

**STATEMENT OF DR. MIGUEL LAPUZ
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VETERAN CARE
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. SENATE**

JULY 12, 2023

Good morning, Chairman Tester, Ranking Member Moran, and Members of the Committee. I appreciate the opportunity to discuss the Department of Veterans Affairs' (VA) views on pending legislation regarding health care benefits. I am accompanied today by Dr. Matthew Miller, Executive Director – VA Suicide Prevention, Office of Mental Health and Suicide Prevention, Dr. Cynthia Gantt, Deputy Director, Office of Patient Centered Care and Cultural Transformation, and Dr. Leslie Sofocleous, Executive Director, Program Management Office, Electronic Health Record Modernization – Integration Office. VA does not have views on S. 2067, the Service Dogs Assisting Veterans Act, but will provide them to the Committee for the record.

S. 449 Veterans Patient Advocacy Act

S. 449 would amend 38 United States Code (U.S.C.) § 7309A to require VA, beginning no later than one year after enactment, to ensure that there is no fewer than one patient advocate for every 13,500 enrolled Veterans and that highly rural Veterans may access the services of patient advocates, including, to the extent practicable, with respect to assigning patient advocates to rural community-based outpatient clinics (CBOC). Within two years of enactment, the Comptroller General would have to submit to Congress a report evaluating the implementation by VA of these changes.

VA does not support this bill. VA agrees with the intent of the Veterans Patient Advocacy Act. Over the last few years, the role of the patient advocate has expanded because of the enactment of the Comprehensive Addiction and Recovery Act of 2016 (Public Law 114-198), the VA MISSION Act of 2018 (Public Law (P.L). 115-182), Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (the Isakson-Roe Act; Public Law 116-315), the Veterans COMPACT Act of 2020 (Public Law 116-214), and the Honoring our PACT Act of 2022 (Public Law 117-168).

VA has explored establishing a set ratio, as the bill would do, but believes that a focus on program outcomes would be a better model. VA is concerned that a specific staffing ratio for patient advocates could result in facilities having too many patient advocates and too few providers or other necessary support staff. Advances in technology or different staffing models may yield the same or even better outcomes for Veterans than a codified staffing ratio would do.

VA's goal is to ensure the Patient Advocacy Program is responsive to Veterans' needs based on evidence of what those needs are and strongly recommends continued examination of data analytics from VA facilities to determine how best to proceed in this area. Although the data collected provided insights to overall staffing levels, it is unclear to what extent across VA a patient advocate is designated specifically to rural or highly rural CBOCs. VA will analyze the data with this consideration in mind to advance and expand access to patient advocacy services across VA.

VA also expresses concern regarding the timeline for implementation that would be required; one year is not sufficient time to implement the changes the bill would institute. VA welcome the opportunity to brief the Committee on research and analysis outcomes to better inform the intent of this bill.

VA does not currently have a cost estimate for this bill.

S. 495 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 three 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. This bill could result in a shift of some payment from Medicaid to VA.

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

VA appreciates 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 one 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 a timeline providing two 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 Veterans Integrated Service Network (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, VA seeks clarification as to whether the requirements 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 Isakson-Roe Act related to per diem payments for Veterans who do not meet all the requirements for per diem payments for domiciliary care in 38 C.F.R. part 51; VA recommends the bill be amended to allow for, but not require 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 State 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 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 fiscal year (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.

S. 853 VA Zero Suicide Demonstration Project Act of 2023

Section 2 of S. 853 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 (HHS); 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 five years, but VA could extend the Program for not more than two years if VA notified Congress.

VA does not support this bill as written.

VA does not support this current bill for clinical, fiscal, empirical, contractual, 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 a top clinical priority, and VA is implementing a comprehensive public health approach with the goal of reaching all Veterans within and outside the health care system. This approach is in full alignment with the President's 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/Department of Defense (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 Veterans and 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 9-month Zero Suicide Initiative at the Manchester VA Medical Center. The Manchester VA Medical Center (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. 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 the 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 health care 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.

S. 928 Not Just a Number Act

Section 2 of this bill would require VA, not later than 18 months after enactment and not later than September 30 of each year thereafter, to submit to Congress and publish online a report to be known as the National Veteran Suicide Prevention Annual Report.

VA supports section 2, if amended. Since 2016, VA has produced and published an annual report regarding Veteran suicide with the latest available data. VA's National Veteran Suicide Prevention Annual Report already includes most of the information that would be required by the bill.

In addition to other technical amendments regarding the scope of several of the data elements, VA recommends the following amendments. First, suicide data is reported by sex, not gender, so VA could not disaggregate rates based on gender. The bill would also require a comparison to "Veterans who have never received health care from the Veterans Health Administration", but VA generally only compares with Veterans who have not received care from VHA within the past five years.

Second, VA is unable to provide trend information about Veterans who "applied for [a guaranteed] loan" or "who were turned down for such a loan by a lender." Most lenders in VA's guaranteed loan program are authorized to close loans without prior VA approval, and VA does not have access to the data on the applications they receive, unless the loan is closed. Further, VA believes that the report should include comparison data for Veterans who are rated as eligible for a specially adapted housing (SAH) grant under chapter 21, title 38, United States Code, and those who use their SAH grant to adapt or purchase a home. This critical benefit helps severely disabled Veterans achieve and maintain independence in their homes and communities, which may in turn affect their mental health outcomes.

Finally, this section would establish a process under which VA could request an extension for submitting a report, but the bill section lacks clarity on whether one or both Committees would have to approve the extension for it to be granted, how the extension would be communicated to VA, and if the Committees' respective responses would be

subject to a timeline. Also, this section refers to “suicide deaths,” as well as “suicide rates or deaths,” which raises technical questions about the scope of the report (i.e., whether “suicide” modifies rates and deaths or if VA is expected to report on non-suicide deaths).

These additional requirements would necessitate further collaboration and resources, but VA could generally provide the information required by this report within existing funding.

Section 3 of the bill would require VA, not later than three years after enactment, to submit to Congress and publish online a report that analyzes which benefits and services from VA (including VBA) have the greatest impact on prevention of suicide among Veterans, including recommendations for potential expansion of services and benefits to reduce the number of Veteran suicides.

VA supports section 3, with amendment, subject to the availability of appropriations. The three-year timeline may prove challenging. Suicide is a rare event with no single cause. Because it is the result of a complex interaction of risk and protective factors, to determine which have the “greatest impact” on preventing a suicide event is extremely difficult. Implementing interventions and programs at individual, interpersonal, community and societal levels takes time and coordination, with ongoing quality improvement revising and improving programs over time for maximum benefit. These processes impact comparability of programs year to year, resulting in less than helpful conclusions and comparisons.

The term “benefits and services” is undefined, but VA assumes this to be intentional on the part of the drafter to be broadly inclusive. We do note that this analysis could only identify correlations and not causation. Particularly given that those who are eligible for more benefits are often at higher risk, this analysis may not be able to produce much meaningful conclusions. Presently, VA is engaged in evaluating community and clinical interventions aimed at reducing Veteran suicide.

VA welcomes the opportunity to discuss this bill section further with the Committee to ensure there is a clear scope and methodology for implementation. VA estimates this section would cost approximately \$1.2 million in FY 2024; VA also estimates it would take approximately five years to complete this review, and the total cost over that time would be approximately \$18.5 million.

Section 4 of the bill would require VA, in collaboration with CDC, to develop a toolkit for State and local coroners and medical examiners that contains best practices for accurately identifying and reporting suicide deaths of Veterans and reporting such deaths to the CDC and other applicable entities. Not later than two years from enactment, VA would have to make the toolkit available online.

VA does not support section 4. VA currently has an interagency agreement with the Substance Abuse and Mental Health Services Administration that supports

outreach and efforts, and VA collaborates with CDC to access data from its Violent Death Record. Additionally, the Governor's Challenge has developed a toolkit that is more broadly applicable (not limited to State and local agencies or coroners). VA is also working, under section 303 of the STRONG Veterans Act, to provide additional support in this area. VA believes these current efforts sufficiently meet the intent of this section; legislating in this area could negatively impact current efforts and duplicate costs.

While the toolkit in this bill would be hosted on the VA website, it appears that most of the expertise for developing the toolkit, as well as the strategy and recommendations piece of the initial report detailed in section 3, would likely need to come from the Centers for Disease Control and Prevention (CDC). Veteran-specific information (in particular, identifying Veteran status) would come from VA, but vitals statistics expertise generally and vitals expertise relative to coroners and medical examiners specifically is housed in the National Center for Health Statistics within CDC. It is not clear from the bill whether CDC would make the final determination on recommendations from the report because the report would be hosted on the VA website. The same applies to the toolkit. The bill also does not include an authorization of appropriations for HHS related to the development, management, or publication of the report required by section 2 or the toolkit in section 4; both of these efforts could require relatively significant staff time to develop, but maintenance and annual evaluation and revisions would be less costly.

Section 5 of the bill would require VA, after submittal by the Comptroller General to Congress of the management review required by section 403 of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (the Hannon Act, Public Law 116-171), to review the findings and recommendations of the management review and conduct a study on the feasibility and advisability of creating a suicide prevention office at the level of the Office of the Secretary.

VA supports section 5. VA supports conducting a study on the feasibility and advisability of creating a suicide prevention office at the level of the Office of the Secretary. VA concurs with the plan to submit a report to Congress that summarizes any planned reorganization that would result from the leadership review of the study, including a strategy for leadership of this new office.

VA estimates the study required by this section would cost approximately \$600,000 to complete. The Office of Mental Health and Suicide Prevention (OMHSP) has experience completing a similar related feasibility and advisability study that focused on a broad review of suicide prevention related organizational structure (with the assistance of a contractor) as part of the Hannon Act. We believe Section 5 is asking for a similar type of analysis, so those costs were utilized.

S. 1037 VA EHRM Standardization and Accountability Act

Section 2(a) would prohibit VA from commencing a program activity at a VHA facility where no program activity has commenced as of the date of enactment of the

Act until VA submits to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives written certification that the electronic health record (EHR) system has met the following improvement objectives: (A) minimum uptime and system-wide stability standard; and (B) submission of a report detailing the completion status of corrections to the customization and configuration of workflow designs related to the EHR system. The provisions of section 2 would sunset once VA has completed certifications consistent with this section for VHA facility complexity levels 1, 2, and 3.

VA does not support section 2(a). This would prohibit VA from carrying out certain activities under the Electronic Health Record Modernization Program (EHRM) until the completion of sections 2(a)(2)(A) and (B). VA does not support the prohibition against commencing program activities until the completion of these sections, which do not consider the current EHRM Program Reset and infrastructure activities that necessitate continued engagement given the implementation lead time. Continuing program activities provides VA the opportunity to effectively incorporate Reset results and, where feasible, to standardize the current EHR to support future deployments and thereby reduce potential configuration rework that could have significant cost impacts later.

Section 2(b) of this bill would require the Under Secretary for Health, in consultation with the VHA facility director, to submit to the Secretary, and the Secretary to transmit to the House and Senate Committees on Veterans' Affairs, written certification that the staff and infrastructure of the facility are adequately prepared to receive the EHR system. This section would also require VA to provide written certification for one VHA facility for each of the complexity levels 1, 2 and 3.

VA does not support section 2(b). The written certification outlined by the bill is duplicative of VA's existing concurrence processes. VA has already implemented a consistent go-live approval process for each deployment of the EHR system that would satisfy this requirement. Specifically, infrastructure readiness is assessed through the current state review (CSR) process and addressed before deployment operations begin. Deployment kickoff starts one to two years prior to go-live, and there are weekly working deployment meetings with the facility, change leadership team and change sponsor to walk through outstanding issues. Approximately 8 weeks before go-live, VHA, EHRM-Integration Office (IO), VISN and site leadership meet weekly to review the readiness checklist and areas of concern. VA has also introduced formal Go Live Readiness Assessments which address risk and assess both site and solution readiness in the pre-go-live period and include a formal deployment decision.

VA fully supports section 2(c) of this bill, which would exclude application of this section to any facility jointly operated by VA and DoD. We note the term "joint" is not defined, and there are 65 facilities in which DoD and VA have partially integrated facilities (e.g., labs, audiology, etc.), with embedded staff, enhanced sharing of medical services, equipment, and non-medical staff. At these locations, a single, common health care record is anticipated to increase efficiency in operations and patient care.

To date, 119 of 138 DoD worldwide medical facilities have adopted the single, common EHR; 109 of 109 Department of Homeland Security (DHS) Coast Guard shoreside medical sites have adopted the new EHR; and 7 Department of Commerce National Oceanic and Atmospheric Administration sites have implemented the new EHR.

Section 2(d) would require submission of initial (i.e., not more than 30 days after the Act's enactment) and quarterly reports to the Committee on Veterans' Affairs of the Senate and the Committee on Veterans' Affairs of the House of Representatives, consistent with the elements outlined in section 2(d).

VA does not support section 2(d). With the EHRM Program Reset underway and the need to collaborate with DoD on systems and networks within the Federal EHR environment, providing an initial report within 30 days of enactment is not feasible. VA currently provides quarterly reports to Congress in accordance with section 2 of Public Law 117-154 (VA Electronic Health Record Transparency Act of 2021) and section 503(b) of Public Law 115-407 (Veterans Benefits and Transition Act of 2018) on deployment activities, and information on the topics listed can be added to those existing reports.

Section 2(e) provides definitions of EHR system and program activity.

VA support section 2(e), with amendment. VA recommends updating section 2(e)(2) to read: "(2) The term 'program activity' means any local or national workshop and/or training activities under the Electronic Health Record Modernization Program before the certification of the electronic health record system."

S. 1040 Prohibiting Smoking in Facilities of the Veterans Health Administration

This bill would repeal section 526 of Public Law 102-585 and amend 38 U.S.C. § 1715 to prohibit any person (including Veterans, patients, residents, employees, contractors, or visitors) from smoking on the premises of any VHA facility. The bill would prohibit the use of cigarettes, cigars, pipes, and any other combustion or heating of tobacco, as well as the use of any electronic nicotine delivery system, including electronic or e-cigarettes, vape pens, and e-cigars. The prohibition would apply to any land or building that is under VA's jurisdiction, under the control of VHA, and not under the control of the General Services Administration.

VA strongly supports this bill. Legislation to prohibit smoking on the premises of any VHA facility will ensure that VA can provide a smoke-free health care environment. Currently, there are more than 4,000 local or State, territorial, or commonwealth hospitals, health care systems and clinics, and at least four national health care systems (Kaiser Permanente, Mayo Clinic, SSM Health Care, and CIGNA Corporation) in the United States that have adopted 100 percent smoke-free policies

that extend to all their facilities, grounds, and office buildings. Absent this legislation, VHA patients, health care providers and visitors may not have the same level of enduring protection from the hazardous effects of second-hand smoke exposure as do patients and employees in these other systems. Currently, approximately 12.7 percent of Veterans enrolled in VA health care are smokers. Many of the non-smokers are also older Veterans who may be at higher risk for cardiac or other conditions that may make them even more vulnerable to the cardiovascular events associated with secondhand smoke.

