA welcomes the opportunity to discuss this section with the Committee.

Cost Estimate. VA does not currently have a cost estimate for section 404, but is continuing to assemble the relevant data.

Section 205(a) would require VA, within one year of enactment and annually for the next three years, in consultation with VSOs, Veterans, caregivers of Veterans, employees, and other stakeholders, to submit to Congress a report containing recommendations for legislative or administrative action to improve the clinical appeals process of the Department with respect to timeliness, transparency, objectivity, consistency, and fairness.

VA does not support section 205, because it is too prescriptive. Specifically, VA cites concerns with the proposed reporting of appeal volume and outcomes, which also appears to inaccurately describe some existing processes. For example, VA notes that requests for community care that are not approved do not amount to a denial of care – that care, so long as it is necessary, is still furnished directly by VA. VA also does not support requirements to consult with a variety of stakeholders.

This section would require VA to create an advisory committee subject to FACA, the National Records Act, the Privacy Act, the Freedom of Information Act, and the Government in the Sunshine Act. However, this section does not provide sufficient guidance to VA to establish, manage, or terminate this committee. The section 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 section could strike the requirement to establish an advisory committee, or specifically exempt the working group from FACA requirements, and avoid these issues altogether.

Cost Estimate. VA does not have a cost estimate for section 205.

Conclusion

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