STATEMENT OF
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BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

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

H.R. 1182 Veterans Serving Veterans Act of 2023

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

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

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

Position: VA does not support

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

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

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

Finally, section 5127(a) of the NDAA allows Veterans who served in a medical occupation while serving in the Armed Forces to provide a history of their medical experience and competencies to facilitate civilian medical credentialing and hiring opportunities for Veterans seeking to respond to a national emergency. VA activated this portal on the VA Careers website May 1, 2023, and transitioning military personnel with relevant medical experiences can already self register.

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

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

H.R. 1278 would amend subsection (g) of 38 U.S.C. § 111 to require VA to ensure that the mileage rate paid under subsection (a) is equal to or greater than the mileage reimbursement rate established by the General Services Administration (GSA) for the use of privately owned vehicles by Government employees on official business when no Government vehicle is available. The bill would also remove the mileage rate

in subsection (a), which is currently $0.415 per mile, and instead specify that the mileage rate would be determined in accordance with subsection (g).

Position: VA supports, subject to the availability of appropriations

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

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

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

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

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

Position: VA does not support the bill as written

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

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

VA has made suicide prevention is a top clinical priority and is VA implements a implementing a comprehensive public health approach to with the goal of reaching all Veterans within and outside the healthcare system. This approach is in full alignment with the President's new White House Strategy for Reducing Military and Veteran Suicide, advancing a comprehensive, cross-sector, evidence-informed public health approach with focal areas in lethal means safety, crisis care and care transition enhancements, increased access to effective care (consistent with the VA/DoD Clinical Practice Guideline for the Assessment and Management of Patients at Risk for Suicide), addressing upstream risk and protective factors and enhanced research coordination, data sharing and program evaluation efforts. The FY 2023 Budget and the FY 2024 Budget request sufficiently supports VA's system of comprehensive treatments and services to meet the needs of each Veteran and the family members involved in the Veteran's care.

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

Fiscally, the bill's requirements would come at unknown and unaccounted for cost to VA, which would likely require VA to divert resources from other suicide prevention programs and initiatives demonstrating solid, empirical evidence of progress. We welcome a conversation on the Institute's total costs of the Program to comply with the requirements in the bill prior to further action by the Committee. VA would then need

adequate time to review and calculate indirect and opportunity costs associated with all phases of program implementation and with costs and cost parameters or assumptions provided by the Institute.

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

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

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

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

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

H.R. 1774 VA Emergency Transportation Act

H.R. 1774 would amend 38 U.S.C. § 1725 by replacing the term "emergency treatment" as used throughout the section with the term "emergency services" along

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

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

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

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

VA recommends section 1725(h)(2)(B)(i), as well as redesignated (h)(3)(C), include non-Department facilities. VA may be able to interpret the phrase "to a Department…facility" to include a non-Department facility authorized to furnish services by VA, but we believe a clear statement by Congress would make this simpler. This amendment would address situations where, for example, a Veteran has reached the point of stability and no longer requires emergency treatment but needs continued care (e.g., inpatient care) or needs a higher level of care not available at the first facility. With

this proposed change, if the Veteran is eligible to elect to receive such care through the Veterans Community Care Program and chooses to do so, under 38 U.S.C. § 1725, VA could reimburse for the Veteran's transport by ambulance or air ambulance from the non-Department facility that furnished emergency treatment to another non-Department facility that would furnish inpatient care, for example. The proposed change would clarify VA's authority to pay for emergency transportation under 38 U.S.C. § 1725 in the case of such a transfer.

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

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

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

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

In carrying out the pilot program, VA could enter into agreements for the provision of assisted living services on behalf of eligible Veterans with a provider participating under a State plan or waiver under title XIX of the Social Security Act (42 U.S.C. § 1396 et seq.) or a State home recognized and certified under 38 C.F.R. part 51, subpart B. VA could not place, transfer, or admit a Veteran to any facility for assisted living services under the pilot program unless it determined that the facility met the standards for community residential care established in 38 C.F.R. §§ 17.61 – 17.72 and any additional standards of care VA may specify. State homes would have to meet such standards of care VA may specify. VA would pay to a State home a per diem for

each Veteran participating in the pilot program at the State home at a rate agreed to by VA and the State home. In the case of a facility that is a community assisted living facility, VA would pay to the facility an amount that is less than the average rate paid by VA for placement in a community nursing home in the same VISN and would re-evaluate payment rates annually to account for current economic conditions and current costs of assisted living services. Upon termination of the pilot program, VA would have to provide to all Veterans participating in the pilot program at the time of the termination of the pilot program the option to continue to receive assisted living services at the site they were assigned, at VA expense, and for such Veterans who do not opt to continue to receive such services,

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

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

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

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

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

Third, the bill needs to clarify whether the other requirements in in 38 U.S.C. §§ 1741 1745 and in VA regulations should apply if the payments to State homes are intended to be accomplished by a grant program. VA has been working to implement section 3007 of the Johnny Isakson and David P. Roe, M.D., Veterans Health Care and Benefits Improvement Act of 2020 (Public Law 116-315) related to per diem payments for Veterans who do not meet all the requirements for per diem payments for domiciliary care in 38 CFR part 51; we recommend the bill be amended to allow for, but not require (at least not initially) participation of State homes to ensure that the existing efforts to comply with section 3007 are not delayed or interrupted by implementation of this new authority. We further note that selecting a State home for a location could present other issues, as VA does not manage or control State homes. Presumably, VA would need to establish standards and parameters for a program that a Sate home could then opt into or apply to furnish.