As with other health care systems, VA believes its employees and Veteran patients have a right to be protected from secondhand smoke exposure when working or seeking health care at a VA facility. For Veteran smokers who are inpatients, nicotine replacement therapy is available. VA also offers tobacco cessation programs and resources for its employees. VA recommends including an effective date to facilitate implementation.

VA estimates that this bill would not result in any costs because it is consistent with current policy.

S. 1125 EHR Program RESET Act

S. 1125 includes 6 titles and 18 substantive sections. VA does not support the RESET Act as currently written. Although VA generally agrees with several provisions of the bill, VA finds that many of the bill's provisions reduce managerial flexibility and create a significant operational burden. Both outcomes would impede or slow VA's ability to successfully execute the EHR Modernization program and deliver value to Veterans, clinical staff and the Veterans Health Administration (VHA) system as a whole. VA believes there is room for discussions relative to many of the proposed requirements. VA welcomes the opportunity to work with the committees to provide technical assistance to meet congressional intent while resolving potential conflicts with organizational structure and existing legal requirements.

Section 101 of this bill would establish, within VHA, a program to modernize the EHR and other relevant health information technology systems of the Department; a Program Management Office, with specifically defined functions and duties; and a Deputy Chief Information Officer for Electronic Health Record and Health Information Technology.

VA cites concerns with section 101. VA acknowledges the intent of section 101 is to realign the existing EHRM-Integration Office under VHA, with a portion of the office realigning under the Office of Information and Technology. Additionally, while the Deputy Secretary would remain accountable for the program, both the Under Secretary for Health and the Chief Information Officer would have responsibilities associated with the programmatic, technical, and functional execution of the program.

VA can support this proposal though cites concerns that under current EHRM appropriations the account is to be 'administered' by the Office of the Deputy Secretary. Changes of the organizational structure would potentially require clarification or adjustments to current appropriation law.

Section 102 would establish a permanent advisory subcommittee of the Special Medical Advisory Group on electronic health record and health information technology modernization within 60 days of enactment of the Act.

VA supports section 102.

Section 201 would suspend new go-live deployments until certain healthcare performance baseline or national metrics for continuation of the Program are met or exceeded.

VA cites concerns with section 201. As demonstrated by the Program Reset and VA's proactive decision to halt further deployments of the EHR until critical issues are addressed and the system is optimized, VA concurs with pausing deployments until certain thresholds are met. However, VA believes that the timelines stipulated in section 201 are too short. This bill requires completion of a re-organization and establishment of national standards within 60 days; this is not feasible. Additionally, while VA agrees there is a need to establish metrics for the EHRM program, the trigger requirements and timelines for pursuing alternative or replacement solutions, as outlined are too rigid and will not allow for the risk-based decision making that is needed in the context of the massive change effort incumbent within VA's EHRM effort.

Section 202 would establish reporting pre-requisites prior to continued deployment of the new EHR system at additional locations and facilities.

VA does not support section 202. VA believes section 202 is unnecessary since many of the proposed actions in this section are already in progress as part of VA's self-initiated reset efforts with more improvements being implemented over the coming months. Moreover, VA cannot support the specified timeline of 30 days for the report on the metrics, readiness criteria, and governance process to be used to determine whether to proceed with deployment or a continued pause. Additionally, the requirement to determine whether the record is ready for continued deployment in June 2023 has been overcome by the program Reset announcement on April 21, 2023, thereby rendering this requirement unnecessary.

Section 203 speaks to Congress' sense that training and change management should be led by VA and specifically VA employees who understand the legacy VistA system of the Department, the existing and future standardized workflow of the Department, and the history, culture, and mission of the Department.

VA has no objections to section 203.

Section 301 of the bill would require that a report be submitted to the appropriate committees of Congress, summarizing the standard support services that the Department does or intends to provide to each facility in preparation for potential future deployment, and, at a minimum, include the items enumerated in section 301(b)(1)-(6). This report would be due no later than 90 days after enactment. Section 302 would amend section 503(b) of the Veterans Benefits and Transition Act of 2018 regarding quarterly report requirements.

VA supports sections 301 and 302 with amendments. VA already provides regular reports to Congress on deployment activities and information on the topics listed in sections 301 and 302, but elements of these sections can be added to existing report requirements without legislation. However, portions of the bill need further clarification, including the definitions of some terms, frequency of reporting, and establishment of realistic timelines for providing financial data. VA welcomes the opportunity to work with the Committee to provide technical assistance on this section.

Section 401 would require VA to terminate all contracts with Oracle Cerner for training and change management related to EHRM and prohibit VA from issuing task orders for training and change management activities with Oracle Cerner or subcontractors.

VA does not support section 401. A process is already underway to evaluate the timeline to transition Oracle Cerner's training and change management efforts to more of a support role. Given the magnitude of the task, VHA is not yet ready to assume management lead of all training and change management activities. As acknowledged in Section 401, VA will still require some level of contract support. VA has concerns about a 275-day timeline for successful procurement of alternative contract resources. VA also requires sufficient time to transition the responsibilities to a new contractor and to validate that the new VA-led and contractor-supported training has been successful. In addition, if there are areas where Oracle Cerner needs to support VA or a new training contractor regarding the VA and alternative contractor's training and change management efforts, VA needs to be able to issue necessary task order to Oracle Cerner to allow such support.

Section 402 would designate a lead negotiator for all current and future contracts relating to the new EHR.

VA does not support section 402. VA does not support the need for stronger contract negotiation and the designation of a new lead negotiator per section 402, as the negotiation objectives identified have been achieved, the contract negotiations are already complete and VA has awarded Option Period 1.

Section 403 would require VA to negotiate a contract for independent oversight and validation of functions described in section 403(c).

VA supports section 403, with amendments. Although VA supports the proposal in section 403 for independent verification and validation (IV&V) and has agreed to such a proposal during public hearings, it does not support the proposed timeline. VA welcomes the opportunity to work with the Committee to develop a more appropriate timeline for implementation of the elements described in this section.

Section 404 would require VA to submit a report to Congress on maintain the legacy Veterans Health Information System Technology Architecture (VistA) system no later than 60 days after enactment and not later than 90 days after the beginning of each Fiscal Year thereafter with a termination date of 15 years post enactment.

VA supports section 404.

Section 405 would require VA to submit to Congress a report on alternatives to current EHR technology and the Oracle Cerner product.

VA does not support section 405. VA believes it would be premature during the current Program Reset to provide a report on possible alternatives to the Oracle Cerner EHR and its current contract with VA. Based on the results of the Program Reset, VA will determine the next steps. If the results suggest the need to pursue a different solution, a new acquisition strategy will be developed, which will evaluate alternative competitive solutions. Furthermore, if the report currently required by section 405 were to be mandated nonetheless, VA submits that the proposed timeline of 60 days is not adequate for production of a quality product that encompasses an analysis of alternative technologies in the EHR space, market trends, reinvestment of expenditures, the impact of aligning and interoperating with DoD's MHS GENESIS, and other matters as required.

Section 406 would require VA to submit a report to Congress on leadership, engagement and management, strategic planning, contracting and contract oversight and program management in the implementation of the EHR between 20217 through the date of the report and any large acquisitions and major modernizations conducted, including those that are ongoing or planned by the Department after the date of the report no later than 180 days after enactment.

VA does not support section 406. VA already provides reports on leadership, acquisition and contracting oversight lessons learned as part of our existing reporting process. Therefore, VA believes section 406 is unnecessary. Information detailing steps to improve the composition of and management of task orders are not specifically included in Congressional reporting at this time but can be incorporated in existing reporting.

Section 407 would require VA to submit a report to Congress on contract savings, services provided at no cost to VA and contract costs incurred with respect to Oracle Cerner product no later than 90 days after enactment.

VA supports section 407, with amendments. VA already provides reports on contract costs and savings to Congress, and the elements in this section can be added to existing requirements. Section 407(3) ties back to reporting under Sections 301 and 302 and as noted, VA welcomes the opportunity to work with the Committee to provide technical assistance on that section, and by extension, this one as well.

Section 501 would require, not later than 90 days after the date of the enactment of the Act, and not less frequently than quarterly thereafter, VA to submit to Congress quarterly reports on system uptime, modernization and coordination activities for DoD IT systems that are relied upon by VA to deliver health care, compensation, memorial benefits, and other services. Section 502 would require coordination with DoD, with a report submitted to the appropriate committees of Congress, and the Committees on Armed Services of the Senate and House of Representatives detailing the additional support needed from DoD to make the current and future delivery of health, benefits, memorial affairs, and other services of the VA, stable and successful.

VA does not support sections 501 and 502. Sections 501 and 502 have potential conflicts with the National Defense Authorization Act (NDAA) for Fiscal Year 2020 (the FY 2020 NDAA, Public Law 116-92, section 715) relating to authority and responsibility of the Federal Electronic Health Record Modernization (FEHRM), which requires the FEHRM office to submit a report on its activities during the preceding calendar year. This includes information on progress implementing a single, comment Federal EHR. Additionally, given the inter-agency nature of these reports and their statutorily described role, VA believes the FEHRM may be best equipped as the lead. Finally, the requested timelines for initial delivery of the reports in sections 501 and 502 do not seem feasible. There already exists a statutorily-established body, the VA-DoD Joint Executive Committee, to address VA-DoD IT and data issues or concerns.

Section 601 of the bill would require, not later than 180 days following enactment, and periodically thereafter, submission of a report to the appropriate committees of Congress detailing any legislative action, including resources, required to carry out the Act of implement a modernized EHR.

VA supports section 601. Section 602 of the bill would require, not later than 180 days following enactment, a report on the current state and level of interoperability with the VA's legacy VistA EHR and legacy applications, including the Joint Longitudinal Viewer, as well as the Oracle-Cerner product in use at the five deployed sites within VA.

VA supports section 602, if amended, and subject to the availability of appropriations. VA notes that section 602 has significant overlap with the NDAA of 2020 (P.L. 116-92, section 715), which requires the FEHRM office to submit a report on its activities during the preceding calendar year. Additionally, the FEHRM Interoperability Progress Quarterly Report includes updates on interoperability modernization in response to House Report 117-388, page 261, accompanying H.R. 8236, the Department of Defense Appropriations Bill, 2023. In addition to concerns regarding duplication of existing FEHRM reports, the contents of the report described in

section 602(b)(1-7) and (c)(1-3), cannot be completed solely by VA. As the FEHRM is currently completing the 2020 NDAA-mandated assessment and report, VA requests the FEHRM remain lead as planned to deliver under section 715 of the FY 2020 NDAA or that this section be issued as an amendment to that law to identify additional reporting requirements and establish the FEHRM as responsible for reporting. This would alleviate redundant efforts and leverage existing contractual support already aligned to this effort.

If enacted, section 602 would have additional costs. However, given the complexity of FEHRM involvement and potential to leverage existing contractual support, VA does not have a cost estimate for section 602 of this bill.

S. 1172 RELIEVE Act

Section 2(a) of the bill would amend 38 U.S.C. § 1725(b)(2)(B) to create an exception to the requirement that an enrolled Veteran has received care under chapter 17 within the 24-month period preceding the furnishing of emergency treatment at a non-VA facility to receive reimbursement from VA. This exception would make eligible for potential reimbursement Veterans who have not yet received care under chapter 17 but who enrolled and received emergency treatment within the first 60 days of the Veteran's enrollment. Section 2(b) would provide that the amendment made by section 2(a) would apply with respect to emergency treatment furnished on or after the date that is one year after the date of enactment.

VA supports this bill, subject to the availability of appropriations. This bill aligns with VA's legislative proposal Waiver of 24-Month Requirement for Reimbursement of Emergency Treatment under 38 U.S.C. § 1725 for Recently Enrolled Veterans. While there are only a few Veterans who might qualify under this exception, VA has no other means for reimbursing these Veterans unless VA is notified that the care was provided by a network provider under the Veterans Community Care Program (VCCP). This bill would provide an important benefit to this population.

We would appreciate the opportunity to discuss further with the Committee current limitations related to this authority and other possible options that might help ensure Veterans who might not otherwise know about these limitations to be reimbursed for their emergency treatment.

VA cautions that if rulemaking is required to implement this new authority, the one-year implementation timeline may be difficult to achieve, and VA therefore recommends a two-year timeline to ensure compliance.

VA estimates this bill would cost \$5.2 million in FY 2025, \$28 million over 5 years, and \$60 million over 10 years.

S. 1315 Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023

S. 1315 contains two titles and a total of 19 substantive sections.

Section 101 would amend 38 U.S.C. § 1703B regarding VA's access standards to expand and codify VA's existing access standards established in regulation at 38 C.F.R. § 17.4040. Specifically, it would create a new section 1703B(a) that would provide that covered Veterans would be eligible to elect to receive hospital care, medical services, or extended care services under section 1703(d)(1)(D) (the eligibility criterion for VCCP based on VA's designated access standards) if VA determined, with respect to primary care, mental health care, or extended care services (excluding nursing home care), VA could not schedule an in-person appointment for the covered Veteran with a VA health care provider at a facility that is located less than a 30-minute average 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 average drive from the Veteran's residence or during the 28-day period after the date on which the Veteran requests such appointment. The availability of telehealth appointments would not be taken into consideration when determining VA's ability to furnish such care or services in a manner that complies with the access standards. VA could prescribe regulations that establish a shorter average drive 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 EHR and provide the Veteran a copy of that documentation in writing or electronically. If a Veteran had an appointment cancelled by VA for a reason other than the request of the Veteran, VA would have to calculate the wait time from the date of the request for the original, canceled appointment.

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

Proposed section 1703B(c) would require 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 VCCP). Section 101 would also strike section 1703B(g), which allows VA to establish through regulation designated access standards for purposes of VCCP eligibility and would make other conforming amendments.

VA opposes section 101. VA is opposed to codification of access standards. Limiting 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 such treatment and services, although we oppose codifying this in law.

VA also 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 is considering how best to consider telehealth with regard to its access standards, including considering how to best prioritize the Veteran's preference..

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 102 of the bill would amend 38 U.S.C. § 1703(a) by adding a new paragraph (5) that would require VA to notify a covered Veteran in writing of the eligibility of the Veteran for care or services under this section as soon as possible, but not later than two business days, after the date on which VA is aware that the Veteran is seeking care or services and is eligible for such care or services under § 1703. VA would have to provide such Veterans periodic reminders, as it determines appropriate, of their ongoing eligibility under § 1703(d). VA could provide covered Veterans notice electronically.

