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

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Chairwoman Miller-Meeks, Ranking Member Brownley, and other members of the Subcommittee: thank you for inviting us here today to present our views on several bills that would affect VA programs and services. I am accompanied by Dr. Antoinette Shappell, Deputy Assistant Under Secretary for Health for Patient Care Services, and Dr. Thomas Emmendorfer, Executive Director, Pharmacy Benefits Management.

VA does not have views H.R. XXXX, Protecting Veteran Access to Telemedicine Services Act. VA will provide these views to the Subcommittee in a letter after the hearing.

H.R. 217 CHIP IN for Veterans Act

Summary: Section 2(a) of the bill amends the Communities Helping Invest through Property and Improvements Needed (CHIP IN) for Veterans Act of 2016 (P.L. Law 114294) to make that authority permanent and removing the cap of donations under the program.

Position: **VA supports this bill.**

Views: VA supports this bill because it provides an additional method by which the needs of Veterans and VA may be served outside of the traditional procurement processes. VA has used authority given under the pilot to award two projects, an Ambulatory Care Center in Omaha, Nebraska (which began providing care to Veterans in late 2020), and a hospital currently in construction in Tulsa, Oklahoma. Making the pilot program permanent would provide an additional opportunity for VA to modernize and expand its infrastructure to provide world class health care to Veterans. Projects approved, funded, and constructed using this authority would typically provide faster speed to market at a lower cost than conventionally approved and funded projects. The CHIP IN for Veterans Act is another tool available to VA.

Currently, the CHIP IN for Veterans Act of 2016 is set to expire in 2026, and it sets a maximum of five projects that can be donated under the authority. Given the

success in the two projects to date, VA would take the lessons learned and best practices from those projects and apply them to future donations across the country.

Cost Estimate: There are no costs to VA associated with this bill.

H.R. 658 Qualifications for Marriage and Family Therapists

Summary: The bill would amend 38 U.S.C. § 7402(b)(10) to add a new subparagraph (B) that would state that, to be eligible to appointed to a marriage and family therapist (MFT) position and qualified to provide clinical supervision, a person would have to have the requirements currently set forth in law (which would be redesignated as subparagraph (A)) and be authorized to provide clinical supervision in the State where the person has been designated as an approved supervisor by the American Association for Marriage and Family Therapy.

Position: VA does not support this bill.

Views: In 38 U.S.C. § 7402, the basic qualification standards for various health care professionals. Currently, there are no statutory requirements for supervisory roles in any title 38 positions. Thus, VA has authority to establish qualification standards in VA policy for all levels of the position (for example entry level, full performance level, supervisory level, and so on.).

The current standards for MFTs were written by a group of subject matter experts (SME) in the MFT discipline. They considered whether the State designation would be appropriate or the supervisor designation from the American Association for Marriage and Family Therapy (AAMFT). The SMEs did not find the AAMFT Supervisor designation and a State credential to be equivalent due to significant variability across States.

After careful consideration, VA decided the AAMFT Supervisor designation is necessary to ensure individuals trained as MFTs are prepared to provide the best quality marriage and family therapy to the Nation's Veterans.

VA does not view the requirement to obtain an AAMFT Supervisor designation as a barrier. VA provides individuals in covered assignments who are AAMFT supervisor candidates 2 years from date of placement to obtain the AAMFT supervisor designation.

Under VA’s initial MFT qualification standard, dated September 28, 2010, an individual qualifies if they graduate from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). Section 239 of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017 (Division A of Public Law 114223), enacted September 29, 2016, provides for regionally accredited programs to qualify for MFT positions. VA revised the qualification standard April 18, 2018, to include regionally accredited programs. However, as February 24, 2025, there are only 234 MFTs currently onboard, compared to 901

Licensed Professional Mental Health Counselors (LPMHC). LPMHCs have more rigorous qualification standards (i.e., requirement to graduate from an accredited program).

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

H.R. XXXX Saving Our Veterans Lives Act

Summary: Section 2(a) would create a new 38 U.S.C. § 1720K that would require VA to carry out a program to provide to eligible Veterans, upon their request, covered items and information relating to the benefits of, and options for, secure firearm storage. The term "covered item" would mean a lock box that: is used for the secure storage of a firearm; is designed and marketed to deny unauthorized access to, or render inoperable, a firearm or ammunition; may be unlocked only by means of a key, combination, or other similar means; is in compliance with the applicable standard of American Society for Testing Materials; is manufactured in the United States; and is not eligible or intended for commercial or individual resale. The term "eligible Veteran" would mean a Veteran, as defined in 38 U.S.C. § 101, and an individual described in 38 U.S.C. § 1720I(b), which generally refers to former Service members with other-than-honorable discharges and who have other qualifying service. Section 2(b) would make a clerical amendment to reflect the amendment made by subsection (a).

Section 2(c) would require VA, in consultation with representatives of organizations and agencies that are subject to a memorandum of understanding with VA on preventing Veteran suicide and other such entities as VA determines appropriate, to develop an informational video on secure storage of firearms as a suicide prevention strategy and publish such informational video on a VA website. VA would also have to publish information to inform individuals who participate in the program under the proposed section 1720K that any lockbox furnished pursuant to such program is not eligible or intended for commercial or individual resale.