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

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

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

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

H.R. 2768 would require VA to establish a grant program, known as the PFC Joseph P. Dwyer Peer Support Program, under which VA would make grants to eligible

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

Position: VA opposes

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

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

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

significantly impede any oversight and accountability efforts by VA to ensure the proper use of Federal funds.

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

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

H.R. 2818 Autonomy for Disabled Veterans Act

Section 2(a) of H.R. 2818 would amend 38 U.S.C. § 1717 to increase the amount available to eligible Veterans for improvements and structural alterations furnished as part of home health services. In the case of medical services furnished under section 1710(a)(1) or for a disability described in section 1710(a)(2)(C), the amount available for improvements and structural alterations would be increased from $6,800 to $10,000. For all other enrolled Veterans, this amount would be increased from $2,000 to $5,000. Section 2(b) would make this change effective for Veterans who first apply for such benefits on or after the date of enactment. Section 2(c) would provide that a Veteran who exhausts his or her eligibility for benefits under section 1717(a)(2) before the date of enactment would not be entitled to additional benefits by reason of these amendments. Section 3 of the bill would further amend section 1717 to include a new

subsection (a)(4) that would require VA to increase on an annual basis the dollar amount in effect under subsection (a)(2) by a percentage equal to the percentage by which the Consumer Price Index (CPI) for all urban consumers (United States city average) increased during the 12-month period ending with the last month for which the CPI data is available. In the event the CPI did not increase during such period, VA would maintain the dollar amount in effect during the previous fiscal year.

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

VA recommends the bill remove the distinction between the levels of benefits available to Veterans with a service-connected disability and those without by making all eligible Veterans able to receive a lifetime benefit up to $9,000. The $9,000 amount is appropriate because the most common home improvement and structural alteration to accommodate a disability involves renovation of a bathroom, and the national average cost for a bathroom modification is $9,000. Further, VA recommends an index, such as one focused on construction costs, for determining cost index. VA further notes it is unclear how the adjustment for inflation that would occur as a result of section 3 would affect Veterans who have used but not exhausted their benefits as of the day before the date of enactment, as described in section 2(c) of the proposed bill. VA recommends the bill include limitations on the number of times a Veteran could use this benefit to ensure appropriate administration of this program, proper use of Federal resources and to avoid disparate effects on similarly situated Veterans. While the benefit is a "lifetime" benefit, VA believes a limited number of disbursements would provide a more equitable program that would also be easier to administer. VA welcomes the opportunity to work with the Committee on language to address these concerns.

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

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

H.R. 3520 Veteran Care Improvement Act of 2023

Section 2(a) of H.R. 3520 would amend 38 U.S.C. 1703B regarding VA's access standards to expand and codify VA's existing access standards established in regulation at 38 C.F.R. § 17.4040. Specifically, it would create a new section 1703B(a) that would provide that covered Veterans could receive hospital care, medical services,

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

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

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

Position: VA opposes Section 2

VA is opposed to codification of access standards. Removing the ability of the Secretary to develop and publish such standards for VA diminishes the Secretary's authority to ensure Veterans receive the right care, at the right time. This bill fails to consider other market forces that also impact access to care outside of VA and would not allow VA to consider and incorporate those forces to meet Veterans' needs for

timely, high quality care. Moreover, VA cannot support codification of residential treatment and rehabilitative services as proposed in this bill. VA generally supports establishing a wait-time standard of 10 or fewer days for the delivery of care, although we oppose codifying this in law.

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

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

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

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

Finally, VA notes that section 2 would require VA to engage in consultation with various stakeholders; this could invoke the Federal Advisory Committee Act and require VA to form multiple new Federal Advisory committees. VA recommends amending the bill’s language to clarify that consultation activities are exempt from the Federal

Advisory Committee Act. In the alternative, the consultation requirements could be removed, which would also address this concern.

