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BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

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LEGISLATIVE HEARING

WEDNESDAY, SEPTEMBER 11, 2024

SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
U.S. HOUSE OF REPRESENTATIVES,
Washington, DC.

The subcommittee met, pursuant to notice, at 10 a.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meek [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meek, Radewagen, Bergman, Murphy, Van Orden, Luttrell, Kiggans, Brownley, Levin, Budzinski, and Landsman.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. I agree with yesterday's hearing that members need to be given a map and a watch to be on time to hearings. That includes both sides of the aisle. It is not directed to one or the other.

We welcome all members of the subcommittee and our witnesses. We look forward to a very productive session today on some impactful veterans legislation.

Before we begin, however, I would like to take a moment to remember the nearly 3,000 American lives that were lost 23 years ago today. Please join me in a moment of silence for the 9/11 victims and their families. Thank you.

Today, we will be discussing 16 bills. Each bill would attempt to improve the delivery of healthcare to the men and women who have served. These bills include creative solutions that would seek to address difficult problems, including a pilot program to fill vacant shifts, reforms to ensure that the U.S. Department of Veterans Affairs (VA) has the authority to prescribe medicine, and a study which looks at the mental health crisis that affects our veteran community.

I would now like to take a moment to discuss my bills, H.R. 9438, the No Wrong Door for Veterans Act and H.R. 9478, Veterans Sports Act. H.R. 9438 would seek to reauthorize an incredibly important VA mental health program, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

The Fox Grant Program is a successful grant program that enables the VA to provide grant funding to community-based organizations to help organizations in communities where veterans live expand the reach of their mental health efforts.

My bill would reauthorize the Fox Grant Program for an additional 3 years until 2028. It would also make changes to the administration of the program including improvements to coordination of care between VA providers and grantees and the standardization of the veteran intake process.

This program is another avenue for veterans to receive brain health support. There should be no wrong door when it comes to seeking brain health, and I am proud to have introduced this bill to continue and improve this amazing program.

My second bill is H.R. 9478, the Veterans Sports Act. This legislation would provide access to adaptive limbs for amputee veterans by ensuring that they are able to have the highest quality of life that we can provide them.

This bill would amend existing law to ensure the availability of adaptive sports and recreation prostheses limbs by recognizing them as medically necessary for veterans living with limb loss.

I think it is critical that we ensure that disabled veterans have the equipment and tools they need to live active lifestyles as they please in order to allow them to live the fullest and make them whole.

I am proud to introduce these bills and look forward to discussing the many others on our agenda.

I want to again thank our witnesses for being here today and those organizations that submitted statements for the record. It is a privilege to collaborate on crafting impactful legislation for our veterans and to address some critical issues facing them.

I now yield to Representative Cherfilus-McCormick for her opening remarks.

OPENING STATEMENT OF SHEILA CHERFILUS-MCCORMICK, ACTING RANKING MEMBER

Ms. CHERFILUS-MCCORMICK. Thank you, Chairwoman Miller-Meeks.

Thank you to our witnesses for being here today to discuss these bills. I am sitting in for Ranking Member Brownley who, unfortunately, could not be here today. I know she is disappointed to not be here, especially not to be able to speak about her bill, the Have You Served Act, which is on the agenda for today.

I will take the opportunity to recognize her for her work on this issue. So often just asking the question have you served could make a huge difference in recognizing and supporting veterans.

Helping service providers learn how to appropriately talk about veteran status and where to connect them to resources will change lives. Representative Brownley's bill will create grants to establish ask the question campaign training programs, establish key matrices for the training and improving outreach about the efforts. I want to thank her for leading this effort.

We will also consider several other bills today sponsored by my Democratic colleagues which will increase access to VA healthcare, especially for rural veterans. This includes the Rural Veterans Transportation to Care Act, which will expand the VA's very popular highly rural transportation grant program and expand the program to serve veterans in rural in addition to highly rural communities.

It also includes the New Mexico Rural Veterans' Healthcare Access Act, which would adjust Veterans Integrated Service Network (VISN) lines to ensure veterans in New Mexico can easily receive travel reimbursement when accessing care at the nearest VA medical facility to them.

I am also glad we are considering the Veterans Sentinel Act legislation to address suicides that occur on VA campuses. While these events are rare, they are tragic and devastating for VA and to all of the veterans' community.

Representative Crow's bill would create a task force to identify root causes for these events and analyze ways to stop further events from happening.

Finally, we will consider a bill to give co-pay parity to veterans that identify as Native Hawaiians and strengthen VA coordination with the Native Hawaiians' health care system.

However, I am disheartened to see so many bills from my Republican counterparts on the agenda that focus on diverting more care out of VA. We know that VA provides the best care and that more often than not veterans want to receive their care from the VA.

Some of these bills, like the Veterans Mental Health Access Act and the No Wrong Door for Veterans Act, propose to send more money to outside entities creating grant funding giveaways with no or very few strings attached.

These bills lack vital matrices to monitor the performance of grantees and ensure these programs are meeting their intended purposes.

I look forward to hearing from our VA witnesses about the department's view on all these bills on today's agenda and how we can work together to ensure VA can serve veterans to the best of their ability.

I am also looking forward to hearing from our Veterans Service Organization (VSO) partners about what these bills would mean for their members.

With that, Madam Chairwoman, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Cherfilus-McCormick.

We have a full agenda today so I will be holding everyone to 3 minutes per bill to get through in a timely manner.

This morning we are joined by several of our colleagues who will testify on their bills. We are appreciative of their work in serving our Nation's veterans.

With that, I ask unanimous consent that all non-committee members be waived on to speak on their bills from the dais. Hearing no objections, we will move forward.

I now recognize Representative Luttrell. You are now recognized for 3 minutes.

STATEMENT OF MORGAN LUTTRELL

Mr. LUTTRELL. Thank you, Madam Chairwoman. The Service Dogs Assisting Veterans Act, or the SAVES Act, would require the secretary to establish a 5-year pilot program that would award competitive grants to nonprofit organizations providing service dogs to the eligible veterans.

This bill would ensure that veterans receiving service dogs through these grants are not charged fees and are provided with a veterinarian insurance policy for their service dogs. The bill would also establish a process for granting service dogs to veterans with mental health conditions and would authorize the secretary to allocate up to $10 million annually for the program.

This builds upon previous legislation, the Puppies Assisting Wounded Service Members, or PAWS, for Veterans Therapy Act, Public Law 117–37, which expanded efforts to support veterans with Post-Traumatic Stress Disorder (PTSD) and other service-related injuries with service dogs.

The VA refers veterans to nonprofit organizations to receive these service dogs, but the process can often be lengthy and with veterans waiting up to 1 to 3 years, and the availability of the of the dogs is extremely limited.

The SAVES Act aims to address these limitations and wait times by expanding the avenues that veterans can receive service dogs from VA to nonprofit organizations. Generally, nonprofit organizations are expected to provide these service dogs quicker than VA due to there being less bureaucracy.

This legislation also looks at addressing the needs of our veterans. Amid that is why it expands the scope of the disabilities covered for the veterans who qualify for service dogs and will allow veterans who suffer from blindness, visual, or mobility impairments, seizures, post-traumatic stress disorder, and traumatic brain injuries to qualify as well.

Veterans face a wide range of issues and there is never a one-size-fits-all approach. I am pleased to introduce this piece of legislation or this bill and it is bipartisan. It does have bipartisan support. Thank you.

Ms. MILLER-MEEKS. Thank you, Representative Luttrell.

Typically, we would go to the Democrat. The Democrat up to speak next is not here so we are going to go to Representative Franklin. Representative Franklin, I now recognize you for 3 minutes.

STATEMENT OF SCOTT FRANKLIN

Mr. FRANKLIN. Thank you, Madam Chairman. This is a solemn morning, as you noted, as we recognize the 23d anniversary of the attacks on 9/11. That evil act of cowardice sent many of our sons and daughters to foreign soil to defend our Nation.

Two decades now and trillions of dollars spent, an entire generation at this point of our young men and women who answered the call to join our armed forces to defend our great Nation, many of them have now joined the ranks of veterans who served in previous eras.

It is the duty of this panel, our primary duty I would argue, to ensure that these brave Americans receive the best care and the benefits they have earned.

Despite the sacrifices our veterans and their families have made, reports indicate they are being cutoff from certain services the VA is obligated to provide them.

Recently, the VA has been pushing more veterans back into VA facilities from community care providers without consideration of

continuity of care when deciding in a veteran's best medical interest. This abruptly cuts off veterans from longtime treatment plans and providers they trust.

It is difficult for veterans to build rapport with a provider or a counselor and then be forced to find a new one, creating gaps in care. These gaps can negatively impact all aspects of life for veterans and their families.

It is unconscionable this would be allowed to even happen and that this committee would do so. It is something we must stop.

I am concerned by the comments by members of the committee that appear to be in direct opposition to community care. The same comments advocate shrinking the funding and size of the program.

The rationale often centers around the VA's recent efforts to increase convenience with new clinics and improve care by recruiting new specialists. I applaud those efforts, including the opening of a fantastic new clinic in my hometown of Lakeland, Florida.

I consider those efforts to be table stakes. The VA can always be striving to improve. Excellent care at VA facilities and providing flexibility to veterans are not opposing missions. VA must continue to improve care and expand convenience for our veterans. They deserve nothing less.

I believe, and I know many of my colleagues here agree, veterans should be able to choose the care that works best for them, whether that is inside the VA or out, especially for those who are already using community care.

My bill, the Ensuring Continuity in Veterans Health Act, protects veterans who have chosen to utilize community care. It will also provide clarity for veterans concerned that they will lose their provider.

Specifically, this requires the VA to consider continuity of care in determining best medical interest of a veteran. This will provide disruption in care for veterans already receiving services from community care providers. Most importantly, it will allow veterans to continue choosing the most convenient care for them.

I would like to thank the chairman for supporting this legislation, and I look forward to working with the committee to mark up this bill in the coming days. I urge we take it to the House floor for a vote.

Thank you, Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Franklin.

I now recognize Representative Vasquez for 3 minutes.

STATEMENT OF GABRIEL VASQUEZ

Mr. VASQUEZ. Thank you, Chairwoman Miller-Meeks and Ranking Member Brownley, for allowing me to testify today in support of my bill, the New Mexico Rural Veterans Healthcare Access Act.

Traveling across my district can take up to 9 hours from Jal, New Mexico to Zuni Pueblo. That means that nearly 50,000 veterans who call New Mexico's Second District home have more difficulty accessing critical resources, including VA healthcare, which is largely contained in two Veteran Integrated Service Networks.

However, in southern New Mexico, the lines do not work and veterans suffer. This problem has been occurring for over a decade. In

fact, I started this fight as a staffer before I became a Member of Congress.

The current lines force veterans in Otero and Edi Counties to travel more than 4 hours to Albuquerque instead of nearby El Paso less than an hour away for healthcare. Traveling long distances for basic care referrals and other appointments creates an incredible hardship for those who served our country.

It is not just long distances. It is the dignity of care and extended waiting times. The VA will only provide a mileage reimbursement to veterans who seek service within their VISN lines.

A veteran in Carlsbad is faced with an unjust choice. Get reimbursed for a 9-hour trip to their designated VA hospital in Albuquerque or bear the cost themselves for a 4-hour trip to El Paso.

Our veterans opt for the closest VA but are not receiving any mileage reimbursement for going outside their VISN lines, defeating the purpose of this system.

I recently met with both the directors of the Albuquerque and El Paso VA healthcare systems and brought the ranking member of the Veterans Affair Committee to listen directly to veterans about the hardships that they face. Everybody in the room agreed that the line should be changed.

As legislators, we cannot leave our rural veterans behind. The Veteran Integrated Service Networks were created to make sure veterans are organized into a system where they have access to what they need, but for the rural veterans in my district in southern New Mexico that benefit simply does not exist.

My bill, the New Mexico Rural Veteran Healthcare Access Act, would move Edi and Otero Counties in my district into Veteran Integrated Service Line 18. This change would give these veterans closer access to specialty care and mileage reimbursement for the VA hospital trips that they are already making.

To the veterans of New Mexico's Second congressional District, know that I am here fighting for you. Whether you are in Edi or Otero County, Dona Ana or Bernalillo, you all deserve equal access to the benefits that you deserve.

I urge support for my legislation in this committee, and I yield back. Thank you, Mrs. Chairwoman.

Ms. MILLER-MEEKS. Thank you, Representative Vasquez.

I now recognize Representative Self for 3 minutes.

STATEMENT OF KEITH SELF

Mr. SELF. Thank you, Chairwoman Miller-Meeks. I am honored to introduce H.R. 9485, the Enhancing Faith-Based Support for Veterans Act of 2024. This important legislation addresses a crucial gap in the spiritual care provided to our veterans.

Under this bill, VA chaplains would be required to offer veterans the option to order their name and contact information to be shared with non-VA religious or faith-based organizations of their choice. In other words, this option is at the sole discretion of the veteran.

This step will ensure that veterans have access to the spiritual care they need and want, regardless of their faith.

This issue was brought to our attention by a dedicated Army veteran who also serves as a Catholic Eucharistic Minister in the Dal-

las Diocese. He learned of the problem through a parishioner who had been bringing Catholic communion to the Sam Rayburn Memorial Veterans Center and Bonham VA Clinic for many years.

However, 2 years ago, they were informed that due to a change in policy access to VA patients had been revoked. H.R. 9485 aims to fix these issues by allowing veterans to complete a privacy release form, similar to what all of our constituents have to fill out before opening casework.

This will enable the VA to connect them with chaplains or religious leaders who can offer the specific spiritual support they need and want. By passing this bill no veteran would be denied the spiritual care they require due to bureaucratic red tape.

I am grateful to my constituent who brought this issue to light, and I look forward to working with my colleagues to advance this bill through Congress. I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Self.

I now recognize Representative Gluesenkamp Perez for 3 minutes.

STATEMENT OF MARIE GLUESENKAMP PEREZ

Ms. GLUESENKAMP PEREZ. Thank you to the chairwoman and ranking member for the opportunity to testify today about my bill, Rural Veterans Transportation to Care Act.

Almost exactly 1 year ago today I heard from one of my counties in my district that they had just received notice from the VA that they were no longer eligible for the VA highly rural transportation grant program.

The county had been operating a van for the purposes of transporting veterans to the Department of Veterans Affairs facilities to receive medical care free of charge since 2014.

Over the years, this service has proven essential to veterans seeking essential care to things like chemotherapy and critical surgeries and treatment for heart conditions.

In 2022 alone, the van made approximately 300 trips and transported between 40 and 60 veterans. However, due to the definition of eligibility for these grants as set in statute, as fewer than seven residents per square mile Skamania County learned that due to new Census data and migration changes that happened during the pandemic, that our rural county was no longer considered rural enough.

Now we are at 7.15 residents per square mile. With just 1 week's notice we lost transportation funding.

I sent a letter to the Secretary of Veterans Affairs McDonough in October urging the VA to fill transportation gaps for rural veterans and work with Congress to redefine highly rural.

In a reply earlier this year the department expressed support for the provision outlined in Rural Transportation to Care Act. The bipartisan bill would improve how VA measures rurality, helping more veterans living in rural areas get transportation to VA or VA-authorized healthcare facilities.

The bill would also expand eligibility to both rural and highly rural counties, as well as tribal organizations.

Last, the legislation would increase the maximum funding amount so transportation services could keep pace with inflation.

It is our responsibility to our Nation's heroes to ensure that our Nation's heroes are well supported after returning from home and can access the benefits they have earned and deserve. Just last week, I was visiting with veterans in Pacific County about how vital these kinds of transportation services are, and they are literally life or death.

People who have been waiting for appointments for 18 months can lose an appointment if they are just 10 minutes late or 15 minutes late to their appointment, setting them back 10 months to care.

Access to professional, reliable transportation is critical to deliver lifesaving care to our veterans. As veterans across my district and the country face dramatic reductions in lifesaving services, it is our duty to make sure they are not left behind.

This bipartisan bill will not only restore critical healthcare transportation services for Skamania County veterans but will also newly expanded eligibility to make sure more veterans in rural areas around the country have a safe and reliable way to get to their appointments and receive the care they deserve.

I thank you again for the opportunity to testify on this bill and I look forward to continuing to work on getting this across the finish line.

Ms. MILLER-MEEKS. Thank you very much, Ms. Gluesenkamp Perez.

The chair now recognizes Representative Womack for 3 minutes.

STATEMENT OF STEVE WOMACK

Mr. WOMACK. I thank the Chairwoman Miller-Meeks and Ranking Member Brownley, and distinguished members of the subcommittee. I want to thank you for considering my bill, H.R. 9324, the Protecting Veteran Access to Telemedicine Services Act of 2024.

I would also like to express my sincere gratitude for allowing me to speak in support of this legislation today. This bill seeks to ensure that our Nation's veterans, whether they reside in bustling urban centers or in the most remote areas of our country, have uninterrupted access to the healthcare services they need and deserve.

As you are aware, the Ryan Hate Online Pharmacy Consumer Protection Act was enacted in 2008 to regulate the prescription of controlled substances via telemedicine in response to the rise in online pharmacies and the potential for misuse.

This law plays an important role safeguarding public health, but also has not been updated to reflect the differences between 2024 compared to 2008 and does not acknowledge the difference between VA and general civilian online pharmacies.

During the COVID–19 pandemic, requirements under the Ryan Hate Act for a patient to meet with a practitioner in person for the prescription of a controlled substance were temporarily waived.

The Drug Enforcement Administration (DEA) and U.S. Department of Health and Human Services (HHS) announced the temporary extension of these flexibilities, but that extension expires at the end of this year. My bill, the Protecting Veteran Access to Telemedicine Services Act of 2024, would permanently extend this exemption to allow healthcare professionals employed by the VA to

prescribe medically necessary controlled substances to veterans via telemedicine under certain conditions.

This exemption has been a lifeline for our Nation's veterans and without a permanent exemption, many veterans could see their access to vital healthcare services severely restricted.

For our veterans in urban areas, the expiration of this exemption would mean longer wait times for in-person appointments, further straining an already burdened VA healthcare system.

The situation is even more critical for veterans in rural areas. These veterans face unique challenges, including geographical isolation and limited access to healthcare providers. The Ryan Hate Act exemption has enabled them to receive care from VA providers and specialists who may be hundreds of miles away without the need for costly and time-consuming travel.

The continuation of this exemption is not just a matter of convenience. It is a matter of necessity. It ensures that veterans in every corner of this country have equal access to the care they so desperately need and they deserve.

It is an honor to speak in support of my legislation today. I urge my colleagues on this subcommittee to support the bill and to act swiftly in passing this legislation.

Our Nation's veterans have sacrificed so much for our freedom. It is our duty to ensure they receive the care they have earned in a manner that meets their needs in today's world.

With that, Madam Chairwoman, I yield back my time.

Ms. MILLER-MEEKS. Thank you very much, Representative Womack.

The chair now recognizes Representative Tokuda for 3 minutes.

STATEMENT OF JILL TOKUDA

Ms. TOKUDA. Thank you, Chairwoman Miller-Meeks, Representative Cherfilus-McCormick, and distinguished members of the Health Subcommittee, thank you for including my bill, H.R. 8562, the Parity for Native Hawaiian Veterans Act, in today's legislative hearing and for the opportunity to speak in support of this important bill.

In the United States there are approximately 614,600 Native Hawaiian veterans, including nearly 275,000 in my home State of Hawaii. According to a May 2022 report by the Veterans Health Administration (VHA), Native Hawaiian and other Pacific Islander veterans aged 45 and older experienced significantly less access to checkups and routine care than their white counterparts.

The report concluded that "work is needed to improve the veteran experience of care among

[Native Hawaiian and other Pacific Islander] veterans" and better information could be "helpful in understanding and addressing their disparities."

They served and sacrificed the same as their fellow veterans, yet our country is failing to meet our obligations to them. More must be done to eliminate needless barriers to care for our Native Hawaiian veterans.

That is why I have introduced the Parity for Native Hawaiian Veterans Act to ensure Native Hawaiian veterans can access

health care services in a similar manner as their American Indian and Alaska Native counterparts.

To fulfill the Federal Government's trust responsibility to the Native Hawaiian community it is vital that Native Hawaiian veterans be treated the same as other Native American veterans and explicitly included in Federal programs and policies supporting other Native veteran populations.

Currently, the Indian Health Service (IHS), Tribal health programs, and IHS-funded urban Indian organizations can seek direct reimbursement from the VA for services rendered to eligible American Indian and Alaska Native veterans.

The Parity for Native Hawaiian Veterans Act would codify the same reimbursement relationship between VA and the Native Hawaiian health care systems that have been authorized by Congress to provide comprehensive health promotion and disease prevention services, as well as primary health services to our Native Hawaiians.

With more locations near to where Hawaiians live, this is about meeting our veterans where they are at and greatly increasing their access to care.

My bill does three things. It updates the definition of Native Hawaiian in statutes governing veterans' care and benefits. It eliminates co-pays for qualified Native Hawaiian veterans. It allows the VA to directly reimburse the Native Hawaiian health care systems for care provided to Native Hawaiian veterans.

This bill was developed in consultation with Papa Ola Lokahi, which has been authorized by Congress to coordinate and assist healthcare programs and services provided to Native Hawaiians. The bill also incorporates technical assistance from VA and past work by the Office of Hawaiian Affairs.

Ultimately, the Parity for Native Hawaiian Veterans Act is about improving healthcare access and affordability for Native Hawaiian veterans and ensuring all veterans are provided the care they need and are entitled to as a result of their service to our country.

I look forward to working with members of this committee and Senator Hirono, who has introduced identical legislation in the Senate, to advance this measure forward in Congress. Mahalo and I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Tokuda.

The chair now recognizes Representative Chavez-DeRemer for 3 minutes.

STATEMENT OF LORI CHAVEZ-DEREMER

Ms. CHAVEZ-DEREMER. Chairwoman Miller-Meeks and Vice Chair Cherfilus-McCormick, thank you for inviting me today to speak on behalf of my legislation, the VA Geriatrics and Gerontology Advisory Committee Expansion Act.

This bill is simple. It would include a representative of the National Association of State Veterans Homes (NASVH) on the Department of Veterans Affairs Geriatrics and Gerontology Advisory Committee.

NASVH has been great partners and supporters of this legislation. Their goal as an all-volunteer organization is to promote and

enhance the quality of care and life for veterans and families in their network of homes through education, networking, and advocacy.

There are 169 VA-recognized State Veterans Homes across the Nation, including two in Oregon, one in The Dalles, and one in my district in Lebanon, Oregon.

The Geriatrics and Gerontology Advisory Committee was authorized in 1991. Its primary role is to advise the VA on geriatric research education and assess the demand for long-term veteran care and the VA's ability to provide for its plan to meet these geriatric services.

A representative from NASVH having full representation on the committee would be able to bring new, unique, and tested clinical expertise to strengthen this mission. With over 8 million living veterans who are aged 65 and older, many still from our greatest generation, there is an everlasting need to strengthen and expand long-term care options for our veterans.

The amount of nursing home care offered by the VA is currently not meeting the overall number of eligible veterans. NASVH will be able to offer nursing home care, experience combined with the ability to stretch adequate resources and serve as many veterans as possible, including expanding care to veterans who can be serviced in their own communities and homes.

With a nationwide network, NASVH has the capabilities to understand the changing demographics, needs, and preferences of veterans in all areas of the country. I believe State Veterans Homes have the full capability to advise the VA on the long care options, and I also believe the VA must also make a long-term commitment the State Veterans Homes.

I have appreciated the ongoing support of Chairman Bost and the committee here today and thank them for their steadfast support and leadership in aiding our Nation's veterans.

They were kind enough to visit my district back in June to tour the Portland VA Medical Center and also help me hosting a listening session in Bend, Oregon, where we heard directly from local veteran constituents on the issues they face in receiving the care they deserve.

One of the main issues we discussed was long-term and community care for the aging veterans. Further, I echoed those concerns of Oregonian veterans in writing to Secretary McDonough asking the department to respond to a series of questions that were raised during that listening session by July 31. We have yet to receive that response from the VA.

I urge Secretary McDonough to respond to these questions quickly because they are questions not coming from me. They are questions from our veterans, the very ones he was appointed to and confirmed to serve.

Again, I want to thank my colleagues on both sides of the dais for their consideration of this legislation, and I urge their support. Passing the VA Geriatrics and Gerontology Advisory Committee Expansion Act will be a clear win for the States Veterans Homes, network, and for our Nation's aging veterans.

With that, Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Chavez-DeRemer.

As is our practice, we will forgo a round of questioning for those members waiving on to present their bills. They have excused themselves or they may now be excused.

I now invite our first panel to the table. Joining us today from the Department of Veterans Affairs is Dr. Carolyn Clancy, assistant under secretary for Health, Discovery, Education, and Affiliate Networks, Veterans Health Administration.

She is accompanied by Dr. Matthew Miller, executive director, Office of Suicide Prevention, Veterans Health Administration, Dr. Ajit Pai, executive director, Office of Rehabilitation and Prosthetic Services, Veterans Health Administration, and Mr. Ryan Heiman, acting director, Member Services, Veterans Health Administration.

Dr. Clancy, you are now recognized for 5 minutes to present the department's testimony.

STATEMENT OF CAROLYN CLANCY

Dr. CLANCY. Well, good morning, Chairwoman Miller-Meeks and acting Ranking Member Cherfilus-McCormick, and members of the subcommittee. Thank you for the invitation to present our views on several bills that would affect VA programs and services.

I am not sure if we have name tags so we will just point out Dr. Matthew Miller, Dr. Ajit Pai, and Mr. Ryan Heiman, who are with me here today.

Today's date, as noted by you earlier, Madam Chair, holds profound significance in our Nation's history and for VA. Twenty-three years ago our Nation was under attack, and in the aftermath many brave Americans honorably answered the call to serve, creating a new generation veterans, each with unique challenges and healthcare needs for nearly 2 decades of conflict.

Our solemn duty is to ensure that all veterans receive the exceptional care and respect they deserve. The sacrifices and those of their families underpin our unwavering commitment to VA's noble mission.

While we are prepared to discuss all proposed legislation, I will highlight a few bills in these opening remarks. The No Wrong Door for Veterans Act proposes changes to VA's Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

Key provisions extend this program's duration, modify the definition of emergency treatment, and require baseline mental health screening for grantees using the Columbia-Suicide Severity Rating Scale, also known as the C-SSRS. The bill also requires annual briefings between grantees and VA Medical Center personnel.

We support the bill's intent but have concerns. We are opposed to codifying C-SSRS use as this could prevent adapting more effective future tools.

Additionally, we recommend extending the pilot to allow the program to run a full 8-year period and also recommend increasing authorized appropriations to reflect the extended program duration and allow nationwide scaling.

Our teams are prepared to collaborate with your offices to incorporate these recommendations and others noted in the written statement.

Next, H.R. 6291, Have You Served Act, provides a grant program encouraging human services professionals. State and local governments. and community providers to inquire about military service.

This bill would authorize VA to make up to 25 grants annually not exceeding $200,000, each to eligible entities for developing or expanding ask the question campaigns. These campaigns are crucial to identifying and supporting veterans in various community settings.

We support the bill's intent but recommend technical and clarifying edits for successful implementation, including expanding the scope of eligibility and supported services and other amendments would just be needed to provide VA with some flexibility in program administration.

With respect to H.R. 6330, the Veterans' Sentinel Act, Section 2(a) would require VA to establish a pilot program for a working group to collect and analyze data regarding on-campus suicides and attempted suicides.

We support this section but recommend technical edits to ensure optimal use of resources for preventing veteran suicide.

We recommend that Congress avoid legislating a specific methodology or evaluation approach, allowing VA the flexibility to determine the best strategies and apply innovative solutions to address this critical issue. As written, we anticipate significant implementation costs.