Section 2(d) would require VA to design and carry out a public education campaign to educate Veterans eligible for covered items under the proposed section 1720K to inform them of the availability of such covered items.

Section 2(e) would establish a rule of construction that nothing in this Act could be construed: to collect personally identifiable information of an individual who participates in the program under the proposed section 1720K for purposes of tracking firearm ownership; require any individual to register a firearm with VA; require mandatory firearm storage for any individual; prohibit any individual from purchasing, owning, or possessing a firearm under 18 U.S.C. § 922; discourage the lawful ownership of firearms; or create or maintain a list of individuals participating in the program.

Section 2(f) would authorize to be appropriated to VA $5 million for each of FY 2025 through 2035 to carry out this section.

Position: VA does not support this bill as drafted.

Views: VA strongly agrees with efforts to reduce Veteran suicide, which may include providing lock boxes to Veterans. However, the bill as drafted is too broad, and the resources needed to implement would significantly exceed the authorized appropriation of $5 million per year. We welcome the opportunity to meet with the Committee to pursue amendments that would address the concerns described below and align with VA's current program.

Late last year, VA established a lock box distribution program, where VA providers can place orders for lock boxes for enrolled Veterans. VA's program also includes education materials for Veterans and clinicians. VA clinical practice guidelines recommend the distribution of lock boxes as a risk mitigation strategy for Veterans at risk of suicide. Our current efforts are focused on Veterans with a risk of suicide, documented within the last 12 months, placing them at medium- to high-risk of suicide who have access to firearms; this access includes peripheral access, where a Veteran may not own a firearm, but may live in a home where someone else does. Through VA's current initiative, providers can place orders for lock boxes, track these orders, and ensure distribution.

The bill would require VA to develop education and training content, as well as a public education campaign, but VA is already working to increase awareness of firearm safety programs like the one described above. The bill is fairly prescriptive in terms of what material must be developed (an informational video), and how this would be developed. VA currently provides materials developed in collaboration with organizations like the National Shooting Sports Foundation (NSSF) and others, which we believe to be sufficient for our current needs. VA has not engaged in a broader public awareness campaign because VA cannot furnish lock boxes to persons other than enrolled Veterans with a documented clinical need. To avoid confusion, our communications are focused on enrolled Veterans and providers to ensure they can access available resources. Additionally, VA's mandatory suicide prevention training course, VA SAVE, includes information on accessing lock boxes through VA, and VA's collaboration with PsychArmor has supported updating this content and distributing it more widely.

VA has concerns about the scope of this bill, which would require VA to carry out the program to provide lock boxes to all Veterans, not just those enrolled in VA care, and not just those at risk of suicide. It would also include former Service members whose service does not qualify them as Veterans for purposes of title 38, United States Code. VA estimates that the lock boxes it distributes cost, on average, $150 each, so making these available to all 18 million Veterans in the United States, with no limitation on the number of lock boxes that could be obtained, could result in a significant drain on VA resources. Further, given the specific parameters that lock boxes must meet, this may increase the average cost per box even more. For example, VA does not currently provide fingerprint-enabled boxes, as the purpose of the lock boxes is to create time and space between suicidal ideation and action and a digitally accessible device would

frustrate that purpose. However, if VA were required to make these available under the program, the costs could also increase.

Given these concerns, we anticipate that the $5 million authorization limit would be reached well before the demand had been met, which would likely lead to frustration on the part of Veterans who may have greater need but who are unable to be among the first to receive a lock box under this program. We further note that the $5 million in authorization would also be applicable to the outreach and education efforts, which by themselves could easily eclipse the authorized limit.

Beyond these substantive concerns, VA has several technical comments on the bill. First, VA notes that there is already a section 1720K, as well as a section 1720L, in title 38, United States Code. As a result, the bill would need to amend this designation to avoid creating duplicate sections in the United States Code. Second, section 2(f) would authorize to be appropriated to VA $5 million for each fiscal year (FY) through FY 2035 “to carry out this section”, but this creates some ambiguity as to the scope of that authorization, because section 2(a) would separately create a new section of the United States. Code (proposed section 1720K). If the intent is for this $5 million to be available to carry out the program under proposed section 1720K, we recommend the legislation clearly state that. In the absence of any amendment, VA would interpret the authorization to also include the program under the proposed section 1720K.

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

H.R. XXXX Women Veterans Cancer Care Coordination Act

Summary: Section 2(a) of the bill would require VA, not later than 1 year after enactment, to hire or designate a Regional Breast Cancer and Gynecologic Cancer Care Coordinator (coordinator) at each Veterans Integrated Services Network (VISN). Each coordinator would have to report directly to the Director of the Breast and Gynecologic Oncology System of Excellence (BGOSoE). Section 2(b) would state that Veterans would be eligible for care coordination provided by a coordinator if the Veteran is diagnosed with a breast or gynecologic cancer or has been identified as having a pre-cancerous breast or gynecologic condition and is eligible for health care under the Veterans Community Care Program (VCCP). Section 2(c) would require VA to establish regions for purposes of care coordination provided by coordinators; in establishing such regions, VA would have to assign all VA facilities to an appropriate region under the supervision of the BGOSoE Director and a designated coordinator and take into account existing VISNs and the specific needs of Veterans in each region, including Veterans living in rural communities. Section 2(d) would require that coordinators be responsible for carrying out six defined duties, as well as such other duties as may be determined appropriate by VA. Section 2(e) would require VA, not later than 3 years after enactment, to submit to Congress a report on health outcomes, an evaluation of what changes or additional resources are needed to further improve breast and gynecologic cancer care and coordination, and any other matters VA determines appropriate. Section 2(f) would define the term “community care provider” to mean a

