STATEMENT OF
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BEFORE THE
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Good morning, Chairwoman Brownley, Ranking Member Bergman and other Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect Department of Veterans Affairs (VA) programs and services. Joining me today are Dr. Amanda Johnson, Director for Women's Reproductive Health, Women's Health Services, VHA, and Mr. Garth Miller, Executive Director for Member Services, Health Eligibility Center, VHA.

H.R. 291 VA COST SAVINGS Enhancement Act

H.R. 291 would require VA to identify facilities that would benefit from cost savings associated with the use of an on-site regulated medical waste treatment system over a 5-year period. VA would have to develop a uniform regulated medical waste cost analysis model to be used to determine the cost savings associated with the use of an on-site regulated medical waste treatment system at VA facilities. The model would have to be designed to calculate savings based on a comparison of two factors: first, the cost of treating regulated medical waste at an off-site location under contract with a non-Department entity; and second, the cost of treating regulated medical waste on-site based on the equipment specification of treatment system manufacturers, with capital costs amortized over a 10-year period. At each VA facility identified as potentially benefitting from cost savings associated with the use of an on-site regulated medical waste treatment system over a 5-year period, the Secretary would have to secure, install and operate an on-site regulated medical waste treatment system. Any medical waste treatment system purchased would have to be purchased under the purchase agreement known as the "VHA Regulated Medical Waste On-Site Treatment Equipment Systems Blanket Purchase Agreement," or any successor, contract, agreement or other arrangement. The term "regulated medical waste" would have the meaning given that term in 49 C.F.R. § 173.134(a)(5), concerning regulated medical waste and infectious substances or any successor regulation, but if state law is more expansive, then the definition in state law would apply.

VA opposes this bill as written. As a general principle, we do not believe it is advisable for Congress to mandate overly-circumscribed contract specifications which would require the use of specific contract vehicles or could have the effect of requiring specific vendors, as section 2(d) of the bill would do. Such efforts are likely to result in

greater costs to VA, and consequently the taxpayer, because the requirement would prohibit the use of competitive procedures.

Further, we have technical concerns with the legislation. First, the definition in the bill of "regulated medical waste" cites to 49 C.F.R. § 173.134(a)(5) and refers to "infectious substances." However, "infectious substance" is defined in 49 C.F.R. § 173.134(a)(1), while "regulated medical waste" is defined in section 173.134(a)(5). Moreover, section 173.134(a)(1)(ii) specifically excludes regulated medical waste. As a result, it is unclear what definition VA would be expected to use in this context. Second, the bill provides that "in the case of an applicable State law that is more expansive, the definition [of regulated medical waste] in the State law shall apply." This could prove complicated to administer, as the meaning of the term "more expansive" is unclear; and some definitions may be more expansive in one regard but less expansive in another. Nor is it clear how the complexity of state-specific definitions would reconcile with a Blanket Purchase Agreement.

H.R. 345 Reproductive Health Information for Veterans Act

H.R. 345 would direct VA to provide abortion counseling to a Veteran who has an unwanted pregnancy. This counseling would have to include options for the Veteran regarding unwanted pregnancy including termination; accurate health information based on the health of the Veteran regarding such options; and information regarding the location nearest to the Veteran's residence where the Veteran may receive safe medical or surgical termination of the unwanted pregnancy.

We support this bill with technical amendments. It is critical for health care professionals to be able to advise Veterans about the full scope of their reproductive health options as part of promoting, preserving or restoring the health of the Veteran. Providing education and information, and answering Veterans' questions, are important to ensuring that Veterans can make informed decisions about their health care. This includes discussing the range of reproductive health services VA offers, including fertility treatment, preconception care and maternity and newborn care. The current limitation on abortion counseling has been a longstanding ethical challenge for VA providers. To the extent that abortion counseling coheres with accepted professional standards and is part of evidence-based clinical practice guidelines from professional medical societies, abortion counseling is consistent with VA health care providers' responsibility to inform pregnant Veterans about clinically-appropriate alternatives. Yet VA providers also have professional obligations to adhere to Federal regulation, which in this case hampers their ability to ensure the patient's right to informed participation in their health care decisions.