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

It is also unclear what is anticipated as the penalty for non-compliance in any situation where VA was unable to meet this requirement. VA welcomes the opportunity to work with the Committee to modify the process for notifying eligible Veterans to meet the intent of this section more feasibly.

Section 103 of the bill would amend 38 U.S.C. § 1703(d)(2) by adding new subparagraphs (F) and (G). These amendments would require VA to ensure that criteria developed to determine whether it would be in the best medical interest of a covered Veteran to receive care in the community include the preference of the Veteran

regarding where, when, and how to seek care and services and whether the covered Veteran requests or requires the assistance of a caregiver or attendant when seeking care or services.

VA does not support section 103. The wording in this section creates ambiguity and may shift this decision-making regarding the best medical interest of the Veteran from a joint decision to a unilateral one by the Veteran. Specifically, it is unclear whether the “preference of the covered veteran regarding where, when, and how to seek hospital care, medical services, or extended care services” would allow a Veteran unilaterally to determine his or her eligibility for community care if the Veteran stated a preference for community care. If the Veteran can choose to be seen in the community based on this preference, even if the provider did not agree, then 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.

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 care, would create confusion in practice. VA agrees that a Veteran’s need for an attendant or caregiver is relevant and already considers consistent with 38 C.F.R. § 17.4010(a)(5)(vii)(E)). However, a Veteran’s “request” for a caregiver or attendant does not establish need, but this section would qualify a requesting Veteran for community care irrespective of need.

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

Section 104 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (o) that would require VA, if a request for care or services under the VCCP is denied, to notify the Veteran in writing as soon as possible, but not later than two business days, after the denial is made of the reason for the denial and how to appeal such denial using VHA’s clinical appeals process. If a denial 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.

VA does not support section 104. VA is concerned that a statutorily prescribed two-business day notification deadline would be operationally burdensome, especially in

cases where notification by electronic communication is unavailable. It is also unclear the penalty for non-compliance in a situation where VA was unable to meet this requirement. Section 104 is ambiguous, as it refers to a Veteran not meeting the eligibility access standards; however, VA must be able to schedule an appointment that meets the eligibility access standards, and if it cannot, then the Veteran is eligible. We believe this was intended to apply when VA has determined that the access standards are met, and when a covered Veteran is ineligible for community care. We further note that the language would only apply to eligibility determinations regarding the access standards and would not apply to determinations regarding any other eligibility criteria.

VA is working to modify the process for notifying Veterans that VA has determined they are not eligible for community care to ensure they are notified in the timeliest fashion possible while avoiding some of the barriers that would be created by this section as written. We do not believe legislation is needed in this regard.

Section 105 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (p) that would require VA to ensure that Veterans were informed that they could elect to seek care or services via telehealth, either through a VA medical facility or through the VCCP, if telehealth is available to the Veteran, is appropriate for the type of care or service the Veteran seeks, and is acceptable to the Veteran.

VA supports section 105, with amendments. While VA supports this section, it is unclear whether the bill is intended to establish that a Veteran's preference to not receive care via telehealth would also be binding on how they receive care through the VCCP. If that is the case, that could result in additional costs to VA and could create network adequacy issues, as VA currently allows Veterans who decline VA-administered telehealth to receive telehealth from a community provider. VA welcomes the opportunity to discuss recommended amendments and cost implications of this section.

Section 106 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (q) that would establish that an agreement by a covered Veteran and the referring provider under § 1703 regarding the best medical interest of the covered Veteran or regarding eligibility for care or services under this section is final and may not be changed by VA without the knowledge and consent, documented in writing, of the covered Veteran and the provider unless there is a statutory or regulatory barrier preventing VA from providing the care or services in question.

VA does not support section 106. 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. While the bill would provide an exception for cases when there is a statutory or regulatory barrier preventing VA from providing the care or services, it is not clear that this exception would address the types of scenarios described above. 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.

Finally, the proposed § 1703(q) would refer both to an agreement regarding the best medical interest of the veteran and to agreements "regarding eligibility for care or services under this section". It is not clear what this phrase is intended to convey, as the only agreements made between Veterans and referring providers concern whether receiving care in the community is in the Veteran's best medical interest. We recommend clarifying this to ensure that this phrase does not apply more broadly than intended.

Section 107 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, as part of the VA Solid Start Program, 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.

VA does not support section 107. The provisions of section 107 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 108 would require VA, working with third party administrators (TPA) and acting through the Center for Innovation for Care and Payment (CICP), to develop and implement a plan with a TPA to provide monetary and non-monetary incentives to health care providers under section 1703(c) that furnish care or services under the VCCP pursuant to an agreement with a TPA and submit that plan not later than 180 days after the date of enactment. No health care provider or TPA could be penalized for not carrying out any part of the plan. This section could not be construed to be a pilot program subject to the requirements of 38 U.S.C. § 1703E.

VA does not support section 108. VA does not support section 108 for several reasons. First, we do not believe it is necessary to specify the organization that would carry out this effort. Second, VA already has the authority to engage in efforts to support patient scheduling with community providers; indeed, sections 131-134 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (Division U of Public Law 117-328, 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. Third, given the contractual requirements that would be necessary to implement this section, the timeline (submitting a plan within 180 days) would be unrealistic.

Fourth, 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.

Section 109 of the bill would amend 38 U.S.C. § 1703(i)(5) to require VA to incorporate, to the extent practicable, the use of value-based reimbursement models to promote the provision of high-quality care. It would further require VA to negotiate with TPAs to establish the use of value-based reimbursement models under the VCCP. It would also impose additional reporting requirements associated with these efforts.

VA supports section 109. 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.

Section 110 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.

VA does not support section 110. VA's contracts for community care generally include a 180--day timely filing requirement. Providers are aware of the 180-day timely filing requirement when agreeing to their contracts with the TPAs. Additionally, section 142 of the recently enacted Cleland-Dole Act amended 38 U.S.C. § 1725 to require 180 days for timely filing, which is consistent with current section 1703D. 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.

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

Section 111 of the bill would require VA's Office of Inspector General (OIG), as OIG determines appropriate, to assess the performance of each VAMC.

VA has no objection to section 111 and defers to OIG.

Section 201(a) would express the sense of Congress regarding the importance of value-based care. Section 201(b) would require VA, within 90 days of enactment, to establish a working group that would have to be composed of individuals within VA, other Federal agencies, and could include other individuals from the private sector. Section 201(c) would require that within one year of establishing the working group, that group would have to develop a strategic plan to shift VHA to a value-based care system; this plan would have to include at least a dozen specific elements. Under section 201(d), within 30 days of the completion of the strategic plan, VA would have to submit the strategic plan to Congress. Section 201(e) would require that within 180 days of submitting the strategic plan to Congress, VA would have to commence a five-year pilot program to implement the strategic plan, including implementation of the plan for the delivery by VHA of primary care, inpatient and outpatient mental health treatment, and inpatient and outpatient substance use treatment.

VA does not support section 201. Initially, it is unclear if the intent of this provision is to evaluate value-based payment of VA employees in shifting to a value-based care system. This could have significant effects on the VA workforce and would require significant changes to VA's statutory authority. Such changes would also create significant uncertainty for employees in terms of benefits and future effects. If Congress intends for VA to change its salary and benefits structure for employees, it should clearly state so. It is also unclear whether this is intended to ensure VA does not provide certain types of care or services, or at least does not do so in certain circumstances, in the interest of value-based care. Certain locations might be able to provide services at lower cost but at more distance for Veterans, and it is unclear whether this type of arrangement would be supported under this proposal. The term "value-based care" is fundamentally unclear, and VA would need further understanding before it could support this effort. VA generally supports producing better outcomes at lower costs, but the specific parameters of this proposal and how this works in particular cases is unclear in the abstract. We would appreciate the opportunity to discuss these ideas further with the Committee.

Additionally, this section would require VA to develop and implement a plan, including potentially nationwide, when VA would not yet have the results of its analysis to determine whether the plan is feasible or advisable. We recommend separating such a determination from any future requirements for action or implementation.

We note that several of the elements required to be included in the strategic plan are duplicative of, or only slightly different from, requirements in other statutes, including 38 U.S.C. § 7330C (the quadrennial VHA review) and the recently enacted 38 U.S.C. § 1704A, as added by section 194 of the Cleland-Dole Act. Particularly given the timing of when this strategic plan would be completed and the requirements to complete

reviews under these two other statutes, this could result in duplication of efforts and could delay implementation of one or all of these efforts if VA staff are required to work on all of these efforts simultaneously.

Additionally, it is not clear whether the pilot program referenced here would be carried out by the CICIP or another entity. If the CICIP is expected to be responsible, 38 U.S.C. § 1703E defines a specific process for carrying out pilot programs under that authority, and VA can only proceed with such a pilot with Congressional approval. Given the absence of any specific direction in this section that CICIP implement the pilot (as opposed to sections 108(a) and 202(a) of this bill), we would not interpret this as requiring CICIP to implement this authority.

As a technical matter, we note that some of the titles of positions in subsection (b)(2) are inaccurate; for example, the correct titles would be “the Under Secretary for Health” and “the Assistant Secretary for Information and Technology”.

Section 202 would require VA, working with TPAs and acting through the CICIP, to develop and implement a plan to establish an interactive, online self-service module: (A) that would allow Veterans to request appointments, track referrals for care, and receive appointment reminders; (B) to allow Veterans to appeal and track decisions relating to denials of requests for care and services under VCCP and denials of requests for care and services at VA facilities; and (C) implement such other matters as determined appropriate by VA in consultation with TPAs. Within 180 days of enactment, VA would have to submit to Congress this plan. Following submittal of the plan, VA would have to submit to Congress quarterly reports for two years containing any updates on the implementation of the plan. This section could not be construed to be a pilot program subject to the requirements of 38 U.S.C. § 1703E.

VA does not support section 202. VA objects to a statutory requirement to work with the TPAs, as this could narrow the Secretary’s authority and flexibility to design systems and processes that are responsive to the needs of Veterans. VA is working to implement many of the functions described in this section, such as by allowing Veterans to request and schedule appointments on their own and by allowing Veterans to appeal and track decisions. However, a single, consolidated module that would perform all of these functions would likely be very difficult to build and operate. We also do not support requiring the CICIP to implement this program as it is not clear that the Center would have the resources or expertise to manage an information technology platform like this. The Secretary should have the discretion to determine which offices would be best to implement this authority.

Section 203 would create a new 38 U.S.C. § 1703G that would require VA to publish online the average wait time for a Veteran to schedule an appointment at each VA medical center for the receipt of primary care, specialty care, and mental health care measured from the date of request for the appointment to the date on which the care was provided. VA would have to update these wait times not less frequently than monthly.

VA supports section 203 with amendments. VA currently provides this information pursuant to section 206 of the Veterans Access, Choice, and Accountability Act of 2014 (the Choice Act, 38 U.S.C. § 1701, note), but this section would not rescind that authority. We recommend repealing section 206 of the Choice Act if Congress intends to codify a permanent requirement like this. VA does not anticipate any additional costs would result from this section.

Section 204 would require VA, upon the enrollment of a Veteran in VA health care and at least annually thereafter, to solicit from Veterans their preferences for scheduling appointments for health care and related services furnished by VA, including through non-VA providers.

VA opposes section 204. This language is overly prescriptive and unnecessary, as many of these preferences are already captured by VA. Additionally, VA currently is developing updates to reflect scheduling preferences.

Section 205 would require VA, within one year of enactment, to develop, validate, and implement a staffing model for the Office of Integrated Veteran Care (IVC), VISNs, and VA medical centers that includes appropriate target staffing levels nationally, regionally, and locally to ensure timely access to care and effectively oversee the provision of care by VA.

VA does not support section 205. The requirements seem to conflate access to care and scheduling; while scheduling is necessary for access to care, it is not sufficient, as an appointment could be scheduled before it should occur (as in the case when tests or other procedures are needed before other care can be provided). Ensuring timely access to care is a Departmental responsibility, not solely a responsibility of those who are scheduling appointments. We are concerned that including performance metrics that could influence performance ratings could create incentives that would not reflect the needs or interests of Veterans seeking care from VA.

Additionally, VA currently has an Office of Integrated Veteran Care (IVC) staffing tool to guide local facilities on their staffing needs. VA is also developing staffing models for all VA medical centers with a focus on the metric of timely access to care. This initial assessment, starting with primary care and select specialties, should be completed by the end of calendar year 2023. However, these models are complex and have not been attempted at VA or other Federal agencies in the past. Specialty care analysis will take additional time to complete and review with VA medical centers and VHA leadership.

Section 206(a) would amend the CACP's authority in 38 U.S.C. § 1703E in ten ways.

VA does not support section 206(a). VA has concerns with this section. First, moving the CACP to the Office of the Secretary could lead to operational disruptions, cause work output delays, and create confusion through this reorganization.

Additionally, the apparently expanded scope of the Center's authority would still be constrained by the current statutory focus on testing payment and service delivery models to reduce expenditures while preserving or enhancing the quality of care furnished by VA. It seems unlikely that VA could test payment and service delivery models to determine whether these models (1) improve access, quality, timeliness, and satisfaction of care, (2) create cost savings for VA, and (3) increase productivity, efficiency, and modernization throughout VA. The broader scope would seemingly include authorities or programs relevant to VBA, construction, IT, and other programs, but the core requirement to test payment and service delivery models to reduce expenditures while preserving or enhancing care would still apply.

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

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

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

Section 206(b) would require the Comptroller General, within 18 months of enactment, to submit to Congress a report on the efforts of the CICIP in fulfilling the

objectives and requirements under 38 U.S.C. § 1703E and containing such recommendations as the Comptroller General considers appropriate.

Section 206(c) would require the CICP, not later than one year from enactment, to establish a three-year pilot program in not fewer than five locations to allow enrolled Veterans to access outpatient mental health and substance use services through the VCCP without referral or preauthorization.

VA has no objections to section 206(b); VA opposes section 206(c). VA has no objections to section 206(b) and defers to the Comptroller General on this provision.

Concerning section 206(c), we know there are a number of Veterans being recruited to participate in treatment programs, but VA has no means to verify that the care being provided is high quality, economical, or appropriate. Treatment plans are designed to address the unique needs of Veterans, who may need a more structured environment and schedule to succeed in their path to recovery. This raises concerns about the delivery of care to Veterans, and whether participation in some such programs might deter Veterans from seeking other, evidence-based care. A recent study demonstrated the efficacy of VA's integrated system, particularly for patients with mental health needs, but this type of program would impede our ability to furnish this integrated care.