health care provider described in 38 U.S.C. § 1703(c) that has entered into a contract or agreement to furnish care and services (other than care related to breast and gynecologic cancer) to Veterans under the VCCP. It would also define the term "breast and gynecologic cancer community care provider" to mean a breast or gynecologic cancer care provider descried in 38 U.S.C. § 1703(c) who has entered into a contract or agreement to furnish care or services related to breast or gynecologic cancer to Veterans under the VCCP. The term "breast cancer" would have the meaning given that term by the Director of the BGOSoE. The term "gynecologic cancer" would mean cervical cancer, ovarian cancer, uterine cancer, vaginal cancer, vulvar cancer, and gestation trophoblastic neoplasia. The term "non-Department facility" would have the meaning given that term in 38 U.S.C. § 1701.

Position: VA supports this bill, subject to amendments and the availability of appropriations.

Views: VA generally agrees that establishing a center and system like the BGOSoE would be advisable and beneficial if resources were not an issue, but there are other initiatives that VA would place as a greater priority in terms of patient outcomes than this proposed system. We recommend the bill be amended to support the current BGOSoE model, where this system hires cancer care coordinators, rather than the VISNs. By managing this program nationally, VA can maintain its current flexibility to respond to evolving needs locally, regionally, and nationally, and to ensure resources are devoted where they will have the greatest effect and benefit for Veterans. For example, the bill would require VA to hire or designate a coordinator in each VISN, even when we may not have sufficient patient populations to justify a full-time coordinator in each VISN. The organizational structure contemplated by this bill is inconsistent with current practice and operations. Also, the bill would require VA to establish regions for purposes of care coordination, but it is unclear if these regions are intended to duplicate, overlap, or represent subdivisions of existing VISNs. VA believes legislation that expands on our current efforts, and provides the necessary resources to support such expansion, would be beneficial to Veterans.

Many Veterans seeking breast or gynecologic cancer care from VA receive this care from community providers, and care coordination is a critical component to ensuring positive patient outcomes. Coordination can ensure Veterans are receiving timely, high-quality care, and are satisfied with their experience. VA has developed a care coordination navigator tool that we believe addresses many of the objectives of this bill. Our current efforts would not address everything this bill would require, but we are working to enhance our capabilities for these cancers and others as well. We would be happy to provide a demonstration to the Committee of our current efforts if that would be helpful.

We do have some concerns with the specific requirements in this bill. The requirement to make "regular contact with each Veteran based on the Veteran's specific medical needs when the Veteran receives care from a community care provider" could be burdensome on Veterans and VA staff; Veterans may be receiving care for services

completely unrelated to breast or gynecologic cancer care, but requiring coordinators to contact Veterans about this care could be overwhelming for Veterans and staff. Some of the information VA would be required to furnish, such as how to access emergency care, is already provided to enrolled Veterans.

VA also cautions that some of the reporting requirements in this bill may not be realistic or reliable, particularly given the potentially small populations involved. For example, it may not be possible to compare health outcomes of Veterans who received cancer care at a VA facility and those who received such care from a non-VA provider. We emphasize that, if enacted, VA could only report this information nationally, both to ensure data validity and integrity as well as to ensure patient confidentiality and privacy. Some of the data elements may not be able to be captured as written; for example, the patient safety requirements, particularly for non-VA care, would not be able to be gathered and verified. As noted earlier, VA would need appropriate staffing to ensure the data elements required in these reports could be collected and analyzed.

VA has some additional technical comments on this bill, particularly regarding the reporting requirements, and would be happy to work with the Committee to address them.

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

H.R. XXXX No Wrong Door for Veterans Act

Summary: This draft bill would make 11 amendments to section 201 of the Commander John Scott Hannon Veterans Mental Health Care Improvement (Hannon) Act of 2019, P.L. 116-171, which authorized the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SPGP). First, it would change the requirement for the Secretary to consult with the Office of Mental Health and Suicide Prevention (OMHSP) in carrying out this program. The Secretary would instead be required to consult with the Assistant Under Secretary for Health (AUSH) for Clinical Services. Second, it would limit the amount of grant funds that could be awarded, reducing the amount from $750,000 to $500,000 per fiscal year, plus $10,000 per eligible individual who receives suicide prevention services provided or coordinated by the grantee. It would also limit the use of grant funds to provide that not more than 5% of a grant could be spent on food and non-alcoholic beverages in a fiscal year. Third, it would amend subsection (d)(2), which governs the use of preference in awarding grants, to provide that VA could not give preference to an eligible entity solely because the eligible entity previously received, or applied for, a grant under this section. Fourth, it would amend subsection (f), which governs requirements for application for grants, to add a new paragraph (3) that would require applications from entities that previously received grant funds to include evidence that the entity used such grant funds to serve a significant number of Veterans. Fifth, it would require the Secretary to provide to the appropriate personnel of each VA medical center (VAMC) within 100 miles of the primary location of a grantee a briefing, not less than once per calendar quarter, about the grant program to improve the coordination between a grantee and the VAMC personnel. VA could permit