To be clear, this bill would not authorize VA to provide abortions; it would only allow VA to provide patient education to ensure Veterans can make their choices regarding their care.

As a technical matter, we note that this language is not limited to Veterans enrolled in VA health care. We are unclear whether that is intentional. Further, the term "unwanted pregnancy" is not defined. Presumably it refers to whether the Veteran wants to continue the pregnancy (including whether continuing the pregnancy would jeopardize the health of the Veteran). However, for many Veterans, it may not be clear, at least immediately, whether the pregnancy is wanted or not, so limiting the provision of this counseling to only certain types of pregnancies could be inadvisable. We think it would be more appropriate to revise the language to authorize VA to provide counseling on the full range of options regarding pregnancy, including the availability of maternity and newborn care from VA to Veterans enrolled in the VA health system, or otherwise eligible to receive such health care services from VA. This would ensure that VA is able to educate our patients fully and empower them to make their own decisions. Finally, we note that the bill would require VA to provide information regarding the nearest location (to the Veteran's residence) where the Veteran could receive safe medical or surgical termination of the unwanted pregnancy. It is unclear how VA could obtain the information necessary to make these determinations, particularly regarding safety. We also note that such referrals could raise endorsement issues.

We estimate this bill would not result in any additional cost, if enacted.

H.R. 1216 Modernizing Veterans' Health Care Eligibility Act

Section 2 of H.R. 1216 would establish a Commission on Eligibility to examine eligibility for VA health care. For ease of understanding, the provisions of this bill will be summarized in terms of their requirements related to the appointment of the Commission and other personnel matters, then the powers and duties of the Commission.

Appointment and Personnel Matters

The Commission would be composed of 15 voting members appointed by Congressional leaders and the President (who would appoint the Chairperson). At least one member would have to represent an organization recognized by VA for the representation of Veterans under 38 U.S.C. § 5902; at least one member would have to have experience as senior management for a private integrated health care system with an annual gross revenue of more than $50 million; at least one member would have to be familiar with Government health care systems (including those of the Department of Defense (DoD), the Indian Health Service (IHS) or federally-qualified health centers); and at least one member would have to be familiar with, but not currently employed by, the Veterans Health Administration. The appointment of the Commission members would have to be made within 1 year of enactment, and members would be appointed for the life of the Commission. If a vacancy arose, it would not affect the powers of the Commission and would be filled in the same manner as the original appointment. The Commission's first meeting would have to occur not later than 15 days after the date on which eight voting members have been appointed. The Commission would meet at the

call of the Chairperson, and a majority of members would constitute a quorum, but a lesser number could hold hearings.

Members of the Commission who are not an officer or employee of the Federal Government would be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under 5 U.S.C. § 5315 for each day (including travel time) during which such member is engaged in the performance of the duties of the Commission. Members of the Commission who are officers or employees of the United States would serve without compensation in addition to that received for their services as officers or employees of the United States. Members of the Commission would be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized under subchapter I of chapter 57 of title 5, U.S.C., while away from their homes or regular places of business in the performance of services for the Commission. The Chairperson of the Commission could, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other personnel as may be necessary to enable the Commission to perform its duties. The Chairperson could fix the compensation of the executive director and staff without regard to chapter 51 and subchapter III of chapter 53 of title 5, United States Code, except that the rate of pay for these staff could not exceed the rate payable for level V of the Executive Schedule under 5 U.S.C. § 5316. Any Federal Government employee could be detailed to the Commission without reimbursement, but such would be without interruption or loss of civil service status or privilege. The Chairperson could procure temporary and intermittent services under 5 U.S.C. § 3109(b) at rates for individuals that do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under 5 U.S.C. § 5316. The Commission would terminate 30 days after the date on which the Commission submits its final report. VA would make available to the Commission such amounts as the Secretary and Chairperson jointly consider appropriate for the Commission to perform its duties under this section.