Section 2(b) would require VA to annually evaluate statistical trends of suicides and attempted suicides by veterans that occur on VA property and determine recommendations for prevention, and we support this section, recognizing the need for timely and useful surveillance efforts to end veteran suicides.

We defer to the Comptroller General regarding Section 2(c).

Finally, we appreciate the committee's interest in two bills resembling legislative proposals in fiscal years 2024 and 2025 Presidential budgets, H.R. 7504 and H.R. 9324, which would both make important progress in reducing barriers disproportionately affecting rural and otherwise underserved veterans.

We support both bills, however, several technical and clarifying edits technically are needed to fully address the intended problems.

Thank you for your ongoing support of programs supporting our Nation's veterans. Your dedication has improved the lives of those who have served our country, and we look forward to working together with you to develop innovative solutions and develop emerging challenges to meet veterans' evolving needs. Your partnership is absolutely invaluable.

Madam Chair, Ranking Member, this concludes my statement and we are happy to answer questions.

[THE PREPARED STATEMENT OF CAROLYN CLANCY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much, Dr. Clancy. Typically I will reserve my questions until the end so that other members can go prior to me, so Representative Cherfilus-McCormick, I now recognize you for 5 minutes.

Ms. CHERFILUS-MCCORMICK. Thank you, Madam Chair.

Dr. Clancy, in your testimony you suggest that Representative Brownley's bill be modified to provide greater clarity in terms of

how the grant program would be administered to include the application process, the award of grants, and requirements for applications.

Could you elaborate on this? What kind of requirements for applicants would be most helpful to ensure grants are awarded to appropriate entities?

Dr. MILLER. Thank you for the question. As we have indicated, we fully support the spirit and the intention of the Have You Served as to the question of legislation.

This is in direct reinforcement of Governor's Challenge goal number one, which is to better identify veteran service members, family members in the community, and in turn, connect them to care.

I think the increased clarity that is requested around the application process, applicant requirements, awarding of grants, and use of grant funds can relatively easily and in a straightforward manner be worked through within the markup process. Our team stands by ready to offer suggestions therein.

Ms. CHERFILUS-MCCORMICK. Thank you.

My next question is for Dr. Clancy, but I guess you are directed to who can best answer it. As written, Representative Brownley's Have You Served Act is pretty deferential to the secretary on the topic of what VA resource grantees should connect veterans to.

In your written testimony, you recommend that the bill be amended to be more specific about the array of VA services and benefits to which grantees should connect with veterans. Can you expand on how you believe those services should be identified and why more prescriptive language would be helpful to VA in ensuring veterans can be connected with those programs?

Dr. CLANCY. Great questions, thank you. Also for Dr. Miller.

Dr. MILLER. I think that that is our—I think it is a really good question. It is always a fine line between writing this in a way that is broad versus overly prescriptive to find the right balance and mix.

I think the right subject matter expertise teams between the Veteran Experience Office and our Partnerships Office would happily sit down and talk about the specifics to strike that balance in a way that most fully supports the spirit and the intention of this bill.

Ms. CHERFILUS-MCCORMICK. Thank you. I think this question is going to be for you also, Dr. Miller. I appreciate the VA's testimony on the Have You Served Act and the recommendation that the scope of eligible entities that can apply for these grants to be expanded.

Can you speak to some of the work that the community partnership in the VA, in the Vet Resource Community Network and the VHA National Center for Healthcare Advancement and Partnership that this bill might be able to help and support it becoming law?

Dr. MILLER. This bill as it is currently written speaks very directly and I must say, from my perspective, I appreciate it as such to the efforts being conducted through the Governor's Challenge. It highlights efforts that eight states and one U.S. territory are currently engaged in with ask the question and seeks to expand those efforts.

In the spirit of expansion, it also looks at and offers to look at other partnerships, such as those that are engaged and structured through the Veterans Experience Office (VEO) and through the National Center for Healthcare Advancement and Partnerships (HAP). It is opening the door to other partnerships beyond Governor's Challenge and drawing them in.

Ms. CHERFILUS-MCCORMICK. Well, I have a quick question. I wanted to shift toward Veterans Sentinel Act. Dr. Miller. I was glad to learn from your testimony that VA established an interagency workgroup to address the U.S. Government Accountability Office's (GAO) recommendations regarding on-campus suicides.

Can you share what the VA's existing interagency workgroup has done to improve VA's response to on-campus suicide, particularly in improving processes?

How long does VA intend to continue convening the working group and would codify the working group help ensure this work continues?

Dr. MILLER. Three improvements stand out to me to offer to you in response to your question. Improvement number one from the interagency workgroup is we have improved the process of the informational briefing system such that we have standardized the process across VHA, Veterans Benefits Administration (VBA), and National Cemetery Administration (NCA) so that standardized information is included.

Number two, we have included in the process very specific checkpoints for asking was an Root Cause Analysis (RCA) conducted? Was a peer review conducted? Creating hard stops with those questions.

Three, we have addressed direct needs that have been identified, parking lot signs being one. We in Fiscal Year 2023 provided parking lot signs to 100 percent of VA facilities. In Fiscal Year 2024 we are offering 7,000 additional parking lot signs with the Veterans Crisis Line (VCL) number and 988 updates.

Ms. CHERFILUS-MCCORMICK. Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you very much.

The chair now recognizes herself for 5 minutes. Dr. Clancy, the VA's testimony request for moving the statutory cap on Fox Grant amounts, VA has not properly managed grant funds within the first 2 years of the program, given that some organizations are receiving the full grant the amount and serving less than 20 veterans a year.

How do you justify removing the cap when the VA is not properly overseeing these funds?

Dr. MILLER. I am happy to take that question, ma'am. As the program that administers the Staff Sergeant Gordon Parker Fox Grant Program, I appreciate your question. I thank you for it.

The request to adjust the cap is in response to adjustments to something we all have been talking about, inflation so that the awards as it continues are reinforcing of current costs and adjust to current costs.

I think panel two members noted the advantage of this as well within their written statements.

Ms. MILLER-MEEKS. Thank you.

Dr. Clancy, given the significant, and I realize that you may refer this, given the significant physical and mental health benefits of adaptive prostheses and terminal devices for sports and recreational activities, why does the VA not support including these devices in the definition of medical services under Title 38?

Dr. CLANCY. This is Dr. Pai, who is the expert here. Thanks.

Dr. PAI. Good morning, Chairman. We already include that definition of adaptive sports devices in our regulations and our clinicians are prescribing them.

Ms. MILLER-MEEKS. You said you include a definition but does that definition mean that they are—it does not mean that they are medically necessary?

Dr. PAI. Correct. With adaptive sports and let me say that we really appreciate the intent and the spirit of this legislation. These devices are highly complex, right? An individual with an amputation has to go through weeks, months, sometimes years of rehabilitation and their medical comorbidities can impact their ability to utilize that device.

You know, we just have had the Paris Paralympics and we are really proud of our 13 veterans that we support over there. What we see is that the rehabilitation for this type of journey can take even longer than just that initial phase.

We really want to make sure that a veteran has consistent and constant participation in that activity so that they can really benefit with lifelong care.

Ms. MILLER-MEEKS. I just want to make sure I understand this correctly. You support the current regulatory framework. You are not opposed to these devices being utilized. Is the problem with codifying these provisions into law problematic because you are afraid veterans will not get the rehabilitative services that they need?

Dr. PAI. No, ma'am. We just feel that the legislation is redundant because we are already doing that. We understand that there are veterans out there that are having challenges, and we really want to make sure that we are hearing from those veterans, from those districts, from yourself and other Congress persons to make sure that we are caring for those veterans.

I understand that there is a question of will one clinician prescribe something that another clinician may not prescribe? We are really putting in efforts to educate our clinicians.

Ms. MILLER-MEEKS. Right, thank you, which is why we need to have it codified into law. Thank you for that.

I had another question in regards to the Have You Served Act, Dr. Clancy. Rather than setting up a new program, why cannot grants be utilized for those entities that are already doing this?

In Iowa we have veteran service organizations in every single county. Why could not these grants go to them or why could not these grants go to our, you know, our great veteran service organizations, such as the Legion, Disabled American Veterans (DAV), Wounded Warrior Project, Purple Heart, Veterans of Foreign Wars of the United States (VFW).

There are too many. If I left you I do apologize.

Why not give the grants to existing organizations who already work with veterans and are adept at that?

Dr. CLANCY. I think the short answer is we could certainly do that and happy to work with your staff on that. At the same time, we would also like to recognize that there are places that are beyond the reach even of those phenomenal organizations and not preclude their contributions as well.

Ms. MILLER-MEEKS. Oh, interesting. The smallest town in Iowa of 200 people has a VSO but thank you so much for that.

I am seeing no other members. I think this round of questioning is over. Our second round of questions, do you have a second round of questions?

Ms. CHERFILUS-MCCORMICK. Yes.

Ms. MILLER-MEEKS. The chair now recognizes Representative Cherfilus-McCormick.

Ms. CHERFILUS-MCCORMICK. Thank you.

I appreciate your testimony points. I appreciate that your testimony points out that while on-campus deaths by suicide are tragic, they are relatively rare among all suicide deaths.

However, we have no way of knowing how many veteran deaths by suicide may be occurring at community care facilities or their root causes.

Would VA be able to apply the same investigation method in this bill, which is the Veterans Sentinel Act, to suicide deaths that occur at community care facilities if we were to amend the bill to include that?

Dr. MILLER. Happy to answer that question. There have been 20 on-campus suicides to the present day this fiscal year. Adding information from non-VA sites applicable to veterans, I think, would be value added to our awareness and surveillance process.

We would be very happy to take a look at what would be needed to engage that process with our community partners, yes.

Ms. CHERFILUS-MCCORMICK. Thank you. I want to also talk briefly about the New Mexico Rural Veterans' Healthcare Access Act.

Dr. Clancy, in your testimony regarding the New Mexico Rural Veterans Healthcare Access Act, you mentioned that VA is taking action to address this issue. However, there are veterans currently electing to receive their care on the El Paso VA healthcare system because it is closer to them.

However, in VA's eyes they live within the catchment area of the Albuquerque VA and are therefore officially assigned to that facility and only receiving travel reimbursement when they travel to that facility.

What actions, if any, can the VA take right now to address this without requiring VISN lines to be redrawn to ensure that veterans who are already doing this are able to get their transportation reimbursed?

Dr. CLANCY. Great question. Mr. Heiman.

Dr. HEIMAN. Sure. Thank you, Ranking Member Cherfilus-McCormick and also thank you to Representative Vasquez for his testimony earlier.

We agree with the interest of examining the particular lines. That is something that we do not feel we need a law to actually accommodate, and as such, we are currently looking into every-

thing from referral patterns to transportation reimbursement, as you mentioned and as Representative Vasquez mentioned.

We are committed to this and we intend to brief the committee as well as local delegations of these efforts in and around the end of the calendar year.

Ms. CHERFILUS-MCCORMICK. Does VA have any plans to adjust the VISN boundaries to account for these veterans? If so, what is keeping the VA from doing this as expeditiously as possible?

Dr. HEIMAN. Thank you for the question. We are actively looking into what those boundaries could be, and I think certainly redistricting or reapplying the VISN structure and boundaries is something that is within our control and something that we are actively working at between VISN 22 and VISN 17.

Ms. CHERFILUS-MCCORMICK. Dr. Clancy, I understand that your testimony that the SAVES Act, which would create a 5-year pilot grant program for nonprofit organizations to provide service dogs to veterans, would likely require new staff in a dedicated office.

Do you have an idea of how many additional staffs would be needed to administer this program and within which program office with VHA would you house this program?

Dr. CLANCY. I will need to take that for the record, Congresswoman. I do not think it would be an enormous lift in terms of the number of staff, and I am guessing it would probably come under prosthetics but I do not want to speak for my colleague here. We will get back to you on that. He was about to say no.

Ms. CHERFILUS-MCCORMICK. Dr. Miller, can you explain more about why VA is concerned about the No Wrong Door Act codifying the Columbia-Suicide Severity Rate Scale as the only tool Fox Grant recipients may use to complete baseline mental health screenings?

What is the current practice? What are some other possible tools that could be used, and how would limiting the program to Columbia-Suicide Severity Rating Scale affect grantees and outcomes?

Dr. MILLER. Thank you for the question and let me be clear that the Suicide Prevention Program Office supports the Columbia as a scale from a validity and reliability perspective and sees the value of its role.

I think our concern can best be summarized in terms of codifying it as the tool to use. If a more effective tool arises in the next 2 to 3 years we want to be able to flexibly adjust to that and our current bylaws allow for that rather than an act of Congress, literally, to adjust from the Columbia to a different measure.

Ms. CHERFILUS-MCCORMICK. Thank you very much.

I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Cherfilus-McCormick.

The chair now recognizes Ranking Member Takano for 5 minutes if he has questions.

Mr. TAKANO. Thank you, Chair Miller-Meeks.

Dr. Miller, we received VA's interim report on the Fox Grant Program that included some limited data on the effectiveness of the program so far, and we appreciate that VA anticipates having additional data in its final report and believe these data will help Con-

gress and VA evaluate whether the program is working as intended.

Do you believe that limiting grantees to the Columbia-Suicide Severity Rating Scale would impair the level of data that grantees can collect and therefore limit our ability to assess the effectiveness of the program if we reauthorize it?

Dr. MILLER. Thank you for your question, sir, good to see you. Yes. We do believe that limiting to the Columbia would impact the reliability and the validity of outcome evaluation of the Fox Program.

With that said, we do not necessarily read in the legislation that outcome data is restricted to the Columbia necessarily as there are other measures and broader measures of well-being, mental health, financial status that will also be included in the outcome measures as part of the Fox Grant Program.

Mr. TAKANO. Okay. Well, I want to, kind of, switch gears here and talk about H.R. 9426 to carry out a pilot program under the secretary under which the secretary may fill vacant shifts at medical facilities of the Department of Veterans Affairs with non-departmental healthcare providers.

While I appreciate my majority counterpart's intent in putting forth a bill that would allow VA to use contractors to cover vacant shifts at VA medical facilities, I share VA's concern that key aspects of the bill are not clearly defined and the implementation would be difficult.

However, knowing that staffing shortages are often a concern for medical centers, I am glad to hear that our VISNs are already offering clinical resource hubs to ensure staffing needs are met in times of vacancies.

Can you expand on how that is activated and if it has so far been sufficient to address shortages?

Dr. CLANCY. I will give you a couple of examples. The notion is if a veteran, for example, is seen at Detroit and by a primary care clinician who then believes that that clinician needs a specialist but that specialist is not available or they do not have the capacity to see that veteran in a timely way at that facility, through this clinical resource hub they can identify another facility in the network where the veteran could get that care.

This has worked extremely well, as I understand it, in VISN 23, you know, which is Minnesota, Iowa, South Dakota, and North Dakota. It has allowed them to bring much more of the cardiology care back into VA.

Obviously, in areas in all of those states where there are not cardiologists everywhere. It also works very well on a number of other networks, but that is the intent of it.

In other words, the VISN is more than just a silent overseer, if you will, of multiple freestanding facilities but really is leveraging their capability as a system within a system, if that makes sense?

Mr. TAKANO. Dr. Clancy, are these, in this example you gave, would the cardiologist, would that be a VA doctor or maybe potentially a contract doctor?

Dr. CLANCY. A VA doctor.

Mr. TAKANO. Okay. That is through, so it is called a clinical resource hub?

Dr. CLANCY. Yes.

Mr. TAKANO. How does VA currently decide how and when to activate contracts with temporary help service firms?

Dr. CLANCY. We have put together a new contract, I think a year and a half ago, the interim critical staffing program where we can hire a whole array of medical, nursing, and other healthcare specialties as needed.

That would be activated by individual facilities. It can also activate administrative and managerial support as needed as well.

Mr. TAKANO. To what extent are these already in use?

Dr. CLANCY. I would have to take that for the record and get back to you, sir, because it became live shortly before we realized that we needed to be more strategic with hiring and so forth.

Mr. TAKANO. Madam Chair, I have a couple more just odd questions or do you want to just, kind of, stop now for now? Okay. All right. All right that is fine. I will yield back.

Mr. TAKANO. Thank you very much, Ranking Member Takano.

On behalf of the subcommittee, seeing that no other members are here, I wanted to thank all of you for your testimony and for joining us here today. You are now excused, and we will wait for a moment as the second panel comes to the witness table.

Dr. CLANCY. Madam Chair, I had one quick question. Representative Tokuda from Hawaii made a point today which clarified an issue for us which may require a correction or addendum to the written statement. Is that feasible?

Ms. MILLER-MEEKS. I think that you can submit that for the record.

Dr. CLANCY. Perfect, thank you.

Ms. MILLER-MEEKS. Welcome, everyone, and thank you for your participation today. On our second panel we have Mr. Brian Dempsey, director of Government Relations for the Wounded Warrior Project, Ms. Missy Meyer director of Community Integration at America's Warrior Partnership (AWP), Mr. Clark Pennington, chief operating officer at the Independence Fund, and Mr. Jon Retzer, deputy national legislative director for health at Disabled American Veterans.

Mr. Dempsey, you are now recognized for 5 minutes.

STATEMENT OF BRIAN DEMPSEY

Mr. DEMPSEY. Thank you. Chairwoman Miller-Meeks, Ranking Member Takano, and distinguished health subcommittee members, thank you for inviting Wounded Warrior Project to testify at this morning's hearing to discuss legislation intended to improve VA's ability to provide better access to care and ensure better health outcomes for our Nation's veterans.

Honoring and empowering wounded warriors has been at the heart of our mission since 2003. Meeting the needs of those who volunteered to serve our Nation and protect the freedoms we enjoy as Americans is not only a solemn obligation but a national priority.

Our written statement reflects our views on several of the bills before you, but for today's hearing on the anniversary of the September 11th attacks that led to our founding, I am going to focus

on legislation that we believe will be most impactful on the lives of the post-911 wounded, ill, and injured warriors that we serve.

First, we support H.R. 9438, the No Wrong Door Act, which would reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program through 2027 and extend an important tool for VA to provide upstream suicide prevention services in communities around the country.

We remain hopeful that the Fox Grant Program becomes a permanent fixture in VA's public health strategy, however, we believe that attention should be given to how service eligibility determinations are made and how clinical care can be responsibly provided before the program is made permanent.

To that end, we support adoption of the Columbia protocol for baseline mental health screenings, which were used at Wounded Warrior Project for the same purpose.

Second, we support H.R. 9427, legislation that would allow VA to provide grants to nonprofit organizations to provide outpatient mental health treatment services to veterans. While we appreciate the need to keep VA as a coordinator of unfragmented clinical care, we believe that embracing grants to direct care programs is a commitment most consistent with putting the needs of the veteran first, particularly when skepticism toward VA in the veteran community is an unfortunate reality for some.

We believe this legislation can be thoughtfully incorporated into the No Wrong Door Act so that grants are carefully coordinated with other community-based efforts to help serve an overarching intent to connect veterans to the care and support they need now, but also foster a healthier awareness of and trust in the VA services that are available.

Third, we support draft legislation to include a representative of the National Association of State Veterans Homes on the Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs.

VA's long-term support services reached just over a half a million veterans last year and 30 percent were under the age of 65.

While we do not have figures to definitively state how many of these younger veterans served after 9/11, one of Wounded Warrior Project's most significant programs, the independence program, supports warriors with moderate and severe traumatic brain injury symptoms or other debilitating injuries or illnesses for whom independent living may be far from assured in both the near and long term.

We need to plan for their futures and the present needs of aging veterans is more important than ever. We need to ensure that critical stakeholders in VA's long-term support service portfolio have a voice in that planning.

Shifting attention to veterans whose injuries may be more evident, we are proud to support H.R. 9478, the Veterans Supporting Prosthetics Opportunities and Recreational Therapy Act. This bill would raise adaptive prostheses and terminal devices for sports and other recreational activities to the same level as wheelchairs, artificial limbs, and special clothing as far as how VA is prepared to assist veterans on their path to a new normal.

Under current law, VA will not provide adaptive recreation equipment to a veteran unless it is part of a medical or rehabilitative treatment plan. This legislation would effectively remove this barrier between the veteran and the support they may need to pursue activities like biking, swimming, or weightlifting that can be every bit as beneficial to mobility and mental well-being as clinical or guided rehabilitative care.

We are proud to support this legislation because we have seen firsthand the positive and life-changing effects of adaptive equipment on a veteran's quality of life and mental health.

Last, I would also highlight the needs of post-911 veterans with traumatic brain injury as a basis for our support for H.R. 7504, the Rural Veterans Transportation to Care Act. Traumatic brain injuries and related neurocognitive impairment can challenge, if not totally eliminate, a veteran's ability to travel to and from VA medical appointments. Some may rely on caregivers but extensive commutes can add to the stress of caring for a loved one.

Others may rely on public transportation, which can be very tedious and time consuming, if it is even available in the rural areas where they live. The Rural Veterans Transportation to Care Act would expand access to VA's highly rural transportation grants to veterans residing in rural areas.

This VA grant-based program currently only helps veterans in highly rural areas travel to VA or VA-authorized health care facilities, but there are clearly many more who could benefit from this critical service.

Ladies and gentlemen, it is my distinct honor to be here to represent our Nation's wounded warriors and their families. Thank you for letting us do our part to keep the promise.

This concludes my testimony and I look forward to your questions. Thank you.

[THE PREPARED STATEMENT OF BRIAN DEMPSEY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Dempsey.

Ms. Meyer, you are now recognized for 5 minutes.

STATEMENT OF MISSY MEYER

Ms. MEYER. Chairwoman Miller-Meeks, Ranking Member Takano thank you so much for the privilege of being here today to testify. There are two bills that I would like to discuss today.

First, America's Warrior Partnership is in support of H.R. 9427 introduced by Chairman Bost to carry out the pilot program to provide grants to outpatient mental health facilities. The more our Nation can expand access to mental health care for veterans the better, but it must be done with a holistic approach.

Every veteran is unique. Offering counseling is wonderful. Additional choices such as outpatient facilities for mental health, access to traumatic brain injury treatments, since it is often concurrent with mental health crisis, and post-traumatic growth training can expand the resources that are available.

The main focus of my testimony today is going to be on the No Wrong Door for Veterans Act. AWP is focused on outreach to all veterans and as we told the committee last year, the original idea

of the SSG Fox Grant had a singular goal, find veterans in the community that need help and help them.

To reach that goal, Congress needs to implement reforms that specifically bring back outreach as the singular focus, streamline the intake into the VA for eligible Fox participants, and hold organizations accountable.

We are thankful for the committee's hard work on this program, and we offer a few observations and suggestions. As one of 80 grantees we have done a significant amount of outreach since Fox inception.

Currently we have screened 1,917 warriors for the risk of suicide using the Columbia-Suicide Severity Rating Scale, or the C-SSRS. 370 of those warriors discussed and disclosed some level of suicide risk or a previous attempt. That is 19 percent.

Ninety-four percent of the warriors that have turned to AWP with their thoughts and trusted us with the risk of suicide, were not seeking assistance for a mental health-related issue. The SSG Fox Program is working. Relationships are being built and connections to resources are made.

The Fox Grant is a success story and asking the question works. AWP, the VA, and Congress have all played an integral part in saving the lives of these warriors, but there is more to do.

First, we are thankful for the inclusion of language that directs briefings for VA employees in regard to the SSG Fox Program and ensuring a bi-direction, solid, working relationship with local VA staff is essential.

It is more important than ever that we have education for front-line staff at the VAs to understand this program and its purpose.

While the legislation mandates the C-SSRS as the only required screening protocol, AWP recommends also adding language that would make the additional baseline assessments discussed earlier as optional.

Rarely do veterans in our program complete all five of the additional baseline assessments and very rarely do they complete them twice as required. The assessments have been described as both triggering and redundant by both our staff and the warriors that they are being administered to.

Third, the emergent care section is very helpful. AWP recommends adding a section that clearly lays out expectations for the program and identifies boundaries for both the VA and the grantees.

The SSG Fox Grant Program is about outreach, however, the line has become muddied and expectations can be unclear. To fix this it would be helpful to add a section that requires a specific program on-ramp for veterans identified as eligible and in need of VA care.

The process does not need to be complex. It does not need to be burdensome. It can be done through the 988 crisis line. It can be done through local Veterans Affairs Medical Centers (VAMC) with expedited care or even a dedicated line for grantees to call when we have an eligible participant.

The key here is expedited. If we are going to ask the question we need to have a plan for the answer.

Fourth is accountability. The Fox Grant Program is working and to keep the program successful Congress and the VA must hold organizations accountable with verifiable metrics.

AWP recommends adding a section requiring the VA to develop accountability metrics in regard to outreach, screenings, eligible participants identified in the course of the program, referrals, et cetera and then require regular reports back to Congress.

While accountability and metrics are vital, the data collection tool implemented by the VA at the end of 2023 has had the opposite of its intended effect. The Fox Grant Program's assessments are meant to be anonymous but currently the tool requires a Social Security number and a date of birth to enter any data into the tool.

This has caused AWP to go from reporting nearly 100 percent of our data to less than 5 percent. AWP has suggested returning to the original anonymous participant identification numbers instead of requiring our warriors to provide personal health information to be in the program.

Finally, the only limitation AWP has on being more successful is funding. If the ceiling on grants was doubled tomorrow so would our outreach efforts. For these suggestions, please see our written statement that we have submitted.

Thank you for the opportunity to testify, and I look forward to any questions you may have.

[THE PREPARED STATEMENT OF MISSY MEYER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Meyer.

The chair now recognizes Mr. Pennington for 5 minutes.

STATEMENT OF CLARK PENNINGTON

Mr. PENNINGTON. Chairwoman Miller-Meeks, Ranking Member Takano, and distinguished members of the subcommittee, on behalf of Sarah Verardo, Chief Executive Office (CEO) of the Independence Fund, thank you for the opportunity to testify before you today.

The Independence Fund was founded in the halls of Walter Reed to serve catastrophically wounded veterans, their caregivers, and their families. While the Independence Fund submitted written testimony on most of the bills before the subcommittee, I will limit my remarks to two pieces of legislation that impact our constituency the most.

In 2017, VA promulgated a regulation entitled, "Prosthetics and Rehabilitative Items and Services" under 38 CFR, Part 17 that specifies when adaptive creative recreation equipment within prosthetics may be approved.

The regulation cites, "An item that is designed to compensate for or that may by design compensate for loss of physical, sensory, or cognitive function and is necessary for a veteran to actively and regularly participate in a sport, recreation, or leisure activity to achieve the veteran's rehabilitative goals."

This definition appears to cover items like a running blade, climbing blade, a swimming or diving prosthetic, among others. However, the regulation potentially limits VA's approval at a local level of such an item for a veteran unless it is part of a medically necessary rehabilitation plan to meet a medical goal and not for a

long-term life or health plan and a routine solitary or group activity for what VA states is only for personal enjoyment.

The wording of that regulation has the potential to bias VA practitioners and VA employees in the prosthetics approval chain from allowing these devices to be approved, ordered, manufactured, or provided to veterans who seek to remain active throughout their lives beyond the rehabilitation phase.

The very nature of this regulation appears to be at odds with VA's often invoked philosophy around whole health of the veteran and the VA's implied mission to help veterans heal and incrementally or ultimately achieve some degree of self-actualization and self worth despite their medical history.

The idea of using whole health approach to medicine is an important aspect of improving mental health and reducing suicide. Because of the disparity between VA's whole health philosophy and the regulation it imposes, limiting when veterans can obtain adaptive prosthetics, the Independence Fund is pleased to support Chairwoman Miller-Meeks' legislation that will amend Section 1702, Subparagraph 6 to specifically include adaptive prosthesis and terminal devices for sports and other recreational activities to the list of medical services VA must provide.