VA has significant concerns with section 206(c) for several reasons. First, section 206(c) would seemingly conflict with § 1703(a)(3), which requires that covered Veterans only receive care through the VCCP "upon the authorization of such care or services by the Secretary". If Veterans could self-refer for care, unless VA were to issue a blanket authorization (and it is not clear that doing so would satisfy the requirements of 38 C.F.R. § 17.38(b), that VA determines the care is necessary to promote, preserve, or restore the health of the Veteran), it would still need to authorize this care individually. Further, VA's contracts are structured to rely upon an authorization from VA for care (other than walk-in care under § 1725A) and would require contract modifications to effectuate this under the CCN contracts. If this section is intended to establish a program separate from the VCCP, the MISSION Act was enacted to consolidate and simplify community care eligibility; this proposal would be a step back toward what the MISSION Act was intended to fix.

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

patient safety and outcomes retroactively, which would make implementation of a value-based model even more difficult.

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

Finally, section 206(c) would require the CICP to carry out a pilot program under § 1703E, but it is not clear whether this supersedes the waiver process required by § 1703E(f) or not.

Section 207 would require VA, within one year of enactment, to establish an online health education portal that includes interactive online educational modules to ensure enrolled Veterans understand their basic health care eligibilities and entitlements under the laws administered by VA, including the VCCP.

VA does not support section 207. VA already has an existing portal that could meet the requirements of this section, so VA does not believe it is necessary to establish such a portal.

Section 208(a) would require VA, within one year of enactment and annually for the next three years, in consultation with VSOs, Veterans, caregivers of Veterans, employees, and other stakeholders, to submit to Congress a report containing recommendations for legislative or administrative action to improve the clinical appeals process of the Department with respect to timeliness, transparency, objectivity, consistency, and fairness.

VA does not support section 208. Section 208 is too prescriptive, specifically with the proposed reporting of appeal volume and outcomes. VA does not support requirements to consult with a variety of stakeholders. VA also notes that request for community care that are not approved do not amount to a denial of care – that care, so long as it is necessary, is still furnished by VA.

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

requirement to establish an advisory committee, or specifically exempt the working group from FACA requirements, and avoid these issues altogether.

S. 1436 CHARGE Act of 2023

This bill contains three titles that include six substantive provisions.

Section 101(a) of this bill would amend 38 U.S.C. § 2011 by adding a new subsection (i) that would prohibit VA from making any grants or providing any per diem payments under 38 U.S.C. § 2012 for more than 12,000 transitional housing beds for homeless Veterans furnished by grant recipients or eligible entities under such sections on average each year. Section 101(b) of the bill would amend 38 U.S.C. § 2012 by adding a new subsection (f) that would require VA to submit to Congress a report on the rate for per diem payments under this section that includes, for each VISN, the average rate for such payments, a list of locations where the rate for such payments is within 10 percent of the maximum rate for such payments, and the average length of stay by Veterans participating in programs under 38 U.S.C. § 2011(a). Section 101(c) of the bill would provide that, during the three-year period beginning on the date of enactment, the maximum per diem payment rate would be 200 percent of the rate authorized for State homes for domiciliary care. It would not amend section 2012 to make this change. Section 101(d) would require VA, not later than 540 days after enactment, to submit to Congress a strategic plan for the provision of grants and per diem payments for services furnished to homeless Veterans under 38 U.S.C. §§ 2011 and 2012.

VA supports section 101, if amended, subject to the availability of appropriations. VA recommends several technical amendments to adjust the timeframe for the reporting requirements and for the maximum rate to align the timeframes with the timing of a new FY and in light of other considerations, such as the strategic plan required by subsection (d). The technical edits also would cite to 38 U.S.C. § 2012 instead of § 2011(a) and would include a rate change for all of the transitional housing grants under 38 U.S.C. § 2012(a)(2)(B) instead of only some of the grants. Finally, the technical amendments would increase the authorization of appropriations for the Grant and Per Diem (GPD) program (38 U.S.C. § 2016) to provide VA clear authority to provide necessary resources required to implement this legislation and existing programs to assist Veterans experiencing homelessness through the GPD program. These technical amendments align with one of VA's FY 2024 legislative proposals (#74, Increase the Maximum Per Diem Rate for Services to Homeless Veterans under the Grant and Per Diem (GPD) Program).

VA estimates this section would cost a total of approximately \$296.0 million in FY 2024 and \$913.1 million for the three-year term authorized by this section. VA's cost estimate assumes the continuation of the 200 percent rate until a new GPD rate is adopted in law following the submission of VA's strategic plan. If new legislation were not enacted, then to prevent a cliff effect, VA assumed the program would remain at the 200 percent rate and the estimated cost would be \$1.56 billion over five years, and \$3.31 billion over ten years. Compared to the authorized level of \$257.7 million, this

would be an increase of \$38 million for FY 2024 and \$140 million over three years. If no new legislation were enacted, the increase would be approximately \$272 million for the five-year period from FY 2024 through FY 2028 and approximately \$737 million for the ten-year period from FY 2024 through FY 2033.

The projected costs estimated here are lower than the projected costs estimated in VA's FY 2024 legislative proposal because adjustments are made to align with the new transitional housing grants scheduled to start on October 1, 2023, when VA will be awarding fewer beds compared to previous projections. The decrease reflects actual needs in communities as expressed by applicants and accounts for the most recent State domiciliary rate change, effective April 2023.

Section 102 of the bill would create a new 38 U.S.C. § 2069(a) that would authorize VA to provide to homeless Veterans and Veterans participating in the Department of Housing and Urban Development (HUD)-VA Supportive Housing (VASH) program, as VA determines, necessary, the following: (1) assistance required for the safety and survival of the Veteran (such as food, shelter, clothing, blankets, and hygiene items); (2) transportation required to support the stability and health of the Veteran (such as transportation for appointments with service providers, the conduct of housing searches, and the obtainment of food and supplies); (3) communications equipment and services (such as tablets, smartphones, disposable phones, and related service plans) required to support the stability and health of the Veteran (such as through the maintenance of contact with service providers, prospective landlords, and family members); and (4) such other assistance as VA determines necessary. A new § 2069(b) would authorize VA to collaborate, to the extent practicable, with one or more organizations to manage the use of VA land for Veterans experiencing homelessness for living and sleeping. Collaboration that would be authorized by this provision could include the provision of food services and security, by either VA or the head of the organization concerned, for VA property, buildings, and other facilities. A new § 2069(c) would provide that these authorities would terminate on the date that is three years after the date of enactment.

VA supports section 102, subject to the availability of appropriations. This section is very similar to one of VA's FY 2024 legislative proposals related to flexibility in the provision of assistance to Homeless Veterans. This proposal would continue the authority VA was able to use during the COVID-19 public health emergency to provide additional assistance and support to Veterans experiencing homelessness and Veterans participating in HUD-VASH to great effect. VA recommends permanent authority be granted, rather than authority that is subject to termination after three years. We do not believe a statutory time limit would provide stability and assurance to Veterans experiencing homelessness and Veterans participating in HUD-VASH. A permanent authority would provide assurances for Veterans and likely would result in lower per capita costs to the Department, as VA could negotiate contracts that could cover multiple years (provided appropriations are available for such purposes). Operating with a shorter statutory authority would prevent VA from such long-term arrangements and would likely result in higher costs.

This section would afford VA the authority it had during the COVID-19 public health emergency to furnish critically essential resources and services for homeless Veterans, including assistance required for safety and survival; transportation required to support stability and health; communications equipment and services to connect with service providers, prospective landlords and employers; payments toward security deposits and resources to increase housing options; and other assistance as VA determines necessary.

During the public health emergency, having this authorization transformed VA's effectiveness and efficiency in service provision to homeless Veterans. Before this authorization, VA could not use funds to provide these essential services or goods and had to rely on donations or community organizations to fill the service gaps, which were not always readily available, and VA is in the same position again today. The inability to consistently meet these gaps in services is disruptive and causes delays in permanent housing placement. VA providers need the continued flexibility and access to critical resources provided by this authority to execute the mission of making Veteran homelessness a rare, brief, and non-recurring experience.

In recent years, VA providers have excelled at reducing Veteran homelessness; however, the Veterans who remained unhoused or at risk often present with complex needs and face unprecedented barriers, such as high cost of food, increased housing costs, and lack of public transportation.

To complete the mission of housing all homeless Veterans is complex and multifaceted, VA needs to broaden its scope of resources and services to homeless Veterans.

VA estimates section 102 would cost a total of approximately \$20.5 million in FY 2024 and \$64.1 million for the 3-year term of this section of the bill. Should Congress continue authorizing VA under this section after the initial three years, VA estimates the 5-year cost would be \$111.5 million, and the 10-year cost would be \$243.4 million.

Section 103 of the bill would create a new 38 U.S.C. § 2070 that would require VA, to the extent practicable, to ensure that Veterans participating in or receiving services from a program under chapter 20 of title 38, U.S.C., have access to telehealth services to which such Veterans are eligible under the laws administered by VA, including by ensuring that telehealth capabilities are available to such Veterans, VA case managers of programs for homeless Veterans authorized under chapter 20, and community-based service providers for homeless Veterans receiving funds from VA through grants or contracts.

VA does not support section 103. In accordance with current practice and previous interpretations, VA is authorized to provide telehealth equipment to Veterans as well as case managers and grantees or contractors.

The proposed bill would only require VA to “ensure that veterans participating in or receiving services from a program under this chapter have access to telehealth

services to which such veterans are eligible under the laws administered by the Secretary” (emphasis added). In other words, VA would have to ensure that Veterans who are eligible for telehealth services can receive telehealth services. In this context, telehealth services are simply a modality for delivering services for which the person is otherwise eligible. It is VA’s longstanding interpretation that the agency has authority to provide internet-enabled devices as contemplated by this section. VA does not have a cost estimate for this section.

Section 201 of the bill would authorize VA, on or before September 30, 2023, to complete any home visit required under 38 U.S.C. § 1720G or 38 C.F.R. part 71 with respect to a Veteran and their caregiver through video conference or other available telehealth modality, if agreed to by the Veteran or caregiver.

VA supports section 201, if amended. VA has resumed providing in-person home visits for the Program of Comprehensive Assistance for Family Caregivers but appreciates the flexibility this section would provide to allow VA, on a case-by-case basis, to conduct virtual visits through video conference or other available telehealth modality until September 30, 2023. As a technical edit, we recommend the bill clarify that VA can complete any home visit required under “such section or part” with respect to Veterans caregivers, as the bill refers to visits under § 1720G or 38 C.F.R. part 71.

Section 301 of the bill would define the term “State home” for purposes of sections 302 and 303 of this bill to have the meaning given that term in 38 U.S.C. § 101(19).

VA has no objection to section 301.

Section 302 of the bill would provide that, during the period between the date of enactment and September 30, 2024, the occupancy rate requirements for State homes for purposes of receiving per diem payments under 38 C.F.R. § 51.40(c) would not apply.

VA supports section 302. This section would provide State homes with flexibility to adjust to changing situations as the public health emergency has ended. This bill would provide State homes an opportunity to continue to receive support through FY 2024 as many of them have had staffing limitations that have affected their ability to maintain the occupancy rate. VA estimates this section would cost a total of approximately \$4 million in FY 2023 and \$29.3 million through September 30, 2024, authorized by this section.

Section 303 of the bill would authorize VA to provide to State homes medicines, personal protective equipment (meaning any protective equipment required to prevent the wearer from contracting an infectious disease, including gloves, N-95 respirator masks, gowns, goggles, face shields, or other equipment required for safety), medical supplies, and any other equipment, supplies, and assistance available to VA.

VA supports section 303, if amended, subject to the availability of appropriations. State homes are generally responsible for ensuring they have the resources to furnish care to Veterans in their facilities, and VA supports their efforts through daily per diem payments for eligible Veterans. We are concerned that, as written, this authority could eventually expand to include support Congress has not otherwise authorized or intended VA to provide.

VA recommends that the legislation be amended to only apply during a declared public health emergency. This would ensure that VA could provide assistance during emergency situations (without the need for a subsequent Act of Congress) but not during times of normal business operations. VA does not have a cost estimate for this section.

S. 1545 Veterans Health Care Freedom Act

This bill would require VA, through the Center for Innovation for Care and Payment (CICP), to carry out a pilot program in a minimum of four VISNs to improve the ability of eligible Veterans to access hospital care, medical services, and extended care services through the “covered care system” (defined as each VA medical facility, health care providers under VCCP and eligible entities or providers that have entered into a Veterans Care Agreement, VCA, under 38 U.S.C. § 1703A) by providing eligible Veterans (meaning those enrolled in VA health care) the ability to choose health care providers.

Section 2(h) would require VA to carry out the pilot program during a three-year period beginning on the date that is one year after the date of enactment. Section 2(h) also would amend 38 U.S.C. § 1703(d) to add a new paragraph that would provide that, beginning on the date that is four years after the date of enactment, Veteran eligibility for VCCP based on the existing five eligibility criteria. VA would furnish care and services to covered Veterans “with the same conditions on the ability of the veteran to choose health care providers” as provided for in this bill. The bill would also amend 38 U.S.C. § 1703A(a)(1) to add a new subparagraph (E) that would state that the requirements in law that care or services can only be furnished under this section when such care or services are not feasibly available from a VA facility or through a contract or sharing agreement would not apply with respect to furnishing care and services under this section beginning on the date that is four years after the date of enactment. Beginning on the date that is four years after the date of enactment, VA would have to furnish care and services to Veterans under chapter 17 of title 38, U.S.C., at VA medical facilities, regardless of whether the facility is in the same VISN as the VISN in which the Veteran resides.

Section 2(i) of the bill would require VA, on a quarterly basis for the first two years following enactment, to submit to Congress a report on the implementation of the pilot program, and one of the reports would have to include a description of the final design of the pilot program. On an annual basis beginning one year after enactment and ending on the date of the conclusion of the pilot program, VA would have to submit to Congress a report on the results of the pilot program.

Section 2(j) would authorize VA, in consultation with Congress, to prescribe regulations to carry out this section. Section 2(k) would state that no additional funds would be authorized to be appropriated to carry out this section, and the amendments made by this section.

VA opposes this bill. We note that this bill appears to misunderstand the authority provided to VA under 38 U.S.C. § 1703A. Section 1703A authorizes VA to enter into VCAs and use VCAs in limited circumstances. These limitations were established because VCAs are not subject to general contracting requirements under the Federal Acquisition Regulations and the VA Acquisition Regulations. Section 1703A is an authority for how VA purchases care, not how or when it authorizes care. The principal statute through which Veterans are authorized to receive community care is 38 U.S.C. § 1703, which established the VCCP. The proposed amendments to § 1703A would undo the careful limitations Congress established to ensure that VCAs are used on a limited basis when conventional procurement options are not available or practical. Further, this bill would radically expand the scope of § 1703A to now control both the authorization of care and the purchasing of care as well, obviating (or at least duplicating) the VCCP authority under section 1703. We strongly recommend against changes to § 1703A without careful consideration of the effects and consequences that would result.