a representative of a grantee to attend these briefings. Sixth, it would extend the authority to carry out this pilot program until September 30, 2028. Seventh, it would amend subsection (n), which requires VA to provide care to eligible individuals in certain situations, to state that grantees would have to notify eligible individuals receiving suicide prevention services that the eligible individual may receive emergent suicide care under 38 U.S.C. § 1720J. Grantees would also have to notify VA if the individual requests such emergent suicide care. Eighth, it would authorize the appropriation of $157,500,000 for FY 2026-2028. Ninth, it would amend subsection (q)(3), which defines the term "eligible entity" for purposes of this law, to require entities to have continuously provided mental health care or support services in the United States during the 2-year period before the date on which the entity applies for a grant. It would also include health care providers within subparagraph (A), which currently refers to incorporated private institutions or foundations that operate on a non-profit basis and that have a governing board that would be responsible for the operation of suicide prevention services. Tenth, it would make a technical change to the definition of emergency treatment. Finally, it would amend subsection (q)(11)(A)(ii), which defines suicide prevention services as including a baseline mental health screening for risk. The amendment would provide the baseline mental health screening for risk must use a protocol selected by VA. Section 2(k)(2) of the bill would provide a rule of construction that, in addition to the protocol selected by VA, VA may furnish another protocol to a grantee, and a grantee may use another protocol to screen for risk.

Position: VA supports the bill, subject to amendments and the availability of appropriations.

Views: VA supports four of the amendments this bill would make, specifically; (1) extending the duration of the pilot program through FY 2028; (2) requiring grantees to inform individuals, and VA when indicated, that they may receive emergent suicide care under 38 U.S.C. § 1720J (which is already occurring); (3) the additional requirement that eligible entities must have continuously provided mental health care or support services in the United States during the previous 2 years; and (4) the technical correction to the definition of emergency treatment (which would have no substantive effect on benefits for eligible individuals). VA continues to appreciate Congress's support of the SPGP, and we look forward to Congress reauthorizing the program; we also appreciate the opportunity to meet with the Committee to discuss the concerns we identify below.

VA has significant concerns with some of the changes this bill would make and seeks amendment to these provisions. The proposed cap of $500,000 per grantee per fiscal year (which we assume to be the intent, but the bill technically strikes the language making clear that the cap applies "per grantee per fiscal year"), plus an additional $10,000 per grantee per fiscal year for each eligible individual who receives suicide prevention services provided or coordinated by the grantee, does not align with the way Federal assistance through grants is operated by funders and recipients. Applicants propose the number of Veterans to be served and estimate their costs within their application. It would be incredibly difficult, if not impossible, to actually implement

this type of award schedule, as it would require significant reconciliation based on the actual versus projected number of eligible individuals served; further, any upward adjustments at the end of the year would likely have little effect in terms of further outreach or support. The mechanics, both for VA and for grantees, would likely prove incredibly onerous.

The required quarterly briefings to VAMCs would likely require resources disproportionate to the value that would be realized from sharing this information. VA currently provides information to facilities and staff to support coordination, and we believe these efforts are sufficient. Further, the specification of not more than 100 miles from the primary location of a grantee is less useful than the service area of the grantee.

VA is concerned about allowing grantees to use a different protocol for the baseline mental health screening for risk besides the protocol furnished by the Secretary. The current baseline mental health screening protocol is the collection of five screenings that assess mental health, well-being, financial stability, and social support. These inform the individual's treatment plan and referral needs; they also are vital to program evaluation because they are conducted both pre- and post-service delivery. To determine service and program effectiveness, it is essential that all grantees use the same protocol for this. The Columbia-Suicide Severity Rating Scale is currently a tool used by VA as one component of eligibility screening, in that it identifies individuals with suicidal thoughts and behaviors. If Congress's intent is simply to allow grantees to use a different protocol to determine the degree of risk for eligibility, we believe this needs to be clarified, though this could raise concerns with creating disparate approaches. VA has already established in regulations that both determining the degree of risk for eligibility and the baseline mental health screening protocol require the use of validated tools provided by VA and announced in each notice of funding opportunity. We believe this arrangement preserve's VA's flexibility to ensure the best results for Veterans. We are concerned that the rule of construction in section 2(k)(2) of the bill creates ambiguity, as it would provide that, "In addition to the protocol selected" by VA, VA "may furnish another protocol to a grantee", and "a grantee may use another protocol to screen for risk". The use of the phrase "another protocol" in both subparagraphs (A) and (B) could be read to mean that VA could establish one protocol and furnish another, and the grantee could use only one of these two options. Alternatively, subparagraph (B) could be read to mean that VA could establish one protocol, furnish another one, and the grantee could pick a completely different protocol on its own. For the reasons expressed above, we strongly recommend against this second reading, as it would make comparisons between grantees extremely difficult, if not impossible, and it could produce more confusion as to eligibility determinations as well.