This legislation will ensure veterans seeking to enjoy and benefit from physical and psychological aspects of recreational activities will now be guaranteed access to the prosthetics they need to thrive. The Independence Fund encourages the committee to quickly pass this legislation.

Suicide prevention is one of VA's stated healthcare priorities. In 2020, Congress passed into law Commander John Scott Hannon Veteran Mental Health Care Improvement Act. Included in that act is the staff Sergeant Parker Gordon Fox Suicide Prevention Grant, which provides grant recipients the means and authority to evaluate suicidality through a mental health assessment.

In the case the veteran is deemed to need access to immediate higher level mental health care due to acute suicidal crisis, the statute requires the secretary to furnish that care. What is missing from the statute is the time requirement in which that care must be placed.

Along with reauthorizing the grant program, the No Wrong Door for Veteran Act mandates that if the secretary cannot provide the emergent care within 72 hours, the veteran will be deemed eligible for emergent suicide care under Paragraph 1720J of Title 38.

This is a much-needed provision. Veterans who are in acute crisis do not have days or weeks to be placed in a care setting that can address the crisis. This legislation will ensure that every care option is used so veterans are not left on their own while they are in the greatest period of need.

The Independence Fund fully supports the enactment of this legislation. This concludes my testimony and I am happy to answer questions.

[THE PREPARED STATEMENT OF CLARK PENNINGTON APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Mr. Pennington.

Mr. Retzer, you are now recognized for 5 minutes.

STATEMENT OF JON RETZER

Mr. RETZER. Chairwoman Miller-Meeks, Ranking Member Takano and Member Bergman, thank you for inviting DAV to offer our views on the veterans' healthcare bills being considered by the subcommittee today.

Many veterans do not recognize their veteran status and are not receiving care and benefits through the Veterans Health and Benefits Administration and community services.

By asking have you served healthcare providers and community partners can identify veterans who might otherwise go unnoticed and ensure they receive tailored healthcare, access to benefits, and community services. For this reason, DAV is pleased to support H.R. 6291, Have You Served.

Data is essential for preventing veteran suicide by identifying at-risk individuals, tailoring their interventions, and monitoring trends. Leveraging data enables VA to comprehend veteran suicide complexities, devise effective prevention strategies, and ultimately save lives.

Therefore, DAV supports H.R. 6330, the Veteran Sentinel Act, but recommends expanding its scope to also include collecting suicide data for veterans using the veterans community care program.

2.7 million rural and highly rural veterans confront unique obstacles in accessing VA's top-notch healthcare services. DAV supports H.R. 7504, the Rural Veterans Transportation to Care Act that would modify the existing transportation grant program to improve access to healthcare for rural veterans.

H.R. 9324, the Protecting Veteran Access to Telemedicine Service Act, would enhance telehealth care accessibility for veterans in remote or underserved areas by eliminating the in-person visit, a requirement for prescribing certain controlled medications.

DAV supports this bill as it would guarantee continuous medication access for veterans, regardless of their ability to physically go to a VA facility.

H.R. 9427 would direct the VA to carry out a pilot grant program for non-VA outpatient mental health facilities to ensure the delivery of culturally competent, evidence-based mental health care for veterans.

Rather than creating a parallel system with little oversight and potential lower standards of care, we recommend increasing the number of VA mental health clinicians to reduce the wait times for mental health care in VA and veteran community care program settings.

The recent VA Red Team report emphasized the need to expand the use of VA direct healthcare and balance the use of community healthcare services to prevent the erosion of the VA healthcare system.

Madam Chair, H.R. 9438, and No Wrong Door for Veterans Act, would amend and reauthorize the VA Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. DAV has no concerns about the provision to reauthorize the Fox Grant Program for an additional 3 years.

However, the bill would also establish a new access standard mandating a 72-hour deadline for the VA to provide services after

a veteran is referred to non-suicidal mental or behavioral health follow-up care.

Although we prioritize timely access to mental health services for veterans, this provision may risk disconnecting them from VA and other necessary support services. For these reasons we do not support this provision of the bill.

DAV supports H.R. 9478 to include adaptive prosthesis and terminal devices for sports and other recreational activities in VA's medical service package. These devices will help to promote physical activity and overall well-being among veterans, allowing them to engage in sports and recreational activities that they need and enjoy.

DAV supports the Safeguarding VA's Healthcare Workforce Act which would allow VA to bring in outside healthcare providers when they need to fill vacant shifts, ensuring enrolled veterans have timely access to care.

However, we highly recommend VA prioritize its efforts to maintain proper hiring and retention practices, strengthen internal staffing levels, and remain the primary provider and coordinator of care while effectively utilizing community care networks.

Finally, DAV supports the Service Dogs Assisting Veterans, SAVES, Act that would establish a pilot program to award grants to nonprofit organizations to assist in providing service dogs to eligible veterans.

This bill would also ensure prescribed service dogs are provided at no cost, that there is reimbursement for any required follow-up training, and as well as coverage of veterinary benefits for the life of the service dog.

Chairwoman Miller-Meeks, this concludes my testimony and I am pleased to answer questions you or members of the committee may have.

[THE PREPARED STATEMENT OF JON RETZER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you very much.

Thanks to all of you for your thoughtful comments.

I now recognize general Bergman for 5 minutes.

Mr. BERGMAN. Thank you, Madam Chair.

Thanks to all of you for being here today and your thoughtful, articulate, and timely testimony, not only timely in the subject at hand, but maintaining yourself within the standards of time. You know, you did not waste any time. You got right to the point.

I would like to focus on two important bills that will help improve veterans' access to mental health care and suicide prevention programs. First, the No Wrong Door for Veterans Act, which I joined Chairwoman Miller-Meeks in introducing last month. Despite spending more and more money each year on VA suicide prevention programs, more and more veterans continue to take their lives every day.

There is a—it leaves a hole not only, I think, I know in the family's heart, but it leaves a hole in those of us, and you included, trying to do the right thing for the right reasons for our veterans. It takes a little bit out of you every day knowing that we are still dealing with this.

The Fox Grant Program, which I helped to champion during the 116th Congress, complements VA's existing suicide prevention efforts by targeting veterans outside of the VA system and ensuring that those in need are able to receive evidence-based care.

The No Wrong Door for Veterans Act will reauthorize and improve the Fox Grant Program so that more veterans can continue to receive the suicide prevention that they need, prevention and care that is, not just prevention.

Second, I would like to highlight Chairman Bost's Veterans Mental Health Access Act which would create a pilot program to increase veterans' access to behavioral health care in the community. Both of these bills would make real changes to address the veteran mental health and suicide epidemic while protecting and complementing the important work of the VA.

Now for questions. Ms. Meyer, could you speak to the bureaucratic barriers at VA that might prevent a veteran from receiving mental health or suicide prevention care?

Ms. MEYER. Thank you for the question. The barriers tend to be twofold, one of them being the requirements of the program to be enrolled, participating in the lengthy and sometimes, well, most of the time redundant baseline mental health screenings.

We may have a veteran that is qualified based on the C-SSRS, however, they do not want to participate in four or five other baseline assessments, so they are now ineligible so they would not be then enrolled in the Fox Grant Program. AWP will still refer them to the VA.

Mr. BERGMAN. Okay. Do you think that the bills like Chairman Bost's Veterans Mental Health Access Act will give more options to veterans who need mental health care?

Ms. MEYER. We hope so.

Mr. BERGMAN. Okay.

Mr. Pennington, how has the Fox Grant Program improved veteran access to suicide prevention care?

Mr. PENNINGTON. Well, I would say that the Fox Grant is obviously an opportunity for organizations to capitalize on that funding to move their programs forward.

At the Independence Fund we do not typically take part in that in our suicide prevention. Our operation resiliency program is a program that is funded through 100 percent donations.

The Fox Grant is enabling us to also reach out to organizations like law enforcement and using that opportunity to educate law enforcement, who is typically our first responders onsite with somebody who is in crisis. That is a huge opportunity for us under the Fox Grant.

Mr. BERGMAN. Okay. I am going to interpret, but what you said is that the reforms to the Fox Grant Program included in H.R. 9438 will actually improve in broad-based, you know, more broad basing of these efforts and hopefully targeted to appropriate and much in need veterans.

Mr. PENNINGTON. Yes, sir.

Mr. BERGMAN. Okay.

Well, then with that, Madam Chair, I know there was a couple of hearings ago I went over my time so I am going to yield back 35 seconds.

Ms. MILLER-MEEKS. Thank you very much, General Bergman.

I now recognize myself for 5 minutes. Mr. Dempsey, can you elaborate on the benefits of requiring the baseline screening to be conducted using the Columbia protocol in terms of streamlining intake and standardizing data collection as specified in the reauthorization of the Fox Grant Program?

Mr. DEMPSEY. Of course. Thank you, Madam Chair. Our perspective on that bill in using the Columbia protocol is very much rooted in our own personal experience at Wounded Warrior Project where our largest programming investment has been in the delivery of mental health support and related care.

We recently established a triage team to help assign veterans to several programs within a continuum of support. The Columbia protocol has allowed us to quickly and effectively screen veterans for their risk of suicide and help assign them to the appropriate level of care.

I think it is the efficiency that you can move through and screen that has been the most beneficial aspect of us, but I would be happy to follow up with colleagues of mine who work with warriors directly and then we can, perhaps, provide some more insight on just how effective that has been for our organization. Thank you.

Ms. MILLER-MEEKS. Thank you.

Ms. Meyer, as you know, many VA medical facilities are not aware of the Fox Grant Program. Can you tell me why you think the quarterly briefings in this bill would build partnerships between the community and the VA, as well as increase care coordination and ultimately provide better care to our veterans?

Ms. MEYER. Yes, ma'am. Thank you for your question. I think that the quarterly briefings would be successful. When you become a grantee you are required to reach out to all the suicide prevention coordinators within your community and so we have done that.

Then the gap so far has been that then the frontline staff answering the phone has no idea when I call and say, hi, I am a Fox Grantee and I am a Fox participant. They do not even know what that is.

Making sure that they understand, knowing who we are when we make the phone call, knowing why we are calling to serve that veteran immediately would just, I think it could change the intake process completely.

Ms. MILLER-MEEKS. Thank you.

Mr. Retzer, the H.R. 9324, Protecting Veteran Access to Telemedicine Services Act of 2024, how do you believe this bill would better serve rural veterans who may not have a VA provider within a reasonable driving distance?

Mr. RETZER. Thank you for that question, very good question. We look at this situation as our veterans that are in challenges with barriers for geographical location or even climate, they may not be able to make their way VA all the time.

That brings a risk when there is a deadline to get their medications on time. Many other medications that they are taking actually are much needed for lifesaving purposes and actually have some risky side effects if they do not have that continuity of care from their medication. That is one of the things that we see in the

advancement in the use of telemedicine to be able to facilitate that gap and barrier.

Ms. MILLER-MEEKS. Thank you very much.

Mr. Pennington, in regards to H.R. 9478, the Veterans Sports Act, you have noted concerns about VA's policy of not providing adaptive recreation equipment such as adaptive prostheses or terminal devices when the equipment is intended solely for recreation.

How many veterans have you heard from who were denied such equipment due to this policy and could you provide any specific examples of veterans who are affected by this limitation and the impact it had on their physical, and even more importantly, their mental or emotional well-being?

Mr. PENNINGTON. Yes, ma'am, thank you. In reference to that, I mean, you can look back to a survey that we conducted in 2021 where we reached out to a significant population within our constituency that is seeing a significant reduction in the opportunity for recreational prosthetics.

I can bring two examples to you right now that we are currently working with the VA on that has specifically requested swimming blades, specifically requested opportunities to continue recreational opportunities and activities that they did prior to their injury that they no longer can do because of their injury and therefore is impacting their mental health.

Because of some of the restrictions in not just the fitting of a prosthetic to the individual initially, then the opportunity to have access to recreational prosthesis is not a significant mental health barrier for them.

We saw a significant decline in both of these that we have access to and that we presented to the committee before in the past that we really believe that this opportunity improves their mental health.

I did hear from the VA during their testimony here today that they believe this is already part of their process. I would say that the information coming from that level down to the practitioners inside of those VISNs is not happening because they are being denied access to these recreational prosthetics that ultimately go to mental health improvement.

Ms. MILLER-MEEKS. Thank you very much.

As a doctor and veteran I can certainly testify to the need for making people whole, similar to what their lives were before their injuries.

Seeing that no other members are here, I would recognize the ranking member for closing remarks but he is not here.

On behalf of the subcommittee I want to thank you all, all of the witnesses for being here today. I look forward to working with you and with the VA to address some of the issues facing our veterans and some of the points brought up today in testimony.

The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include extraneous material. Hearing no objection, so ordered.

I want to thank the members and witnesses for their participation today. This hearing is now adjourned.

[Whereupon, at 11:30 a.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Carolyn Clancy

STATEMENT OF CAROLYN CLANCY M.D., MACP
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VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

SEPTEMBER 11, 2024

Good afternoon, Madam Chair, Ranking Member Brownley, and other Members of the Subcommittee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today are Dr. Matthew Miller, Executive Director of the Office of Suicide Prevention, Dr. Ajit Pai, Executive Director for the Office of Rehabilitation and Prosthetic Services, and Mr. Ryan Heiman, Acting Director for Member Services.

VA does not have views on section 3(b) of H.R. 8562 or the draft bill that would require VA to carry out a pilot program to provide grants to outpatient mental health facilities. VA will provide these views to the Subcommittee in a letter after the hearing.

H.R. 6291 Have You Served Act

Section 2(a) would require VA to make grants to eligible entities for the purpose of carrying out the Ask the Question campaigns to encourage human services professionals, State and local governments, and community providers to ask consumers whether they or a loved one have served in the Armed Forces. Section 2(b) would require eligible entities that receive a grant use it to develop or expand an Ask the Question campaign and for associated program costs. Section 2(c) would define eligible entities to mean a State, Native American, or Alaska Native Tribe that develops a Governors Challenge Action plan (in the case of a State) or a Veteran suicide prevention plan (in the case of a Native American or Alaska Native tribe) and submits to VA a proposal for the implementation of such plans. Section 2(d) would require VA to provide technical assistance to eligible entities that receive grants. Section 2(e) would permit VA to make up to 25 grants for fiscal years (FY) 2024-and 2026, but each grant could not exceed $200,000. Section 2(f) would require eligible entities, as a condition of receiving a grant, to agree to submit to VA a report on the key performance indicators for the training provided using the grant funds. Section 2(f) would also require VA, no later than 1 year after enactment, to submit a report to Congress on the implementation of section 2, and for each fiscal year for which VA makes a grant under section 2, to submit a report to Congress on performance indicators for the training provided under such grants. Section 2(g) would require VA, in coordination with the Director of the Office of Management and Budget (OMB), to develop a plan to work with each Federal department and agency to implement Ask the Question campaigns, where appropriate,

through any social service or health care programs they operate. Section 2(h) would authorize $6 million each for fiscal years 2024 through 2028 to be appropriated to VA. Section 2(i) would define the term State to mean each of the several States, territories, and possessions of the United States, the District of Columbia, and the Commonwealth of Puerto Rico.

VA supports this bill, subject to amendments and the availability of appropriations. VA generally supports the bill's intent to encourage human services professionals, State and local governments, and community providers to ask consumers whether they or a loved one have served in the Armed Forces. However, the bill requires additional technical and clarifying edits to ensure VA can carry out this grant program. The bill needs greater clarity in terms of the application process; requirements for applicants; the award of grants; the use of grant funds; and the administration of the grant program. VA also recommends modifying some of the requirements in the bill, such as the provision of technical assistance and the content of such assistance, to be more permissive to ensure that VA has the necessary flexibility to support the successful implementation by grantees. Additionally, we recommend the bill be updated to clarify the time period(s) in which VA would be authorized to make these grants. First, subsections (e) and (h) refer to FY 2024, which is nearly over. Also, if enacted, VA would need time to publish regulations and develop a grant program to implement this authority. Second, the 3-year authorization period in section 2(e) (for fiscal years 2024 through 2026) does not align with the 5-year authorization of appropriations period in section 2(h) (for fiscal years 2024 through 2028). Additionally, section 2(e) would provide VA with discretionary authority to make up to 25 grants in fiscal years 2024 through 2026 but would require that each such grant be in an amount up to $200,000. The bill is silent on any limits to the number and amount of such grants in the fiscal years after 2026.

VA further recommends the bill be amended to support a broader array of VA services and benefits, including peer support, transition needs, and local community engagement related to a range of efforts, including increasing access to health care and benefits, promoting food security, combatting homelessness, improving employment and education opportunities, and addressing transportation needs. VA also recommends expanding the scope of eligible entities that can apply for grants to consider community partnerships and collaborations engaged in the VetResources Community Network managed by VA's Veterans Experience Office, and Veteran community partnerships managed by the VHA National Center for Healthcare Advancement and Partnerships.

VA would be pleased to provide technical assistance to this legislation to address these recommendations.

VA estimates this bill would cost $3.1 million in the first fiscal year that it could implement this authority (likely FY 2026); $5.3 million in the second year; and $13.7 million over a 3-year period, as seems to be contemplated in section 2(e).

H.R. 6330 Veterans' Sentinel Act

Section 2(a) would require VA, within 90 days of the date of the enactment of this Act, to establish in the Office of Mental Health and Suicide Prevention (OMHSP) a pilot program for at least 2 years under which VA establishes a working group to collect and analyze data regarding on-campus suicides and attempted suicides. The working group would have to include staff from across VA and would report directly to the OMHSP Executive Director. The working group would have to use root cause analysis (RCA) to review all on-campus suicides and attempted suicides; conduct Behavioral Health Autopsy Program (BHAP) assessments document reasons for any deficiencies in the collected data with respect to on-campus suicides; and communicate every 90 days with VA medical centers (VAMC) and field offices to coordinate the collection and review actions of the working Group with review actions carried out by VAMCs and field offices. The working group would have to consider, and could implement for purposes of the pilot program, improvements to the process by which VA collects data on on-campus suicides and attempted suicides to unify the disparate sources of such data. VA would have to provide to Congress annual briefings on the progress and findings of the working group. Within 30 days of the completion of the pilot program, VA would have to submit to Congress a report detailing the effectiveness of the working group and any recommendations to enhance the data collection and management by VA with respect to on-campus suicides and attempted suicides.

VA supports section 2(a), subject to amendments. Annually, Veteran suicide deaths that occur on VA property represent less than 0.5% of the more than 6,000 Veteran suicides each year. Although on-campus suicides among Veterans represent a small fraction of overall Veteran suicide events, the impact is often widely felt among those who love, care for, and serve Veterans.

In 2020, the Government Accountability Office (GAO) issued a report, *Veteran Suicide: VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides* (GAO 20-664),[1] which cited concerns with VA enterprise-wide processes for on-campus suicide surveillance. In response to GAO's recommendations, VA established an intra-agency workgroup; improved processes to accurately identify all on-campus Veteran deaths by suicide; and expanded analyses of on-campus Veteran suicides with annual reports of detailed findings that include information from RCAs and BHAP data. These efforts are in line with the general requirements of this section.

However, VA recommends some changes to section 2(a) to ensure resources can be used optimally to prevent Veteran suicide. Initially, it is important that the bill be amended to only impose requirements, such as using RCAs or BHAPs, when advisable. We recommend this for two reasons. First, BHAP family interviews are voluntary, and VA cannot mandate or require that family members complete an interview. Second, RCAs are extremely time- and resource-intensive, but they are not always necessary to determine how or why a suicide occurred. By extension, VA does not require RCAs for all suicide attempts or deaths by suicide that occur on a VA property. Similarly, BHAP

[1] https://www.gao.gov/products/gao-20-664

chart reviews are completed for all identified Veteran deaths by suicide, regardless of whether they are on-campus, but they are not completed for non-fatal suicide attempts, regardless of where they occur. If Congress were to require VA to conduct an RCA, in particular, for every suicide attempt on VA property, VA would require a significant increase in resources to support these efforts but would not expect to see sufficient value from this information to justify the investment. VA recommends that Congress not legislate a particular methodology or evaluation method, as this could also restrict VA's ability to develop and apply new and innovative solutions.

VA further recommends that references to OMHSP be removed (including in subsections (b) and (c) of section 2), because that Office no longer exists. We recommend against further specifying responsibilities for sub-organizations within VA; requiring the Secretary to take action is sufficient.

VA estimates section 2(a) would not result in any additional costs if it were amended as discussed above. If section 2(a) were enacted as written, while VA is unable to project a specific amount, it expects the costs would be significant.

VA supports section 2(b). Section 2(b) would amend section 1709B of title 38, United States Code to require VA, on an annual basis, to evaluate the statistical trends of suicides and attempted suicides by Veterans that occur on VA property and determine recommendations for preventing such suicides and attempted suicides. In its annual report to Congress under this section, VA would have to include the evaluation and recommendations and such other matters as determined appropriate.

The National Strategy for Preventing Veteran Suicide (2018-2028) underscores the importance of surveillance-related goals and objectives. Timely and useful surveillance efforts are needed to improve the ability to collect, analyze, and use information for action to bring an end to suicides among Veterans. Section 2(b) would support these efforts and ensure regular focus on these issues while ensuring that Congress would be informed of matters related to suicide prevention.

VA estimates section 2(b) would result in no additional costs.

VA defers to the Comptroller General regarding section 2(c). Section 2(c) would require the Comptroller General, within one year of the date of the enactment of this Act, to submit to Congress a report on the actions OMHSP has taken to meet VA's priority objective of preventing Veteran suicide, the challenges OMHSP has faced in making such actions, and recommendations for improvements.

H.R. 7504, Rural Veterans Transportation to Care Act.

Section 2(c) would require the Comptroller General, within one year of the date of the enactment of this Act, to submit to Congress a report on the actions OMHSP has

taken to meet VA's priority objective of preventing Veteran suicide, the challenges OMHSP has faced in making such actions, and recommendations for improvements.

This section would amend section 307 of the Caregivers and Veterans Omnibus Health Services Act of 2010 (Public Law 111-163; 38 U.S.C. § 1710, note), as amended, which requires VA to establish a grant program to provide innovative transportation options to Veterans in highly rural areas. The bill would amend this authority to include rural areas as well. It would also make tribal organizations eligible to be awarded a grant. It would amend the maximum amount of a grant under this section from $50,000 to $60,000 and would provide an exception to this threshold if the recipient is required to purchase a vehicle to comply with the requirements of the Americans with Disabilities Act of 1990 (ADA), 42 U.S.C. § 12101 et seq.), in which case the maximum grant amount would be $80,000. The bill would replace the current definition of highly rural in section 307 with definitions for the terms rural and highly rural, which would have the meanings given those terms under the Department of Agriculture Rural-Urban Commuting Areas coding system. It would also add a definition of the term tribal organization, which would have the meaning given such term in section 4 of the Indian Self-Determination and Education Assistance Act (25 U.S.C. § 5304). Finally, the bill would authorize to be appropriated such sums as may be necessary to carry out section 307 and remove the current language authorizing the appropriation of $3,000,000 each for fiscal years 2010 through 2022.

VA strongly supports this bill, subject to amendments and the availability of appropriations. This bill is very similar to a VA legislative proposal in the FY 2024 President's Budget request. We recommend the bill be amended to reflect VA's proposal more closely. Specifically, we recommend including county Veterans Service Organizations as eligible recipients and authorizing up to $140,000 for grantees needing to purchase a vehicle to comply with the ADA. We also recommend amending the definitions of the terms rural and highly rural in the bill to allow VA to use the Department of Agriculture Rural-Urban Continuum codes to define eligibility based on counties. Finally, we recommend including specific authority for VA to establish limitations regarding the purchase of new vehicles, including the frequency of vehicle purchasing and the number of vehicles that can be purchased by each grantee.

Lack of transportation in rural and highly rural areas is a well-known barrier to access to care. VA wants to ensure that Veterans living in rural and highly rural areas have access to transportation for their VA-authorized medical care and supports use of this grant program.

The current definition of highly rural in section 307 makes grants under this authority available only to applicants in 25 States. Expanding the scope of this grant to include rural, in addition to highly rural, areas and additional eligible recipients who serve Veterans in these areas would increase the impact of this program and would allow more eligible Veterans the opportunity to receive medical care that they may not otherwise receive.

VA's proposal matches H.R. 7504 in seeking an increase to the maximum amount of each grant from $50,000 to $60,000. Based on experiential data, an increase would help grantees avoid shortfalls caused by increasing costs in transportation. However, unlike H.R. 7504, which would authorize up to $80,000 if a grant recipient is required to purchase a vehicle to comply with the ADA, VA's proposal would make available up to an additional $80,000 to a grantee for whom the purchase of a vehicle is required to comply with the ADA, and use of an ADA-compliant vehicle ADA is required to implement or continue the grantee's transportation services under section 307. Currently, otherwise-eligible grantees who lack such vehicles may not apply or continue their program because of the high cost of purchasing vehicles needed to comply with the ADA.

VA would be pleased to provide additional technical assistance to this legislation to address these recommendations.

VA estimates this bill, as amended, would cost $24.3 million in FY 2025; $28.0 million in FY 2026; $147.4 million over 5 years, and $306.4 million over 10 years.

H.R. 8562 Parity for Native Hawaiian Veterans Act

Section 2 would amend 38 U.S.C. § 3765(3)(B), part of the Native American Direct Loan (NADL) statutes, to revise the definition of Native Hawaiian. This amendment would refer to the definition in section 801 of the Native American Housing Assistance and Self-Determination Act of 1996 (NAHASDA), 25 U.S.C. § 4221, rather than the definition in the Hawaiian Homes Commission Act (HHCA).

VA has no objection to this section. VA believes the substitution would not, on its face, have any effect on the use of the NADL Program. As such, VA has no objection to the amendments in section 2 of the bill.

VA's program authority under 38 U.S.C. §§ 3761 and 3765(1)(B) is limited to making direct housing loans to Native American Veterans residing on trust land, such as native Hawaiian Home Lands. It is VA's understanding that, even if this bill were enacted, the Department of Hawaiian Home Lands would continue to use the HHCA definition in determining who is a native Hawaiian eligible to lease Hawaiian Home Lands. If that is correct, then it would seem the number of Veterans using the NADL Program in Hawaii would, as now, be limited to those who meet the definition of native Hawaiian under the HHCA.

If the intent of the bill is simply to align VA's NADL definition with the one in NAHASDA, VA has no objection or technical recommendations. If, however, the intent is to provide more Veterans the opportunity to obtain NADL Program loans on Hawaiian home lands, we recommend consulting the Department of Justice, the Department of

Interior, and the Department of Hawaiian Home Lands for further technical assistance regarding the HHCA.

VA does not estimate any costs associated with section 2.

VA does not support section 3(a). Section 3(a) would add a new section 1703G to title 38 of the United States Code. Subsection (a) of this new statute would require VA to reimburse a Native Hawaiian health care system for the costs of care or services provided through such systems to Veterans eligible for such care or services from VA, regardless of whether such care or services are provided directly by VA, through purchased or referred care, or through a contract for travel. The phrase, Native Hawaiian health care system, would have the meaning given that phrase by section 12 of the Native Hawaiian Health Care Improvement Act (42 U.S.C. § 11711).

VA appreciates that Native Hawaiians have a unique experience and history, but this legislation raises operational and equity concerns and includes unclear language that could frustrate efforts to implement it, if enacted.

Initially, it is not clear that the legislation is necessary. Native Hawaiian health care systems may already be eligible to join VA's Community Care Network (CCN) and be paid for services furnished through VA's Veterans Community Care Program (VCCP). All enrolled Veterans in Hawaii are eligible for the VCCP based on residing in a State without a full-service VAMC. To the extent the Native Hawaiian health care systems have entered into agreements to furnish care through VCCP, Veterans could elect to receive this care from them.