The bill's efforts at modifying 38 U.S.C. § 1703, the VCCP authority, would create significant ambiguity that could have unpredictable effects on Veteran eligibility for community care. Specifically, the bill would reverse all existing criteria for community care eligibility except for permissive eligibility upon the determination by VA that a medical service line is not providing care that complies with VA's standards for quality (under 38 U.S.C. § 1703(e)). VA has strong empirical basis on which it can make future estimates regarding the resources needed for the VCCP. This bill would create a wholesale change in eligibility in ways that would likely make past models for future demand inapplicable, or at least subject to a significantly greater margin for error. Further, prohibiting additional appropriations to carry out the amendments made by this bill would create significant risk of a shortfall of funding if demand for community care increased. In such a situation, VA would be forced to delay care for Veterans when funds cease to be available.

The bill would amend § 1703(d) to require VA to furnish care and services to covered Veterans "with the same conditions on the ability of the veteran to choose health care providers" as provided for in this bill. However, those "conditions on the ability of the veteran to choose health care providers" are not well-defined. For example, section 2(c) would provide that eligible Veterans participating in the pilot program could elect to receive care "at any provider in the covered care system"; however, section 2(d)(2) would require the primary care provider of the eligible Veteran to coordinate with VA and other providers in the covered care system and refer Veterans to specialty care providers as clinically necessary. In this context, it is unclear whether the primary care provider issuing the referral determines which provider sees the patient

or whether the patient determines which provider sees the patient. Further, it seems very likely that designated primary care providers, particularly those who are not VA employees, are unlikely to know how to make referrals within the “covered care system”, and our contracts are not structured in a way to permit them to do so (except in limited circumstances where a bundled set of services has been authorized). If a non-VA provider were selected as the primary care provider, this would make care coordination by VA extremely difficult, or perhaps impossible, which could jeopardize patient care and limit VA’s ability to ensure proper care is being authorized and furnished. Moreover, § 1703(a) would remain unchanged, and paragraph (2) of that subsection requires VA to coordinate the furnishing of care, while paragraph (3) of that subsection states that care and services can only be provided upon VA’s authorization. It is not clear that VA could structure the pilot program consistent with these requirements. This would significantly complicate care coordination efforts and could jeopardize patient care.

There are several elements of VA care that are subject to additional restrictions or eligibility criteria such as dental or domiciliary care. Therefore, allowing Veterans to select their own provider could produce significant complications in verifying that such care is statutorily authorized. If enacted, Veterans could choose certain providers for certain care, and receive a referral for that care, before VA could determine whether or not the Veteran was eligible for such care. This could produce confusion and frustration for Veterans and providers.

We also note that the language regarding the eligibility of Veterans to elect to receive care outside their home VISN, this currently happens today in many situations, particularly when Veterans are located along the border of two VISNs. Further, in the pilot program phase of this authority, it is unclear how this would affect a Veteran’s ability to elect to receive care from a VISN that isn’t participating. Similarly, it is unclear whether this is intended to authorize additional beneficiary travel payments when Veterans elect to receive care at a different location. We note the bill would not alter VA’s authority to furnish beneficiary travel payments, which are generally limited only to the nearest VA facility.

To the extent that it is the drafter’s intent to allow non-VA providers to authorize and approve care at VA expense, this would allow non-governmental employees to commit VA resources, which raises significant concerns regarding fiscal responsibility and accountability. This would further exacerbate the concerns noted previously regarding budget predictions and accuracy would seemingly increase the risk of a shortfall in funding that would lead to curtailing and delaying care for eligible Veterans. Additionally, VA’s contracts with TPAs are not designed to facilitate the type of network that this bill would seemingly envision; VA is in the beginning stages of pursuing the second generation of Community Care Network (CCN) contracts, but if this bill were enacted, those efforts would need to be revised significantly to account for this future program. Assuming that VA could find vendors willing to bid on such a revised contract, this could delay VA’s ability to operate with a full and complete network of providers. Further complicating this issue, VA does not just rely on its CCN TPAs to furnish care –

through VCAs and local contracts, VA supplements the TPAs' network of providers. It would be extremely difficult if not impossible to integrate these providers into the "covered care system" described in this bill.

We have additional concerns with other specific provisions in the bill. For example, the bill refers to carrying out a pilot program through CICP, but it is not clear if this is intended to mean that the pilot program would involve a waiver request submitted to Congress for approval and otherwise subject to the limitations set forth in 38 U.S.C. § 1703E. Section 1703E(g)(2) generally prohibits VA from expending more than \$50 million in any FY in carrying out pilot programs, and this proposal would almost certainly exceed that amount. It also is not clear that this proposal would meet the requirements of § 1703E(a)(3)(B), which requires VA to test payment and service delivery models to determine whether such models create cost savings for the Department. The pilot program proposed in this bill seems unlikely to do so.

The bill's reporting and briefing requirements under section 2(i) would represent additional administrative expense for the Department. Section 2(j), which would authorize VA, in consultation with Congress, to prescribe regulations, is ambiguous as to its intended effect. VA would almost certainly need regulations to implement the pilot program, and it would need to promulgate regulations to reflect the changes that would be made to § 1703. However, this provision of the bill seems to condition VA's prescribing of regulations to only what is done in consultation with Congress. During the drafting and development phase of the rulemaking process, much of the work is considered pre-decisional and deliberative in nature. It is unclear what level of "consultation" is intended, and at some point, that level of involvement could present challenges in terms of fulfilling the Secretary's responsibility to execute and carry out the law. Section 2(g) would require VA to furnish to eligible Veterans information on cost sharing, but other than VA copayments, there are no cost shares associated with care for VA enrollees. It is unclear if this reference is intended to authorize VA to impose additional cost shares or not.

Regarding extended care services, VA generally requires Veterans receiving nursing home care (whether in a VA community living center, a State nursing home, or a community residential center) to receive their primary care from the institutional providers to ensure there is no duplication of services and to avoid fragmentation of care. By including extended care services within the scope of this bill, the language could create situations where such care cannot be coordinated effectively, increasing the risk of adverse outcomes for Veterans while increasing costs to VA.

There are several technical issues with the bill. First, the bill does not address when or how a Veteran could elect to change their designated primary care provider (who could be a specialty care provider). If Veterans could regularly change their provider, this would further complicate administration and would make it more likely that Veteran care would be fragmented.

VA notes that the VA MISSION Act of 2018 (the MISSION Act) was enacted just over five years ago and has been in effect for just over four years. This bill would, in large measure, represent an abandonment of the principles and rationale of the MISSION Act. We do not believe that is an appropriate course of action.

VA does not have a cost estimate for this bill but is concerned that this could have a significant and unpredictable effect on demand; when combined with the prohibition on the authorization of additional appropriations, this puts at peril VA's ability to carry out the VCCP and furnish Veterans community care.

S. 1612 Reimburse Veterans for Domiciliary Care Act

Section 2(a) of this bill would require VA, within 90 days of enactment, to prescribe and publish in the Federal Register a proposed rule implementing section 3007(a) of the Isakson-Roe Act (38 U.S.C. § 1741, note). Section 3007(a) of the Isakson-Roe Act required VA to modify 38 C.F.R. § 51.51(b) to provide VA the authority to waive the requirements under that provision for a Veteran to be eligible for per diem payments for domiciliary care at a State home if the Veteran has not met fewer than four of the requirements in such section or such waiver would be in the best interest of the Veteran. Section 2(b) of the bill would require VA, within 180 days of the publication of the initial rule (or 260 days from enactment, whichever occurs first) to prescribe and publish in the Federal Register a final rule implementing section 3007(a) of the Isakson-Roe Act. Section 2(c) of the bill would require that, in prescribing the proposed and final rules, VA would have to ensure that VA's authority to provide payments to State homes pursuant to these rules is retroactive to January 5, 2021.

VA does not support this bill. This bill is unnecessary because VA is actively working on this regulation, which proposes to amend its medical regulations and State Veterans Home (State home) regulations that govern the eligibility for domiciliary care.

S. 1828 Veterans Homecare Choice Act of 2023

Section 2 of this bill would amend 38 U.S.C. § 1703 in two ways. First, it would amend subsection (c), which defines eligible entities and providers for purposes of the VCCP, to include any nurse registry, including any registered nurse, licensed practical nurse, certified nursing assistant, home health aide, companion, or homemaker furnishing services through a nurse registry. Second, it would define the term "nurse registry" in a new subsection (o)(3) to mean a person that satisfies any applicable State licensure requirement and that procures, or attempts to procure, contracts or other agreements on behalf of registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers under which such individuals can provide health care-related or assistive services and receive compensation for such services.

VA does not support this bill. This bill's addition of nurse registries under § 1703(c) would likely have no significant effect on the VCCP because nurse registries

already are an eligible entity or provider. Any entity or provider that is potentially an eligible entity or provider must enter into an agreement with VA to furnish covered health care services and comply with the terms of that agreement and any applicable laws and regulations. Being an eligible entity or provider does not mean that such entity or provider is participating under the VCCP.

However, VA understands that some State laws (such as Florida) require providers in a nurse registry to be independent contractors that have agreements directly with the patient. It is unclear how VA would contract with the registry instead of the provider and still provide protections to Veterans with billing issues from independent contractors. This could present complications that would make the attempted inclusion of nurse registries, at least as described in this bill, more difficult.

The requirement that a nurse registry be a person that “satisfies any applicable State licensure requirement” could raise concerns that such persons would not meet the same standards required by other providers. Licensure requirements can vary greatly by State, and a State’s requirement for nurse registry license alone may not provide enough oversight of these providers. Florida law, for example, appears to preclude any such oversight, where it states that “A nurse registry may not monitor, supervise, manage, or train a registered nurse, licensed practical nurse, certified nursing assistant, companion or homemaker, or home health aide referred for contract under this chapter.” See 2022 Florida Statutes, § 400.506(19). In this case, VA contracts would need to provide additional requirements to ensure patient safety that may be uniquely applicable to these registries.

We also have several technical concerns with the bill, some of which raise substantive concerns about the possible effects of the bill if enacted. The term “companion”, for example, is undefined, and the intended effect of its inclusion is unclear. Additionally, the term “nurse registry” is defined to mean a person, while we believe in most situations the registry would be an entity. Further, a person or entity that “procures, or attempts to procure, contracts or other agreements on behalf” of nurses or other providers could potentially include a much broader category of organizations than is intended—labor unions or employment companies, for example, would seem to fit this description. Finally, the term “health care-related or assistive services” is undefined, and these may include services that are not hospital care, medical services, or extended care services (which is all that can be provided under the VCCP pursuant to § 1703).

VA does not have a cost estimate for this bill.

S. 1954 Improving Whole Health for Veterans with Chronic Conditions Act

Section 2 of the draft bill would express the sense of Congress regarding VA care providing better outcomes at lower costs, the consequences of poor dental care on diabetes and heart disease, and the consequences of such conditions. Section 3 of the draft bill would define the term “covered care” to mean dental care that is comprehensive in nature and consistent with the dental services and treatment

furnished by VA pursuant to 38 U.S.C. § 1712(a)(1)(G). The term “covered veteran” would mean a Veteran who is enrolled in VA health care (or is not enrolled but is otherwise entitled to hospital care and medical services pursuant to § 1705(c)(2)), is not eligible for dental services and treatment and related dental appliances under the laws administered by VA as of the date of enactment, and has a diagnosis of type 1 or type 2 diabetes or ischemic heart disease.

VA defers to Congress regarding section 2 and cites concerns with section 3. VA cites concerns with section 3, specifically with the definition of a covered Veteran. Making eligible any Veteran who “has a diagnosis of—(i) type 1 or type 2 diabetes; or (ii) ischemic heart disease” would seemingly require that the Veteran have a current diagnosis of one of these conditions. If the Veteran’s condition improved such that they no longer had the condition, they would no longer be a covered Veteran. In such a situation, their eligibility under this provision would end. We recommend that in such a scenario, there be a wind-down period to allow for current treatment to continue until the episode of care is complete. We further note concern that providing eligibility for dental benefits based on a diagnosis could unintentionally incentivize Veterans who might otherwise be on the borderline but managing their conditions to allow their condition to worsen to qualify for dental benefits. Additionally, VA is concerned that a focus on certain diagnoses could create health inequities for other Veterans.

Regarding the definition of covered care, the definition would use the term “comprehensive”, but this term itself is not defined. Absent a specific definition, we would apply VA’s existing definition of “comprehensive dental care” from VHA Handbook 1130.01(1) as this is what is available to Veterans pursuant to 38 U.S.C. § 1712(a)(1)(G). In the alternative, we recommend revising the definition of “covered care” to focus instead on providing cost-effective, evidence-based dental care based on community standards that improves their oral health.

Section 4 would require VA, not later than one year after enactment, to carry out a four-year pilot program under which VA would furnish covered care to covered Veterans for the duration of the pilot program. VA would have to carry out the pilot program at each VA medical center and community-based outpatient clinic with an established dental clinic.

VA does not support section 4. VA is currently at maximum operating capacity within its facilities in terms of the number of Veterans it can see, and the expansion of eligibility this bill would create would be far more than VA could accommodate. This additional care would need to be furnished by community providers, which would increase administrative expenses and would also demand more time of VA providers.

Regarding the provision that would require VA to test the efficacy of dental therapists, we note that dental therapists are currently only allowed to practice in various settings in 13 States. Only five schools in three States offer programs that are approved by the American Dental Association Commission on Dental Accreditation. Dental therapists work under the supervision of a dentist and can provide limited dental

treatments. Dental therapists do not receive the extensive training, and clinical experience dentists obtain. Many Veteran patients require the management of multiple physical and mental comorbidities and multiple prescription medications. The average VA dental patient is approximately 58 years old, taking over ten medications, and has a higher caries risk. Allowing Veterans to seek restorative oral health care from a dental therapist poses a potentially significant overall health risk. A licensed dentist's professional education and clinical expertise are essential for the thorough evaluation and comprehensive treatment of patients in VA.

Similar to our earlier concern regarding section 3 and the need for a wind-down period for Veterans who no longer qualify for care under the pilot program, a similar wind-down process may be needed for the end of the pilot program as well to avoid interruptions in care. Otherwise, VA would need to cease authorizing episodes of care that would extend beyond the period of the pilot program well in advance of the actual termination date to avoid losing authority to furnish services in the middle of an episode of care.