Powers and Duties

The Commission would have the power to hold hearings, sit and act at such time and places, take testimony and receive evidence as the Commission considers advisable. The Commission could secure directly from any Federal agency such information as it considers necessary to carry out this section, and upon request of the Chairperson, the heads of such agencies would be required to furnish such information to the Commission. The Commission would be required to undertake a comprehensive evaluation and assessment of eligibility to receive health care from VA. In undertaking this evaluation, the Commission would have to evaluate and assess general eligibility; eligibility of Veterans with service-connected conditions; eligibility of Veterans with non-service-connected conditions; eligibility of Veterans who have other insurance or health care coverage (including Medicare and TRICARE); eligibility of Veterans exposed to combat; eligibility of Veterans exposed to toxic substances or radiation; eligibility of Veterans with discharges under conditions other than honorable; eligibility for long-term care; eligibility for mental health care, assigned priority for care, required copayments

and other cost-sharing mechanisms; and other matters the Commission determines appropriate.

The Commission would submit to the President, through VA, a report not later than 90 days after the date of the initial meeting on the Commission's findings with respect to the required evaluation and assessment and such recommendations as the Commission may have for legislative or administrative action to revise and simplify eligibility to receive health care from VA. Not later than 1 year after the date of the initial meeting, the Commission would have to submit a final report on the findings of the Commission with respect to the required evaluation and assessment and such recommendations as the Commission may have for legislative or administrative action to revise and simplify eligibility to receive VA health care. The President would require VA and such other heads of relevant Federal Departments and agencies to implement such recommendations set forth in the Commission's final report that the President considers feasible and advisable and determines can be implemented without further legislative action. Not later than 60 days after the date on which the President receives a report from the Commission, the President would have to submit to the Committees on Veterans' Affairs of the House of Representatives and Senate and such other Committees as the President considers appropriate, a report. The report would have to include an assessment of the feasibility and advisability of each recommendation contained in the Commission's final report, and for each recommendation assessed as feasible and advisable, whether such recommendation requires legislative action (and if so, whether such legislative action is recommended), a description of any administrative action already taken to carry out a recommendation and a description of any administrative action the President intends to be taken to carry out a recommendation and by whom.

We appreciate the Committee's interest in assessing eligibility for VA health care. Eligibility is the door that allows Veterans and other beneficiaries to access VA services, so it is fundamental to everything we do. In some respects, though, it is inaccurate to think of eligibility as a single door – there are many laws that establish eligibility for certain VA benefits and for certain veteran and other veteran affiliated populations. Eligibility determinations can be quite complex because Veterans or other beneficiaries may qualify for the same or similar services under multiple different laws. As an example, VA recently reviewed its authorities related to the provision of mental health care and identified more than 20 different statutes that defined eligibility for different services or different populations. These varying standards and rules can make eligibility determinations more complex for VA to administer and for Veterans and the public to understand. Complexity is not necessarily a problem if it produces the right results for Veterans. Our primary focus, though, is ensuring that our system is designed to provide what is best for Veterans.

VA has a number of concerns with the proposed bill and opposes it as currently written. Initially, the intended outcome of the Commission is not clear. Depending upon the composition and focus of the Commission, it may recommend narrowing or expanding eligibility (or both, but in different ways or for different populations). Given the

central role of eligibility in accessing VA health care services, proposed changes could have far-reaching effects and unintended consequences, including effects on the amount of resources VA needs to execute its responsibilities. We are particularly mindful of the potential effects changes to eligibility may have on current beneficiaries. We would appreciate the opportunity to discuss with the Committee the underlying concerns motivating this bill, as we may be able to identify alternatives to strengthen the system. For example, we have previously recommended to the Committee that we engage in discussions to address complexities associated with VA's emergency care reimbursement authorities. As noted earlier, VA is authorized to provide forms of mental health care under more than 20 different authorities. Addressing some of these areas first could have a more immediate beneficial impact.