Several of the amendments are unnecessary, including the change to require the Secretary to consult with the AUSH for Clinical Services instead of OMHSP (as the OMHSP reports to the AUSH for Clinical Services). OMHSP has separated into the two following offices: the Office of Mental Health and the Office of Suicide Prevention. We recommend the bill strike any reference to a sub-component of VA, as this would avoid further confusion that might arise from reorganization or renaming of existing offices.

The responsibility for implementation ultimately rests with the Secretary, so identifying further offices is neither necessary nor constructive. Also, VA does not view a limitation on the use of funds for food and non-alcoholic beverages as necessary within the pilot phase, where VA continues to gather data to inform the extent of this funding need and the justification for any such limitations. We do note that the limitation on non-alcoholic beverages implies there is no limitation on alcoholic beverages, which we do not believe would be appropriate. The amendment to require applications submitted by previous grantees include evidence that they served a significant number of Veterans is both vaguely defined and unnecessary as renewal applications and grantee performance reports already discuss this.

VA also recommends including additional amendments to section 201 of the Hannon Act in this bill. VA recommends removing the requirement to coordinate with the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide Task Force because this Task Force is no longer operational.

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

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

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

H.R. XXXX Providing Veterans Essential Medications Act

Summary: This bill would amend 38 U.S.C. § 1745(a)(3), which generally dictates terms of payment by VA to state homes for nursing home care provided to

certain Veterans. Specifically, this bill would create a new subparagraph (B) that would state, in addition to payment pursuant to a contract or agreement with each State home for nursing home care for eligible Veterans, VA would have to, at the election of a covered state home, reimburse a covered state home for a costly medication or furnish such costly medication to the covered state home. The term "costly medication" would be defined to mean a drug or medicine for which the average wholesale price for 1 month's supply, plus a 3% transaction fee, exceeds 8.5% of the payment under the contract or agreement by VA to a covered state home for care provided to the Veteran who receives the costly medication during a month. The term "covered State home" would mean a state home that, in the course of nursing home care provided pursuant to a contract or agreement, provides to a Veteran a costly medication.

Position: VA does not support.

Views: VA supports the intent to ensure state Veteran homes are adequately supported in covering the costs to care for Veterans. However, VA is concerned that several of the terms in this bill are ambiguous; several are too specific; and ultimately the bill could result in unintended or adverse consequences for Veterans. We would appreciate the opportunity to discuss this bill and VA's concerns with the Committee.

Initially, it is not clear that this bill is needed. Section 1745 already provides that each contract or agreement between VA and a State home is based on a methodology, developed by VA in consultation with State homes, to adequately reimburse the State home for the care provided by the State home under the contract or agreement. If the current methodology is inadequate, there are existing statutory means of updating it without further legislation. VA is not aware of existing data demonstrating that the existing prevailing rates paid to state homes by VA is insufficient for the patient population receiving care as it relates to high-cost medications.

Second, several of the bill's amendments could have significant unintended consequences to the operation of VA's programs due both to ambiguity in some terms and too much specificity for others. The proposed payment methodology is not aligned with how VA currently pays for and purchases medications. VA often obtains medications at significant discounts because of the size of the VA system, but the bill would not necessarily allow state homes to take advantage of VA's savings. For example, the bill would provide that VA would have to, "at the election of a covered State home", reimburse the covered state home for a costly medication or furnish such costly medication to the covered state home. However, this is unclear as to whether this is a one-time choice made by the state home, or if literally each costly medication administered to each Veteran is subject to this election. If VA were required to track each specific request for each medication for each Veteran, this could be extremely complicated to administer, track, and monitor. Further, if a state home elected that VA would furnish the costly medication, but VA had none in stock (or could not provide any in a reasonable and clinically appropriate time period for the Veteran), it is not clear what repercussions would follow. VA could be forced to maintain a surplus of costly medications to ensure that it could meet any demand from covered state homes, but

some of this medication could end up going to waste if it could not be used before it expired. VA has mechanisms in place to ensure it maintains a sufficient supply for its own needs, but it would likely have more difficulty and result in more cost if it needed to maintain inventory for state homes as well. The bill is also unclear as to the units that constitute a costly medication. For example, some medications may have a high up-front cost that might qualify, but could be used multiple times, such that the "average wholesale price" would fall below the threshold the bill would establish. Similarly, it is unclear what happens if a Veteran only needs a small dose of an otherwise expensive medication. The bill is unclear as to whether the state home could require VA to reimburse the entire cost of the medication or only the per unit cost of the medication. Depending on how this is implemented, VA could end up paying significantly more than its actual costs objectively should be. The "8.5 percent of the payment" language is also unclear, as it appears to reference the entire cost of the payment under each contract or agreement with a state home, which may cover multiple Veterans, or if the "8.5 percent of the payment" phrase is intended to only apply to a single Veteran.

VA is also concerned about several of the provisions in the bill that are too specific. In particular, VA is concerned about the "3 percent transaction fee" language in proposed subparagraph (C)(i). While this would technically only apply to the determination of which medications are considered "costly medications", this could be interpreted to require VA to include in its reimbursement this 3% fee, if the state home elected to be reimbursed, even if VA's transaction fees are actually much less. This would result in a windfall for state homes at the cost of other Veterans VA could serve. We recommend the bill clearly state that the amount that VA would reimburse would be separately established and that the 3% transaction fee would not be applicable to the reimbursement rate. In other words, the 3% transaction fee defines what would be reimbursable, not how much VA would reimburse.