While the bill purports to authorize VA to collect copayments for covered care, it is unclear how exactly this would operate. Copayments generally apply for Veterans in Priority Group 7 or 8, while dental care is generally for Veterans seeking service-connected care, and VA's regulations at 38 C.F.R. § 17.108(e)(7) state that outpatient dental care provided under 38 U.S.C. § 1712 is not subject to copayment requirements. In this context, if the bill is intended to have VA collect copayments, we recommend a clearer statement of authority in this regard. Similarly, it is unclear whether the limitation in VA's current dental program on the value of care that can be authorized (an amount not to exceed \$1,000) would apply in the context of this pilot program, but we would not read this to include that limit.

Finally, VA would be unable to set up and implement a pilot program of this size and complexity within only one year.

Section 5 would require VA, to ensure it has sufficient staff to provide covered care to covered Veterans, to implement a loan reimbursement program for qualified dentists, dental hygienists, and oral surgeons who agree to be appointed at VA and serve at a dental clinic for a period of not less than the duration of the pilot program under section 4. VA could not reimburse more than \$100,000 for each dentist, \$25,000 for each dental hygienist, and \$40,000 for each credentialed Doctor of Medicine in dentistry serving as an oral surgeon and participating in the program. VA could reimburse an individual serving in multiple positions not more than \$140,000.

VA does not support section 5. VA already has two education loan repayment programs that can be leveraged for recruitment and retention of dentists, dental hygienists, and doctors of medicine in dentistry serving as oral surgeons. VA believes that the current Education Debt Reduction Program (EDRP) would be a more effective means to offer incentives for recruitment than the proposed authority here. The Student Loan Repayment Program could also be used for hybrid Title 38 positions as well. The

Education Debt Reduction Program (EDRP) provides reimbursement of qualifying education loan debt up to \$200,000 over a five-year service period for direct patient care providers (Title 38 and Hybrid Title 38 employees), and the Student Loan Repayment Program (SLRP) can be used to repay up to \$100,000 in education loan debt (Hybrid Title 38 and Title 5 employees). A loan repayment program specifically for dentists, dental hygienists, and doctors of medicine serving as oral surgeons, as outlined in section 5, would create disparity in loan repayment amounts and additional administrative burden to manage a separate loan repayment program.

We note that the timing of section 5 may not align well with the timing for section 4. Specifically, section 4 would require VA to begin the pilot program within one year of enactment. If VA were to commence the pilot program within one year, it is unlikely that it would be able to make awards for loan reimbursement under section 5 to support the delivery of care under the pilot program.

Section 6 would authorize to be appropriated for FY 2024 such sums as may be necessary to carry out this Act. The amount authorized to be appropriated would be available for obligation for the eight-year period beginning on the date that is one year after the date of enactment.

VA has no objection to section 6.

S. XXXX Leveraging Integrated Networks in Communities for Veterans Act (LINC VA Act)

Section 2(a) of this draft bill would require, not later than one year after the date on which VA submits to Congress the report required by section 201(k)(1) of the Hannon Act (38 U.S.C. § 1720F, note), VA's Center for Innovation for Care and Payment to carry out a pilot program under which VA would establish community integration network infrastructure to provide services for Veterans.

Section 2(h)(1) would define the term "community integration network infrastructure" to mean infrastructure used to enable the coordination, alignment, and connection of covered entities for purposes of communication, service coordination, and referral management of services, with respect to services such as nutritional assistance, housing, health care (including preventive health intervention, chronic disease management, and behavioral health care), transportation, job training, child development or care, caregiving and respite care, disability assistance, and other services as determined by VA.

Section 2(h)(2) would define the term "covered entity to mean any community-based organization that accepts referrals from health care organizations and that provide various services (such as nutritional assistance, housing, health care (including preventive health intervention, chronic disease management, and behavioral health care), transportation, job training, child development or care, caregiving and respite care, and disability assistance); public or private health care provider organizations;

public or private funded payors of health care services (including home- or community-based services); State, local, territorial, or Tribal health and social services agencies; State public housing authorities or housing finance agencies; public health information exchanges or public health information networks as defined by VA; or other similar entities as determined by VA.

Section 2(b) would require VA, in carrying out the pilot program, to establish a new or enhance an existing interoperable technology network that includes certain defined functions.

Section 2(c) would require VA to carry out the pilot program at not fewer than one facility in each VISN.

Section 2(d) would require VA, in carrying out the pilot program, to coordinate with existing community networks.

Section 2(e) would require VA to track the accuracy of referrals of Veterans to community networks under the pilot program, the response time of providers to which such Veterans are referred, and the outcome of the initial meeting between a Veteran and a provider.

Section 2(f) would require VA, not later than three years after amounts are first appropriated to carry out the pilot program, to submit to Congress a report indicating the social service needs of Veterans reflected by the use of services under the community integration network infrastructure established under the pilot program.

Section 2(g) would require the Comptroller General to conduct an evaluation that measures the overall impact of the community integration network infrastructure with respect to changes in individual and population health outcomes among Veterans, changes in access to health care or social services among Veterans, and such other factors as the Comptroller General considers appropriate.

VA does not support section 2. We agree with the areas of focus identified in the bill, but there are several key undefined elements of this pilot program. The bill describes a wide range of potential entities that could participate; however, it is not clear if Congress intended VA to vet or review role prior to an entity's use of or access to the interoperable technology network. Similarly, if the intent is to ensure that only enrolled Veterans are participating in the pilot program, for example, we would have a clear means of ensuring VA can provide such support and services. If this is intended to allow any Veteran or former Service member to use these resources, it is unclear whether VA would need to evaluate and determine eligibility, and if so, how it would do so. It is unclear if the pilot program is meant to operate by VA referring Veterans to specific providers or if this is intended to be a self-referral model, and if the latter, the tracking requirements in subsection (e) would likely be very difficult to meet. Whether VA would be referring Veterans or not, it is unclear whether the bill assumes that VA would have a

role in vetting organizations or providers participating in the network, and if so, how VA would do so fairly and competently.

It is unclear if organizations would need to have a license or be approved through some type of accreditation process to ensure that Veterans are accessing safe, legitimate, and quality service providers; this would make sense, but would involve significant administrative expense in areas where VA has comparatively little experience. It is similarly unclear what level of participation or interest there would be among potential community organizations and providers; it may make more sense to conduct a market assessment or analysis before requiring VA to construct and operate a network if no entities or providers are interested in participating in the first place. Finally, the intended outcomes are not clear. Presumably, facilitating connections between Veterans and providers, and between different providers, is intended to provide a greater network of support for Veterans and their families, but it is not clear how VA would measure these outcomes. Again, given the societal nature of many of the issues addressed in the bill, defining discrete outcomes or metrics would likely be difficult and imprecise.

Beyond these general concerns, the bill presents implementation challenges for VA in several areas. First, the bill is unclear as to whether VA would be able to establish the type of network required by section 2(b) of the bill, particularly within one year of enactment. The type of interoperable technology network could be incredibly complex and expensive to develop, implement, and maintain, given the variability in terms of services, providers, and resources of those providers to meet the needs of Veterans participating in this program. Given the responsibilities of other Federal agencies, as well as local and State governments, integration and coordination are critical. The impact to IT development and sustainment resources would be significant and, if not fully funded in addition to existing priorities, would likely be devastating to other projects. The specificity of the bill in several areas—for example, identifying specific ICD-10 codes—would exacerbate the difficulty of implementation and increase cost.

VA notes that the bill would require compliance with applicable Federal and State privacy laws, but the bill is unclear as to whether this applies to VA or only to non-VA parties using the exchange.

We would appreciate the opportunity to discuss the intent of this proposal. VA built a process to screen Veterans for needs regarding social determinants of health through the Assessing Circumstances & Offering Resources for Needs (ACORN) Initiative, which is being piloted in over 20 VAMCs. This effort is currently in a pilot phase but has already completed more than 5,000 screens.

Section 3 would require VA to collect from Veterans enrolled in VA care, as part of routine screenings conducted under the laws administered by VA, information related to social determinants that may factor into the health of such Veterans. The information would have to include standardized definitions for identifying social determinants of health needs identified in the ICD-10 diagnostic codes Z55 through Z63, Z65, and Z75

(as in effect on the date of enactment). The definitions would have to incorporate measures for quantifying the relative severity of any such social determinant of health need identified in an individual.

VA does not support section 3. VA does not have the capacity to collect the data required by this section, as this would require Bidirectional Health Information Exchange (BHIE) capabilities with community facilities, which would likely come at significant expense. Also, as noted above, VA's efforts through the ACORN Initiative may already address some of the intended outcome of this section. VA believes it would be more prudent to wait for the results of this effort before imposing system-wide requirements that may present cost and implementation challenges without being more effective.

Section 4 would require VA, in implementing this Act, to consider data privacy and how to prevent data blocking and promote interoperability.

VA does not support section 4. Although VA supports the intent of section 4, VA does not support other sections of this bill to which section 4 would apply. VA supports the protection of Veterans' privacy and information security, however, because section 4 would apply to the program required by section 2, and VA has concerns with section 2, VA does not support this section. Additionally, VA notes several areas where section 4 is incomplete.

First, the pilot program required by section 2 would require the disclosure of personally identifiable information (PII) and protected health information (PHI) to community networks that are non-health care providers for purposes beyond treatment of the Veteran (e.g., job training). VHA, as a covered entity under the Health Insurance Portability and Accountability Act, is required to have legal authority to make such disclosures of PHI. This section, as drafted, does not provide such authority and would likely require VHA to obtain signed, written authorizations from the Veterans participating in the pilot program for disclosure to each entity or for each purpose; this could hinder the success or the ability of the pilot to determine its true effectiveness (beyond the reasons previously articulated). Second, the administrative overhead of obtaining signed, written authorizations and developing an electronic system for storing the authorization to allow an easy mechanism for checking the validity of those authorization before sharing any PHI with the community networks could be considerable.

S. XXXX Making Community Care Work for Veterans Act of 2023

The draft "Making Community Care Work for Veterans Act of 2023" consists of 3 titles and 22 substantive sections.

Section 101 of the bill would amend 38 U.S.C. § 1703 by adding a new subsection (m) regarding the scheduling of appointments. Specifically, this would require VA to ensure that an appointment for a covered Veteran for care or services under the VCCP is scheduled for non-urgent appointments within seven days of the

date on which a VA clinician determined the care was needed or the Veteran presents to VA requesting care, whichever is sooner. For urgent care, VA would have to ensure appointments are scheduled within 48 hours instead of seven days. VA would have to submit to Congress quarterly reports on the average time it takes each VA medical facility to schedule appointments for care or services, broken out by primary care, mental health care, and each type of specialty care. Any facility whose average time is more than seven days would have to submit to the USH an explanation for why the average time is more than seven days, a remediation plan to bring the average time down to at least seven days, and an explanation for how each issue identified as a factor for the delay in scheduling is being mitigated. If the USH determined an explanation was insufficient, the USH would have to consult with any TPAs responsible for administering the network on how network insufficiency can be overcome and examine whether the TPA is meeting contractual obligations. VA would have to comply with these requirements within 60 days of enactment.

VA does not support section 101. The scheduling standard of seven-days that would be required by this bill would create significant operational challenges for VA. Currently, only a small number of sites could meet the seven-day standard. The current average across the system is 28 days. The key reasons most facilities are unable to schedule community care consults within seven days are: (1) the consult forwarding timeline (as schedulers cannot create appointments they cannot see); (2) communications regarding community care appointments taking more than two or three days (even for self-scheduled consults) and (3) staffing shortages within community care teams. Consults forwarded from an internal service to community care are included in this measure, and this processing time needs to be considered as well. If the seven-day timeline only started once the consult was received by the community care team, VA could meet that requirement. VA does not support this section for several reasons.

First, VA would need to implement changes in systems and processes, and possibly in contracts, before sites could consistently meet the seven-day standard. VA could not complete the work required to implement these changes within 60 days of enactment. Second, it is unclear what the consequences are if VA is unable to ensure an appointment is scheduled within these timeframes.

Third, the scope of this section is unclear. Neither the term “urgent appointment” nor “non-urgent appointment” is defined, so VA would need to interpret these phrases, likely based on clinical determinations. However, what constitutes “urgent” care can vary across different specialties. When a Veteran presents to VA, additional clinical evaluations may be needed to determine in the first place whether the appointment is an urgent one or not, but this time does not appear to be contemplated within the prescribed timelines. We also note that the term “urgent” could create ambiguity given its use in other contexts (such as under 38 C.F.R. § 17.4600, implementing the walk-in care authority under 38 U.S.C. § 1725A). In VA’s electronic health records (EHR), in the Cerner system, “urgent” is used to refer to consults that need to be completed within 72 hours, and “STAT” consults need to be completed within 24 hours. There is no

similar “urgent” consult status in VA’s Computerized Patient Record System (CPRS), which would need to be updated to account for this.

Section 102 would amend 38 U.S.C. § 1703B to expand and codify VA’s existing access standards established in regulation at 38 C.F.R. § 17.4040. Specifically, section 102 would create a new section 1703B(a) that would provide that covered Veterans would be eligible to elect to receive non-VA hospital care, medical services, or extended care services if VA determined it was unable to schedule an appointment within its designated access standards. Section 102 would also amend the current requirement that VA meet the access standards when furnishing care and services through the VCCP by allowing health care providers who are not covered by a TPA to request a waiver to this requirement.

VA does not support section 102. VA generally opposes 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 section fails to consider other market forces that also impact access to care outside of VA and would not allow VA to consider and incorporate those forces to meet Veterans’ needs for timely, high-quality care.

VA appreciates the provision that would grant an opportunity for providers who are not covered by a TPA to request an exemption from the access standards. This requirement was imposed through section 125 of the Cleland-Dole Act, and as VA has expressed to the Committee, this would prove extremely difficult, if not impossible, for such providers to meet. We have technical recommendations on how to ensure this language works appropriately to reduce the burden on such providers while ensuring Veterans are able to access timely, appropriate care close to home. This language, for example, would still require providers to request a waiver, versus allowing VA to waive requirements on behalf of providers for whom compliance with these standards (particularly the average drive time standards) would be difficult or impossible.

Section 103 would amend 38 U.S.C. § 1703(d) to add a new paragraph (4) that would require VA, in determining whether it could schedule an appointment within the access standards established under § 1703B, to only consider the availability of a telehealth appointment if the Veteran accepts the use of telehealth.

VA supports section 103. VA appreciates and fully supports the requirement that, in making determinations about scheduling appointments, VA must consider a telehealth appointment. This is consistent with VA’s interest in accommodating a Veteran’s interest in receiving a telehealth appointment.

Section 104 would amend 38 U.S.C. § 1703(d) to establish that an agreement by a covered Veteran and the referring provider under § 1703 regarding the best medical interest of the covered Veteran is final and not subject to review or approval by VA. Covered Veterans and their referring clinicians could correct any errors made with respect to an agreement.