We are cognizant of the current environment in which this bill is being considered as well. We know the Committee is hard at work to enact legislation regarding military environmental exposures, which would have a significant effect on VA programs and services, if enacted. In addition, VA recently submitted its recommendations to the Asset and Infrastructure Review (AIR) Commission on efforts to modernize and realign the VA health care system. In the midst of these efforts, conducting a comprehensive assessment of eligibility may be complicated given the uncertainty of how these other efforts will unfold. This may, again, suggest the value of a more focused approach. We believe flexibility, particularly with regard to military environmental exposures, is important, as we cannot know today what exposures may happen in the future, so a single standard for eligibility in this area in particular could prove inadequate to the needs of future Veterans and their families.

There are elements of the Commission on Eligibility's duties that we believe should be considered as well. First, we note that the Commission would not consider the definition of who is a Veteran for purposes of VA health care. As important as eligibility is, the definition of who is a Veteran precedes that analysis. This may be an important element to consider given the bill's focus. Second, the bill does not specifically address eligibility for community care, and it is unclear if that is within the intended scope. Given the relatively recent enactment of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 and the creation of the Veterans Community Care Program in 2019, that may be unnecessary, but it may be an important consideration as we contemplate the effects that eligibility changes might have on modeling for demand and our network of community providers. Third, we believe it would be important for the Commission to focus on disparities in access to health care and to consider whether there is equitable access to VA health care as well. These are important issues to VA, as we strive to understand barriers to opportunity with the goal of providing everyone, especially those in underserved communities, with fair access to health care and benefits.

The bill would direct the Commission to consider several specific areas where VA is already taking relevant actions. For example, concerning Veterans exposed to toxic substances or radiation during military service, VA is already working to expand its focus on environmental exposures. These efforts are generally focused on certain

specific exposures to help obtain information on the affected population. We are working to identify conditions specific to the Operation Enduring Freedom/Operation Iraqi Freedom cohort, as well as others (such as those who served at Karshi Khanabad Air Base). This work can help make the affected population more identifiable and help focus research and treatment efforts. Another area of focus in the bill is on Veterans eligible for Medicare and TRICARE. As VA previously testified before the Oversight and Investigations and Technology Modernization Subcommittees on March 30, 2022, we agree that the Federal Government should not pay twice for the same medical services, so focusing on these dually-eligible persons may help in this regard. We would again express our interest in working with the Committee to address our concerns with that legislation. The bill would also have the Commission examine eligibility for long-term care. Eligibility for institutional extended care was established by law more than 20 years ago and has remained fairly stable. The elderly population in America, though, is growing. As Veterans age, approximately 80% will develop the need for long-term services and supports. Some of VA's top efforts focus on helping Veterans as they age at home, and VA operates a spectrum of Home-Based and Community-Based Services. We want to emphasize that the Commission's examination of eligibility for long-term care should consider the increasing number of non-institutional alternatives VA has developed and offers to ensure an accurate reflection of the availability of clinically-appropriate care.

We note for the record that, while this bill would not alter eligibility for any care or services, the Commission's recommendations ultimately could lead to such changes through subsequent action, and the financial effects of eligibility changes could be significant. We recommend the Committee bear this in mind as it continues to consider this bill.

We do not have a cost estimate for this bill.

H.R. 1957 Veterans Infertility Treatment Act of 2021

Section 2 of H.R. 1957 would amend chapter 17 of title 38, United States Code, by adding a new section 1720K on infertility treatment and standard fertility preservation services. Proposed section 1720K(a) would require VA, in furnishing medical services under chapter 17, to furnish infertility treatments (including through the use of assisted reproductive technology (ART)), standard fertility preservation services, or both, to a covered Veteran or a partner of a covered Veteran, if the Veteran and the partner apply jointly for such treatments or services through a process prescribed by VA. VA could furnish not more than three completed cycles that result in live birth or six attempted cycles of in vitro fertilization (IVF), whichever occurred first, to an individual. VA could furnish IVF treatment using donated gametes or embryos. Proposed section 1720K(b) would establish that nothing would be construed to require VA to provide maternity care to a covered Veteran or partner of a covered Veteran in addition to what is otherwise required by 38 U.S.C. § 1786. Proposed section 1720K(c) would define terms, including ART, covered Veteran, infertility and partner. ART would include IVF and other fertility