The bill could also result in unintended or adverse consequences for Veterans. This section would require VA to assume additional liability for specific types of care for which the state homes are responsible. In doing so, this could remove incentives for State homes to provide certain medications that might be more clinically appropriate to Veterans because VA would not be financially responsible for them. By making VA responsible for additional payments for some medications but not others, this bill could incentivize the use of those medications over other, more effective or appropriate medications. VA also recommends against basing prices on the "average wholesale price", which is, in most circumstances, an arbitrary cost that does not reflect the actual purchase price of medications. The use of the average wholesale price would likely inflate actual costs as VA pays less than this price.

Cost Estimate: VA does not have a cost estimate for this bill but anticipates the costs could be significant.

H.R. XXXX Establishing the Period for Referrals for the Veterans Community Care Program

Summary: The draft bill would amend 38 U.S.C. § 1703(a)(2), which requires VA to coordinate the furnishing of care and services under the VCCP including coordination of several programmatic requirements. Specifically, the bill would include a new subparagraph (E), which would require VA to coordinate care by ensuring the period during which the referral of a covered Veteran, made by a VA health care provider to a non-VA provider, for care or services under the VCCP is valid and begins on the day that the covered Veteran has the first appointment with such non-VA provider.

Position: VA supports this bill, subject to amendments to clarify its intent and effect.

Views: VA supports the apparent intent of this legislation but recommends further changes for clarity. As written, the proposed subparagraph (E) is difficult to understand grammatically given the number of subordinate clauses used. It appears the intent is to ensure that a referral for care from a non-VA provider is valid beginning on the date of the first appointment with a non-VA provider. This intent would seem to be relevant given that eligible Veterans who elect to receive care through VCCP can elect to receive an episode of care from an eligible non-VA provider; VA has defined the term "episode of care" through regulation to mean "a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year". See 38 C.F.R. § 17.4005. The bill, then, would presumably mean the period for an episode of care (which is up to 1 calendar year, but may be less in some situations) would begin on the date of the first appointment with a non-VA provider. VA supports this interpretation of the bill.

VA policy is currently consistent with the proposed text, but VA practice has been inconsistent in this regard. We are working to update training, documentation, and guidance to the field to ensure the date of the first appointment is the basis for the period of an authorized episode of care.

VA appreciates the opportunity to work with the Committee to ensure this bill text is clear and does not create any unintended consequences.

Cost Estimate: VA does not anticipate additional costs for this bill.

H.R. XXXX Veterans Supporting Prosthetics Opportunities and Recreational Therapy Act

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

Position: VA supports this bill, subject to amendment.

Views: VA fully supports ensuring that eligible Veterans in need of adaptive recreation equipment, including adaptive prostheses and terminal devices for sports and other recreational activities, are able to access these items. VA has already included these items in its regulations at 38 C.F.R. § 17.3230(a)(1)(ii), which includes adaptive recreation equipment among the items and services VA will provide Veterans if VA determines that such items and services: (1) are needed to promote, preserve, or restore the health of the Veteran (under 38 C.F.R. § 17.38(b)); (2) serve as a direct and active component of the Veteran's medical treatment and rehabilitation; and (3) do not solely support the comfort or convenience of the Veteran. These regulations are VA's interpretation of sections 1701 and 1710 of title 38, United States Code, in this area. VA has defined adaptive recreation equipment at 38 C.F.R. § 17.3210 to mean an item that is designed to compensate for, or that by design compensates for, loss of physical, sensory, or cognitive function and is necessary for the Veteran to actively and regularly participate in a sport, recreation, or leisure activity to achieve the Veteran's rehabilitation goals as documented in the Veteran's medical record.

VA believes this language would be redundant given current regulations and practice. In addition, we express concern that enacting a bill of this type could result in confusion in this area. Such confusion could jeopardize or frustrate the delivery of benefits to Veterans because this language does not align exactly with VA's current regulations. This could lead to an inference that the bill is intended to create benefits different from VA's current regulations and could lead to litigation. We recommend Congress include the following rule of construction to address these concerns: "Nothing in this Act shall be construed to alter the scope of benefits the Secretary currently provides to eligible Veterans under section 17.3230 of title 38, Code of Federal Regulations, or successor regulations." We would be happy to work with the Committee on this language.

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

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

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

H.R. XXXX Veterans National Traumatic Brain Injury (TBI) Treatment Act

Summary: Section 2(a) of the bill would require VA to implement a pilot program to furnish hyperbaric oxygen therapy (HBOT) to Veterans with TBI or posttraumatic stress disorder (PTSD) through health care providers who are not VA employees, Medicare providers, Department of Defense (DoD) providers, Indian Health Service (IHS) providers, or Federally-qualified health centers.

Section 2(b) would require VA to select three Veterans Integrated Services Networks (VISN) in which to operate the pilot program.

Section 2(c) would establish in the general fund of the Treasury the VA HBOT fund; the sole source of monies for the fund would be from donations received by VA for the express purposes of the fund. The amounts in the fund would be available without fiscal year limitation to pay for HBOT, and the fund would terminate on the day that is 5 years after the date of the enactment of this Act (as established by section 2(d)).