VA does not support section 104. 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 provider 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 section 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 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 105(a) would amend 38 U.S.C. § 1151(a) by adding a paragraph that would require VA to pay compensation if a Veteran's disability or death was caused by hospital care or medical services furnished under proposed section 1703 of title 38, United States Code, and the proximate cause of the disability or death was carelessness, negligence, lack of proper skill, error in judgment, or similar instance of fault by the provider or an event not reasonably foreseeable. Section 105(b) would create new 38 U.S.C. § 1151(d) that would provide the amount of any judgment awarded to an individual in a civil action brought by the individual against a non-VA provider in a court of competent jurisdiction for a disability or death caused by hospital care, medical services, or an extended care services furnished by a non-VA provider would be offset by the amount of any compensation awarded to the individual under such subsection for such disability or death.

VA does not support section 105. Veterans and survivors injured by non-VA providers have remedies available through the common law torts system. Non-VA providers have financial liability protection available through malpractice or professional liability insurance coverage. By inserting the potential for recovery under the VA disability compensation program into cases where non-VA providers harm their patients or clients, this amendment may shield both those providers and their insurers from the consequences of their actions. Doing so may shift the economic burden of those consequences from the persons who cause harm and insurance companies to the

taxpayers. Insurers of community care providers could receive a windfall if Veterans or their survivors choose to pursue benefits under § 1151 in lieu of civil tort litigation. That potential is not remote: the evidentiary standard for establishing entitlement to VA benefits (claimants receive the benefit of the doubt when the evidence is at least approximately balanced or nearly equal on a material fact) is lower than the standard generally required in civil tort actions (where plaintiffs must establish elements by a preponderance of the evidence), and the VA disability claim adjudication system is paternalistic whereas civil litigation is adversarial in nature.

Second, by having VA assume a community care provider's liability, section 105 could change the nature of the VA-community care provider relationship such that the non-VA community care provider may be viewed by courts as an "employee." This could result in other unforeseen and potentially detrimental changes to the VA-community care provider relationship. 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 (or, as could be the case here, Federal employees). This proposal could change the obligations imposed upon these providers.

Third, VA benefits claims processors would have to develop evidence regarding alleged insufficient care furnished by non-VA parties. This would almost certainly increase VA's administrative demands and slow the processing of other Veterans' benefits claims. Moreover, non-VA providers may be reluctant or unwilling to provide evidence necessary to properly process claims under § 1151, particularly when the facts involved in civil tort litigation relate to the alleged harm at issue in the § 1151 claim.

Finally, this section would make VA liable for the negligence of a non-VA provider or an unforeseeable event while under a non-VA provider's care. That concept is in tension with the basic principle that negligent parties should be held responsible and bear the financial liability for the consequences of their conduct. That principle has evolved, at least in part, to ensure that parties are incentivized to exercise appropriate caution and skill in their endeavors. By effectively shifting financial liability from non-VA community care providers to VA, section 105 diminishes that principle and could detrimentally impact the level of diligence exercised by non-VA providers and negatively impact the nature of the care they provide to Veterans.

Section 106 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.

VA does not support section 106. VA's contracts for community care generally include a 180-day timely filing requirement. Providers are aware of the 180-day timely filing requirement when agreeing to their contracts with the TPAs. Additionally, section 142 of the recently-enacted Cleland-Dole Act amended 38 U.S.C. § 1725 to require 180 days for timely filing, which is consistent with current section 1703D. 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 107 would require VA to carry out a program under which VA could furnish outpatient services through a VCCP provider to a covered Veteran who is eligible for such services under criteria established by VA and chooses to self-refer for routine vaccinations and routine vision and hearing services.

VA does not support section 107. The-referral model creates a greater risk of Veterans visiting providers who are no longer participating in the VCCP, which would result in Veterans being billed directly for these services. When VA authorizes and schedules care, Veterans know that the provider they are visiting is in VA's network and will bill VA for the care provided (or at least that VA will be responsible for paying for the care provided). Every day, providers join and leave the network, so a provider that a Veteran had been seeing who was in VA's network may not be if the Veteran self-refers for another appointment. Additionally, the term "routine" is used to describe both vaccinations and vision and hearing services, but this could create some confusion as to the scope of benefits. Vaccines, for example, could be administered on a routine basis (e.g., preventative) or on a therapeutic basis (e.g., curative), such as when a tetanus shot is administered after a person steps on a rusted nail. The language of the bill would not seemingly cover this therapeutic treatment. We also note the scope of "vision and hearing services" is not defined; for example, it is unclear whether, for example, these are intended to include only examinations or if items such as eyeglasses or hearing aids are also intended to be included and furnished by non-VA providers. If the latter, this could significantly expand the parameters of this program and result in additional costs to VA.

Finally, the MISSION Act was enacted to consolidate and simplify community care eligibility, which became overly confusing and costly for Veterans and VA. In creating a parallel authority for the receipt of community care, this proposal would be a step back toward what the MISSION Act was intended to fix.

Section 108 would require VA, within 60 days from enactment and monthly thereafter, to submit to Congress a report containing information on the timeliness of referrals for non-VA care by calculating a number of specific steps in the process.

VA supports section 108, if amended. VA generally supports this section but is concerned that VA may not be able to produce data for the entirety of the previous month due to lags in collecting and validating some data. VA recommends a timeline of 180 days for the first report, as the 60-day timeline would be very challenging to meet., VA wants to ensure that data reported on a monthly basis reflect longitudinal trends, rather than simply point-in-time numbers. VA welcomes the opportunity to provide additional technical assistance on this section. VA does not estimate there would be any costs associated with this section.

Section 109 would require VA, within one year of enactment, to require that covered providers submit to VA data required to be collected and considered by VA pursuant to VA's standards for quality (under 38 U.S.C. § 1703C). If a covered provider did not provide these data to VA, VA could not permit the covered provider to participate in the VCCP. VA would have to encourage other, non-covered providers to submit such data on a voluntary basis. VA would have to publish and maintain online an up-to-date list of all health care providers that have provided such data and that are high-performing providers, as determined by VA.

VA does not support section 109. VA has several concerns with this section. First, VA would have to identify covered providers who would be required to provide such data as a condition for participation in the VCCP. VA's determination would be based on providers VA has determined have "sufficient resources to submit the data required". This would likely only be our largest providers, such as health care systems or hospital systems. However, these providers are also often among our busiest providers and those most integral to ensuring Veterans have timely, quality care close to home. Imposing additional requirements on these providers could result in abrasion or refusal to participate in the VCCP, which would result in fewer options for care for Veterans. Second, any requirements to exclude certain providers from the existing TPA contracts would require bilateral contract modifications, which would likely prove costly to VA and could jeopardize network adequacy if such large providers are unwilling to collect and report these data.

VA cannot provide a cost estimate for this section because it would require contract modifications that would have to be agreed to by VA and non-VA parties.

Section 110 would require VA to establish a program under which VA would provide a "High Compliance" rating for community providers who comply with three specified requirements VA could provide a financial incentive for community care providers with a "High Compliance" rating. VA would have to establish a plan to promote this program and to encourage the participation of community care providers in the program.

VA cites concerns with section 110. VA is concerned that this program could create provider abrasion, as it would require providers to complete additional training and submit a certain percentage of medical records within established time periods that are not generally consistent with industry standards. The percentage requirement could disadvantage smaller providers who see fewer patients, in which case a single late submission could prevent their qualifying as a High Compliance provider. The bill would permit VA to provide financial incentives for providers who achieve a “High Compliance” rating, and we believe this would likely be necessary given the additional effort involved; however, it is unclear the contractual mechanism by which these incentives would or could be applied to providers themselves (versus incentivizing the TPAs to incentivize certain providers’ behavior).

We are unsure what such requirements would cost because this would need to be negotiated bilaterally. It also is not clear that many Veterans would value a provider who meets the requirements of being a “High Compliance” provider more than one who does not. It seems unlikely that most Veterans would care whether medical documentation is submitted back to VA within 15 or 20 days of completion of treatment, for example. Maintaining a list of these providers would also require additional administrative resources, which could detract from care delivery.

Section 111 would require VA, in consultation with HHS and the National Coordinator for Health Information Technology, to create an implementation plan for VA to adopt national interoperability standards for the electronic transfer of health information, including information used to inform quality metrics, between VA and community providers. Within 180 days of enactment, VA would have to submit to Congress a report on this plan, including a timeline for adopting interoperability standards and an indication of any resources VA may request from Congress to implement such standards.

VA supports section 111 with amendments. VA supports standards with all health information exchange participants however, VA does not believe 180 days would be a realistic timeline to develop a plan given the involvement of the TPAs. We recommend this be extended to at least a one-year period. We also note that the plan would likely need to include exceptions for small providers, particularly those in rural areas, who may not have adopted electronic health records. We recommend this provide flexibility for this plan to adopt standards, as practicable. Finally, we recommend an analysis of VA and provider participation in the Trusted Exchange Framework and Common Agreement instead of, or in addition to, the standards evaluation.

Section 112 would require VA, within one year of enactment, to complete an analysis of the feasibility and advisability of establishing a community care network for the provision of care to Veterans in the Republic of the Philippines. Within 180 days of the completion of this analysis, VA would have to submit to Congress a report on this analysis and including various assessments.

VA supports section 112. VA agrees that an analysis and report of the feasibility and advisability of such a network would be helpful. We do not estimate any

additional costs would be incurred for this analysis, as VA could complete this analysis within existing resources.

Section 113 would require VA, not later than 180 days after enactment, to carry out a two-year pilot program to test the efficacy of hiring general dentists at the facility level to manage approval by VA of treatment plans requested by dental providers in providing community care and hiring dental specialist at the VISN level to aid in approving treatment plans requested by community dental providers.

VA does not support section 113. This section is unnecessary, as several facilities have already hired general dentists to manage community care consults. At the VISN level, we are not sure about the intent, as there are multiple dental specialties, and this section could create confusion as to reporting. If instead the intent is to reduce burden on dentists in the clinical setting, VA could hire more general dentists and other dental allied health personnel (dental assistants and hygienists).

Section 114 would require VA to conduct a review of rate waivers for TPAs under the VCCP to identify whether those waivers are helping to alleviate community-specific challenges, including scarcity of medical services associated with access to care.

VA cites concerns section 114. VA does not track the data this report would require in an easily reportable format. This would result in additional costs to VA (including potentially the costs of contract modifications). Subject to the availability of appropriations, VA has no objection to providing additional information to Congress.

We note as a technical matter that subsection (a) only appears to require a single review, but subsection (c) would require annual reports on the results of the review. Either subsection (a) should be amended to require VA to conduct annual reviews or subsection (c) should be amended to only require a single report.

Section 115 would require the Comptroller General to submit to Congress a report on dental care furnished by VA under the VCCP.

VA defers to the Comptroller General on section 115.

Section 201 would create a new subchapter X in chapter 76 of title 38, U.S.C., called the Start and Stay at VA Program. Under a new § 7699C-1, as part of the Educational Assistance Program, VA would have to carry out a program to provide scholarships (consisting of the payment of reasonable educational expenses to VA employees serving as a medical support assistant (MSA), advanced MSA, lead MSA, or supervisory MSA who have been employed by VA in one or more of those positions for at least two years, who have been accepted for enrollment or are enrolled as a student in certain courses of education or training (such as those listed as a requirement for any hard-to-hire or hard-to-recruit positions, those the completion of which results in any other degree or certification that VA considers appropriate for purposes of the program, and those related to business, health care administration, or human resources), and who have a record of VA employment that demonstrates a high likelihood the individual

will be successful in completing the course of education or training and in gaining employment in a field related to such course of education or training.

Under a new § 7699C-2, VA could also provide lump-sum education debt reduction to eligible individuals to consist of payment of principal and interest under student loans. In exchange for a one-time lump sum payment, participants would agree to be employed for at least three years at VA, at least two of which would be served in the position of MSA, advanced MSA, lead MSA, or supervisory MSA (the remainder of the period could be served in a hard-to-hire or hard-to-recruit position). Participants would be liable for breach of their service agreements.

A new § 7699C-3 would require VA to develop an outreach program to Tribal Colleges and Universities, historically Black colleges and universities, high schools in rural areas, community colleges, transition assistance programs for members of the Armed Forces, and spouses of such members.

VA does not support section 201. Though VA has provided technical assistance on this section, we believe VA's current incentives (scholarship programs, debt reduction, other recruitment, retention, and relocation incentives) provide sufficient incentives for VA staff. More specifically, the Student Loan Repayment Program (SLRP) provides broader support than these sections would authorize, as the SLRP is currently utilized for a range of professions, including MSAs. Between 2020 and 2022, we have seen a significant increase (more than 400 percent) in use of this program for MSAs. Additionally, VA has given more than 200 Employee Incentive Scholarship Program (EISP) awards for MSAs since 2019.

Section 202 would amend 38 U.S.C. § 7673(c) to increase the number of allowable years under the Employee Incentive Scholarship Program (EISP) from six school years to eight school years and from the equivalent of three years of full-time coursework to four such years.

VA supports section 202, with amendments, subject to the availability of appropriations. VA supports this section, but there are additional amendments that would be needed to ensure this section has its intended effect (specifically 38 USC § 7672(e)(A) and (B), § 7673(b)(1) and (c)). VA recommends an amendment to ensure the amount authorized is in alignment with other authorities.

This has a 5-year cost of \$48.9 million for both New & Current scholarship recipients.

Section 203 would authorize VA to establish a program to connect covered individuals with peer mentors to facilitate sharing of best practices and leadership experiences and to foster opportunities to develop knowledge and skills needed to lead VA medical facilities successfully. Within one year of enactment, and annually for three years, VA would have to submit to Congress a report on the mentorship program.

VA supports section 203, if amended. Section 203 would provide the opportunity to continually improve the VA medical center leadership workforce. Moreover, this section would afford the opportunity to spread best practices while using field-based evidence. This section would promote and build network opportunities between new and seasoned medical center directors while promoting High Reliability Organization principles across the VHA enterprise. VA recommends removing or clarifying the phrase “across the Department” in subsection (e)(5). VA estimates section 203 would cost approximately \$537,600 in FY 2024, \$3.3 million over five years, and \$8.6 million over ten years.

Section 301 would add a new 38 U.S.C. § 1706B that would establish a requirement that VA ensure appointments scheduled at VA facilities are scheduled for non-urgent appointments within seven days of the date on which a VA clinician determined the care was needed or the Veteran presents to VA requesting care, whichever is sooner. For urgent care, VA would have to ensure appointments are scheduled within 48 hours instead of seven days. VA would have to comply with these requirements within 60 days of enactment.