treatments in which both eggs and sperm are handled when clinically appropriate. Covered Veterans would be enrolled Veterans who have infertility. Infertility would mean a disease or condition characterized by the failure to conceive a pregnancy or to carry a pregnancy to live birth after 1 year of regular, unprotected sexual intercourse or the inability of a person to reproduce either as an individual or with the partner of the individual and would include instances in which a person is at risk of falling within those criteria as determined by a licensed physician based on the medical, sexual and reproductive history, age, physical findings or diagnostic testing or a combination thereof, of the person or any planned medication therapy, surgery, radiation, chemotherapy or other medical treatment. The term partner would mean, with respect to a Veteran, an individual selected by the Veteran who agrees to share with the Veteran the parental responsibilities with respect to any child born as a result of the use of any infertility treatment under this section.

Under section 3 of the bill, VA would have to prescribe regulations within 18 months of the date of enactment to carry out the new section 1720K. During the period beginning 180 days after the date of enactment and the date on which regulations are prescribed, VA would ensure that fertility counseling and treatment furnished pursuant to section 234(a)(1) of the Military Construction, Veterans Affairs and Related Agencies Appropriations Act, 2021 (Division J of P.L.116-260) or other provisions of law include the following two elements: the Secretary could furnish such counseling and treatment to the partner of a Veteran covered by such provision without regard to whether the partner and Veteran are married, and the Secretary could furnish such counseling and treatment using donated gametes or embryos.

VA strongly supports the policy goals of this bill. In the Department's Fiscal Year (FY) 2023 budget request, VA proposed creating new authority to enhance equity by expanding access to ART, including IVF and adoption reimbursement to single Veterans; those in same-sex relationships; and those who need donor gametes or embryos to build their families. Our proposal would fill a gap created by the legal requirements, exclusions and limitations in VA's current authority. It would also help VA comply with its statutory mission to provide a complete set of hospital care and medical services for Veterans. While we understand and agree with the intent of the bill to make these services available to a broader population, we believe that expanding our current authority, consistent with our proposal, to those who have lost the ability to procreate through their service to this country or through VA treatment would ensure those with the greatest sacrifice are served.

We would like to work with the Committee to provide technical assistance to ensure this bill reflects the Department's proposal. Specifically, we believe the inclusion of adoption benefits is an important element for those Veterans who may be unable to have children of their own. VA has been working on technical assistance on this bill in response to a request from the Committee identifying specific concerns with some of the provisions in the bill, and we look forward to providing that to the Committee shortly after the hearing. Additionally, we would like to discuss with the Committee concerns about the joint application requirements in this bill.

We do not have a cost estimate for the bill as written. We estimate the cost of the Department's proposal to establish treatment authority for infertility counseling and infertility treatment using ART for certain Veterans and their partners, along with the authority to provide reimbursement for adoption-related expenses for certain Veterans, would have a cost in FY 2023 of $10.6 million, a 5-year cost of $54.7 million and a 10-year cost of $116.7 million.

H.R. 6273 VA Zero Suicide Demonstration Project Act of 2021

Section 2 of H.R. 6273 would require VA, not later than 180 days after the date of enactment, to establish a pilot program called the Zero Suicide Initiative (hereafter, the Program). The Program would have to implement the curriculum of the Zero Suicide Institute of the Education Development Center (the Institute) to improve safety and suicide care for Veterans. The first year of the Program would be dedicated to development, including planning and site selection. VA would develop the Program in consultation with the Secretary of the Department of Health and Human Services; the National Institutes of Health; public and private institutions of higher education; educators; experts in suicide assessment, treatment and management; Veterans Service Organizations; and professional associations VA determines relevant to the purposes of the Program. The Program would have to consist of not less than 10 weeks of education regarding suicide care, beginning with the selection of five to 10 staff leaders from each of five participating VA medical centers who would complete the organizational self-study of the Institute as a team; attend the 2-day Zero Suicide Academy of the Institute; formulate a plan to collect data to support evaluation and quality improvement using the data elements worksheet of the Institute; communicate to staff at the respective site the adoption of a specific suicide care approach; administer the workforce survey of the Institute to all staff at the respective site to learn more about perceived comfort with and competence in caring for patients at risk of suicide; and review, develop and implement training on processes and policies regarding patients at risk of suicide.