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

Position: VA does not support Section 3

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

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

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

Position: VA does not support Section 4

While this section purports to include additional factors that would be considered by VA clinicians and Veterans when determining whether receiving care in the community is in the Veteran's best medical interest, the wording of these changes create ambiguity and may shift this decision-making from a joint decision to a unilateral one by the Veteran. Specifically, it is unclear whether the "preference of the covered veteran regarding where, when, and how to seek hospital care, medical services, or extended care services" would allow a Veteran unilaterally to determine his or her eligibility for community care if the Veteran stated a preference for community care. If

the Veteran can choose to be seen in the community based on this preference, even if the provider did not agree, then by definition, the Veteran would be choosing to receive care that was not in the Veteran's best medical interest (in the judgment of the clinician). If, on the other hand, the Veteran's referring clinician only needed to "consider" the Veteran's preference, but the preference was not determinative, it is not clear that this would have any effect on operations or eligibility, and thus would seem unnecessary. Determinations regarding a Veteran's best medical interest already considers the distance between a provider and the Veteran, the nature of the care or services required, the frequency of the care or services, the timeliness of available appointments, the potential for improved continuity of care, the quality of care, and whether the Veteran would face an unusual or excessive burden in accessing VA facilities.

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

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

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

Position: VA does not support Section 5

Similar to section 3, VA is concerned that a statutorily prescribed two-business day notification deadline would be administratively burdensome, especially in cases where notification by telephone or electronic communication is unavailable. It is also unclear what is anticipated as the penalty for non-compliance in any situation where VA was unable to meet this requirement. As written, section 5 includes a paradox, proposed 38 U.S.C. § 1703(o)(2) would state that if VA denied a request by a Veteran

for care or services through the VCCP because the access standards are not met, VA would have to provide notice and an explanation of the determination. However, if VA was unable to schedule an appointment that met the designated access standards, then the Veteran would be eligible, so there would be no denial. We believe this was intended to apply when VA has determined that the access standards are met, and when a covered Veteran is ineligible for community care, rather than when the access standards are not met. We further note that the language would only apply to eligibility determinations regarding the access standards and would not apply to determinations regarding any other eligibility criteria.

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

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

Position: VA supports section 6, with amendments

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

Section 7 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (q) that would prohibit VA from overriding an agreement between covered Veterans and their referring providers regarding the best medical interest of the Veteran to receive care in the community unless VA notified the Veteran and the referring

provider in writing that VA could not provide the care or services described in the agreement.

Position: VA does not support Section 7

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

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

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

Section 8 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (r) that would require VA to conduct outreach to inform Veterans of the conditions for care or services under section 1703(d) and (e), how to request such care or services, and how to appeal a denial of a request for such care or services using VHA's clinical appeals process. VA would have to inform Veterans upon their enrollment in VA care, and not less frequently than every two years thereafter, about this information, and VA would have to ensure that this information is displayed publicly in each VA medical facility, prominently displayed on a VA website, and included in other outreach campaigns and activities conducted by VA. Section 8(b) would also amend 38 U.S.C. § 6320(a)(2)(A) would be amended to require VA, as part of the Solid Start program, to proactively reach out to newly separated Veterans to inform them of their eligibility for programs of and benefits provided by VA, including how to enroll in the system of annual patient enrollment under section 1705 and the ability to seek care and services under sections 1703 and 1710.

Position: VA does not support Section 8

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

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

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

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

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

Position: VA supports Section 9

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

VA does not have a cost estimate at this time because the specific terms and parameters surrounding value-based reimbursement are subject to contract negotiations, and VA cannot predict what reimbursement models would be adopted

through such negotiations. We would be happy to discuss the potential cost estimates with the Committee and others as needed.

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

Position: VA does not support Section 10

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

We note, though, at present, claims for service-connected emergency care under 38 U.S.C. § 1728 must be filed within two years of the date of service (see 38 C.F.R. § 17.126), and claims under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) must be filed within one year of the date of service (see 38 C.F.R. § 17.276). CHAMPVA claims are generally processed separately, and claims under section 1728 represent a relatively smaller number of claims processed by VA. Further, because claims under section 1728 are claims for service-connected care, a longer filing period helps ensure more Veterans receive benefits under this authority, which seems justified based on their service-connected disabilities.

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

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

Position: VA does not support Section 11

VA does not support a statutory requirement in this area. As written, the language is ambiguous as to whether a screening is required within 72-hours or whether care would need to be delivered within the 72-hour period. VA is already moving in the direction of conducting screening within 48-hours of a request of presentation of a need for care. We caution that a hard line in statute can prove difficult to administer in complicated cases (such as when a Veteran is known to need care but

is not medically stable, as in the case of a recovering overdose), and the consequences of failure to meet the 72-hour standard are not defined. Further, it is not clear if this is intended to establish eligibility for community care, and if so, how this is reconcilable with the changes proposed to section 1703B under section 2 of this bill.

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

Position: VA does not support Section 12

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

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

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

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

Position: VA has no objection, defers to OIG.

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

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

section would have to be budgeted and appropriated through a separate appropriation account, and VA would have, in the budget justification materials submitted to Congress, have to include a separate statement of the amount requested to be appropriated for that fiscal year for this new separate account. There would be authorized to be appropriated $50 million for each of fiscal years 2023 through 2025 to carry out this section.

Position: VA does not support Section 2

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

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

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

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

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

Conclusion

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