VA does not support section 301. There are several issues with this section that create implementation challenges. First, VA would require significant clarification with regard to the definition of “urgent care”, and the application of varying time requirements associated with different types of urgent care. Second, it is unlikely VA would be able to develop this requirement into a functional application within 60 days, as development of an additional requirement would inevitably require software modifications and other administrative actions prior to being applied. Section 302 would amend 38 U.S.C. § 1703C in several ways.

First, it would require VA ensure that the standards for quality are comparable to industry standards to ensure there is adequate transference between care furnished by VA and non-VA providers. Second, it would require VA to collect and consider additional data for purposes of establishing the standards for quality, specifically datasets that include elements relating to equitable care, and measurements of standards for quality that include measurements of the following: the degree to which care is furnished uniquely to patient needs; workforce safety; employee engagement; safety culture; outcomes on patient quality of life; and such other matters as VA considers appropriate.

Third, VA would need to consult with the Indian Health Service in its consultation with all pertinent Federal entities (which currently includes DoD, HHS, and CMS). Fourth, when collecting, considering, and applying data related to patient care for purposes of establishing standards for quality, VA would have to ensure no metric is being over- or under-analyzed.

Fifth, in establishing standards for quality, VA would have to utilize the most current practices in extracting and analyzing relevant data, utilize all relevant data available to VA, ensure the most efficient use of time and resources related to the use of data scientists employed by VA, and collaborate, as appropriate, with all pertinent

Federal entities, entities in the private sector, and other non-governmental entities in establishing the standards for quality.

Sixth, within seven years of enactment, and not less frequently than once every five years thereafter, VA would have to update the standards for quality pursuant to the requirements for establishing such standards set forth in law, as amended. Within 30 days of any update of the standards for quality, VA would have to submit to Congress a report on such updated standards.

Finally, VA would have to publish the quality rating of VA medical facilities on the Hospital Compare website (through CMS) not less frequently once every three years, publish that rating pursuant to VA's standards for quality, and ensure that VA solicits public comment not later than two years after updating the standards for quality.

VA does not support section 302. VA has already taken many of the actions this section would require. VA has aligned its standards for quality with industry standards used by community counterparts, and this is an inherent part of the existing process. Where alignment is possible and appropriate for Veteran care, it has already been undertaken. VA already has existing data sources for most of the areas this section would require VA to include, but it is likely that finding appropriate, accurate, actionable, and comparable community benchmark data at a facility or provider level would be very challenging and untenable in some cases. VA also updates quality ratings for its facilities more often than once every three years.

Though VA has provided technical assistance to this section, VA cites several concerns with specific language in this section. For example, it would also likely be very difficult measure a safety culture for non-VA providers or entities because there is no way to determine if they measure a culture of safety within their organizations, if they subscribe to high-reliability organization principles, how they report patient safety concerns within their organizations, or otherwise exhibit a safety culture.

Section 303 would impose a number of requirements related to VA's Mental Health Residential Rehabilitation Treatment Program (MH RRTP); MH RRTP would be defined to mean the array of VA programs and services that comprise residential care for mental health and substance use disorders (SUD) and includes the programs designated as of the date of enactment as domiciliary residential rehabilitation treatment programs. In general, VA would have to fulfill all requirements under this section within one year of enactment, unless otherwise specified.

VA supports section 303, with amendments, subject to the availability of appropriations. VA agrees with many of the intended outcomes of this section and has already established such requirements through policy. Many of the timelines and procedural requirements are consistent with current practice and policy, and VA currently makes both actual and prospective wait time data available to facility and VISN leadership.

VA generally supports making transportation available to Veterans in need of MH RRTP, as this could address barriers to access for this type of care. VA acknowledges that residential rehabilitation treatment often involves extensive travel; current data indicate that Veterans receiving community residential treatment care are traveling 189 miles on average to access such care.

However, VA cites concerns with several provisions in this section. First, this section refers to Veterans self-referring for MH RRTP care. MH RRTP is a form of domiciliary care, and domiciliary care includes additional requirements that must be met to receive such care (see, e.g., 38 U.S.C. § 1710(b); 38 C.F.R. § 17.47). While Veterans can unofficially self-refer for MH RRTP, verification of their eligibility occurs during the screening process. If this language is not modified, VA would interpret this phrase in light of these requirements.

Second, the language regarding Veterans' preferences for where to receive care between VA and non-VA facilities is unclear—the bill would require VA to “provide the veteran an option to select the preference of the veteran” and would require VA to “incorporate the preference” of the Veteran, but none of this could be easily or clearly implemented as written. It is unclear whether this is intended to establish that the Veteran's preference controls or if VA is to be provided discretion to make a decision inconsistent with the Veteran's preference (and if so, on what basis VA could make such decisions).

Third, this section would require VA to provide Veterans with a list of locations that meet their care needs and the preferred start date for the Veteran to receive residential care, but it is unclear how this provision would interact with the admission options just described. If VA was able to place the Veteran in an MH RRTP bed within the established time period and at an accessible VA facility, it is unclear what value would be realized in providing information about other locations. This also could reduce current protections to ensure there is a clear admission date provided at the time a Veteran is assessed as appropriate for residential admission. Current policy allows referring providers to refer Veterans to a range of programs both within and outside of VA. The section would require VA, in making screening, admission, and placement decisions to consider family- or occupational-related preferences or circumstances. Given the variety of factors VA would have to consider, some of these could lead to conflicting conclusions, and it is not clear how the drafters would intend VA to resolve such dilemmas. In the absence of further legislative clarity, VA would have to address these matters through rulemaking or policy.

VA cites concerns with the reporting requirements in this section. First, VA would be required to include a review of wait times under MH RRTP disaggregated by wait times for both VA and non-VA facilities. VA does not have consistent data on community wait times, and there are many such community programs (some within VA's network and some outside). To gather this data for community wait times within VA's network, VA would need to renegotiate contract terms with at least the two TPAs and potentially others, which would result in additional administrative costs to VA.

Second, there is no current mechanism to determine participation in a treatment track as data are captured at the official program level only. Third, the requirement to include recommendations under this report could be duplicative or conflict with the recommendations VA provides under section 503 of the STRONG Veterans Act (Division V of P.L 117-328 Division V).

Fourth, VA notes the definition of MH RRTP in the bill would technically include the Compensated Work Therapy-Transitional Residence (CWT-TR) programs, but that does not appear to be the focus. VA recommends specifically excluding CWT-TR because of its distinct role. VA also recommend removing subsection (e), regarding appeals, as VA already has a clinical appeals process.

Finally, VA recommends that if these requirements will continue to govern MH RRTP care (as appears to be the case) that this be codified in title 38, U.S.C., to allow for easier reference and amendment in the future. VA welcomes the opportunity to discuss this section with the Committee. VA is working to assemble the necessary data, but VA does not have a cost estimate for this section at this time.

Section 304 would require VA, within 18 months of enactment, to publish an online portal allowing individuals applying for medical care under the Civilian Health And Medical Program of the Department of Veterans Affairs (CHAMPVA) to submit application materials electronically, view the status of their application online, and select their preferred method of communication regarding their application (which VA would have to use upon the first attempt to contact the individual if there are any issues with the application).

VA supports section 304, if amended, subject to availability of appropriations. Creating an online portal will provide an additional communication tool that will allow VA to provide real-time information to beneficiaries and providers. It is anticipated that the online portal will remove administrative barriers that may exist when requesting a status, of a claim submitted to the program for reimbursement as well as providing a venue for the submittal of critical documents to establish eligibility for health care under CHAMPVA. Furthermore, VA will have the ability to utilize the portal to support other family member programs such as the Spina Bifida Health Care Benefits, Children of Women Vietnam Veterans, Camp Lejeune Family Member, and the Foreign Medical programs. Providing an online portal will demonstrate VA's commitment to utilize technology to enhance customer service as well as offer a similar option that is available to beneficiaries utilizing insurers of health care in the community.

The 18-month period provided in this section would provide not enough time to establish the portal described in this section. This portal would require multiple interfaces between complex claims processing and financial management systems. VA would likely need to contract for the construction of this portal and would also need additional staffing to support development of this portal. VA believes it would be possible to complete construction of the portal within 18 months from the date a contract is awarded, and we expect a contract award would take at least 12 months. If this

section is amended to provide VA additional time and resources, VA would support this section.

VA offers several technical comments on this section. First, this section would require, as a necessary element of the portal, individuals receiving care through CHAMPVA the ability to reprocess a denied claim electronically, but CHAMPVA beneficiaries do not process or reprocess claims—VA does. We believe this should state that individuals could request that VA reprocess a claim. Second, the portal would only be required to allow CHAMPVA providers to submit medical claims documentation, but it seems like these providers should also be able to request VA reprocess a claim (or file an appeal). VA estimates that expenditures to create an online portal to be approximately \$23.1 million in FY 2025, \$24.8 million over 5- and 10-years.

Section 305 would require VA conduct a review of the workflows directly associated with processing referrals of patients between VA facilities to identify specific delays or bottlenecks in such referrals.

VA does not support section 305. VA has already conducted a review as described in this section as part of the audits required by section 3102 of the Isakson-Roe Act, and VA is already working to issue a new directive in this regard later this year. Further, there are ongoing efforts to review the current process maps, identify any bottlenecks, and mitigate any delays related to referral processing. Finally, VA has published inter-facility consult guidance in the Referral Coordination Initiative guidebook and this will be published in a standard operating procedure format with publication of the updated VHA consult directive referenced above.

S. XXXX Rural Vital Emergency Transportation Services (VETS) Act

Section 2 of this draft bill would require under regulations prescribed by VA, to pay or reimburse a highly rural Veteran ambulance, including air ambulance, to a VA or non-VA provider for care authorized under the laws administered by VA regardless of whether the Veteran qualifies for payments or allowances for beneficiary travel under 38 U.S.C. § 111. The term “highly rural veteran” would mean a Veteran who is located in an area rated as a 10 or higher under the rural-urban commuting areas coding system of the Department of Agriculture.

VA does not support this bill. VA agrees with the intended goal of this legislation, but VA has a number of concerns with the text as written. VA provided technical assistance on an earlier draft of the bill where we raised several concerns regarding the scope of the text. We would appreciate the opportunity to discuss this bill further, particularly in terms of how this bill would operate given other authorities beyond § 111 (such as § 1725) for VA to pay or reimburse for emergency transportation costs.

S. 1951 VA Income Eligibility Standardization Act

Section 2(a) of the draft bill would amend 38 U.S.C. § 1710(a)(3), which generally authorizes VA to furnish hospital care, medical services, and nursing home care, to the extent resources and facilities are available, to Veterans not otherwise eligible for VA care under paragraphs (1) or (2) of such subsection. The amendments would require VA to furnish hospital care and medical services, and would permit furnishing nursing home care, which VA determines to be needed for such Veterans. It would also amend § 1710(a)(4) to clarify that this requirement would only be effective in any FY only to the extent and in the amount provided in advance in appropriations Acts for such purposes. Section 2(b) would require VA to eliminate all subcategories of priority for enrollment established by VA for Veterans eligible under Priority Group 8 of the enrollment system and ensure that all Veterans eligible for enrollment could enroll in VA's patient enrollment system.

Section 3 of the bill would require VA to ensure that all Veterans, once enrolled in VA's enrollment system, remain enrolled in such system and may continue receiving health care furnished by VA if they choose, subject to such cost-sharing requirements as may apply to the Veteran under existing provisions of law.

VA does not support this bill. VA broadly agrees that expanding eligibility for VA health care is important. This bill would expand eligibility for enrollment to 4.7 million more Veterans who are currently ineligible based on their income level. Approximately 76 percent of Veterans ineligible based on income under the age of 65 have employer-sponsored health insurance, and approximately 93 percent of similar Veterans over the age of 65 have Medicare coverage.

However, even if Veterans who enroll in VA health care under this expansion use VA for only a small portion of their health care needs due to their other coverage options, this bill could have a significant impact on capacity as hundreds of thousands of new Veterans could seek care from VA, which would negatively affect access to care for current enrollees and users (including Veterans with service-connected disabilities). For the population under the age of 65, this bill would largely result in a cost shift from private insurance to the Government, and for those over the age of 65, this could result in some shift from Medicare to VA. We also note that granting access to this cohort could have unintended consequence for their eligibility for assistance under the Affordable Care Act or under State programs. We also note, particularly for the older population, that Veterans' demand for non-institutional long-term care services would likely result in significant additional demand for resources from VA. For example, homemaker and home health aide services are unavailable under the Medicare program and these Veterans are unlikely to qualify under State Medicaid programs due to their income levels. This could increase VA's demand for resources considerably. We do not expect there would be a significant shift in either hospice care or skilled nursing care for Veterans over the age of 65 because these services are provided without copayments through the Medicare program.

The bill provides no delayed effective date, so these changes would be effective upon enactment. VA simply does not have the capacity today to accommodate this additional population. VA would likely need time to adjust to a significant expansion of Veteran eligibility to ensure that resources are available to furnish care to these Veterans and those currently enrolled in and receiving care from the system. A sudden expansion of eligibility could result in delays in care for current and new enrollees.

VA cites additional concerns with the bill. First, it is unclear how section 2(b) of the bill would affect VA's authority under 38 U.S.C. § 1705(b)(1) to ensure that the system will be managed in a manner to ensure that the provision of care to enrollees is timely and acceptable in quality. It is also unclear how section 2(b) would affect VA's authority under 1705(b)(2) to establish additional priorities within other priority groups than Priority Group 8. Second, in section (3) of the bill, it is unclear what the phrase "if they choose" is intended to qualify – the receipt of care or the enrollment of the Veteran in VA health care. Currently, VA regulations (at 38 C.F.R. § 17.36(d)(5)) provide for a disenrollment process that can occur at the election of the Veteran. It is unclear if the bill's requirement that the Veteran "remain enrolled" is intended to foreclose this opportunity.

We note that there may be situations where disenrollment could be preferable for the Veteran (for example, if the Veteran would qualify for a subsidy or other benefit based on not having other qualifying health insurance). Third, the provision stating that Veterans "may continue receiving health care furnished by the Department if they choose" is unclear as to whether this is also supposed to be subject to the availability of appropriations under § 1710(a)(4). Finally, the language in section 3 about "cost-sharing requirements as may apply to the veteran under existing provisions of law" would cement in place current copayment requirements. If future regulations or statutes changed copayment (for example, by granting waivers or changing amounts), those changes may not apply to current enrollees but could apply to future enrollees. This could create significant additional complexity. If the drafters simply intended for this to subject enrollees to any cost-sharing requirements as may apply, now or in the future, we recommend striking the phrase "under existing provisions of law".

VA estimates that, if enacted, this bill would result in additional costs of \$544.6 million in FY 2024, \$5.75 billion over five years, and \$14.26 billion over 10 years.

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.