Of the participating VA medical centers, VA would have to select one VA medical center that primarily serves Veterans who live in rural and remote areas. VA would have to select 15 candidate sites by not later than 180 days from the date of enactment and the final five sites by not later than 270 days from the date of enactment. In selecting sites, VA would have to consult with the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, VA's Office of Mental Health and Suicide Prevention, VA's Health Services Research Division, VA's Office of Health Care Transformation and the Institute. In selecting sites, VA would have to consider various factors, such as geographic variation, variations in size of VA medical centers, regional suicide rates of Veterans, population demographic and health characteristics and both the interest in and capacity of VA medical center staff to implement the Program.

Not later than 2 years after the date on which VA establishes the Program, and annually thereafter until termination, VA would have to submit to Congress annual progress reports on the Program. Each report would have to include the progress of staff leaders at each site in carrying out designated tasks; the percentage of staff at each site trained under the Program; an assessment of whether policies and procedures implemented at each site align with standards of the Institute on six different elements; and a comparison of the suicide-related outcomes at program sites and those of other VA medical centers on eight different metrics. Not later than 1 year after termination of the Program, VA would have to submit to Congress a final report containing a detailed analysis of the information in the annual reports; an evaluation of the effectiveness and outcomes of the Program; VA's determination on whether it is feasible to continue the Program; and VA's recommendations as to whether to expand the Program to additional sites, extend the Program or make the Program permanent. The Program would generally terminate after 5 years, but VA could extend the Program for not more than 2 years if VA notified Congress in writing of such extension not less than 180 days before the 5-year period ended.

VA does not support this bill as written for clinical, fiscal, contractual and empirical reasons. Clinically, current efforts commensurate with relevant VA clinical policy and with VA's Suicide Prevention Strategic Plan are more robust than what would be required by this bill. VA's efforts incorporate all foundations within the Institute's Program and offer surveillance, prevention and intervention strategies that exceed the Institute's Program. We request an opportunity to provide a briefing to the Committee comparing VA's clinical approach to and programs within suicide prevention and the Institute's Program.

VA has made suicide prevention a top clinical priority and is implementing a comprehensive public health approach to reach all Veterans. This approach is in full alignment with the President's new National Strategy for Reducing Military and Veteran Suicide, advancing a comprehensive, cross-sector, evidence-informed public health approach with focal areas in lethal means safety, crisis care and care transition enhancements, increased access to effective care, addressing upstream risk and protective factors and enhanced research coordination, data sharing and program evaluation efforts. The FY 2023 Budget request includes $497 million to support suicide prevention initiatives and programs. Funding for mental health increases to $13.9 billion in 2023, up from $12.3 billion in 2022. This funding will support our system of comprehensive treatments and services to meet the needs of each Veteran and the family members involved in the Veteran's care.

From the 2021 National Veteran Suicide Prevention Annual report, we know the number of Veteran suicides decreased meaningfully in 2019, compared to 2018. The unadjusted overall suicide rate for Veterans decreased from 33.0 per 100,000 in 2018 to 31.6 per 100,000 in 2019. Age-adjusted and sex-adjusted suicide rates decreased from 2018 to 2019 approximately 5% among Veterans compared to 1.8% among non-Veterans. These trends are a welcome change from the rising rates of the prior decade. Despite these decreases, Veterans continued to have a greater suicide risk. Age-

adjusted and sex-adjusted suicide rates were 1.5 times higher among Veterans than non-Veterans.