Operationally, VA does not support the establishment of a unique reimbursement program for Veterans who receive care through the Native Hawaiian health care systems to the extent the bill would require VA to do so. Congress and VA have sought to consolidate VA's community care programs, and this bill would represent a divergence from that effort.

The bill includes unclear language as well. For example, it refers to a contract for travel, without specifying what constitutes a contract for these purposes, or even, seemingly, limiting reimbursement to travel related to the provision of health care. Additionally, the term care or services is undefined and could potentially include care or services that are not covered by VA's medical benefits package.

VA does not have a cost estimate for section 3(a) of this bill.

H.R. 9146 Ensuring Continuity in Veterans Health Act

This bill would amend 38 U.S.C. § 1703(d)(2), which sets forth the criteria covered Veterans and their referring clinicians must consider when determining if it

would be in the best medical interest of the covered Veteran to receive care or services through a non-VA entity or provider, to include continuity of care as a criterion.

VA does not support this bill. VA fully supports the consideration of continuity of care as a factor in determining if furnishing care and services through a non-VA entity or provider would be in a covered Veteran's best medical interest under the VCCP. VA has already regulated this in 38 C.F.R. § 17.4010(a)(5)(v), which lists the potential for improved continuity of care as a factor. Because this has already been regulated, this bill is not necessary. VA believes this language would be redundant given current regulations and practice, and enacting a bill of this type could result in confusion in this area given the minor variations in phrasing between this bill and VA's existing regulation.

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

H.R. 9301 New Mexico Rural Veterans Health Care Access Act

H.R. 9301 would require VA, within 180 days of the date of the enactment of this Act, to redraw the boundaries of the Veterans Integrated Service Networks (VISN) to include Otero County and Eddy County, New Mexico, in VISN 17.

VA does not support this bill. VA agrees with the interest in re-examining where the facilities in these two counties report, and efforts are already underway to examine whether shifting these counties from VISN 22 to VISN 17 is appropriate. VA is still examining the data, though, as it needs to ensure that referral patterns and support systems (such as transportation options) could be maintained or enhanced so that Veterans can continue accessing high quality care closer to home. We need to ensure that any change in operational alignment does not adversely affect Veterans' access to care and benefits. VA plans to brief the Committee and the local delegation on its decisions and efforts in this area by the end of this calendar year. We believe that the efforts already underway may obviate the need for this bill.

VA is concerned that legislating VISN boundaries could have adverse effects and consequences. VA has authority today to establish VISNs and adjust their boundaries as needed; if Congress legislates the boundaries in law, VA would be required to continue to adhere to those requirements. This could limit VA's ability to respond to new or evolving concerns, which could have adverse effects on patient outcomes and satisfaction. We note, however, that Veterans are not limited to receiving care only within one VISN. Many Veterans in Otero and Eddy Counties currently receive care through the VA El Paso Healthcare System in VISN 17. In fact, in FY 2024, more than 900 Veterans from these two counties received more than 9,000 encounters at the VA El Paso Healthcare System.

VA does not have a cost estimate for this bill.

H.R. 9324 Protecting Veteran Access to Telemedicine Services Act of 2024

Section 2 of the bill would add a new section 1730D to title 38 of the United States Code regarding the delivery, distribution, and dispensation of controlled medications through telemedicine. The proposed subsection (a) of this statute would state that, pursuant to 38 U.S.C. § 1730C and the requirements of title III of the Controlled Substances Act (CSA), 21 U.S.C. § 801 et seq, covered health care professionals could use telemedicine to deliver, distribute, or dispense to eligible patients a controlled substance that is a prescription drug as determined under the Federal Food, Drug, and Cosmetic Act, 21 U.S.C. § 301 et seq, regardless of whether the professional has conducted an in-person medical examination under the following two circumstances.

First, if the covered health care professional is acting in the usual course of professional practice and is authorized to prescribe the basic class of such controlled substance under an active, current, full, and unrestricted State license, registration, or certification. Second, if the substance is delivered, distributed, or dispensed for a legitimate medical purpose. Proposed section 1730D(b) would require VA to establish in regulations guidelines and a process for the delivery, distribution, and dispensation of a controlled substance pursuant to subsection (a). Proposed section 1730D(c) would provide that nothing in this section could be construed to remove, limit, or otherwise affect any obligation of a covered health care professional under the CSA. Proposed section 1730D(d) would define the terms (controlled substance, deliver, dispense, and distribute) by reference to section 102 of the CSA. It would also define the term covered health care professional to mean a health care professional who is a VA employee appointed under 38 U.S.C. §§ 7306, 7401, 7405, 7406, or 7408; or under title 5; who is not a VA contractor; who is authorized by VA to provide health care under chapter 17; who is required to adhere to all standards for quality relating to the provision of health care in accordance with applicable policies of the Department; who has an active, current, full, and unrestricted license, registration, or certification or meets qualification standards set forth by VA within a specified time frame; and, with respect to health care professionals listed under 38 U.S.C. § 7402(b) (which includes physicians, dentists, nurses, and other providers), has the qualifications for such profession as set forth by VA. The term would also include health professions trainees appointed under 38 U.S.C. § 7405 who are under the clinical supervision of a health care professional described above.

VA strongly supports the bill, subject to amendments. VA currently faces two significant barriers to ensuring providers can furnish care, including prescribing controlled substances, to Veterans through telehealth: restrictions within the CSA, and the variability in State law regarding the use of telehealth. These barriers create significant access challenges for Veterans. This bill appears to be intended to address the first of these barriers. While VA strongly supports the goal of this bill, amendments would be required to ensure it addresses the first issue, and further amendments would be needed to address the second.

As written, this bill appears to be intended to permanently extend Federal pandemic prescribing authorities (which have been continued on a temporary basis through rulemaking by the Drug Enforcement Administration (DEA) and the Department of Health and Human Services through December 2024) that have helped expand access since early 2020. These Federal pandemic authorities allowed qualified VA health care professionals to prescribe controlled substances following a telemedicine assessment, without a prior in-person medical evaluation,[2] when clinically appropriate. If those Federal pandemic authorities are made permanent for VA providers, this could mitigate the risk of access disruption for Veterans who continue to rely on VA telehealth services for critical aspects of their health care. It would further enable VA to more effectively leverage its national, integrated health care resources to Veterans regardless of their geographic location.

While the bill appears intended to address this concern, it does not address similar barriers in variable and fluctuating State laws, thereby limiting its effectiveness in protecting access to Veterans across State lines. The CSA generally prohibits providers from prescribing controlled substances in the absence of an in-person medical evaluation. See 21 U.S.C. § 829(e). Providers can prescribe controlled substances without having conducted a prior in-person medical evaluation if the provider is engaged in the practice of telemedicine (which is limited to seven specific scenarios) or if the provider is a covering practitioner. See 21 U.S.C. §§ 802(54) and 829(e). The practice of telemedicine as defined in the CSA generally requires compliance with applicable Federal and State laws.

These requirements concerning applicable State laws create ambiguity and legal concerns for VA health care professionals that could be subject to different State laws. Applicable State laws could be interpreted under the CSA as those in the provider's State of licensure; the provider's State of practice; the provider's State of registration with the DEA; the patient's State of residence; or the patient's location at the time of the clinical encounter. If one or more of these States' laws apply, a VA provider might be required to operationalize multiple practice standards; provide similar Veterans with different services; modify the treatment of a single Veteran based on the location at the time of a visit; or be prohibited from prescribing medically appropriate treatment at all.

VA has included a legislative proposal in the FY 2024 and FY 2025 President's Budget request to address the risk of variable State laws to Veteran access to care, while ensuring that providers remain subject to the CSA's requirements that prescriptions be for legitimate medical purposes and prescribed in the usual course of practice. Where these requirements are defined by State law, VA's proposal would authorize VA health care professionals to prescribe necessary controlled substances for

[2] As an example, a Veteran's local primary care provider may refer the Veteran for specialized mental health care. The mental health specialist needed is available but works in another State. The mental health assessment and ongoing treatment can be completed entirely through telemedicine. The Federal pandemic authority enabled the mental health specialist to treat the patient, including with controlled substances when necessary, based on their expertise.

their patients when adhering to national prescribing standards, regardless of a Veteran's location in the country and variable State laws.

Specifically, VA's proposal would require VA health care professionals to follow national telemedicine prescribing standards, as outlined in Federal law and regulations and supplemented by VA policy. In areas where a national standard had not been defined, VA health care professionals would follow the laws of their State of licensure.

Authorizing VA health care professionals to follow a single, understandable Federal framework for telehealth-controlled substance prescribing would enable VA to maximally leverage telehealth to expand access, reach vulnerable Veterans in rural communities, and deliver equitable services to all Veterans, wherever they are in the country.

Again, VA greatly appreciates the Committee's interest in addressing access risk for Veterans. VA would further appreciate the opportunity to discuss its proposal with the Committee to facilitate legislative action in this area and to ensure it fully achieves its goal of protecting Veterans' access to critical services by addressing both the Federal- and State-level barriers. We stand ready to provide technical assistance on this bill.

No costs are associated with VA's legislative proposal.

H.R. XXXX Service Dogs Assisting Veterans Act (SAVES Act)

Section 2 of this bill would require VA, not later than 24 months after the date of the enactment of this Act, to establish a 5-year pilot program under which VA would award grants, on a competitive basis, to nonprofit entities to provide service dogs to eligible Veterans. To receive a grant, nonprofit entities would have to submit to VA an application at such time, in such a manner, and containing such commitments and information as VA may require. Applications would have to include a proposal for the provision of service dogs to eligible Veterans, including how the entity would communicate with VA to ensure an increasing number of service dogs are provided to Veterans; a description of training and services provided by the entity; and documentation certifying the nonprofit entity is accredited by Assistance Dogs International or the International Guide Dog Federation, among other requirements.

VA would have to award a grant to each non-profit entity for which VA has approved an application. VA and the entity would have to enter into an agreement containing such terms, conditions, and limitations as VA determines appropriate. VA could establish a maximum amount to be awarded to each non-profit entity each FY under this section and would have to establish intervals of payment for the administration of each grant awarded under this section. Grantees would have to use the grant amounts to plan, develop, implement, or manage (or any combination thereof) one or more programs that provide service dogs to eligible Veterans. VA could establish

a maximum amount for each grant awarded under this section to cover administrative expenses. VA also could establish other conditions or limitations on the use of grant amounts.

Grantees would have to notify each Veteran that receives a service dog through the grant that the dog is being paid for, in whole or in part, by VA, and they would have to inform such Veterans of the benefits and services available from VA for the Veteran and service dog. Grantees could not charge a fee to a Veteran receiving a service dog through the grant.

Veterans with a mental health condition seeking a service dog from a grantee under this section would have to meet with a VA mental health provider. The mental health provider and the Veteran's care team would have to evaluate the Veteran and determine whether the Veteran has substantial mobility limitations, whether the mental health condition of the Veteran is the primary cause of such limitations, and whether a service dog would be the optimal intervention or treatment approach for the Veteran. If they determine a service dog would be the optimal intervention or treatment approach, the mental health provider and care team would have to request a service dog from a grantee on behalf of the Veteran through coordination with the Prosthetic and Sensory Aids Service of the local VAMC.

VA would have to provide to each Veteran who receives a service dog through a grant a commercially available veterinary insurance policy for the service dog, and, if VA provides such a veterinary insurance policy to a Veteran, VA would have to continue to provide the policy without regard to the continuation or termination of the pilot program.

VA could provide training and technical assistance to recipients of grants under this section. VA would have to establish oversight and monitoring requirements as appropriate to ensure grants are used appropriately, and VA could take actions as necessary to address any issues identified through the enforcement of such requirements. VA could require each grantee to provide reports or written answers to specific questions, surveys, or questionnaires as VA determines necessary.

Eligible Veterans would be defined to mean Veterans enrolled in VA health care (or otherwise eligible for care) who have one or more of the following disabilities, conditions, or diagnoses: blindness or visual impairment; loss of use of a limb, paralysis, or other significant mobility issue, including mental health mobility; loss of hearing; posttraumatic stress disorder (PTSD); traumatic brain injury (TBI); or any other disability, condition, or diagnosis VA determines, based on medical judgment, that it is optimal for the Veteran to manage the disability, condition, or diagnosis and live independently through the assistance of a service dog. The term service dog would mean any dog that is individually trained to do work or perform tasks that are for the benefit of a Veteran with a disability, condition, or diagnosis described above and directly related to the disability, condition, or diagnosis of the Veteran. There would be authorized to be appropriated $10 million for each of the 5 consecutive fiscal years following the fiscal year in which the pilot program is established.

VA supports this bill, subject to amendments and the availability of appropriations. For more than 60 years, VA policy and regulations have recognized the value of service dogs for certain conditions and the benefits they can provide to Veterans. VA provides benefits for service dogs for eligible Veterans who have been diagnosed with a visual, hearing, or substantial mobility impairment (including mental health mobility) when the VA clinical team treating the Veteran for such impairment determines, based upon medical judgment, that it is optimal for the Veteran to manage the impairment and live independently through the assistance of a trained service dog. *See* 38 C.F.R. § 17.148(b). VA provides a commercially available veterinary insurance policy for service dogs, as well as payments for travel expenses associated with obtaining a dog if the Veteran is eligible for beneficiary travel under 38 U.S.C. § 111 and 38 C.F.R. part 70 and if pre-approved for such benefits.

While not involving the provision of service dogs, since February 2022, VA has been implementing the Puppies Assisting Wounded Servicemembers for Veterans Therapy Act (Public Law 117-37), which requires VA to conduct a pilot program to provide canine training to eligible Veterans diagnosed with PTSD as an element of a complementary and integrative health program for such Veterans. Service dogs provide essential support for many Veterans.

VA appreciates that this bill has addressed a number of technical concerns identified with an earlier companion draft of this legislation. VA still recommends this bill be amended to those address technical concerns.

We appreciate that the bill generally focuses on creating a more direct connection in the legislation between grant funds and the provision of service dogs to eligible Veterans, but we believe this could be clearer. Specifically, in section 2(d), the bill would require grantees to use funds to plan, develop, implement, or manage (or any combination thereof) one or more programs that provide service dogs to eligible Veterans. Allowing the use of funds to plan a program that provides service dogs, but which ultimately does not provide service dogs, is not an ideal use of funds. We recommend the bill simply state that grantees would use funds to provide service dogs to eligible Veterans. In VA's experience, Veterans can wait between 1 and 3 years between when a dog has been recommended by VA and when a Veteran has been fully paired with a service dog that has graduated training. VA believes the grants provided under this authority could help increase the supply of service dogs to reduce this delay. In any grant program, but particularly in the case of service dog training, it is essential to ensure that funds are properly used.

Several provisions in the bill raise concerns. First, VA recommends clearly aligning the definition of service dog under this section with VA's existing definition in regulations. Second, VA is concerned about the list of disabilities that was presented in the bill. Specifically, the inclusion of TBI, for which a Veteran may already otherwise qualify based on having a significant mobility issue, and PTSD, as there is no substantial evidence to date that service dogs provide improvements in functioning and

quality of life for Veterans with PTSD as compared to emotional support dogs. VA recommends striking these provisions and including other language that would ensure clear authority for the administration of a grant program. We note, similar to the discussion above regarding Veterans with TBI qualifying for a service dog when they have a significant mobility issue, Veterans with PTSD can receive a service dog on the same basis. We further recommend that subsection (f), which would establish a process for Veterans with mental health conditions, be removed. While it is an accurate statement of VA's current policy, the bill does not refer to other types of service dogs, which creates the impression that there would be a different process or expectation for other types of service dogs.

We also note that this proposal would likely require dedicated staff in a new office to administer this program.

VA estimates this bill would cost $0.3 million FY 2025, $0.3 million in FY 2026, $24.1 million over 5 years, and $51.1 million over 10 years.

H.R. XXXX Including Adaptive Prostheses and Terminal Devices for Sports and Other Recreational Activities in Medical Services

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

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

VA believes this language would be redundant given current regulations and practice. In addition, we express concern that enacting a bill of this type could result in confusion in this area. Such confusion could jeopardize or frustrate the delivery of benefits to Veterans because this language does not align exactly with VA's current

regulations. This could lead to an inference that the bill is intended to create benefits different from VA's current regulations and could lead to litigation.

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

Adaptive prostheses are designed to combine and amplify the range of movements a prosthesis can accomplish to help people feel as able-bodied and mobile as possible. A prosthetic terminal device is the part of a person's arm that interacts with the people and things around them. There are activity-specific terminal devices that are more like tools that allow people to tackle specific work tasks or hobbies. The adaptive recreation equipment VA providers prescribe and furnish include adaptive prostheses and terminal devices as explained above.

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

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

H.R. XXXX No Wrong Door for Veterans Act

This draft bill would make several amendments to section 201 of the Commander John Scott Hannon Veterans Mental Health Care Improvement (Hannon) Act of 2019, P.L. 116-171, which authorized the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SPGP). First, it would change the requirement for the Secretary to consult with OMHSP in carrying out this program. The Secretary would instead be required to consult with the Assistant Under Secretary for Health (AUSH) for Clinical Services. Second, it would limit the use of grant funds to provide that not more than 5% of a grant could be spent on food and non-alcoholic beverages in a fiscal year. Third, it would require the Secretary to provide to the appropriate personnel of each VAMC within 100 miles of the primary location of a grantee a briefing, not less than once per calendar quarter, about the grant program to improve the coordination between a grantee and the VAMC personnel. Fourth, it would extend the authority to carry out this pilot program until September 30, 2027. Fifth, it would amend subsection (n), which requires VA to provide care to eligible individuals in certain situations, to state that if VA does not provide services to an eligible individual during the 72-hour period following a referral from a grantee, the eligible individual would be treated as eligible for

emergent suicide care under 38 U.S.C. § 1720J. Sixth, it would extend the authorization of $174 million to be appropriated from FY 2025 until FY 2027. Seventh, it would make a technical change to the definition of emergency treatment. Finally, it would state that the baseline mental health screening for grantees awarded a grant on or after the date of the enactment of this Act would be the Columbia-Suicide Severity Rating Scale (C-SSRS).

VA cannot support the bill as drafted, but could support this bill, subject to amendments and the availability of appropriations. VA supports two of the amendments this bill would make, specifically extending the duration of the pilot program through FY 2027 and the technical correction to the definition of emergency treatment which would have no substantive effect on benefits for eligible individuals. However, VA recommends the authority to conduct the program be extended further to operate for 8 years, or through FY 2030 because the amendment here would only authorize a little more than 2 additional years beyond the current authority).

VA has significant concerns with some of the changes this bill would make and seeks amendment to these provisions. The required quarterly briefings to VAMCs would likely require resources disproportionate to the value that would be realized from sharing this information. VA currently provides information to facilities and staff to support coordination, and we believe these efforts are sufficient. Also, VA is significantly concerned about codifying the use of the C-SSRS, which is currently a tool used by VA as one component of eligibility screening, in that it identifies individuals with suicidal thoughts and behaviors. Placing this in statute would prohibit VA from adopting another more effective tool should one be identified as more appropriate for the community-based setting. VA is invested in robust program evaluation to measure long term outcomes and ultimately identify and scale best practices for maximum benefit. It is essential that VA retains the ability to adjust the program, including the use of specific tools, in response to grantee feedback and early program evaluation outcomes, to include the eligibility scope and process, to best serve at-risk Veterans and their families. We note that VA has already stipulated in its regulations that the screening tool used by grantees must be a validated tool and will be announced in each notice of funding opportunity; this arrangement preserves VA's flexibility to ensure the best results for Veterans.

The change to treat eligible individuals who cannot receive care within 72 hours following a referral from a grantee as an eligible individual under 38 U.S.C. § 1720J also raises significant concerns over its potential inadvertent effects. The term eligible individual, for purposes of the SPGP, already overlaps significantly with eligibility under section 1720J(b), as Veterans (under 38 U.S.C. § 101) and individuals described in section 1720I(b) (referring generally to former Service members with other-than-honorable discharges) already qualify for both programs. Including the 72-hour limitation in section 201 of the Hannon Act could be read to infer that these individuals are not eligible under section 1720J until the 72-hour period has lapsed. The SPGP provides support and services to individuals who screen at low-, moderate-, and high-risk for

suicide, and participants are already referred to VA for routine mental health assessments and care.

Emergent suicide care under 38 U.S.C. § 1720J, by contrast, is available only for Veterans experiencing acute suicide risk. Given the overlapping authority, most SPGP participants are already eligible for emergent suicide care under section 1720J. The only potentially positive effect that could result from this provision would be the inclusion under section 1720J of members of the Armed Forces who are eligible for readjustment counseling services under 38 U.S.C. § 1712A(a)(1)(C)(i)-(iv). It is unclear, though, if this is the intent; if it is, it would seem simpler to amend section 1720J itself, or else only those individuals who are referred through the SPGP would be eligible. For Veterans or former Service members described in section 1720I(b), VA provides same-day care and assessments for mental health issues. In this context, current authority and programs seem to meet or exceed what the bill would provide.

Another concern is that the bill would extend the duration of the program, and it would extend the period of the authorization of appropriations, but it would not increase the amount of authorized appropriations. Without increasing the amount, VA would have no additional funds to carry out the program, which would frustrate the intent of VA and Congress. Consequently, VA recommends increasing the authorized amount of appropriations to reflect the extended time period in which the SPGP could operate. An increased authorization amount would also permit scaling the program to a nationwide effort.

Several of the amendments are not necessary, including the change to require the Secretary to consult with the AUSH for Clinical Services instead of OMHSP (as the Offices of Mental Health and Suicide Prevention report to the AUSH for Clinical Services). OMHSP has separated into two offices, the Office of Mental Health and the Office of Suicide Prevention. We recommend the bill strike any reference to a sub-component of VA, as this would avoid further confusion that might arise from reorganization or renaming of existing offices. The responsibility for implementation ultimately rests with the Secretary, so identifying further offices is neither necessary nor constructive. Also, VA does not view a limitation on the use of funds for food and non-alcoholic beverages as necessary within the pilot phase, where VA continues to gather data to inform the extent of this funding need and the justification for any such limitations. We do note that the limitation on non-alcoholic beverages implies there is no limitation on alcoholic beverages, which we do not believe would be appropriate.

VA also recommends including additional amendments to section 201 of the Hannon Act in this bill. Specifically, VA recommends removing the cap of $750,000 per grantee per fiscal year under section 201(c)(2)(A). This amount has not changed since the first grants were awarded in 2022, and if the program is extended in duration, this cap will mean that grantees will receive relatively less support each year due to inflation. Similarly, to address the issue noted above regarding the authorization of appropriations cap, we recommend authorizing such sums as may be necessary for FY 2021-FY 2030 (or through FY 2027, as the bill would permit). VA further recommends removing the

requirement to coordinate with the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide Task Force, as this Task Force is no longer operational.

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

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

VA estimates the bill, if amended as described above, would cost an additional $0 in FY 2025, $115.5 million in FY 2026, and $613.2 million through FY 2030.

H.R. XXXX Directing VA to Carry Out a Pilot Program under which VA May Fill Vacant Shifts at VA Medical Facilities with Non-VA Health Care Providers

Sections 1(a) and (g) of the draft bill would require VA, not later than 1 year after the date of the enactment of this Act, to carry out a 3-year pilot program under which VA may fill a vacant shift at a VA medical facility with a non-VA health care provider. Section 1(b) would require VA to seek to enter into at least one agreement with an entity that employs or contracts with health care providers and VA would pay the entity a fixed rate for each shift filled by such entity under the pilot program. Section 1(c) would prohibit VA, under the pilot program, from filling a vacant shift at a VA medical facility with a non-VA health care provider unless the number of vacant shifts at the facility reaches a minimum number or percentage prescribed by VA. Section 1(d) would require VA to carry out the pilot program in medical facilities of not more than two VISNs. VA

would have to give preference to facilities located in a rural area or with a historically high rate of vacant shifts. Section 1(e) would require VA to restrict access of non-VA providers to only the medical records of Veterans whom the provider furnishes hospital care or medical services. Section 1(f) would require VA to submit to Congress a report on the pilot program by not later than 21 months after the date on which VA begins the pilot program and 90 days after the date on which the pilot program ends.

VA does not support this bill. VA fully agrees with the desire to ensure that Veterans can retain access to care, but we believe critical elements of this draft bill are undefined and could result in worse patient experiences. Also, we do not believe this draft bill is necessary given other efforts VA is undertaking and VA's existing authority.

Initially, there are key pieces of this draft bill that are not clearly defined. It is unclear what is intended by the term vacant shift. For example, whether this is intended to refer to day-to-day absences (such as unexpected sick leave or travel), or if this is intended to refer to longer duration absences (such as the period following the departure of an employee before a replacement can be hired). VA has developed several options to provide short- to medium-term support when needed based on employee absences or departures. For example, VA has developed VISN-based Clinical Resource Hubs (CRH) to fill short-term, often unexpected absences of employees – particularly providers. CRHs also expand access to care by providing more resources when local facilities experience gaps in care or service capabilities. While the CRHs originally started with a focus on furnishing primary care and mental health, they now provide support for additional specialties. Further, VA awarded a multi-year contract for the Integrated Critical Staffing Program (ICSP) in January 2024. VA has been using the ICSP principally to ensure that qualified staff (often clinicians, but not always) are able to fill positions on a temporary basis while efforts are underway to fill vacancies. We would welcome the opportunity to discuss this program with the Committee, as it may already address many of the concerns that were the basis for this bill. We also have authority under 5 C.F.R. § 300.503 to hire temporary employees via contract for short-term vacancies, and, under 5 C.F.R. § 300.504, we can contract with temporary help service firms for an initial 120 workdays and may extend this to 240 workdays if needed.

Similarly, the draft bill does not define the term provider. Together, these omissions make it impossible to determine whether the bill would raise labor-management concerns. Depending upon the structure of the pilot program and the terms of the contract, this bill could affect our collective bargaining agreements regarding the terms and conditions of employment for our bargaining unit employees. It is also unclear whether this bill would result in issues regarding compliance with OMB Circular A-76, which establishes Federal policy regarding the performance of commercial activities and whether they should be performed under contract with commercial sources or in-house using Government facilities and personnel.

We also have concerns with some of the specific provisions in the draft bill. For example, subsection (b) would require VA to pay the entity a fixed rate for each shift

filled by such entity under the pilot program. VA does not believe that legislating contract terms is an ideal way to ensure that VA is able to obtain favorable terms. A fixed-rate payment structure may be advisable, but it may not be, and without market analysis, this draft bill would force VA to adopt a single approach, regardless of its utility. VA typically does not contract for work paying a fixed rate for each shift. VA normally contracts for full time employees or equivalents with a built-in reduction for hours not actually worked to avoid overpayment. This subsection also raises the question of whether this language would give VA sole source authority to enter into a contract with an entity without regard to competition or set aside requirements under VA's Vets First Contracting Program. This language would also seem to prohibit VA from contracting directly with providers, as it refers to VA seeking to enter into an agreement with an entity that contracts or employs providers. This could also frustrate VA's efforts to fill vacancies with qualified providers if those providers are unwilling to contract with or work for another agency. The draft bill is also silent regarding tort liability, so VA's agreements would need to clarify this.

Additionally, subsection (c) would prohibit VA from filling a vacant shift unless the number of vacant shifts at the facility reached a minimum number or percentage prescribed by VA. It is unclear how VA would determine such a minimum number or percentage. Further, to the extent the facility is at or around this number or percentage, the facility's ability to fill a vacant shift might vary day-by-day (or even hour-by-hour). VA would likely need to develop very specific operational requirements and monitoring systems to ensure compliance with this, which would result in significant additional overhead and administrative costs with little associated value in terms of Veterans' access to care. Subsection (e) would require VA to restrict access to medical records, but this would be technologically difficult to implement. VA currently restricts access to records on a need-to-know basis, but it does not have the means to completely bar access to records to providers with access to the system, as the bill seems to contemplate. Developing systems that are able to restrict this access could result in barriers to care, particularly when unexpected conditions arise among patients being treated by these providers, that might jeopardize patient care. Personal identity Verification (PIV) credentialing is also required to access VA systems, but it is not clear if or how this could be accomplished, in part because it is unclear how many days each provider would work for VA in a given year (which has an impact on PIV credentialing).