Section 2(e) would define HBOT to mean hyperbaric oxygen therapy with a medical device either approved by the Food and Drug Administration (FD)A or issued an investigational device exemption by the FDA.

Position: VA does not support.

Views: The bill would result in significant burdens on Veterans in terms of the time commitment involved in treatment and potential personal liability for portions of treatment that are not covered by VA (such as travel or room and board, if applicable). Further, the resources associated with providing this treatment in terms of clinical and administrative time would mean fewer resources for evidence-based therapies for Veterans.

Additionally, there is no scientific basis to support the clinical efficacy of HBOT as a treatment for PTSD, and there is a strong clinical basis that HBOT is not recommended for treating TBI. In this context, we are concerned that this bill could result in adverse health outcomes for participating Veterans and there is also little ability to monitor performance with definitive, evidence-based metrics.

In 2017, VA initiated a clinical (non-research) program to evaluate the feasibility of referring Veterans diagnosed with PTSD (with or without a history of mild TBI) for HBOT treatment provided by DoD or community providers. This clinical program evaluation was designed to better understand the treatment protocol requirements and burdens on Veterans and VA in the context of PTSD treatment. The evaluation was not designed to examine or measure the efficacy of HBOT as a treatment for PTSD, TBI, or any other indication. VA proactively began the clinical program evaluation to understand the logistical and administrative requirements and barriers for providing this treatment for these indications, which are considered “off-label” because they have not been approved by FDA. VA’s clinical program evaluation found that fewer than half of the Veterans referred completed the full course of HBOT treatment. Some Veterans were not interested in engaging or continuing treatment due to the treatment schedule

(appointments are scheduled for 1 to 2 hours per day, 5 days a week, for 4 to 8 weeks), the need to travel, or the availability of evidence-based treatment alternatives. We anticipate that similar results could occur if this bill were enacted, in which case Veterans would be delayed in receiving evidence-based care to treat their conditions.

VA and DoD have developed evidence-based clinical practice guidelines (CPG) for both TBI and PTSD. The most recent update for the TBI CPGs was completed in June 2021, while the most recent update for the PTSD CPGs was completed in June 2023. The CPGs for PTSD found there is insufficient evidence to recommend for or against HBOT as a treatment for PTSD. The CPGs for TBI strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed to a mild TBI. Published results of scientifically rigorous VA and DoD research on TBI have repeatedly shown that HBOT has the same impact as a placebo and no clinically relevant long-term effects[1,2,3,4,5,6]. In addition to the lack of patient improvement, the use of HBOT after a mild TBI may have harmful impacts, including seizures. Emerging treatments are often marketed to patients struggling with chronic symptoms, and providers need to understand the potential negative impacts that referrals for unfounded treatments can have on the provider-patient relationship. The CPGs explain that when treatments do not work, it may lead to disappointment; damage to a patient's trust; an increased likelihood of the patient taking on a "sick role;" and even harm to the patient. Given the evidence of harm in the literature and FDA's findings, the CPGs conclude that HBOT is not currently identified as a safe or effective treatment after mild TBI.

VA also has procedural concerns with this bill. Initially, the bill seems to establish a parallel program to VCCP for HBOT. Congress enacted VCCP to consolidate the various community care programs and to simplify eligibility by establishing a common set of criteria to determine when Veterans would qualify for community care. This bill appears to require VA to furnish this care exclusively through non-VA providers regardless of whether VA could furnish treatment for PTSD or TBI. The bill expressly excludes VA, Medicare, DoD, and IHS providers, as well as Federally-qualified health centers. Given this narrow range of potentially eligible entities, it is not clear that VA would have any means to verify the quality of those providers or the quality of services they would furnish under this bill. Additionally, this narrow scope of eligible providers

[1] Walker WC, Franke LM, Cifu DX, Hart BB. Randomized, sham-controlled, feasibility trial of hyperbaric oxygen for service members with postconcussion syndrome: Cognitive and psychomotor outcomes 1 week postintervention. Neurorehabilitation & Neural Repair. 2014;28(5):420-432.
[2] Cifu DX, Walker WC, West SL, et al. Hyperbaric oxygen for blast-related postconcussion syndrome: Three-month outcomes. Annals of Neurology. 2014;75(2):277-286.
[3] Wolf G, Cifu D, Baugh L, Carne W, Profenna L. The effect of hyperbaric oxygen on symptoms after mild traumatic brain injury. J Neurotrauma. 2012;29(17):2606-2612.
[4] Miller RS, Weaver LK, Bahraini N, et al. Effects of hyperbaric oxygen on symptoms and quality of life among service members with persistent postconcussion symptoms: A randomized clinical trial. JAMA Internal Medicine. 2015;175(1):43-52.
[5] Weaver LK, Chhoeu A, Lindblad AS, Churchill S, Deru K, Wilson SH. Executive summary: The brain injury and mechanism of action of hyperbaric oxygen for persistent post-concussive symptoms after mTBI (BIMA) study. Undersea & Hyperbaric Medicine. 2016;43(5):485-489.
[6] Boussi-Gross R, Golan H, Fishlev G, et al. HBOT can improve post-concussion syndrome years after mild traumatic brain injury - randomized prospective trial. PLoS One. 2013;8(11):e79995.

could both limit Veterans' access to timely care and would very likely increase costs to VA as there would likely need to be a separate referral, scheduling, and follow-up process created for this authority. We recognize that there is a limited number of providers and HBOT treatment centers, but imposing additional restrictions would seem to make implementation more difficult and costly. Further, given that multiple treatments are often required and the limited number of providers, the likelihood that Veterans would need to travel to receive this care is high. This may be inconvenient and place a significant financial burden on patients.