VA's 2021 annual suicide report provides several anchors of hope. These include:

- There were 399 fewer Veterans who died from suicide in 2019 than in 2018, reflecting the lowest raw count of Veteran suicides since 2007.
- From 2005 to 2018, identified Veteran suicides increased on average by 48 deaths each year. A reduction of 399 suicides within 1 year (from 2018 to 2019) is unprecedented, dating back to 2001.
- The single-year decrease in the adjusted suicide rate for Veterans from 2018 to 2019 was larger than any observed for Veterans from 2001 through 2018. Further, the Veteran rate of decrease (7.2%) exceeded four times the non-Veteran population decrease (1.8%) from 2018 to 2019.
- There was a 14.9% age-adjusted suicide rate decrease for women Veterans from 2018 to 2019.
- Coronavirus Disease 2019 (COVID-19)-related data continue to emerge regarding the impact the pandemic has had on Veterans, and data thus far do not indicate an increase in Veteran suicide-related behaviors.

Fiscally, the bill's requirements would come at an unknown and unaccounted for cost to VA, which would effectively divert resources from other suicide prevention programs and initiatives that are currently demonstrating solid, empirical evidence of progress. We believe it would be appropriate for Congress and VA to have a clear understanding from the Institute of the total costs of the Program to comply with the requirements in the bill prior to further action by the Committee. VA would then need adequate time to review and calculate indirect and opportunity costs associated with all phases of program implementation and with costs and cost parameters or assumptions provided by the Institute.

Contractually, the bill would direct VA to form a legally-binding monetary agreement with a specific entity; this is directly contrary to principles of open competition in procurement, which are designed to ensure the Federal Government receives and commits to a fiscally-sound and operationally-sound exchange that is clearly structured in the public's best interest. This could result in a greater cost to the Department than we might otherwise incur through full and open competition.

We also have concerns about legislating specific arrangements with specific businesses when defining clinical operations. Suicide prevention, in particular, is a dynamic field informed by evidence, and it is an effort of critical importance to Veterans, their families and VA. We believe the best approach is to allow VA to evolve and adopt based on proven clinical interventions, established business practices and equitable and transparent exchange of relevant data, rather than prescribing through statute a single model. We can see value in a study that compares the results of different suicide prevention programs and reporting on those findings to Congress to ensure we have identified effective programs, although the evaluation would need to be carefully

reviewed, constructed and implemented by appropriate data analytics and research design subject matter experts. We are always open to exploring evidence-based work and to testing new approaches. A study of these efforts might yield new, valuable information that could inform policy and training decisions for VA and others.

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

VA does not have a cost estimate for this bill because we do not know what the Institute would charge in terms of access to its materials and training resources or the direct and indirect costs to VA associated with implementation and training.

H.R. 7589 REMOVE Copays Act

Section 2 of H.R. 7589 would amend 38 U.S.C. § 1722B to prohibit VA from imposing or collecting any copayment under the laws administered by VA with respect to any enrolled Veteran for the first three mental health outpatient care visits of the Veteran in a calendar year. The amendments made by this section would apply with respect to mental health outpatient care visits occurring on or after the date of enactment.

VA strongly supports the policy goals of this bill. In the Department's FY 2023 budget request, VA proposed adding a new 38 U.S.C. § 1722C, which would prohibit VA from requiring a Veteran to make copayments for the first three outpatient visits in each calendar year with a qualified mental health professional for the primary purpose of seeking mental health care or treatment for a substance use disorder. The Administration and VA are seeking to expand access and lower out-of-pocket costs for outpatient mental health services. The overarching goal of this proposal and others in the FY 2023 budget request is to recognize that mental health is essential to overall health, and the United States faces a mental health crisis that has been exacerbated by the COVID-19 pandemic. VA's proposal would change the copayments for all enrolled Veterans for outpatient mental health visits to $0 for the first three visits.

We have previously provided to the Committee technical assistance identifying some concerns on a draft of this bill, but we believe the Department's proposal does not

raise the concerns the bill text does. We would like to work with the Committee to ensure this bill reflects the Department's proposal.

We estimate the Department's budget proposal would cost $5 million in FY 2023, $25.6 million over 5 years, and $51.4 million over 10 years.

Conclusion

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