VA is also concerned that the pilot program contemplated in the draft bill might result in inconsistent Veteran experiences. VA has rigorous training requirements for its providers – and many of these were established in law by Congress – and it is not clear that these short-term contracted providers would be able to meet such standards. This could result in differences in experience and qualification for these contracted providers relative to VA employees or significant additional cost to VA if they are able to comply with these requirements.

VA does not have a cost estimate for this bill.

H.R. XXXX Including a Representative of the National Association of State Veterans Homes on the VA Geriatrics and Gerontology Advisory Committee

This bill would amend 38 U.S.C. § 7315(a) to require the Secretary's appointment of members of the Geriatrics and Gerontology Advisory Committee (the Advisory Committee), upon the recommendation of the Under Secretary for Health, to occur in consultation with the President of the National Association of State Veterans Homes (NASVH) with respect to matters concerning such association. It would further require the Advisory Committee to include one representative of NASVH who holds a professional license in nursing home administration.

VA does not support this bill. VA fully supports the participation of a NASVH representative on the Advisory Committee, but we do not believe this bill is necessary because VA is working to appoint a member of NASVH to the Advisory Committee.

We caution that legislating membership of the Advisory Committee could restrain VA's ability to adapt to evolving circumstances in the future. We also have concerns with the language that would apparently subject the appointment of all members of the Advisory Committee, at least with respect to matters concerning NASVH, to the consultation requirements of the NASVH President. While the term consultation is not defined, this could constrain the Secretary's authority to appoint members and would be inconsistent with other laws regarding Federal Advisory Committees.

VA does not believe this bill would result in any appreciable costs.

H.R. XXXX Enhancing Faith-Based Support for Veterans Act of 2024

This bill would add a new section 1730D to title 38 of the United States Code. Under the proposed subsection (a) a VA chaplain, with respect to a patient on whom the chaplain has conducted a spiritual assessment, could transmit the contact information of the patient to a non-VA religious or faith-based organization specified by the patient and upon the election of the patient. The proposed subsection (b) would define the term spiritual assessment to mean an evaluation of a patient entitled to receive medical treatment under chapter 17 by a chaplain employed by VA to gather spiritual information about the patient and inform the medical treatment plan of the patient, if applicable.

VA does not support this bill. VA agrees that Veterans should be able to access spiritual support services from any organization of their choice, but this bill does not provide any new authority and could produce confusion. For example, VA is concerned that the phrase at the election of the patient is too vague, since it does not specifically refer to the patient's authorization required by the Privacy Act or the HIPAA Privacy Rule for the Department to share information as described or provide an exception under those provisions to the general prohibition against disclosure without an authorization. Even if the bill were enacted as drafted, VA would be barred from providing religious or faith-based organizations with patients' contact information unless

the patient signed a completed release of information form. In that context, this is no different than current practice.

There is also some concern that sharing this information could produce conflicts regarding confidential information the patient has shared with the chaplain. The bill also does not define what is a non-Department religious or faith-based organization. The current VA practice involves review and vetting of organizations providing sacramental services to ensure they are appropriate and will support Veterans and not take advantage of them. Without a proper vetting system, Veterans could be abused financially, emotionally, mentally, and spiritually. We believe Congress would need to expressly delegate to VA authority to establish such a system to protect our Veterans if this bill were to become law; there are currently some parameters in place under other programs, such as those administered by the Centers for Medicare and Medicaid Services, that might also be helpful in this regard.

Finally, the definition of spiritual assessment in the bill differs from VA's current use of the term, as VA incorporates ongoing assessments, rather than a single assessment, in evaluating patients and supporting their spiritual needs.

VA does not have a cost estimate for this bill.

H.R. XXXX Requiring Non-Citizen Appointees to Positions in the Veterans Health Administration to be Subject to Background Investigations Prior to Employment

This draft bill would add a new paragraph to 38 U.S.C. § 7407(a), which authorizes VA, in certain situations, to appoint an individual who is not a citizen of the United States to certain positions in VHA. The new paragraph would prohibit VA from making such an appointment unless the person has been subjected to a background investigation.

VA supports this bill, subject to amendments and the availability of appropriations. VA generally supports ensuring that employees have received a background investigation, including non-U.S. citizens, prior to employment. However, the draft legislation does not define what type of background investigation would be required. The Defense Counterintelligence and Security Agency (DCSA) is VA's Investigative Service Provider. DCSA lists five different investigative tiers, ranging from Tier 1 for Low-Risk investigations through Tier 5 for critical-sensitive (national security). The overwhelming majority of VA's employees receive the Tier 1 level investigation, which is based on a low-risk position designation. Background investigation levels are based on a review of the position description to determine the position designation. Therefore, any legislation should state that background investigations are commensurate with the position designation.

Due to limitations in the ability to collect background investigative data outside of the U.S., Tier 1 background investigations on non-U.S. citizens who have not resided in the U.S. or its territories for 3 years or more cannot be completed. This limitation is set forth in the Office of Personnel Management, December 15, 2020, Credentialling Standards Procedures for Issuing Personal Identity Verification Cards under HSPD-12 and New Requirement for Suspension or Revocation of Eligibility for Personal Identity Verification Credentials. As a result, VA began an initiative to review all non-U.S. nationals using another Federal vetting system. On June 13, 2024, VA issued a Department-wide memorandum outlining VA's Enhancement of Security Posture. When the policy is finalized, this initiative will require, among other things, that all non-U.S. nationals undergo a Federal database check utilizing a national vetting system sponsored by the Office of the Director of National Intelligence. The vetting system is a web-based platform that enables United States Government security mission partners to efficiently screen, assess, and track foreign nationals requesting access to Federal Government facilities, personnel, or systems.

VA estimates this bill, as amended, would cost $1.2 million in FY 2025; $1.3 million in FY 2026; $6.7 million over 5 years, and $14.3 million over 10 years.

H.R. XXXX Making Improvements Relating to Conflicts of Interest for Certain VA Employees

This bill would amend 38 U.S.C. §§ 7302 and 7303, which identify functions for health care personnel education and training programs and research programs, respectively. The amendments to section 7302 would allow certain VA employees with dual appointments at the academic affiliate to participate in activities, oversight, supervision, and educational relationships related to formal education and training in a health care profession without regard to the criminal conflict of interest law regarding personal financial interests at 18 U.S.C. § 208 under certain conditions. It would also permit VA employees who serve in a health professions education role at an affiliated entity to communicate with VA regarding such matters without regard to the criminal conflict of interest law regarding claims and other matters affecting the Government at 18 U.S.C. §§ 205 and 203 under certain conditions. The amendments to section 7303 would be similar to those described above but would apply for researchers including those with appointments at the VA affiliated non-profit corporations established under 38 U.S.C. § 7361.

VA does not support the bill as currently drafted. VA supports the intent of this bill, which would resolve conflicts of interest for educators and researchers. We recommend the bill exempt the provisions of 18 U.S.C. §§ 203, 205, 208, and 209 (specifically for the educators and non-research clinicians), as applicable. VA would be ready to provide technical assistance to ensure the text reflects this broader goal, and to discuss VA's concerns with the Committee.

VA estimates the bill would not result in any additional costs and could produce some savings by eliminating administrative burdens.

Conclusion

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

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WOUNDED WARRIOR PROJECT

WOUNDED WARRIOR PROJECT
STATEMENT FOR THE RECORD

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

LEGISLATIVE HEARING
ON

H.R. 9324, Protecting Veteran Access to Telemedicine Services Act; H.R. 9146, Ensuring Continuity in Veterans Health Act; H.R. 7504, Rural Veterans Transportation to Care Act; H.R. 6330, Veterans Sentinel Act; H.R. 8562, Parity for Native Hawaiian Veterans Act; H.R. 6291, Have You Served Act (Ranking Member Brownley); H.R. 9301, to direct the Secretary of VA to include two counties in New Mexico in a certain Veterans Integrated Service Network; Draft, to amend title 38, United States Code (U.S.C.), to include a representative of the National Association of State Veterans Homes on the Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs (VA); H.R. 9427, to direct the Secretary of VA to carry out a pilot program to provide grants to medical facilities for the provision of culturally competent, evidence-based mental health care for veterans, and for other purposes; Draft, to amend title 38, U.S.C., to require that non-citizen appointees to positions in the Veterans Health Administration are subjected to background investigations prior to employment; Draft, Enhancing Faith-Based Support for Veterans Act of 2024; Draft, No Wrong Door for Veterans Act; H.R. 9426, to direct the Secretary of VA to carry out a pilot program under which the Secretary may fill vacant shifts at medical facilities of VA with non-Department health care providers; Draft, to amend title 38, U.S.C., to include adaptive prostheses and terminal devices for sports and other recreational activities in the medical services furnished to eligible veterans by the Secretary of VA; Draft, Service Dogs Assisting Veterans Act; Draft, Conflict of Interest Waiver for VA Researchers.

September 11, 2024

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health – thank you for the opportunity to submit Wounded Warrior Project's views on pending legislation.

Wounded Warrior Project (WWP) was founded to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing life-changing programs and services to more than 216,000 registered post-9/11 warriors and 53,000 of their family support members, continually

engaging with those we serve, and capturing an informed assessment of the challenges this community faces. We are pleased to share that perspective with you as the Subcommittee considers pending legislation that would directly impact those we serve.

COMMUNITY PARTNERSHIP AND ALIGNMENT

Wounded Warrior Project is committed to helping shape and support a community of stakeholders working to improve veteran mental health and prevent veteran suicide. We strongly encourage continuing a public health approach that coordinates action from all government as well as public-private partnerships. Ensuring sufficient funding for and alignment of these efforts is among our highest legislative priorities.

In this spirit, we offer perspective on three bills as part of a single discussion below. As a uniting theme, we believe that no one organization – and no single agency – can fully meet all veterans' needs. Empirically supported mental health treatment absolutely works when it is available and when it is pursued, but the best results will be found by embracing a public health approach focused on increasing resilience and psychological well-being and building an aggressive prevention strategy.

H.R. 6291 – the *Have You Served Act*

Carefully designed outreach strategies are an integral part of building and nurturing relationships in the veteran community. Communication that incorporates elements of military cultural competence and awareness-building can help link veterans and their families to critical benefits and services that may be offered through a single organization or part of a larger network of support. Notably, the first goal in VA's National Strategy for Preventing Veteran Suicide ("Integrate and coordinate Veteran suicide prevention activities across multiple sectors and settings") recognizes that effective outreach and coordination must take place in diverse settings and systems.[1]

The *Have You Served Act* would bolster outreach efforts that have been successfully deployed in communities across the country. The Governor's and Mayor's Challenges to Prevent Suicide Among Service Members, Veterans, and their Families (SMVF) are collaborative programs between the Department of Veterans Affairs (VA), the Substance Abuse and Mental Health Services Administration (SAMHSA), and state, local, tribal, and territorial governments. The purpose of these programs is to use a public health approach to develop and implement best practices to help prevent veteran suicide.

As part of the Governor's Challenge, several states have adopted "Ask the Question" campaigns. This campaign aims to identify suicide risk among Service members and veterans by first asking the question, "Have you, or a member of your immediate family, ever served in the

[1] OFF. OF MENTAL HEALTH AND SUICIDE PREVENTION, U.S. DEP'T OF VET. AFFAIRS, NATIONAL STRATEGY FOR PREVENTING VETERAN SUICIDE 2018-2028, *available at* https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

military?" Asking this initial question helps facilitate a conversation with veterans at risk of suicide and provides an opportunity to connect veterans with valuable tools and resources. For example, in Rhode Island, RI Serves is a network of organizations that serve veterans, Service members, and their families throughout the state. RI Serves has 35 partners, including many service organizations that implement the "Ask the Question" campaign and refer veterans to VA, as appropriate.[2]

The *Have You Served Act* would direct VA to provide grants to states and federal agencies for the purpose of carrying out "Ask the Question" campaigns. The provision of state grants would allow VA to develop or expand existing "Ask the Question" campaigns by providing training to human services professionals, State and local governments, and community providers about how to appropriately ask consumers whether they or a loved one have served in the Armed Forces and to communicate information about resources available at VA. For entities that receive grants, VA would provide technical assistance, including best practices acquired from the experiences of other eligible entities carrying out Ask the Question Campaigns; information on veterans resources in the state where the eligible entity is located; and information about VA screening protocols for assessing suicide risk and social determinants of health. The provision of federal grants would allow VA, in coordination with the Director of the Office of Management and Budget, to develop a plan to work with each Federal department and agency to implement "Ask the Question" Campaigns in social service or health care programs which interact with individuals receiving benefits and services.

While much progress has been made, mental health stigma still exists. The purpose of "asking the question" is to conduct mental health outreach to veterans – in a sensitive and culturally competent way – for those who may be reluctant to reach out themselves or ask for help. The "Ask the Question" campaign would expand mental health resources and improve access to mental health care at both the state and federal levels for veterans.

H.R. 9427 – to direct the Secretary of Veterans Affairs to carry out a pilot program to provide grants to outpatient mental health facilities for the provision of culturally competent, evidence-based mental health care for veterans, and for other purposes.

According to WWP's Annual Warrior Survey, 76 percent of warriors reported post-traumatic stress disorder (PTSD), with nearly half presenting moderate to severe symptoms. PTSD, anxiety, and depression have continually ranked among the top mental health issues among our warriors. Mental health and suicide prevention continues to be a top priority for WWP, and we support an approach that integrates both government as well as non-profit and private organizations to help ensure community alignment to address these issues.

The pilot program proposed by this draft bill would offer grant funding for non-profit organizations who provide evidence-based mental health treatment services to veterans in outpatient facilities or facilities where the organization will provide mental health care to veterans using grant funds. This funding would be used to help ensure that these programs are

[2] DEFENSE-STATE LIAISON OFF., U.S. DEP'T OF DEF., BEST PRACTICES: "ASK THE QUESTION" CAMPAIGN, *available at* https://download.militaryonesource.mil/StatePolicy/pdfs/2022/bestpractices-askthequestioncampaign.pdf.

able to serve all interested veterans with care at no cost. The program would focus on communities that are medically underserved, located near military installations, have large veteran populations, or have large numbers of veterans at high risk for suicide. Grantees would be required to educate care recipients about VA eligibility and encourage them to enroll in VA for healthcare if they are not already enrolled.

An important underlying discussion to this draft legislation is VA's role as a coordinator of care. While WWP appreciates the need to keep VA as a coordinator of unfragmented clinical care, we believe that embracing grants to direct care programs – particularly when skepticism towards VA in the veteran community is an unfortunate reality for some – is a commitment most consistent with putting the needs of the veteran first. According to VA's *2023 National Veteran Suicide Prevention Annual Report*, approximately 17.5 veterans were lost to suicide each day in 2021 and approximately 6.7 of those 17.5 veterans (38%) received care through the Veterans Health Administration (VHA) within the two-year period prior to their death. Among those who used VHA, almost 4 in 10 veterans (39.1%) were not being treated for a mental health or substance use disorder. Stated differently, approximately 13 of every 17 veterans lost to suicide each day in 2021 had not received care or been diagnosed with a mental health disorder by VA within two years of their death.

These figures indicate that a vast majority of veterans who die by suicide are not receiving mental health treatment from VA. Mental health treatment works, but every individual has unique needs, and there is no one-size-fits-all solution. While WWP's Annual Warrior Survey consistently reflects that veterans rank VA as their top mental health resource, barriers to seeking that care remain. Whether due to appointment hours, bad prior experiences, perceived stigma, or the thought that receiving care may take away an opportunity from someone who needs it more, many still choose to not purse mental health care at VA or forego seeking help entirely.

In this context, we must do everything we can to ensure that there is no wrong door to seeking mental health care – even if the first step is taken in the community. For example, WWP was pleased to support the *COMPACT Act*[3], which now allows veterans experiencing a mental health crisis to receive acute and follow up emergent suicide care at no cost from VA and non-VA facilities regardless of eligibility for VA care. This draft legislation may build upon that model and could be considered for inclusion in the *No Wrong Door for Veterans Act* – as one of several suicide prevention services – as an upstream effort to prevent veteran suicide and offer veterans more support before reaching a crisis point.

Draft legislation – the *No Wrong Door for Veterans Act*

Our 2022 Annual Warrior Survey found that the top four service-related injuries and health problems self-reported by WWP Alumni are sleep problems (80%); PTSD (76%); anxiety (76%); and depression (74%).[4] Assisting warriors with these mental health challenges has consistently been WWP's largest programming investment year-to-year. However, WWP

[3] *Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020* (P.L. 116-214 § 201).
[4] A full copy of WWP's 2022 Annual Warrior Survey can be viewed at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.

recognizes that a single organization cannot meet the needs of all post-9/11 veterans and their families. This awareness has led to WWP's partnership and financial support for 212 military and veteran-connected organizations through grants since 2012.

The importance of a community-wide, public health approach to mental health also shaped WWP's advocacy in support of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*, specifically Section 201, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (P.L. 116-171 § 201) (SSG Fox SPGP).

The SSG Fox SPGP is a three-year pilot program that provides grants to community-based organizations and state, local, and tribal governments that provide suicide prevention services for veterans and their families. These suicide prevention services provide upstream interventions before veterans reach the point of mental health crises and allow for spending on activities like outreach, peer support, case management services, and assistance in obtaining VA benefits. In 2022 and 2023, VA awarded $52.5 million to 80 community-based organizations. VA will award the third and final round of $52.5 million in grants by September 30, 2024; these funds will be used by the organizations in FY 2025.[5]

The *No Wrong Door for Veterans Act* would reauthorize the SSG Fox SPGP through 2027. It would also make certain changes and improvements to the program, including: requiring that not more than five percent of a Fox grant may be spent on food and non-alcoholic beverages; requiring that VA provide briefings about the grant program at local Veteran Affairs Medical Centers (VAMCs) every quarter to improve coordination between grantees and VA personnel; and requiring that baseline mental health screenings for risk be conducted using the Columbia Protocol (i.e., the Columbia-Suicide Severity Rating Scale (C-SSRS)).

The changes outlined above would be welcomed. WWP uses the Columbia Protocol for mental health screenings. WWP formally incorporated the C-SSRS as a standardized screener for all warriors and family support members referred for mental health services (i.e., triage) in October 2023. The C-SSRS allows suicide screenings to be conducted in a standardized manner; provides flexibility that anyone can administer a screening, not just a administered a mental health professional; and uses a scale that is concise, valid, and reliable across various settings and for individuals of all age groups. The scale serves to help in identifying risk, assessing severity and immediacy, and determining the level of support required. WWP supports the reauthorization of the SSG Fox SPGP and these proposed amendments to the program.

However, WWP offers a point of consideration for the Subcommittee regarding one additional provision in the *No Wrong Door for Veterans Act*. The bill specifies that, if a community grant partner makes a mental health referral on behalf of a veteran and VA does not provide services to the veteran within 72 hours, that veteran will be eligible for emergency suicide care at no cost, as provided by section 201 of the COMPACT Act. While WWP appreciates the intent of ensuring that a veteran who receives a mental health referral will be guaranteed care within 72 hours by VA, WWP believes a better option would be to empower the

[5] Press Release, U.S. Dep't of Vet. Affairs, VA to Award $52.5 Million in Grants to Local Organizations Working to Prevent Veteran Suicide (Jan. 25, 2024), *available at* https://news.va.gov/press-room/va-to-award-52-5m-grants/.

community partner making the referral with the ability to expand or supplement its ability to provide that mental health care on its own or with recognized community-based providers.

Currently, community partners may use Fox grant funding to provide or coordinate clinical services for emergency treatment for veterans. If a veteran receives clinical services for emergency treatment and requires ongoing services, the grantee must then refer the veteran back to VA for additional care. If they do not, any ongoing clinical services provided are at the expense of the grantee.[6] However, some veterans do not want to receive or are not comfortable receiving care at VA for certain reasons. In these situations, the community partner must then decide whether to stop providing care or whether to provide care at their own expense. This may not be possible for all grantees, putting an end to a veteran's mental health treatment for those who choose not to receive care at VA.

There should truly be "no wrong door" to mental health care. If a veteran is willing to seek mental health care from a community partner, WWP believes a more practical consideration would be to allow community partners to use grant funding for veterans in need of follow-on care. This would reduce the number of referred veterans for whom VA would need to provide free emergency room care in cases in which their referrals are not met within 72 hours. As outlined in the previous draft bill discussion (regarding grants to outpatient mental health facilities), SSG Fox SPGP grantees should be required to educate care recipients about VA eligibility and encourage them to enroll in VA for healthcare.

The SSG Fox SPGP offers innovative mental health programming for veterans suffering from invisible wounds. WWP strongly supports its reauthorization as well as improvements to this critical program to continue supporting a public health approach to suicide prevention. In particular, WWP supports reauthorizing SSG Fox SPGP with additional flexibility to allow community partners the ability to use grant funding to provide follow-on clinical care for veterans, in the same fashion as H.R. 9427 (to direct the Secretary of Veterans Affairs to carry out a pilot program to provide grants to outpatient mental health facilities for the provision of culturally competent, evidence-based mental health care for veterans, and for other purposes).

OTHER LEGISLATION

H.R. 9324 – the *Protecting Veteran Access to Telemedicine Services Act of 2024*

In 2008, the *Ryan Haight Online Pharmacy Consumer Protection Act* became law and required patients to complete at least one in-person visit with a health care provider before that provider could prescribe them a controlled substance. In consideration of the COVID-19 public health emergency, this requirement was temporarily suspended in March 2020. In 2023, both the Drug Enforcement Agency (DEA) as well as the Department of Health and Human Services (HHS) agreed to continue this temporary suspension until December 31, 2024.[7] The *Protecting*

[6] Funding Opportunity: Staff Sergeant Fox Suicide Prevention Grant Program, 89 Fed. Reg. 5310 (Jan. 26, 2024).
[7] Second Temporary Extension of COVID-19 Telemedicine Flexibilities for Prescription of Controlled Medications, 88 Fed. Reg. 69879 (Oct. 10, 2023).

Veteran Access to Telemedicine Services Act of 2024 would make this exemption permanent for veterans and VA providers by authorizing the delivery, distribution, and dispensing of controlled substances to veterans from VA providers without requiring an in-person appointment.

If the current COVID-era extension expires, then rural veterans who do not live near VA or community health care facilities – and who rely primarily on telehealth services – would likely be negatively impacted. Appointment coordination challenges and travel logistics may lead to interruptions in their care or lapses in prescriptions. The list of controlled substances contains not only pain medications, but also multiple mental health drugs that are important parts of treatment plans for many veterans dealing with mental health issues.

Many veterans who began treatment plans that included controlled substance prescriptions during the period of this exemption may not be aware of, or prepared for, the potential interruptions of their care plan. For instance, the *PACT Act*[8], the most comprehensive authorization of VA benefits in recent history, became law in August 2022 while this exemption was in place. More than 1 million *PACT Act*-related claims have since been granted by VA, meaning that none of those veterans have been subject to pre-exemption requirements. This dramatically increases the number of veterans who could have their current treatment plan impacted by the expiration of this exemption.

Wounded Warrior Project supports this bill in its current form, however, should the Committee feel this bill goes too far by removing all requirements for in-person appointments, a modified version authorizing the renewal of controlled substance prescriptions written for veterans during the time period the exemption was in place and who are still seeing the same provider who issued the prescription may help prevent unexpected disruptions of veteran treatment plans.

H.R. 9146 – the *Ensuring Continuity in Veterans Health Act*

Many veterans who use VA for health care are seen by a range of providers over the years, both at VA and within the community care network. During a July 2022 during a House Committee on Veterans' Affairs Health Subcommittee hearing, VA reported that, for services available both at VA and in the community, veterans utilized community care for 44 percent of health care services.[9] Regardless of where a veteran receives care, WWP supports a patient-centric approach to health care decisions.

VA's Veterans Community Care Program (VCCP), codified by the *VA MISSION Act*[10], allows veterans to utilize non-VA providers on the basis of certain criteria. Among several qualifying criteria, veterans may utilize community care in situations in which the veteran and the veteran's referring clinician agree that care and services from a provider outside VA would be in the veteran's best medical interest (38 USC § 1703 (d)(1)(E)).

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[8] *Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022* (P.L. 117-168).
[9] *Examining VA Community Care Access, Utilization, and Expenditures: Hearing Before H. Subcomm. on Health, H. Comm. on Vet. Affairs*, 117th Cong. (2022) (statement of Miguel LaPuz, Acting Dep. Under Sec'y of Vet. Affairs for Health).
[10] *John S. McCain III, Daniel K. Akaka, and Samuel R. Johnson VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018* (P.L. 115-182).

There are several delineated factors for what constitutes a veteran's "best medical interest" (*see* 38 USC § 1703(d)(2)). These factors include the distance between the veteran and the VA facility that would provide the hospital care, medical services, or extended care services the veteran needs as well as the nature and the frequency of the hospital care, medical services, or extended care services required. Other factors for determining whether VA care or community care is in the veteran's best medical interest include the timeliness of available appointments at VA and whether the veteran would face an unusual or excessive burden to access care services from VA. While it may be taken into consideration in certain cases, continuity of care is currently not a requirement for determining what type of care is in a veteran's best medical interest.

The *Ensuring Continuity in Veterans Health Act* would codify continuity of care as a standard factor for consideration when deciding whether community care is in the best medical interest of the veteran. Continuity of care is key to providing the best possible care for veterans. Patients who receive continuity of care experience higher rates of satisfaction, more cost-effective care, and ultimately, better health outcomes.[11] Continuity of care is particularly important for veterans with mental health conditions, such as PTSD, who establish trusted relationships with providers and must interrupt treatment to build trust and reestablish connections with new providers. Patients who must see multiple providers receive fragmented care and are at greater risk for experiencing errors in their treatment, undergoing unnecessary visits and hospitalizations, and developing less trust in their providers.

Wounded Warrior Project supports the *Ensuring Continuity in Veterans Health Act*, and a vision to ensure that veterans do not experience disruptions in needed hospital care, medical services, or extended care services. It would also provide more flexibility and peace of mind to veterans to enhance patient care and ensure a high standard of health care for veterans. Ultimately, WWP supports a veteran-centric approach to health care, in which veterans can trust and rely on the system to support their best interests and provide consistent care.

H.R. 7504 – the *Rural Veterans Transportation to Care Act*

Highly Rural Transportation Grants (HRTGs) are part of a VA grant-based program that helps veterans in highly rural areas travel to VA or VA-authorized health care facilities. The grants supply funding to veteran service organizations and state veterans service agencies to provide transportation services in eligible counties. Currently, VA uses Rural-Urban Commuting Area (RUCA) codes to define rurality for its programs. However, current law (*see* P.L. 111-63 § 307) requires that HRTGs use an alternate definition of rurality, which limits eligibility to counties with fewer than seven people per square mile. Using the 2020 U.S. Census data, only 13 states currently contain counties eligible for these grants,[12] and VA's broader authority to transport veterans to care is set to expire on September 30, 2024.

[11] *See, e.g.*, Maureen Baker & Holly Jeffers, *Continuity of Care: Still Important in Modern-Day General Practice*, 66 BRITISH J. GEN. PRACTICE 396 (Aug. 2016).
[12] U.S. DEP'T OF VET. AFFAIRS, Highly Rural Transportation Grants (last visited Sept. 9, 2024), https://www.va.gov/healthbenefits/vtp/highly_rural_transportation_grants.asp.