The bill does not define which Veterans could receive care under this authority; it is unclear whether this is limited to enrolled Veterans or if another population would apply. Additionally, there are no criteria set forth in the bill to determine when HBOT would be offered to Veterans – whether this would be required to be a treatment of first resort or last resort; purely at the Veteran's election; or as otherwise clinically indicated. We emphasize that providers must determine that care is medically necessary and in the best interest of the patient to furnish it in accordance with current legal and ethical standards. We would infer these requirements would continue to apply if this legislation were to become law in the absence of specific language to this effect, but we recommend the bill include such requirements to reduce the potential for confusion. Given the CPGs described above strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed to mild TBI, it is not clear that VA actually could refer such patients for treatment.

The funding mechanism proposed in this bill also raises significant questions and concerns. No other VA program operates under such parameters as proposed by this bill, so VA would need to develop new procedures and requirements to govern the use of an account like this. It is unclear whether there would be sufficient funds donated to VA to cover the costs of treatment. VA would need to wait until there were sufficient resources in the new HBOT Fund to support the delivery of care, which could delay VA's implementation of this (potentially by months or years). VA would need to develop new processes and procedures to determine who would manage these funds in VA and how the funding would be distributed. It is also unclear whether a new administrative office would be needed to handle the financial aspects that are unique to this arrangement. This could result in additional oversight costs that would divert funds from Veterans care.

We strongly encourage that if Congress wants to create a new program, it should fund this through conventional appropriations measures, rather than relying on donated funds that are dependent on voluntary contributions from third parties. This both ensures accountability for Congress (by ensuring Congress is responsible for funding these programs appropriately) and reliability for VA (by ensuring that there is a clear and dedicated resource pool for different programs).

The bill also has significant technical issues. For example, the bill lacks a clear termination date—the bill only refers to the termination of the HBOT Fund, not the program authority in the first place, which would seemingly require VA to continue the

program after the termination of the HBOT Fund (meaning within current appropriations accounts). In the absence of further clarity, VA would likely have challenges with implementing this bill, and this could further increase administrative expenses that would divert funds from other evidence-based care.

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

H.R. XXXX Copay Fairness for Veterans Act

Summary: The Veterans Preventive Health Coverage Fairness Act would amend 38 U.S.C. §§ 1710 and 1722A(a)(3) to eliminate copayments by VA for hospital care, medical services and medications related to preventive health services. The proposed legislation would also amend 38 U.S.C. § 1701(9) to expand the definition of "preventive health services."

Position: VA supports this bill subject to amendments and the availability of additional appropriations to replace lost revenue from the elimination of these copayments.

Views: The proposed legislation does not appear to impact VA's authority to assess a copayment when an outpatient visit includes services beyond preventive health services or VA's authority to recover reasonable charges from a third-party under 38 U.S.C. § 1729. VA notes that under existing regulatory provisions at 38 C.F.R. § 17.108, outpatient visits solely consisting of preventive screening and immunizations and laboratory services, flat film radiology services and electrocardiograms are not subject to copayment requirements and, pursuant to existing 38 C.F.R. § 17.4600, an eligible Veteran who receives urgent care consisting solely of an immunization against influenza is not subject to a copayment.

VA has technical comments on some of the provisions in this legislation and would be happy to work with the Committee to address them.

Cost Estimate: VA does not have a cost estimate at this time.

H.R. XXXX Directing VA and the Comptroller General to Report on Certain Funding Shortfalls in VA

Summary: Section 1(a) of the bill would require the Comptroller General, within 30 days of enactment, to begin a review regarding the circumstances surrounding, and the causes of, the shortfall in funding of the Veterans Benefits Administration for FY 2024 and the expected shortfall in the funding of VHA in FY 2025. Within 30 days of completing the review, the Comptroller General would have to submit a written report to VA containing the results and findings of the review. Within 30 days of receiving this report, VA would have to submit the report to Congress.

Position: **VA defers to the Comptroller General on this bill.**

Views: VA generally defers to the Comptroller General on this bill, but we note that the bill's requirement for the Comptroller General to submit a report to VA, and then for VA to submit the Comptroller General's report to Congress, is unusual. It would seem more direct for the Comptroller General to simply submit the report to Congress and to VA when complete.

Additionally, there is an ongoing assessment by the Comptroller General and VA's Office of Inspector General (OIG) of VHA's funding estimates. Under Public Law 118-82, Congress has already required VA to submit a report detailing corrections VA will make to improve forecasting, data quality, and budget assumptions relating to budget submissions for VBA funds; Congress also required VA to submit a report on the status of funds available for compensation and pensions and readjustment benefits, with updates every 90 days. This law also directed OIG to review the circumstances surrounding and the underlying causes of the announced shortfall for VBA for FY 2024 and VHA for FY 2025

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

Conclusion

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