There are nearly 2.7 million veterans living in rural areas, 280,676 of which are categorized as highly rural. Many have heightened care needs. The VA Office of Rural Health stated in their winter 2024 newsletter that rural veterans are more likely to experience serious medical issues, such as heart and lung conditions, than veterans in urban areas. Efforts to engage with these veterans include the VA Health and Benefits mobile app as well as programs which bring providers to veterans' homes, but not all services can be accessed through these programs.

Certain care needs require veterans to travel to VA facilities, which can present both financial and physical challenges. Challenges reaching points-of-care include factors ranging from the nature of their disability, dearth of public transportation, and income disparities that affect the ability to provide self-transportation. The Office of Rural Health website shows that 44 percent of rural and highly rural veterans earn less than $35,000 annually and 27 percent do not access the internet at home. Additionally, 55 percent of rural veterans are over the age of 65, though younger veterans can also face travel difficulties due to serious injuries – like traumatic brain injuries and related neurocognitive impairment – sustained during service. Many older or severely injured veterans experience mobility issues or are unable to drive long distances and currently rely on their caregivers to get them to appointments. These extensive commutes add to the stress of caring for a loved one and over time can lead to compassion fatigue, which can manifest as depression, anxiety, and exhaustion, impacting the health of the caregiver.

The *Rural Veterans Transportation to Care Act* would expand access for rural veterans to VA's HRTG Program by increasing the scope of eligibility to both rural and highly rural counties, as well as extending eligibility to tribal organizations. The bill would also increase the maximum annual HRTG funding amount from $50,000 to $60,000, or up to $80,000 for grantees to purchase an Americans with Disability Act (ADA) compliant vehicle.

The *Rural Veterans Transportation to Care Act* would deliver critical assistance more rural veterans in need of care and services at VA and provide caregivers in rural areas with much needed support. WWP supports this legislation and its goal to ensure increased accessibility to high quality health care for veterans in rural areas.

Draft legislation – to amend title 38, United States Code, to include a representative of the National Association of State Veterans Homes on the Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs.

The VA Geriatrics and Gerontology Advisory Committee advises the Secretary of Veterans Affairs and Under Secretary for Health on all matters related to geriatrics, which centers on the care and treatment of older people, and gerontology, which focuses on the broader aspects of the aging process and their impact. The Committee is responsible for assessing the capability of VA's health care facilities and programs to meet the needs of older veterans and conducting site visits to VA's Geriatric, Research, Education, and Clinical Centers (GRECCs) to ensure they meet the goals of properly training health care staff, developing innovative methods of care, and advancing research necessary to meet the needs of an aging veteran population.

This bill would direct VA to include a representative of the National Association of State Veterans Homes with a license in nursing home administration on the VHA Geriatrics and Gerontology Advisory Committee, and to consult with the President of the Association when appointing other Committee members.

Such a perspective would be beneficial to the success of VA's long-term care portfolio and future planning. Following the Civil War, State Veterans Homes were independently established to provide care and shelter to large numbers of homeless and disabled veterans who were not able to care for themselves. Today, these state-run facilities continue to deliver nursing home and adult care for aging and – relevant to the post-9/11 generation of veterans that WWP serves – severely injured veterans. The National Association of State Veterans Homes was later established to improve the care and quality of life of aging veterans and address the needs of state homes through advocacy on a national level.

There are currently 165 State Veterans Homes providing nursing care, adult day care, and domiciliary care across the country. It is important to note, however, that many veterans receiving this care do not fit the typical "geriatric" nursing home profile, and there is an increasing need for VA's Geriatrics and Extended Care services for veterans under the age of 65. The average age of post-9/11 veterans in the U.S. is 37, and our latest annual survey shows that more than three in 10 WWP warriors require aid and assistance from another person as a result of a service-connected injury or illness and necessitate an average of 55 hours of care per week.

As the post-9/11 generation of veterans continues to age, the need for long-term support services and State Veterans Homes is likely to expand. For this reason, including a representative of the National Association of State Veterans Homes on VA's Geriatrics and Gerontology Advisory Committee would provide valuable insight to the Committee's GRECC oversight efforts and help to inform the Committee's future initiatives and recommendations to the Secretary.

Providing long-term care services to veterans who need them earlier in life is a WWP priority. We support this draft bill that would provide critical input on the Committee's future actions to address the population of younger veterans in need of long-term care and support.

Draft legislation – the *Enhancing Faith-Based Support for Veterans Act of 2024*

Faith and spirituality have long shown to aid mental and emotional well-being, especially during periods of grief, illness, or personal hardship.[13] Spirituality is a key component of how WWP defines "quality of life" in our Annual Warrior Survey, and spiritual well-being has shown to be a critical component of post-traumatic growth and provides a positive impact on warriors' mental health quality of life. Though spirituality encompasses an overall well-being related to an individual's identity and purpose in life, the makeup of identity and purpose are often greatly influenced by a person's personal beliefs and faith. Our survey also reflects that nearly 40

[13] *See, e.g.*, Daniel Gillison, Nat'l Alliance on Mental Illness, *The Intersection of Faith and Mental Health* (Aug. 19, 2022), *available at* https://www.nami.org/from-the-ceo/the-intersection-of-faith-and-mental-health/.

percent of WWP warriors cited "prayer, religion, or talking to a religious leader" as a regular tool or resource they used to help manage stress, emotional challenges, and mental health concerns.

While insights like these are encouraging, current VA patient privacy policies limit the ability of VA chaplains to connect veterans with external faith-based resources. The *Enhancing Faith-Based Support for Veterans Act* would allow VA chaplains, with the express consent of the veteran, to transmit the patient's contact information to religious or faith-based organizations following a spiritual assessment.

For many veterans, faith is an important factor in their overall mental and physical health. The emotional support provided through faith and religious community can contribute to a veteran's resiliency and recovery and should be included as an option of their holistic care program. WWP supports this draft legislation that reflects a growing recognition of the need to provide comprehensive support to veterans, including spiritual and faith-based care.

Draft legislation – to amend title 38, United States Code, to include adaptive prostheses and terminal devices for sports and other recreational activities in the medical services furnished to eligible veterans by the Secretary of Veterans Affairs.

Adaptive protheses and terminal devices allow those with limb loss to participate in a variety of sports and other recreational activities, such as running, biking, and swimming. Adaptive prostheses can be designed to fit the user's specific needs, including their activity level, strength, and flexibility, and terminal devices can be designed for specific activities, such as contact sports and other recreational activities. VA's definition of "medical services" includes wheelchairs, artificial limbs, trusses, and similar appliances, and accordingly, VA provides these devices to veterans. However, adaptive prostheses or terminal devices for sports and other recreational activities are not currently part of VA's definition of "medical services."

Although VA clinicians work with veterans to identify recreation activities and needed adaptive recreation equipment to support a veteran's rehabilitation goals, VA will not provide adaptive recreation equipment, including adaptive prostheses or terminal devices, if the purpose of the equipment is to support the veteran's participation in an activity for personal enjoyment.[14] If a veteran wishes to use adaptive recreation equipment, he or she must use it to support rehabilitation goals and, accordingly, must be enrolled in a VA rehabilitation program.

The necessity to participate in such rehabilitation programs can be a deterrent for some veterans. Veterans may not want or have the ability to devote the time required. These programs may also be repetitive in the case of new adaptive equipment to replace similar equipment for which veterans completed rehabilitation training in the past. For these reasons, some veterans may choose not to obtain adaptive recreation equipment if the process is too cumbersome, hindering a veteran's ability to maintain an active and healthy lifestyle. This draft bill would amend 38 U.S.C. § 1701 to add adaptive prostheses and terminal devices for sports and other recreational activities to VA's definition of "medical services."

[14] Prosthetic and Rehabilitative Items and Services, 85 Fed. Reg. 84245 (Dec. 28, 2020).

Improving a veteran's quality of life holistically should be the highest priority for amputees requiring prosthetics. The ability to play sports and participate in other recreational activities can be essential to a veteran's mobility and mental wellbeing. WWP has seen firsthand the positive and life-changing effects of adaptive equipment on a veteran's quality of life and mental health. Through WWP's Adaptive Sports and Soldier Ride programs, warriors learn to use adaptive sports equipment and develop athletic skills. WWP's Soldier Ride program allows veterans across the country the opportunity to engage in multi-day riding events using adaptive equipment that helps warriors build their confidence and strength through shared physical activities in a supportive environment.

Adaptive equipment promotes and supports holistic healthy lifestyles for amputees. WWP recommends that VA authorize adaptive equipment for amputees without requiring that they be enrolled in a VA rehabilitative program for the profound physical and mental health benefits provided by sports and other recreational activities.

Draft legislation – the *Service Dogs Assisting Veterans (SAVES) Act*

Under current regulations, VA does not directly provide service dogs to veterans for physical or mental health conditions. In cases where veterans are approved for a service dog related to physical or mental health limitations, they are referred to an outside agency that has been accredited by either Assistance Dogs International (ADI) or the International Guide Dog Federation (IGDF). While many of the organizations accredited by ADI and IGDF receive funding through donations and grants to offset costs, oftentimes veterans still pay fees or expenses related to obtaining a service dog. These agencies can charge fees to the veteran for application, training services, or travel expenses related to obtaining a service dog.

The *Service Dogs Assisting Veterans (SAVES) Act* would create a pilot program within VA that awards competitive grants to accredited organizations that provide service dogs to veterans, helping to ensure that any veteran in need of a service dog to improve their quality of life is not required to pay any associated costs out of pocket to obtain their service dog.

Notably, this bill contains language that would include PTSD as a qualifying condition for which grant funding can be used to provide a veteran with a service dog. Currently VA's National Center for PTSD states that "there is not enough research to know if dogs help treat PTSD and its symptoms" and maintains that VA is in the process of completing a research study to determine if having a service or emotional support dog helps individuals with PTSD.[15] However, a recent study conducted by the University of Arizona concluded that trained psychiatric service dogs may be an effective complement to usual care for military service-related PTSD.[16]

While WWP encourages more study regarding the potential impact of a service dog for a veteran with PTSD, should a veteran and their care team believe that a service dog would

[15] U.S. DEP'T OF VET. AFFAIRS, Dogs and PTSD (last visited Aug. 22, 2024), https://www.va.gov/healthbenefits/vtp/highly_rural_transportation_grants.asp.
[16] Sarah C. Leighton et al., *Service Dogs for Veterans and Military Members with Posttraumatic Stress Disorder: A Nonrandomized Controlled Trial*, 7(6) JAMA NETWORK OPEN (Jun. 2024).

contribute positively to their PTSD treatment, these grants would ensure that they can obtain that service dog from an accredited source without incurring unexpected out-of-pocket costs. Before moving forward with this draft legislation, WWP recommends that the subcommittee consider bolstering and clarifying certain language to ensure that it meets the desired outcome. First, it may be beneficial to include a list of reporting requirements to measure the success of the pilot against. Second, it may be helpful to provide more clarity on the mobility limitations considered alongside mental health diagnoses – specifically, whether this is limited to ambulatory needs or if it extends to assisting with fear or hesitation about moving in, for example, unfamiliar or crowded locations. Third and finally, it may be beneficial to provide more clarity on the diagnosis and severity of the mental health condition that gives rise to service dog eligibility (e.g., PTSD is listed in subsection j, but mental health is the term used in discussion of mobility issues in subparagraphs f and j).

CONCLUSION

Wounded Warrior Project once again extends our thanks to the Subcommittee on Health for its continued dedication to our nation's veterans. We are honored to contribute our voice to your discussion about pending legislation, and we are proud to support many of the initiatives under consideration that would enhance veterans' access to care and support. As your partner in advocating for these and other critical issues, we stand ready to assist and look forward to our continued collaboration.

Prepared Statement of Missy Meyer

Chairwoman Miller-Meeks, Ranking Member Brownley, and other honorable members of the Subcommittee

Thank you for the honor to testify before the House Veterans Affairs Subcommittee on Health. There are many bills up for discussion today, but my testimony will primarily focus on one: The No Wrong Door for Veterans Act, which reauthorizes the SSG Parker Gordon Fox Suicide Prevention Grant Program.

However, before I discuss the bill, I wanted to mention America's Warrior Partnership's support for another bill being discussed today, H.R. 9427, introduced by Chairman Bost, to carry out a pilot program to provide grants to outpatient mental health facilities for the provision of culturally competent, evidence-based mental health care for veterans.

At AWP, one of the most common requests for health care services is related to mental health. The more our Nation can expand access to mental health care for veterans, the better. But it must be done with a holistic approach. Counseling is a great tool, but every veteran is unique. Offering additional choices, such as outpatient facilities for mental health, access to Traumatic Brain Injury (TBI) treatment (since it is often concurrent with mental health crisis), and Post-Traumatic Growth (PTG) training (both pre-and post-crisis) can expand the resources available.

That being said, AWP is focused on outreach to all veterans. Since I was last before the Subcommittee to discuss the SSG Fox Grant last December, much has changed and much has been accomplished. AWP is one of the most successful recipients of funding from the SSG Parker Gordon Fox Suicide Prevention Grant Program (aka SSG Fox Grant).

As we told the Committee last year, the original idea of the SSG Fox Grant had a singular goal: find veterans in the community that are in need and help them.

However, as the program was implemented by the VA and put into practice by organizations across the country, part of this goal has been diluted and lost. To reach that goal, Congress needs to implement reforms that specifically bring back outreach as the singular focus, streamline the intake into the VA for eligible Fox veterans, and hold organizations accountable.

We are very thankful for all your hard work on this program, Chairwoman Miller-Meeks, Ranking Member Brownley. The introduced legislation, H.R. 9438, to reauthorize the SSG Fox Grant, is a terrific start, and AWP is grateful for your efforts to continue this successful program. To help improve the SSG Fox Grant program, we offer a few observations and suggestions:

Program Overview

As one of 80 SSG Fox Grant recipients, we have done a significant amount of outreach with the program since its inception. From October 2023 to July 2024, AWP produced results:

–1,818 warriors screened for suicidal ideation using the Columbia-Suicide Severity Rating Scale

–13 percent disclosed some level (low, moderate, high) of suicide risk (235)

This rate of outreach, screening, and eligibility is consistent with past years.

The SSG Fox Grant Program is working. Veterans who are both inside and outside the VA and VSO system and in need of assistance are being identified.

Relationships are being built and connections with resources made. Since Fox Grant Inception, 370 veterans have trusted AWP with their thoughts of suicide while only 6 percent of those warriors were seeking assistance for a mental health related issue to begin with. This is a success story and asking "the question" works. AWP, the VA, and Congress have all played an integral part in saving these veterans, but there is more that can be done.

Coordination:

AWP is thankful for the inclusion of language that directs briefings for VA employees about the SSG Fox Grant program. It's important for organizations in the community and the VA to all coordinate together. It is our hope that grant recipients will be invited to these briefings and work together to improve communication and "warm hand-offs" of individual cases as they arise. Previously, many VA staff members had no idea what the Fox Grant is or why grantees were calling asking for assistance with a "Fox Participant." Ensuring a bi-direction, solid working relationship with local Suicide Prevention Coordinators and VA staff is essential, as is more education to frontline staff on the SSG Fox Grant. Accordingly, as an advocate for veterans who trust us, it is essential for the VA to communicate back to grantees their plan and status of that veteran.

Screening Questionnaires:

Next, AWP is very grateful for the inclusion of language in H.R. 9438 that eliminates some of the redundancies and bureaucracy of the screening questions. As AWP mentioned in previous testimony in December 2023, rarely did veterans make it through all the questionnaires, and the Columbia Protocol (C-SSRS) has proven to be the most inclusive and comprehensive set of questions needed to ensure those at risk are identified quickly and easily.

While the legislation mandates C-SSRS as the only required screening protocol, AWP recommends adding language that would make the five follow-on assessments optional. Rarely do veterans make it through all five of the VA-mandated assessment questionnaires, and it has become burdensome on staff as well. Instead, the focus should be on ensuring the veterans have access to resources and not focusing on answering redundant questions.

Crisis Intervention:

In H.R. 9438, the section on "Emergent Suicide Care" is a strong addition. In many instances, AWP has used the 988-emergency crisis line to help veterans identified through Fox Grant outreach. This language helps codify support and resources available to those who are unable to obtain services in the crucial 72-hr window after first contact.

Clearly Defined Pathway for Eligible Individuals:

The addition of the Emergent Care section in H.R. 9438 is very helpful. However, AWP recommends adding a section that clearly lays out the expectations for the program itself and identifies boundaries for the VA and organizations. While AWP does all it can to provide connections to referrals and resources, AWP is not a direct service provider. It is clearly outlined in the scope of the grant proposal. However, the line has become muddied and expectations are often unclear.

To fix this, it would be helpful to add a section that requires a specific program "on-ramp" for veterans identified by grant recipients that need VA care. The process does not need to be complex or burdensome. Since grant recipients have already asked the required questions and processed the information, passing along the information to the VA without burdening the veterans themselves again with tiring, frustrating, redundant questions (which sometimes involve discussing traumatic experiences) would dramatically increase the success rate of the program as well as assist the veteran more efficiently.

This can be done in several ways. For example, requiring that after grantees go through the required screening procedures, eligible veterans must be connected with the 988-crisis line or their local VAMC for expedited care when necessary. In addition, Congress could also mandate that the VA create a dedicated phone line for intakes from grantees that would offer expedited care.

Accountability:

The SSG Parker Gordon Fox Suicide Prevention Grant Program is working. To keep the program successful, we need to ensure all organizations that are receiving grants in the program are held to account. The $750,000 grants come from the trust Congress and the American taxpayers have in our organizations, and AWP holds that trust in the highest regard. Accordingly, AWP holds itself to account regularly with audits and reviews, and we work hard to ensure these funds are maximized efficiently to find veterans in the community and serve them.

At AWP, we hope all other grantees are holding themselves accountable with the same high standards. However, Congress and the VA must also hold organizations accountable with verifiable metrics. AWP recommends adding a section requiring the VA develop accountability metrics that report outreach, referrals, etc—and then require regular reports to Congress. It is the only way to find if some organizations are not fulfilling their responsibility under the program.

For the metrics themselves, it's hard to identify specific keys to success. However, AWP believes the best way to look at program success is to measure the number of screened individuals and the number of eligible veterans, in addition to outreach completed to document efforts toward identifying those in need.

While accountability and metrics are vital, the Data Collection Tool (DCT) implemented by the VA at the end of 2023 has had the opposite of its intended effect. While developed to streamline data submission previously completed in thousands of pdf documents, the result has been a standstill in reporting for many grantees. The SSG Fox Grant Program assessments are meant to be anonymous. The DCT now requires a participant's Date of Birth and Social Security Number to enter any data shared in the DCT. AWP has gone from reporting nearly all data to less than

5 percent. Previously, the program was hindered by the redundancy of assessments and lack of incentive to complete them multiple times. Now that is compounded by the obvious lack of anonymity that comes with providing your PHI to the VA for an "anonymous program." AWP hoped the DCT would save both AWP staff and clients from repetitive and exhausting data reporting, but unfortunately it has only diminished any data collection the VA hoped to gain through this grant.

In February 2024, the VA asked for suggestions on how to remedy this issue. AWP has suggested returning to participant identification numbers that were previously used to report data (created and tracked only by the reporting agency) rather than PHI of participants. This issue remains despite repeated acknowledgements by VA staff that data is not being adequately captured with the DCT as it is.

Grantee Funding:

For AWP, the only limitation in being more successful with the program is funding. If the ceiling on the grants was doubled overnight, so would AWP's outreach efforts.

Accordingly, while $750,000 has been the limit on SSG Fox Grants to date, there are organizations, like AWP, who have successfully utilized the grant and could do more with more. While not for all organizations, raising the ceiling could be beneficial if done correctly. Again, it would require metrics and reporting.

Members of the Subcommittee, thank you again for the opportunity to testify today. We look forward to our continued work together and would like to thank each of you for all your hard work and dedication to those who served in our Nation's armed forces.

Prepared Statement of Clark Pennington

The Independence Fund was established in 2007 to empower our Nation's catastrophically wounded, injured, or ill Veterans, by helping them cope with and overcome the physical, mental, and emotional wounds sustained in service. The Fund is dedicated to improving the lives of Veterans and their families through a range of programs including Mobility, Caregiver Support, Advocacy, Casework, Operation RESILIENCE, Independence@Home, and other Family oriented initiatives, The Independence Fund strives to bridge the gaps in care across all these areas and offers comprehensive support to Veterans and their families in need by working with the Department of Veterans Affairs, Department of Defense Health Agency, State level agencies, non-profit entities, and private mental health professionals.

The Independence Fund is honored to present its views on the legislation that impacts catastrophically disabled veterans and their caregivers.

Draft Legislation to amend title 38, United States Code, to include a representative of the National Association of State Veterans Homes to the Geriatrics and Gerontology Advisory Committee of the Department of Veterans Affairs.

This bill amends section 7315(a) of title 38, USC, requiring the Under Secretary of Health to consult with the President of the National Association of State Veterans Homes (NASVA) when selecting members for appointment to the Geriatrics and Gerontology Advisory Committee. This legislation will also require that the Committee include one representative who holds a professional license in nursing home administration and is a member of the National Association of State Veterans Homes.

The Independence Fund supports this legislation. No other association is more qualified at understanding the needs of aging veterans than members of NASVH, and as such, their participation will be an invaluable in advising the Under Secretary of Health and assessing the capabilities and needs of VA's obligation to care for our aging veteran population.

Draft Legislation to direct the Secretary of Veterans Affairs to carry out a pilot program to provide grants to outpatient mental health facilities for the provision of culturally competent, evidence-based mental health care for veterans, and for other purposes.

The Independence Fund holds no position on this legislation.

Draft Legislation to amend title 38, United States Code, to require that non-citizen appointees to positions in the Veterans Health Administration are subjected to background investigations prior to employment.

The Independence Fund holds no position on this legislation.

Draft legislation to amend title 38, United States Code, to permit the voluntary transmission of patient contact information to certain religious or faith-based organizations by chaplains employed by the Department of Veterans Affairs, and other purposes.

The Independence Fund holds no position on this legislation.

H.R. 9438, a bill to amend and reauthorize the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program of the Department of Veterans Affairs.

This legislation includes four main provisions. First, the bill limits the amount of the grant that can be used on food and non-alcoholic drinks. This is a commonsense amendment that ensures grant recipients are using the bulk of the funding to provide services. Second, the bill requires quarterly updates to VA personnel on grant recipients that are within 100 miles of the VAMC to better educate and coordinate available services the grant recipients provide. Third, this bill requires VA to refer a veteran who needs emergent suicide care to the community if VA cannot provide that care within 72 hours. Last, this legislation will extend the program until September 30, 2027. Veterans who are in crisis cannot wait for care. The Independence Fund fully supports this legislation.

H.R. 9324, a bill that amends title 38, United States Code, to authorize certain health care professionals employed by the Department of Veterans Affairs to deliver, distribute, or dispense to veterans certain controlled medications via telemedicine under certain conditions, and of other purposes.

The Independence Fund supports this legislation. VA is a leader in the use of telemedicine, working to improve access to care regardless of where veterans live or their preferred mode of receiving care should continue to be a priority. A gap in current law, that has been temporarily lifted in response to COVID–19 and is set to expire on December 31, 2024, prevents VA providers from prescribing controlled substances without an in-person medical examination. This legislation will make this authority permanent to VA providers, allowing for increased access and functionality to VA's robust telehealth capabilities.

Draft legislation that directs the Secretary of Veterans Affairs to carry out a pilot program under which the Secretary may fill vacant shifts at medical facilities of the Department of Veterans Affairs with non-Department health care providers.

The VA currently is under a 5-year, indefinite delivery/indefinite quantity contract with the medical staffing company, Aptive, to provide staffing services for all levels of clinical care and administrative support. If this contract is insufficient to fulfil VA's needs, The Independence Fund recommends modifying the current contract.

H.R. 9478, a bill to amend title 38, United States Code, to include adaptive prostheses and terminal devices for sports and other recreational activities in the medical services furnished to eligible veterans by the Secretary of Veterans Affairs.

The Independence Fund fully supports this much needed amendment to law. VA currently applies a 2017 regulation "Prosthetic and Rehabilitative Items and Services, 38 CFR Part 17 that specifies when "adaptive recreation equipment" within prosthetics may be approved, allowing for "an item that is designed to compensate for, or that, by design compensates for, loss of physical, sensory, or cognitive function and is necessary for a veteran to actively and regularly participate in a sport, recreation, or leisure activity to achieve the veteran's rehabilitative goals." This language limits approval of these adaptive and recreational prosthetics when they are specifically part of a medical goal, and not for long term life and health goals that are described as "for personal enjoyment." This regulation ignores VA's philosophy of "whole health." Veterans who have lost a limb and what to begin, return to, or

maintain an activity that keeps them active improve social engagement and psychological and physical health and should not have to be subject to specific medical goals.

Draft legislation to require the Secretary of Veterans Affairs to award grants to nonprofit organizations to assist such organizations in carrying out programs to provide service dogs to eligible veterans, and for other purposes.

Research studies have found that veterans who have PTSD see a 66 percent reduction in symptoms within 3 months of being paired with a service dog. This research found that the presence of the service dog lowers anxiety and depression, improves social functioning and relationship health, and interrupts panic attacks. Unfortunately, the capability of organizations to train and provide service dogs does not meet the demand. This legislation will provide grants to nonprofit organizations to increase the number of dogs that can be trained to be service animals. This is a small investment to increase access to a clinically proven method of improving veterans' mental health. The Independence Fund is proud to support this legislation.

H.R. 9146, a bill to amend title 38, United States Code, to require the consideration of continuity of health care in determining best medical interest under the Veterans Community Care Program, and for other purposes.

This legislation amends Section 1703(d)(2) of title 38 to include continuity of care as a consideration for referral to community care. 1703 (a)(2)(B) requires the Secretary of Veterans Affairs to "ensure continuity of care and services" when coordinating non-VA hospital care. However, under subparagraph (d) "Conditions Under Which Care Is Required To Be Furnished Through Non-Department Providers" there is no mention of continuity of care as a factor for consideration in determining the bast medical interest for when and where a veteran receives care. This legislation includes continuity of care in the list of considerations a provider can use to ensure veterans get non-disrupted care. The Independence Fund suggests that the bill be amended to include guidelines that will prevent CCN providers from requesting additional authorization of care without that care being approved by the PCP or the VA provider who initially authorized the care.

Draft legislation to amend title 38, United States Code, to make improvements relating to conflicts of interest for certain Department of Veterans Affairs employees, and for other purposes.

The Independence Fund does not hold a position on this legislation.

H.R. 9301, a bill to direct the Secretary of Veterans Affairs to include two counties in New Mexico in a certain Veteran Integrated Service Network.

The Independence Fund does not hold a position on this legislation.

H.R. 6291, the "Have You Served Act"

Many State and local governments and community organizations provide benefits and services to military veterans and their families, but all too often veterans are unaware of the benefits. This grant program provides funds to human resource offices in these agencies and organizations to train frontline employees on how to ask about military service as well as build campaigns to proactively inform the veteran community of the programs and services that are unique to that community. The Independence Fund fully supports this legislation.

H.R. 6330, the "Veterans' Sentinel Act"

Every effort must be taken to understand and mitigate the circumstances that lead to suicide. It is particularly disturbing when a veteran dies by suicide on a VA campus. This should signal to VA and advocates alike that the system designed to provide mental health care is inadequate. The Veterans' Sentinel Act call on the Secretary to establish a pilot that would form a working group to collect and analyze data regarding on-campus attempted and completed death by suicide. Importantly, this legislation requires the working group, through the Secretary, to send a report to the House and Senate Committees on Veterans Affairs that outlines any recommendations that can lead to the reduction of suicide attempts on VA campuses. The Independence Fund fully supports this legislation.

H.R. 7504, the "Rural Veterans Transportation to Care Act"

H.R. 7504, the "Rural Veterans Transportation to Care Act" amends current law, allowing transportation grants to include rural regions, which account for 2.7 million enrolled veterans. By expanding access to this population, veterans will have easier access to VA's direct care services. Additionally, this bill will increase the grant amount to modify vehicles to comply with ADA requirements. Both of these provisions are necessary to care for veterans who are catastrophically disabled.

H.R. 8562, the "Parity for Native Hawaiian Veterans Act of 2024"

The Independence Fund holds no position on this legislation.

Prepared Statement of Jon Retzer

Chairwoman Miller-Meeks, Ranking Member Brownley and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's legislative hearing of the Subcommittee on Health. DAV, a congressionally chartered non-profit veterans service organization (VSO), is comprised of nearly one million wartime service-disabled veterans. Its single purpose is to empower veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration today by the Subcommittee.

H.R. 6291, the Have You Served Act

H.R. 6291, the Have you Served Act, would require the Department of Veterans Affairs (VA) to provide grants to eligible organizations for the purpose of conducting "Ask the Question Campaigns" encouraging human services professionals, State and local governments and community providers to ask whether someone has served in the military. By promoting the question "have you served?", the bill seeks to raise awareness about veteran status among health care providers, social service agencies, and the general public. Improved identification of veterans can lead to better access to VA benefits and services and addressing unmet needs within the veteran community.

While DAV does not have a specific resolution on this matter, the bill could potentially get veterans who are unaware of their veteran status access to earned benefits and health care services. For these reasons DAV supports H.R. 6291, in accordance with our Statement of Policy, which calls for enhanced outreach to ensure that all disabled veterans receive the benefits they have earned through their military service.

H.R. 6330, the Veterans Sentinel Act

H.R. 6330, the Veterans Sentinel Act, would address the issue of veteran suicides on VA property by implementing a pilot program within the VA.

This bill would require the VA to set up a working group within the Office of Mental Health and Suicide Prevention for the purpose of gathering and analyzing data on veteran suicides and attempted suicides that occur on VA property. The working group would unify disparate sources of data related to on-campus suicides to improve the accuracy and comprehensiveness of the information collected. Furthermore, the VA would analyze the statistical trends of suicides and attempted suicides at VA facilities annually and be required to report on policies, staffing and resource levels and suggest preventive actions for these incidents.

DAV supports H.R. 6330, the Veterans Sentinel Act, in accordance with DAV Resolution No. 224, which supports program improvement and enhanced resources for VA mental health programs and suicide prevention efforts. We do however, suggest the bill be amended across all veteran care settings to include gathering information on suicide attempts and deaths within the Veterans Community Care Program (VCCP) as well. This expanded study should encompass onsite VCCP suicides and any suicides occurring within 24 hours of Community Care Network (CCN) contact. This timeframe aligns with the VA's current practice for root cause analyses, a standard not yet adopted by the VCCP.

H.R. 7504, the Rural Veterans Transportation to Care Act

The goal of H.R. 7504, the Rural Veterans Transportation to Care Act, is to improve veterans transportation options to VA medical facilities for veterans living in rural areas.

Veterans living in rural areas can face challenges that lead to disparities in access and quality of health care compared with their urban counterparts. This bipartisan bill would expand eligibility to the VA's Highly Rural Transportation Grant Program, which provides grant funding for veteran service organizations and State veterans service agencies to provide veterans transportation in eligible counties by increasing the maximum amount of funding granted to purchase an ADA-compliant vehicle.

The bill would also modify the existing grant program to include both rural and highly rural counties, by redefining "rural" and "highly rural" using Rural-Urban Commuting Area (RUCA) designations to better account for population density, urbanization, and commuting patterns.

Our nation's 2.4 million veterans living in rural areas often face unique difficulties accessing VA health care that those living in urban and suburban areas do not. Chief among them is transportation to VA medical facilities. The nearly 300,000 veterans living in areas considered highly rural face even greater obstacles and deserve increased attention to assistance in accessing VA's high-quality health care.

DAV is proud to support H.R. 7504, the Rural Veterans Transportation to Care Act, in accordance with DAV Resolution No. 42, which calls for ensuring sufficient access to care to meet the health needs of veterans residing in rural or remote areas. This bill would help the VA provide more rural veterans better access to health care and help ensure our Nation keeps its promises to America's veterans.

H.R. 8562, the Parity for Native Hawaiian Veterans Act of 2024

H.R. 8562, the Parity for Native Hawaiian Veterans Act of 2024, would amend title 38, United States Code, and make modifications to the program for direct housing loans and medical care services from the Department of Veterans Affairs for Native Hawaiians.

The bill would modify the definition of Native Hawaiian veterans and aims to improve access to medical care for Native Hawaiian veterans by eliminating copays for services received through the VA, and enabling the Native Hawaiian Health Care System to seek direct reimbursement for certain costs from the VA.

DAV has no resolution on this issue and takes no position on the bill.

H.R. 9146, the Ensuring Continuity in Veterans Health Act

H.R. 9146, the Ensuring Continuity in Veterans Health Act, would ensure that continuity of health care is considered when determining the best medical interest under the Veterans Community Care Program (VCCP).

The proposed legislation would amend title 38, United States Code, to ensure that continuity of health care is a factor considered in determining the best medical interest for veterans using the VCCP. This would be achieved by adding a new subparagraph to Section 1703(d)(2) of title 38, which explicitly includes continuity of care as a consideration. The amendment does not specify the definition of continuity of care or its requirements. The focus is solely on expanding the criteria used by a provider to evaluate the best medical interests of a veteran within the existing framework of the VCCP when VA services are not readily available.

It appears the bill aims to ensure that veterans are able to maintain consistent relationships with their health care providers and/or complete an episode of care when referred to care in the community. We agree it is important that VA maintain quality and consistency of health care services provided to veterans and believe VA already has the authority to consider continuity of care as a factor under the existing statute. At the same time, it is important to point out that numerous research studies have shown that care provided by the VA direct care system is of comparable and often superior quality to that provided by private sector providers and may have other advantages from coordination and continuity of care perspectives.

H.R. 9301, New Mexico Rural Veteran Health Care Access Act

H.R. 9301, the New Mexico Rural Veteran Health Care Access Act, would add two new counties in New Mexico as part of the VA's Veterans Integrated Service Network (VISN) 17. The new areas to be included in the VISN would be Eddy and Otero counties.

Currently, Eddy and Otero counties are part of VISN 22, which covers most of the State of New Mexico. VISN 17 covers all of Texas and small portion of eastern and southeastern New Mexico. This legislation would bring together the final two counties in the southeastern portion of New Mexico and include them in VISN 17.

DAV does not have a resolution specific to VA's VISN system; however, we do not have an objection to the bill's intent to address regional disparities in access to veterans' health services.

H.R. 9324, Protecting Veteran Access to Telemedicine Services Act

This bill aims to permanently extend a pandemic-related exemption that allows VA health care professionals to deliver, distribute, and dispense medically necessary controlled substances to veterans via telemedicine, even if they have not conducted the in-person medical examination.

By removing the requirement for an in-person visit, the bill aims to make health care more accessible for veterans who reside in remote or underserved areas. Last, this bill would ensure that veterans can continue to receive their medications without interruption, even if they cannot physically visit a VA facility.

DAV supports H.R. 9324, in accordance with DAV Resolution No. 42, which supports the right of rural veterans to be served by the VA to the maximum extent practicable and calls for the VA to overcome barriers to care for rural veterans by continuing to improve access to telehealth care initiatives.

H.R. 9427, to direct the VA Secretary to carry out a pilot program to provide grants to outpatient mental health facilities for the provision of culturally competent, evidence-based mental health care for veterans

H.R. 9427 would direct the Secretary of Veterans Affairs to carry out a pilot program to provide grants to non-VA outpatient mental health facilities to ensure the delivery of culturally competent, evidence-based mental health care for veterans.

This bill recognizes the importance and expertise VA provides in the delivery of specialized mental health services to veterans. In doing so, it highlights the need to ensure high-quality, evidence-based care when a veteran is referred to the community for services.

Although DAV Resolution 224 calls to support program improvement and enhanced resources for VA mental health programs and suicide prevention to address the mental health needs of veterans and ensure they receive high-quality, accessible care, we have concerns with this bill. Specifically, that it could potentially weaken the VA's integrated health care system, which conflicts with DAV Resolution 403, calling for strengthening and protecting the VA health care system.

Veterans in need of mental health care are eligible for care via the Veterans Community Care Program (VCCP) if the VA cannot provide it within 20 days or 30 minutes of drive time. This bill would create a system parallel to the existing VCCP and introduces a new structure with competing eligibility rules. For veterans receiving care through the MISSION Act, VA serves as the authorizer of community care when a veteran is eligible. For veterans receiving care through the grant, VA's role in authorizing community care would be bypassed, which eliminates VA as the default provider of care when available in a timely and convenient manner. Under this bill, even when VA services are readily available, a veteran would be entitled to obtain outside care.

This approach sets a precedent that could extend beyond mental health care, potentially leading to a system that is the exact opposite of what MISSION intended, i.e., to rely on community resources to supplement and not supplant VA care.

The recent VA Red Team Report strongly advised for VA to expand direct-delivered care and reduce community-delivered health care to prevent the VA system's collapse. This bill would potentially move in the opposite direction.

If the goal is to reduce wait times for mental health care access in VA and VCCP settings, the most effective solution would be to increase the number of VA mental health clinicians rather than create a parallel system with little oversight and potentially lower standards of care. Medical facilities that are not currently participating in the VCCP who wish to furnish mental health care to veterans should be actively invited to join the VCCP.

H.R. 9438, No Wrong Door for Veterans Act

H.R. 9438, the No Wrong Door for Veterans Act, would amend and reauthorize the VA Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG PGFSP), which supports nonprofit community organizations and government agencies working to serve veterans at risk of suicide. This grant program utilizes a pub-

lic health approach and combines clinical and community-based interventions with a goal of preventing suicide for veterans inside and outside of the VA health care system.

The Fox Grant Program allowed VA to implement a comprehensive mental health screening for grantees to measure the effectiveness of services. In order to combat veteran suicide and assess program outcomes, it is vital to examine data on specific interventions.

The March 2024 congressionally mandated report, *An Interim Report on the Provision of Grants through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SSG Fox SPGP)*, noted under *"Measurement Outcomes"* that grantees spent much of the first year, since January 2023, building and staffing their programs before starting to provide services and screening potential eligible individuals.

Although limited, the data collected from SSG Fox SFGP grantees was considered to be beneficial for reporting, program management, and evaluation. VA indicated it is using the initial year's program data to assess the suitability of benchmarks for future performance standards. Over time, VA predicts an increase in available data and the potential for more program graduates. The final report will better assess the effectiveness, capacity, and the feasibility of expanding grant provisions.

The No Wrong Door for Veterans Act would appear to limit VA in its ability to measure Fox Grant recipients who currently evaluate participants using both pre and post measurements across relevant metrics. Data collection and assessment will help VA make better decisions regarding program effectiveness and the needs for future resource allocation and we believe it is critical to maintain a robust set of metrics and evaluation tools, particularly during the early phase of this program.

The No Wrong Door bill would also implement new access standards that enforce a 72-hour deadline for the VA to deliver services after a veteran is referred for follow-up care for non-suicidal, non-emergency mental or behavioral health. This provision dramatically shortens the timeliness standard for VA mental health care for Fox Grantee veterans from the current 20-day standard to a mere 72 hours. If the VA fails to meet this timeline, the veteran would automatically become eligible for non-VA care, even outside of the Veterans Community Care Program, in line with the COMPACT Act standard, which ensures that mental health care is available anywhere for veterans who are in mental health crisis and at imminent risk for suicide. We are concerned that this unrealistic and unworkable new standard could undermine VA's efforts to provide coordinated mental health care to veterans.

This provision has the potential to negatively affect the VA health care system and the veterans it serves.

Draft bill to include a representative of the National Association of State Veterans Homes on the VA Geriatrics and Gerontology Advisory Committee

This draft legislation would require the VA to include a representative from the National Association of State Veterans Homes, who holds a professional license in nursing home administration, on its Geriatrics and Gerontology Advisory Committee (GGAC).

The VA's GGAC was created in 1980 to address challenges VA faced related to caring for a large influx of aging World War II veterans. One of the committee's main duties is to assess the capabilities of VA's health care facilities to respond with effective and appropriate care and services to address the medical, psychological, and social needs of older/aging veterans.

DAV has no specific resolution that addresses who should be appointed as a member of the VA's GGAC; however, the experience and expertise of a representative from the National Association of State Veterans Homes could be beneficial to the Committee's work and we have no objection to this draft bill moving forward.

Draft bill to require that non-citizen appointees to positions in the Veterans Health Administration are subjected to background investigations prior to employment

This draft legislation would require that non-citizen appointees undergo a background investigation prior to their employment with the VA. Currently, a non-citizen appointee may be hired by VA on a temporary basis under title 38, United State Code.

While DAV has no resolution that addresses VA hiring practices for non-citizen appointees, according to VA, these appointees are subject to background investigations. Furthermore, as part of VA's Personnel Security and Suitability Program, all employees, including non-citizens, are required to meet the necessary security and suitability standards before being hired by VA.

Draft bill, the Enhancing Faith-Based Support for Veterans Act

This draft legislation would allow a VA chaplain to send a veteran's contact information to a non-VA religious or faith-based organization. Once the VA chaplain has completed a spiritual assessment, the veteran must approve/elect to have their contact information shared with a non-VA religious or faith-based organization. The spiritual assessment includes the medical treatment plan of the veteran as well as their personal spiritual information.

While DAV has no resolution that addresses this matter, we have no objection to ensure that veterans have access to a wide range of supportive services, including those offered by faith-based organizations.

Draft bill, Safeguarding VA's Healthcare Workforce Act

This draft bill would establish a 3-year pilot program that allows the VA to fill vacant shifts at its medical facilities with non-Department health care providers once the number of vacant shifts reaches a minimum threshold, predetermined by the Secretary.

This initiative could help address staffing shortages and ensure that veterans receive timely and quality care. By leveraging non-Department health care providers, this program could improve veterans' access to care, especially in underserved areas.

That said, it is important that VA continue to work diligently to ensure appropriate hiring and retention practices are exercised and that internal VA staffing levels continue to be strengthened.

DAV supports this draft bill in accordance with DAV Resolution No. 403, which calls for VA to provide timely and convenient access to care for enrolled veterans, and for VA to remain the primary provider and the coordinator of care, while continuing to optimize the use of community care networks to fill in gaps, particularly in rural and remote areas.

Draft bill, to include adaptive prostheses and terminal devices for sports and other recreational activities in the medical services furnished to eligible veterans by the Secretary of Veterans Affairs

This draft bill would include adaptive prostheses and terminal devices for sports and other recreational activities in the medical services furnished to eligible veterans by the Secretary of Veterans Affairs. A terminal prosthetic device is one that works by means of cables to create voluntary opening and closing for managing a grip.

Amending current medical-services law would be a significant step in enhancing the quality of life for many veterans. The proposed amendment would ensure that veterans have access to adaptive prostheses specifically designed for sports and recreational activities. This can include specialized limbs for running, swimming, cycling, and other activities. By providing these adaptive devices, the amendment aims to promote physical activity and overall well-being among ill and injured veterans, helping them to engage in sports and recreational activities that they enjoy and need to maintain their fitness and independence.

The amendment would establish guidelines for veterans to be eligible for these devices, guaranteeing access through the VA for those in need. VA would not only provide such devices, but also offer training and support to help veterans effectively use their new prostheses. Furthermore, the amendment could stimulate the exploration and creation of new adaptive technologies, guaranteeing veterans have access to state-of-the-art prosthetic and adaptive devices.

DAV supports this draft bill in accordance with DAV Resolution No. 429, which supports sufficient funding for VA prosthetics and sensory aids service and timely delivery of prosthetic items, promoting physical activity and overall well-being among veterans, helping them to engage in sports and recreational activities that they enjoy.

Draft bill, Service Dogs Assisting Veterans Act (SAVES Act)

The SAVES Act would establish a 5-year pilot program to require the Secretary of Veterans Affairs to award grants to nonprofit organizations, accredited by Assistance Dogs International or the International Guide Dog Federation, to assist in providing service dogs to eligible veterans. The bill would also provide for the training of the dogs to assist veterans with various mental health and physical conditions. This bill would also provide each veteran who receives a dog through the grant program a commercially available veterinary insurance policy for the service dog.

DAV supports this draft bill in accordance with DAV Resolution No. 590, which supports a consistent benefit for service dogs, to include that any veteran for whom a service dog is prescribed receives the dog at no cost; there is reimbursement for any follow-up training deemed appropriate; and a veterinary benefit provided for the life of that service dog.

Draft bill to make improvements relating to conflicts of interest for certain Department of Veterans Affairs employees

This draft bill seeks to make improvements relating to conflicts of interest for certain VA employees.

Currently, title 18, United States Code, § 208 addresses conflicts of interest for Federal employees, including those at the VA. This law prohibits Federal employees from participating personally and substantially in any government matter that could affect their own financial interests or those of their family members, business partners, or organizations they are affiliated with. This law ensures that Federal employees, including VA researchers, maintain the highest standards of integrity and avoid any actions that could compromise their objectivity.

In the past, researchers could freely discuss the science with both VA and their academic affiliate without conflict, except for the funding and research agreement. Recognizing their erroneous historical interpretation and the potential legal risks, the VA Office of General Counsel (OGC) concluded that science, funding, and research agreements are all crucial aspects of the matter. Due to this OGC decision, employees working on the matter or research topic must secure a waiver prior to proceeding.

Initially planned for March, the policy's enforcement was deferred by VA until at least September 30, 2024. The absence of a policy for pursuing waivers at VA significantly impacts thousands of researchers by substantially delaying approval of research projects, as they require approval from both OGC and local VAMCs.

Although DAV does not have a resolution specifically addressing conflict of interest matters for Federal/VA employees, research is a critical part of VA's mission of serving our Nation's ill and injured veterans. For these reasons, we suggest that measures taken to address this issue should focus on maintaining quality researchers and employees. VA must ensure that their work can continue without undue administrative burdens.

This concludes my testimony on behalf of DAV. I am pleased to answer questions you or members of the Subcommittee may have.

STATEMENTS FOR THE RECORD

Prepared Statement of U.S. Office of Government Ethics

The U.S. Office of Government Ethics (OGE) is pleased to provide its views on proposed legislation to amend title 38, U.S. Code, to provide exceptions to the criminal conflict of interest laws, 18 U.S.C. §§ 203, 205, and 208, for employees of the Department of Veterans Affairs (VA) who concurrently hold outside positions with certain outside employers. OGE has not reviewed and takes no position on other pending legislation being considered at this hearing.

OGE appreciates VA's and the Subcommittee's ongoing work to address the complex balance between recruitment and retention of qualified VA medical personnel and the need to protect government processes from abuse and conflicts of interest. OGE is concerned, however, that the draft legislation does not effectively balance these competing equities. As written, the draft legislation would disturb the carefully balanced conflict of interest program that has existed for the past 60 years by providing overly broad exemptive relief, reducing oversight and transparency in the process of waiving the conflict of interest laws, and creating inconsistent treatment between dually appointed VA scientists and other scientists. More importantly, OGE believes that the existing legal framework is flexible enough to provide exemptive relief in many cases in which there is a legitimately low risk of an actual conflict of interest.

I. Current Law and Effect of Proposed Legislation

Congress enacted 18 U.S.C. §§ 203, 205, and 208 as part of omnibus legislation updating the Federal bribery, conflict of interest, and graft laws in 1962.[1] These laws were promulgated carefully, with the goals of not only strengthening limitations on conflicts but also ensuring that the government could access qualified experts from outside government, particularly scientists.[2]

Section 208 provides that an employee may not participate in any particular matter in which, to the employee's knowledge, the employee, a spouse, minor child, general partner, or any "organization in which [the employee] is serving as officer, director, trustee, general partner or employee, or any person or organization with whom [the employee] is negotiating or has any arrangement concerning prospective employment" has a financial interest.[3] While the prohibition is broad, it provides several authorities that allow OGE or an agency to waive insubstantial conflicts of interest. These authorities include personalized waivers[4] and regulatory exemptions.[5] The draft legislation would change this framework by creating two special exemptions at 38 U.S.C. §§ 7302(f)(1) and 7303(e)(1) that would allow dually appointed VA employees to participate in health profession education and research particular matters affecting the financial interests of their outside employers—so long as they do not make a final, binding determination related to that matter—notwithstanding 18 U.S.C. § 208(a).

Section 205 provides that an employee may not represent an outside party before the Federal Government in relation to any particular matter in which the United

[1] Modern Bribery, Graft and Conflict of Interest Law, P.L. 87–849, 76 Stat. 1119 (1962). Additional conflict of interest laws are found in chapter 11, title 18, of the United States Code. Employees of the executive branch are also covered by comprehensive standards of conduct found in 5 C.F.R. part 2635.

[2] H. Rep. 748, 87th Cong., 1st Sess. 4 (1961); S. Rep. No. 2213, 87th Cong., 2d Sess. (1962).

[3] 18 U.S.C. § 208(a). For OGE regulations interpreting and providing guidance on § 208, *see* 5 C.F.R. pt. 2640.

[4] 18 U.S.C. § 208(b)(1). Agencies must confer with OGE prior to issuance of an individualized waiver whenever practicable, provide OGE with a copy of each executed waiver, and make each executed waiver available to the public upon request. OGE is committed to reviewing waivers as fast as possible while meeting its responsibility to objectively review the facts of each case to ensure the statutory standard is met.

[5] 18 U.S.C. § 208(b)(2).

States has a direct and substantial interest.[6] Section 203 provides that an employee may not receive any compensation for representational services provided by themselves or another person in any particular matter in which the United States has a direct and substantial interest.[7] Although these two laws apply to all government employees, there are several exemptions, including exemptions for intermittent and temporary appointees.[8] These exemptions balance the need for specialized expertise from outside the government with the need to prevent these employees from using their positions to unfairly advantage their outside employer. The draft legislation would change this framework by creating two special exemptions at 38 U.S.C. §§ 7302(f)(2) and 7303(e)(2), allowing dually appointed VA employees to lobby the government on behalf of their outside employers on health profession education and research matters, as well as receive compensation for those communications, notwithstanding 18 U.S.C. §§ 203 and 205.

II. Concerns Regarding Proposed Legislation

OGE is concerned that the draft legislative exemptions to 18 U.S.C. §§ 203, 205, and 208 are overbroad and lack the necessary protections against substantial conflicts of interest found in current law. Unlike current exemptions to 18 U.S.C. § 208, which are only available when a conflict of interest is insubstantial, remote, or inconsequential,[9] the proposed legislation would allow an employee to participate in any health profession education or research particular matter regardless of how substantial the potential financial gain to their home institution—potentially including multi-million-dollar contracts, grants, cooperative agreements, and other financial assistance arrangements. In addition, by enacting exemptions to 18 U.S.C. §§ 203 and 205, dually appointed VA employees would be free to both lobby for benefits on behalf of their outside employer and participate in the decision to grant those same benefits in their official role, so long as they were not the final signatory. Without necessary safeguards, dually appointed VA researchers could be placed in the position of making decisions not because it is the right thing to do, but because it advantages their home institution.

OGE is also concerned that the draft legislation would remove important checks and balances that ensure that waivers and exemptions are done in an accountable and transparent way. For example, agencies are currently required to consult with OGE prior to issuing individual waivers when practicable and must make those waivers public upon request.[10] Likewise, OGE provides centralized review and issuance of regulatory exemptions to 18 U.S.C. § 208.[11] OGE's involvement ensures that those waivers and exemptions are consistent with the statutory criteria and that these authorities are not subject to abuse. The proposed legislation does not contain similar checks and balances as the existing conflicts of interest statutes.

OGE is likewise concerned that the draft legislation would treat dually appointed VA researchers differently than other VA employees and other scientists and medical professionals that work for other agencies.[12] Avoiding inconsistent treatment and a proliferation of "nonuniform ad hoc exemptions" was one of the principal reasons Congress established a single, uniform set of conflict of interest rules.[13]

Finally, OGE believes that the legislation may be unnecessary. In instances in which a conflict of interest arising from a health professional education or research particular matter is insubstantial, remote, or inconsequential, the VA can issue an individualized waiver or may be able to work with OGE to promulgate an appropriately scoped regulatory exemption. Likewise, dually appointed VA employees serving only intermittently with the government may be able to rely on a pre-existing exemption or receive an individualized waiver of 18 U.S.C. §§ 203 and 205 to communicate on a grant or contract with the United States if the VA Secretary has determined it is in the public interest.

OGE thanks the Subcommittee for the opportunity to present views related to this draft legislation. OGE stands ready to work with the Subcommittee and with VA

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[6] 18 U.S.C. § 205(a)(2).
[7] 18 U.S.C. § 203(a).
[8] 18 U.S.C. §§ 203(c), (e); 18 U.S.C. §§ 205(c), (f).
[9] *See* 18 U.S.C. § 208(b)(1)-(2).
[10] 18 U.S.C. § 208(d)(1).
[11] 18 U.S.C. § 208(b)(2).
[12] Congress recently enacted a limited exemption to 18 U.S.C. § 209 for dually appointed VA researchers. *See* Consolidated Appropriations Act, 2023, P.L. 117–328, § 182, 136 Stat. 5436 (2023) (codified at 38 U.S.C. § 7382(b)). While that provision has no effect on the views in this statement, OGE notes that there are more safeguards that apply to that provision than are found in this draft legislation, including a requirement that the Secretary authorize use of the exemption in writing.
[13] H. Rep. No. 748 at 14.

to identify and implement procedures that ensure the VA can continue to retain qualified VA researchers, while also limiting the influence of conflicts of interest in the research and education process. We believe that an approach is possible that will appropriately balance the needs to secure qualified medical professionals while protecting Government processes from abuse and conflicts of interest.

Please do not hesitate to contact us if we may be of additional assistance.

Prepared Statement of American Federation of Government Employees, AFL-CIO

Chairwoman Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee:

The American Federation of Government Employees, AFL–CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to submit a statement for the record for the September 11 House Veterans' Affairs Health subcommittee legislative hearing. AFGE represents more than 750,000 Federal and District of Columbia government employees, 304,000 of whom are Department of Veterans Affairs (VA) employees. AFGE's positions on several of the bills being considered are below:

H.R. 9146, Ensuring Continuity in Veterans Health Act (Rep. Franklin)

H.R. 9146 requires the Secretary to include "continuity of care" as one of the criteria used to determine when private care would be in the best medical interest (BMI) of a veteran. We oppose this provision because it will make it harder for VA to bring veterans back to VA from private care in instances when private care is no longer in the best interest of the veteran by requiring that continuity of care in the community be considered as a criterion in determining medical best interest. This would hamper VA's efforts to reverse excessive privatization by bringing back more veterans to direct care after receiving private for-profit care. VA already has flexibility under the current statute to consider continuity of care if it is in the best interest of the veteran. But adding it as a required criterion in determining best interest would limit VA's ability to decide that transferring a veteran back to the VA from private care is truly in the best interest of that veteran. This would particularly impact the VA's ability to rein in costly private care following emergency care by transferring veterans to VA hospitals after a veteran has been stabilized. In a recent Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey conducted by the Centers for Medicare & Medicaid Services, nearly 80 percent of VA medical facilities received a four or five-star rating compared to only 40 percent of non—VA hospitals. This only adds to an already large body of evidence that VA provides higher quality care to veterans than private providers. It therefore is neither in the best interest of the veteran nor the taxpayer to legislate keeping veterans out of VA where they receive high-quality care specifically targeted to their needs at lower cost than private for-profit care.

H.R. 6330, the Veterans Sentinel Act

H.R. 6330 establishes an Office of Mental Health and Suicide Prevention, a pilot program under which the Secretary establishes a working group to collect and analyze data regarding on-campus suicides and on-campus attempted suicides. AFGE supports efforts to improve suicide prevention by collecting data on direct care suicides and conducting root cause analysis. However, the bill should be amended to include parallel data collection and analysis for suicides that happen when veterans are served at non-VA facilities.

Pilot program to fill vacancies with non-departmental staff

This bill creates a pilot program under which the Secretary would contract out to fill vacancies at a medical facility with non-department health care providers. This would create a new program that fills vacancies with non-department health care workers in addition to the Integrated Critical Staffing Program (ICSP) for temporary contractors, which the VA already has in place. The ICSP has already created a troubling precedent for outsourcing hiring at the expense of permanent staff. In recent months, VA directed medical centers to remain FTE-neutral, a policy it applied to permanent workers but not to contractors. VA has admitted that it needs an additional 5,000 FTE in Fiscal Year 2025 to meet its direct care needs. If VA continues rely on this privatization accounting scheme to hire contractors to meet these needs and not permanent workers, contract workers will effectively crowd out

funding for permanent FTE. Rather than further expanding costly temporary staffing, the VA should pass a comprehensive recruitment and retention bill that addresses problematic hiring and compensation policies.

Veterans' Mental Health Access Act (Chairman Bost)

The Veterans' Mental Health Access Act would create a pilot for a new program to create non-VA outpatient mental health. This program would provide grants to nonprofit organizations that have operated at least one outpatient mental health facility in the United States for a continuous period of at least 3 years. AFGE opposes creating a parallel private mental health program that supplants VA's direct care system rather than supplement it when veterans cannot reasonably access VA care. Veterans are already eligible for private care if the VA cannot provide it within 20 days or 30 minutes of drive time. VA, however, must authorize this care. This bill would undermine the direct care system by creating a parallel private program that veterans would access without VA authorization. This would erode the integrity of the VA's integrated delivery system which depends on VA to coordinate veterans' care. Finally, the bill does not include quality or licensing standards for these providers. Rather than create a private, standard-free program for mental health outpatient treatment, Congress should invest in direct care mental health by funding additional VA mental health providers.

H.R. 9438, the No Wrong Door for Veterans Act,

H.R. 9438 would amend and reauthorize the VA Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program which supports nonprofit community organizations and government agencies that identify at-risk veterans and provide an array of suicide prevention interventions such as suicide risk education and peer support services. The focus of the program is on supplementing VA's clinical program with community-based prevention programs.

H.R. 9438 introduces a new 72-hour deadline for the VA to provide services after a veteran is referred for follow-up care. If the VA can't meet this deadline, the veteran becomes eligible for private care. This drastically reduces the wait time for VA mental health care from the current 20 days (under the MISSION Act) to just 3 days. This new standard is impossible for the VA to consistently meet. We have opposed other provisions like this. Again, Congress should instead fund additional VA mental health providers.

AFGE looks forward to working with members of the health subcommittee to advance legislation that strengthens the VA workforce to improve veteran care.

Prepared Statement of American Psychological Association, Association of VA Psychologist Leaders, Association of VA Social Workers, National Association of Veterans Affairs Physicians and Dentists, Nurses Organization of Veterans Affairs, Veterans Healthcare Policy Institute

MULTIORGANIZATIONAL STATEMENT FOR THE RECORD

UNITED STATES HOUSE OF REPRESENTATIVES

COMMITTEE ON VETERANS' AFFAIRS

SUBCOMMITTEE ON HEALTH

With respect to

Pending Legislation

September 11, 2024

by the

American Psychological Association
Association of VA Psychologist Leaders
Association of VA Social Workers
National Association of Veterans Affairs Physicians and Dentists
Nurses Organization of Veterans Affairs
Veterans Healthcare Policy Institute

(All are independent organizations, not representing the Department of Veterans Affairs)

Chairman Bost, Ranking Member Takano, and Distinguished Members of the Committee:

On behalf of our organizations, we thank you for inviting us to submit a statement for the record for today's hearing on multiple veteran-related bills. Many members of our organizations have published papers on these topics in peer-reviewed journals. Many of us have also had long careers serving veterans and have previously presented testimony to your committee. In today's statement, we want to convey our appreciation for your leadership and continuing commitment to ensuring that veterans receive the highest level of healthcare and services from the Department of Veterans Affairs (VA) and supplementary care in the private sector when it's necessitated.

While there are 16 bills being considered today, we comment below on the four most closely aligned with our expertise. Those are: Grants to Medical Facilities for the Provision of Culturally Competent, Evidence-based Mental Health Care for Veterans Act, No Wrong Door for Veterans Act, Ensuring Continuity in Veterans Health Act and the Veterans Sentinel Act.

Grants to Medical Facilities for the Provision of Culturally Competent, Evidence-based Mental Health Care for Veterans Act (Draft)

This bill allocates $60 million in grants over three years to eligible mental health care facilities for the provision of culturally competent, evidence-based mental health care for veterans. This proposed legislation presents multiple significant challenges and would severely weaken the VA's integrated healthcare system, as identified below:

Undermines the Veterans Community Care Program (VCCP) created by the MISSION Act

For the last five years, veterans in need of mental health care are eligible for care via the Veterans Community Care Program (VCCP) if the VA cannot provide it within 20 days or 30 minutes of drive time. This bill creates a system parallel to the existing VCCP. This new structure:

(a) Introduces competing eligibility rules. For veterans receiving community care through the VCCP, VA serves as the authorizer of care when a veteran is eligible. For veterans receiving care through the grant, VA's role in authorizing community care would be bypassed.
(b) Ends the principle that VA is the default provider of care when available in a timely and convenient manner. Under this bill, even when VA services are nearby and quickly available, a veteran would be entitled to obtain non-VA care.
(c) Demonstrates a lack of faith in the MISSION Act's framework for utilizing community resources.
(d) Duplicates VA- and VCCP-provided services, unlike the Fox Grant program which purchases services not offered by VA.

The bill's approach sets a precedent that could extend beyond mental health care, potentially leading to a system that is the exact opposite of what the MISSION Act intended, which was to rely on community resources to supplement and not supplant VA care.

Reduces, not enhances, the provision of culturally competent, evidence-based care

The bill mandates that each grant-receiving facility must have at least one clinician trained in culturally competent veterans mental health care. It does not require any providers to be trained in evidence-based care. The requirement of one culturally competent clinician would impact approximately 30 veterans per week at each location. Consequently, most services provided under a $1.5 million grant—or potentially multiple grants of this size—may be delivered by clinicians lacking both cultural competence and evidence-based training. It's important to note that the MISSION Act tasked the VA to establish evidence-based mental healthcare standards for community providers, but no required standards were ever put into place.

Further, there is no requirement for veteran-specific suicide prevention training despite prioritizing areas with large numbers of veterans at high risk of suicide.

Offers no assured improvement in access
While the bill is intended to reduce wait times for initiating mental health care, it fails to establish any concrete standards for timeliness of service. As a result, grantees could potentially have even longer wait times than those currently experienced with VA and VCCP services, undermining the bill's stated objective.

Legitimizes and incentivizes double dipping
The bill allows for "double dipping" by enabling existing VCCP facilities to receive additional funding without increasing services.

Reduces oversight and accountability
The bill lacks crucial quality standards and facility accreditation requirements. It notably omits mandates for accreditation by organizations like the Joint Commission or the Commission on Accreditation of Rehabilitation Facilities. It also fails to require a semi-annual peer review quality assurance system. These standards are integral to VA-delivered mental health care, highlighting a significant disparity in quality assurance between VA and grant-funded facilities.

Furthermore, unlike the VCCP, there's no requirement for grantees to share health records with the VA. Consequently, VA providers won't have access to veterans' records from grant-funded facilities, making care coordination nearly impossible.

Contradicts Expert Findings
The recent Red Team Report strongly recommended expanding VA-delivered care to prevent the VA system's collapse. However, this bill moves in the opposite direction, potentially exacerbating the very issues the report sought to address.

Furthermore, the bill lacks provisions regarding the salary pay structure and other reimbursements at non-VCCP grant facilities. If grant facilities use higher pay scales, there will be pressure for the VCCP to match them. This would lead to an escalation in veteran healthcare costs, which are already under strain.

Recommendation
This bill is unsupportable.

If the goal is to reduce wait times for mental health care initiation in VA and VCCP settings, the most effective solution would be to invest in the training and recruitment of an increased number of VA mental health clinicians rather than create a parallel system with little oversight and lower standards of care. Medical facilities that are not currently participating in the VCCP who wish to furnish mental healthcare to veterans should be actively encouraged to join the VCCP.

No Wrong Door for Veterans Act (Draft)

The No Wrong Door for Veterans Act proposes to renew and modify the 2020 Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. This pilot initiative allocated $174 million over three years to a diverse array of private and government entities, including veterans' associations, social service agencies, and tribal nations. These organizations partnered with the VA to combat veteran suicide at the local level.

Under the Fox Grant Program, 80 grantees receive up to $750,000 annually. Their primary role is to identify and engage veterans exhibiting one or more of 14 defined suicide risk factors. Once identified, these at-risk veterans and their families are provided with targeted services aimed at suicide prevention.

Two sections of the No Wrong Door for Veterans Act are concerning and in need of amendment:

Greatly undermines the existing access standard for VA mental health care
The bill's Sec. 2(e) states "Emergent Suicide Care: If the Secretary does not provide services under paragraph (1) to an eligible individual during the 72-hour period following a referral under subsection (m), such eligible individual shall be treated as eligible for emergent suicide care under section 1720J of title 38, United States Code.''

By way of reference, the alluded Hannon Act Sec. 201 subsection (m) stipulates: "REFERRAL FOR CARE.—(1) MENTAL HEALTH ASSESSMENT.—If an eligible entity in receipt of a grant under this section determines that an eligible individual is at-risk of suicide **or other mental or behavioral health condition** pursuant to a baseline mental health screening conducted under subsection (q)(11)(A)(ii) with respect to the individual, the entity shall refer the eligible individual to the Department for additional care under subsection (n) or any other provision of law." (2) EMERGENCY TREATMENT. —If an eligible entity in receipt of a grant under this section determines that an eligible individual furnished clinical services for emergency treatment under subsection (q)(11)(A)(iv) **requires ongoing services,** the entity shall refer the eligible individual to the Department for additional care under subsection (n)." (**bold** emphasis added).

The June 2024 Fox Grant Interim Report indicated there were thousands of "non-emergency mental health referrals" to the VA in the first year of the program.

Under the COMPACT Act, intervention for high suicide risk is already required to be immediate. The No Wrong Door bill introduces a stringent 72-hour deadline for the VA to provide services following a veteran's referral for follow-up care related to a non-suicidal mental or behavioral health condition. If the VA fails to meet this timeline, the veteran automatically becomes eligible for non-VA care (including outside of the Veterans Community Care Program). This provision dramatically reduces the wait time access standard for VA mental health care for Fox Grantee veterans from the current 20-day standard to three days. Such an aggressive timeframe poses significant challenges for the VA, potentially making consistent compliance impossible. Once Fox Grant-referred veterans seeking VA mental health care are afforded a three-day access standard, non-Fox referrals will likely soon follow. This No Wrong Door provision would

have far-reaching adverse consequences for the VA healthcare system and the veterans it serves. Congress must invest in building the behavioral health workforce to ensure veterans get the care they need.

Weakens the use of measures to evaluate a grantee's effectiveness
The No Wrong Door Act Sec. 2 (h) REQUIRED USE OF CERTAIN SCREENING PROTOCOL stipulates that ''In the case of a grantee awarded a grant under this section on or after the date of the enactment of the No Wrong Door for Veterans Act, such screening shall be the Columbia Protocol (also known as the Columbia-Suicide Severity Rating Scale (C-SSRS))''. This stipulation would likely reduce or eradicate the use of data to measure individual grantee's program effectiveness.

The original Fox Grant law made an important, long-overdue change in procuring community services to supplement VA efforts. Congressman Jack Bergman, the bill's co-author, emphasized: "This bill would develop measurement tools to track the effectiveness of these community-level programs in order to address the suicide crisis and its impact on Veterans." It authorized the VA to establish and apply a comprehensive baseline mental health screening that would be used for outcome metrics. The VA indicated: "Having this screening occur at the beginning and again prior to services ending is important in evaluating the effectiveness of the services provided."

Five well-validated measures were identified for grantees to administer at the beginning and end of participants' involvement. One, the Patient Health Questionnaire-9, explicitly assesses recent suicidal ideation. The others examine mood symptoms, self-efficacy, mental well-being, socioeconomic status, and social support. These additional measures are crucial, given that the programs are not clinical and are expected to impact suicidality downstream. A program's progress and yearly funding renewal are supposed to be based on demonstrated improvement in these instrument scores.

The Columbia Suicide Severity Rating Scale is initially administered to identify high-risk participants requiring immediate intervention. It is not part of the pre- and post-program evaluations.

While the No Wrong Door Act mandates the continued use of the Columbia Suicide Severity Rating Scale, it notably omits any mention of other screening measures used as outcome metrics. This omission of pre- and post-assessment tools from the bill's language potentially compromises the ability to effectively evaluate Fox Grant recipients' impact on psychosocial risk factors. Without these crucial evaluation metrics, it is challenging to accurately assess any program's success in addressing the complex issues surrounding veteran suicide prevention.

Last year, two Senate Veterans Affairs' Committee members introduced the Not Just a Number Act to expand the VA's annual veteran suicide prevention report. Committee Chairman John Tester (D-Mont), one of the bill's co-authors, avowed that, "when it comes to preventing veteran suicide, we've got to be looking at all the data we have on hand to see what's working and what's not." The other author, Senator John Boozman

(R-Ark.), argued, "by coordinating with successful veteran-serving organizations, (the Act) continues our commitment to modernize how we reach and serve veterans who struggle to get the mental health care and support they need. This legislation will help us make better data-driven policy decisions." Senators Tester and Boozman were exactly right that obtaining, utilizing and publicizing of data are pivotal in policy decisions affecting veterans' suicides.

The Interim Report on the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program covering the first year of operation revealed **extremely significant gaps in outcome measurement**. Of the 80 grant program recipients, 55 failed to report any post-service outcome measurements for participants. The remaining 25 grantees had a total of 196 participants (an average of approximately 8 participants per program) who completed services and underwent some degree of pre/post measurement. Twenty-seven percent of eligible participants did not complete even one instrument upon entering their program. Thus, **as of today, grantee effectiveness has been impossible to ascertain—either at the disaggregated grantee level or the entire Fox Grant program**.

Recommendation
The No Wrong Door for Veterans Act weakens the Fox grant program by omitting overt language about outcome measures for mandated screenings. To address this shortcoming, the Act must add stipulations that **explicitly reinforce the requirement for Fox Grant recipients to conduct pre- and post-intervention assessments** across relevant metrics. This approach would ensure robust data collection, enabling a clear understanding of how veterans' scores on the five key measures improve after participating in each grantee's services. The resulting data would equip grant administrators with information needed for informed resource allocation, ultimately contributing to the ongoing efforts to reduce the rate of veteran suicides.

Leveraging non-clinical community organizations is undeniably a crucial component of an effective upstream public health approach to suicide prevention. However, until there is concrete proof of the Fox Grant program's efficacy, and until the mandated MITRE Corporation three-year evaluation is completed, renewal should proceed on a year-to-year basis and avoid inserting the new stipulations identified above.

Ensuring Continuity in Veterans Health Act (Draft)

The Ensuring Continuity in Veterans Health Act aims to amend the MISSION Act's Veterans Community Care Program decision-making process. It would require considering "continuity of care" when determining a patient's best medical interest. However, incorporating the terminology into VCCP referral decisions **could have significant deleterious consequences.**

This bill appears to be a direct response to the March 2024 Red Team Executive Report, titled "The Urgent Need to Address VHA Community Care Spending and Access Strategies," compiled by six impartial experts in healthcare systems and quality. A key recommendation from this report was for the VA to transfer its veterans to VA inpatient units (and subsequent follow-up care) when available, after receiving emergency care in the community.

This Red Team recommendation addresses a critical issue: emergency services constitute the largest category of out-of-network healthcare for veterans, accounting for about 30% of community care spending. Of this, 84% is for inpatient care in community hospitals following ED transfers. The standard practice should involve transferring veterans to local VA hospitals, when beds are available, and the veteran is medically stable for transport. Follow-up care should also be provided by the VA when meeting access standards.

The Red Team Report highlighted that these cost savings would significantly contribute to the long-term viability of the VA healthcare system, which they deemed to be facing "an existential crisis." It noted that the rapidly increasing costs of community care are inadvertently reducing high-quality care choices for millions of veterans who prefer using the VA direct care system for all or part of their medical needs.

The report revealed that community care referrals have been increasing by 15-20% annually in recent years. In FY 2022, over 40% of enrolled veterans received care through the VCCP. The program's cost surged from $14.8 billion in FY2018 to $28.5 billion in FY2023, with projections indicating continued rapid growth unless Congress and VA leaders act swiftly to contain community care referrals and enhance the accessibility of VA's direct care system.

If "continuity of care" becomes the sanctioned justification for admitting post-ED visit veterans into the VCCP, VA's ability to achieve the financial stability necessary for its long-term survival could be hampered.

It's about more than just finances; the quality of healthcare is paramount Just last week, VA hospitals significantly outperformed non-VA facilities in two major independent, nationwide star-rating reviews for patient satisfaction and care quality.

Veterans Sentinel Act (H.R. 6330)

The Veterans Sentinel Act proposes a pilot program for the VA to collect and analyze data on veteran suicides and attempted suicides occurring on VA property. This initiative aims to improve the VA's information gathering process and innovate suicide prevention strategies.

We fully endorse the bill's intentions. Thorough tracking of veteran suicides and attempts, particularly those on VA medical facility grounds, is crucial. Quality improvement indeed begins with comprehensive data.

However, while well-intentioned, the bill omits an indispensable component. More than 40% of enrolled veterans are provided care through the VCCP, and veterans exclusively using VCCP have higher suicide rates than those solely using VA facilities. Yet, the bill doesn't address collecting data on suicides and attempts at VCCP facilities.

An effective Veterans Sentinel Act should address suicides and suicide attempts that occur at VA as well as VCCP facilities. The study should also evaluate the thoroughness of VA and VCCP investigations into suicide deaths and mental health-related sentinel events. This should include the completion of

- Behavioral Health Autopsy Program (BHAP) and Family Interview Contact (FIT-C) forms within 30 days of notification of a veteran's death by suicide,
- mental health-related sentinel events being entered into the Joint Patient Safety Reporting (JPSR) system within 24 hours of event awareness, and investigated and closed within 14 days of the date of entry,
- Root Cause Analyses (RCAs) within 45 days of identified highest-risk patient safety events.

These are the VA's established quality and patient safety standards.

To successfully address veteran suicide, an amendment is necessary. There needs to be a balanced approach that examines the issue across all veteran care settings, not just VA facilities to provide a more complete picture of veteran suicide risks and prevention opportunities.

We thank you for the opportunity to provide our perspectives on the bills. We look forward to working with the Committee to ensure that challenges facing VA are met with parity among all providers so that veterans can continue to receive timely, high quality compassionate care now and into the future.

Respectfully,

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Prepared Statement of Jason Crow

Rep. Jason Crow (CO-06) Submitted Remarks for House Veterans' Affairs Committee
Subcommittee on Health Legislative Hearing
September 11, 2024

Chairman Bost, Ranking Member Takano, and Members of the House Veterans' Affairs Committee:

I am proud to submit this testimony in support of my bill, the Veterans' Sentinel Act. After my military service, I came home to fight for veterans in my community, and I have witnessed firsthand the challenges that veterans face when transitioning to civilian life.

The Veterans' Sentinel Act was developed following an investigation that found multiple mistakes in the Department of Veterans' Affairs (VA) reporting of suicides that occur on campus. It is imperative that we improve the accuracy of data collection and enhance congressional oversight to better understand, and prevent, suicides by U.S. veterans at VA facilities. By increasing access to mental health resources, improving communication between VA agencies, and expanding support for veterans in crisis, this bill has the potential to save countless lives.

As you consider this crucial piece of legislation that addresses the critical issue of veteran suicide prevention, I urge you to remember that veterans are not just statistics – they are our friends, family members, and neighbors who have selflessly served our nation. They deserve our unwavering support and care.

The Veterans' Sentinel Act is a vital step towards ensuring that our veterans receive the care and support they need to thrive. I strongly endorse this legislation and encourage the committee to advance it swiftly.

Sincerely,

Jason Crow
Member of Congress

Prepared Statement of National Association of State Veterans Homes

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

"Caring for America's Heroes"

Statement of
ED HARRIES, PRESIDENT
NATIONAL ASSOCIATION OF STATE VETERANS HOMES (NASVH)

on
DRAFT LEGISLATION TO INCLUDE A REPRESENTATIVE OF NASVH ON THE GERIATRIC AND GERONTOLOGY ADVISORY COMMITTEE

Hearing of the
HOUSE VETERANS' AFFAIRS HEALTH SUBCOMMITTEE
SEPTEMBER 11, 2024

Chairwoman Miller-Meeks and Ranking Member Brownley:

As President of the National Association of State Veterans Homes (NASVH), I appreciate the opportunity to offer our strong support for draft legislation to include a representative of NASVH on VA's Geriatrics and Gerontology Advisory Committee (GGAC). Over the past decade, NASVH has proposed a number of our highly qualified leaders for membership on the GGAC, however none have been chosen, so we are pleased you are considering legislation to accomplish this goal in order to strengthen the work of the advisory committee and improve the lives and outcomes of aging and ill veterans.

We do want to recognize that VA has recently committed to appointing a member of NASVH to the GGAC, and we are grateful for the support of Secretary McDonough and Under Secretary Elnahal. However, given the history of NASVH having nominated multiple State Home administrators and leaders over the past decade, we believe it essential to codify this critical position to ensure representation on the GGAC in the future, regardless of who leads the VA.

As you may know, NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our Homes through education, networking, and advocacy. There are 169 VA-recognized State Veterans Homes (SVHs) across the nation operating 162 skilled nursing care programs, 48 domiciliary care programs, and 3 adult day health care (ADHC) programs. All 169 SVHs are members of NASVH, the only organization that represents their collective interests, and our membership is expected to continue growing with 9 new Homes expected to seek VA recognition by the end of next year.

The State Veterans Homes program is a partnership between the federal government and State governments that dates back to the post-Civil War period. To help cover the cost of care for veterans who choose to reside in SVHs, VA provides per diem payments at different rates for skilled nursing care, domiciliary care, and ADHC. VA also provides State Home Construction

grants to cover up to 65 percent of the cost to build, renovate, and repair SVHs, with States required to provide at least 35 percent in matching funds.

The GGAC was first authorized by Public Law 102-40 in 1991 to advise VA on all matters pertaining to geriatrics and gerontology, and was charged with three specific tasks:

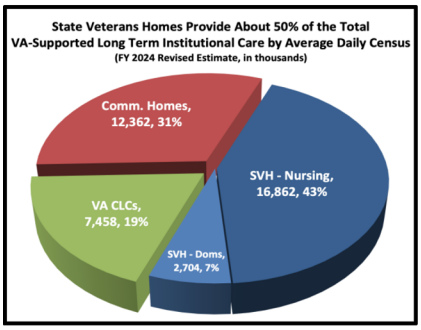
1. Evaluate the operation and effectiveness of VA's Geriatric Research Education and Clinical Centers (GRECCs);

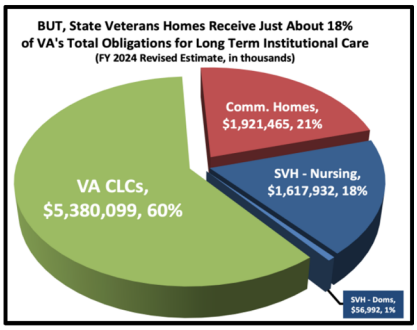
2. Assess the demand for long term care by veterans and VA's capability to provide high quality geriatric and extended care services; and

3. Assess the current and projected needs for veterans' long term care services and VA's activities and plans to meet such needs.

Leaders in NASVH and State Veterans Homes can offer unique experience and expertise to strengthen the GGAC's mission. The draft legislation would require that the NASVH representative have a professional license in nursing home administration in order to provide a different perspective from clinicians and researchers, particularly useful for considering how best to meet veterans long term care needs.

Further, a NASVH representative would add a critical voice commensurate with the leading role that State Veterans Homes play in meeting veterans long term care needs. Today, there are over 30,000 authorized State Home beds providing a mix of skilled nursing and domiciliary care. SVHs provide approximately half of all federally-supported institutional long-term care for our nation's veterans according to VA's most recent budget submission. However, State Veterans Homes will consume less than 20% of VA's total FY 2024 obligations for veterans' long term nursing home care. It's clear that SVHs offer significant value for VA in providing aging and disabled veterans high-quality long term care services.





With over 8 million living veterans aged 65 or older, almost 5 million who are 75 or older, there is an increasing need to strengthen and expand long term care options for veterans. Yet VA supports an average daily census (ADC) of just 32,000 veterans in nursing home settings, which

includes its own community living centers (CLCs), State Veterans Homes, and private community nursing homes. That level of VA support for facility-based care long-term care represents less than one-half of 1% of the approximately 8 million living veterans 65 or older.

VA has been placing greater focus and resources on home- and community-based services (HCBS) and NASVH strongly supports expanding these services to provide aging veterans a full spectrum of long-term care options. However, the amount of nursing home care offered by VA today is woefully inadequate compared to the overall number of eligible veterans. For these reasons, Congress and VA must continue to make smart investments to sustain and expand traditional bed-based care, even while expanding home- and community-based care.

NASVH and our member State Veterans Homes continue to seek new and innovative ways of delivering long term services to aging and ill veterans, including through a range of graduated care options for veterans who need support to age in place. SVHs understand aging veterans' needs and have expertise in connecting them with their VA benefits and services. With our clinical knowledge and extensive infrastructure, State Veterans Homes could serve as hubs in communities across the country, particularly in rural areas, to offer aging veterans a full spectrum of long-term support services, including home-based care.

NASVH has proposed that Congress and VA explore other ways for SVHs to develop new home-based programs, including ones similar to VA's Home-Based Primary Care, Homemaker Home Health Aide Care, Respite Care, Palliative Care and Skilled Home Health Care. Given the flexibility and financial benefits to VA from partnering with State Veterans Homes, there are myriad possibilities for better addressing the changing demographics, needs and preferences of veterans who want to age in their own homes. When they are no longer able to remain at home, SVHs could ease their transitions to facility-based skilled nursing care.

In order to maximize the use of State Veterans Homes' resources and capabilities. VA must fully commit itself to true partnership with States. Too often, SVHs have been an afterthought in VA's planning and budgeting processes; a seat on the GGAC could rectify that.

State Veterans Homes can and must play a greater role in meeting the needs of aging veterans and their caregivers in partnership with VA and other federal agencies. One way to strengthen that partnership is to ensure that NASVH and its members are represented when VA is discussing, evaluating and making plans to improve access to and quality of long-term care for our nation's aging and disabled veterans. For all of the above reasons, we urge you to support the draft legislation mandating a representative of NASVH on the GGAC.

NASVH looks forward to continuing to work with VA and Congress to ensure that veterans have greater access to a full spectrum of long-term care options, whether at home or in nursing homes. Adding the experience and expertise of a NASVH representative will not only benefit the GGAC, but it will also improve the lives of America's heroes.

Thank you for the opportunity to share our strong support for the draft legislation to mandate a NASVH representative on VA's Geriatric and Gerontology Advisory Committee.