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**STATEMENT OF
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COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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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 is a congressionally chartered non-profit veterans service organization (VSO) comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering 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. 41, the VA Same-Day Scheduling Act

H.R. 41, the VA Same-Day Scheduling Act of 2023, would direct the Secretary of Veterans Affairs to ensure the timely scheduling of appointments for health care at medical facilities of the Department of Veterans Affairs (VA).

The Veterans Health Administration (VHA) operates the largest integrated health care delivery system in the United States, providing health care to approximately 6.4 million veterans annually. In the last decade, Congress has taken steps to expand access for eligible veterans to receive care from community providers when they face challenges accessing care at VHA medical facilities; these steps include establishing the Veterans Community Care Program in 2019. While most veterans still receive the majority of their care at VHA facilities, including 170 VA medical centers (VAMC) and over 1,000 outpatient facilities, approximately 2 million veterans received care from non-VHA providers in the community in fiscal year 2021, according to VA.

In recent years, the Government Accountability Office (GAO) and others have reviewed VA's scheduling process and identified specific challenges that VHA has in ensuring that both VHA and community care appointments are scheduled in a timely manner. For example, GAO reported (GAO 23-105617) that VHA's appointment scheduling process for care from community providers was structured in a way that made it difficult to meet the statutorily required time frames for veterans to receive care. This required time frame specified the number of days it should take for a veteran to

receive care under the Veterans Choice Program—the precursor to the current community care program. GAO recommended that VHA establish an achievable wait-time goal for the new community care program to monitor whether wait times for veterans to receive care in the community are comparable with those at VHA facilities. Due to this concern with wait times and other issues, VHA health care continues to be on GAOs' High Risk List.

This legislation would require the Secretary to ensure that whenever a veteran contacts the Department by telephone to request the scheduling of an appointment for care or services at any VA facility, the scheduling for the appointment occurs during that telephone call (regardless of the prospective date of the appointment being scheduled).

DAV strongly supports H.R. 41, in accordance with DAV Resolution No. 435, as it would improve current scheduling procedures and require real-time scheduling practices that ensure more timely access to quality health care services.

H.R. 366, the Korean American VALOR Act

H.R. 366, the Korean American Vietnam Allies Long Overdue for Relief Act, or the Korean American VALOR Act, would recognize and treat certain individuals who served in Vietnam as a member of the armed forces of the Republic of Korea as a veteran of the Armed Forces of the United States for purposes of the provision of health care by the VA.

Currently, section 109 of title 38, United States Code, provides benefits for discharged members of allied armed forces of governments associated with the United States in World War I and II, except any nation which was an enemy of the United States during World War II. The Secretary may prescribe medical, surgical, and dental treatment, hospital care, transportation and travel expenses, prosthetic appliances, education and training. Hospitalization in a Department facility shall not be afforded under this section, except in emergencies, unless there are available beds surplus to the needs of veterans of this country.

This legislation would add a new subsection to section 109 of title 38, United States Code, to allow a person whom the Secretary determines served in Vietnam as a member of the armed forces of the Republic of Korea at any time during the period beginning on January 9, 1962, and ending on May 7, 1975, or such other period as determined appropriate by the Secretary to be eligible for health care treatment by the VA.

DAV does not have a specific resolution to provide VA health care treatment for individuals who served in Vietnam as a member of the armed forces of the Republic of Korea alongside the Armed Forces of the United States as outlined in H.R. 366 and takes no formal position on this bill.

H.R. 542, the Elizabeth Dole Home Care Act

H.R. 542, the Elizabeth Dole Home- and Community-Based Services for Veterans and Caregivers Act would improve VA home- and community-based services for veterans by expanding options for long-term care (LTC) services and supports.

Title 38, United States Code, subsection 1720 C(a)(1), (2) notes that “the Secretary may furnish medical, rehabilitative, and health-related services in noninstitutional settings for veterans who are eligible under this chapter for, and are in need of, nursing home care for veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a service-connected disability; or have a service-connected disability rated at 50 percent or more.”

This bill adds new subsections to subsection 1720 that would direct the Secretary to expand options for LTC through:

- The Program of All-inclusive Care for the Elderly (PACE);
- Veteran-Directed Care;
- Homemaker and Home Health Aide;
- Home-Based Primary Care; and
- Purchased Skilled Home Care.

Additionally, the Purchased Skilled Home Care Program would provide caregiver support services, which includes covered respite services and annual wellness contact.

Subsection 1720 C(d), states that the total cost of providing services or in-kind assistance may not exceed 65% of the cost during that fiscal year. This bill would amend this section by increasing the expenditure cap from 65% to 100% for provided services or in-kind assistance—not to exceed 100% of the cost per year.

Over the next two decades, an aging veteran population, including a growing number of service-disabled veterans with specialized care needs, will require LTC. While the overall veteran population is decreasing, the number of veterans in the oldest age cohorts with the highest use of LTC services is increasing significantly. For example, the number of veterans with disability ratings of 70% or higher, which guarantees mandatory LTC eligibility, and who are at least 85 years old is expected to grow by almost 600%—therefore, costs for LTC services and supports will need to double by 2037 just to maintain current services.

In order to meet the exploding demand for LTC for veterans in the years ahead, Congress must provide the VA resources to significantly expand home- and community-based programs, while also modernizing and expanding facilities that provide institutional care. The VA must focus on addressing staffing and infrastructure gaps in order to maintain excellence in skilled nursing care. The VA also needs to expand access nationwide to innovative and cost-effective home- and community-based programs, such as veteran-directed care and medical foster home care. Unfortunately,

funding for home- and community-based services in recent years has not kept pace with population growth, demand for services or inflation. For noninstitutional care to work effectively, these programs must focus on prevention and engage veterans before they have a devastating health crisis that requires more intensive institutional care.

DAV supports H.R. 542, the Elizabeth Dole Home- and Community-Based Services for Veterans and Caregivers Act, in accordance with DAV Resolution No. 016, which calls for legislation to improve the VA's program of long-term services and supports and increase timely access to both institutional and noninstitutional long-term services and supports.

H.R. 562, the Improving Veterans Access to Congressional Services Act of 2023

H.R. 562, the Improving Veterans Access to Congressional Services Act of 2023, would direct the Secretary of Veterans Affairs to permit members of Congress to use VA facilities for the purposes of meeting with constituents.

The VA Secretary and the Administrator of General Services would jointly identify available spaces in facilities of the Department for such purposes.

The space within a facility of the Department provided to a member would be:

- Available during normal business hours;
- Located in an area that is visible and accessible to constituents of the member;
- Subject to a rate of rent (payable from the member's Representational Allowance or the Senator's Official Personnel and Office Expense Account) that is similar to the rate charged by the Administrator of General Services for office space in the area of the facility; and
- May not prohibit a member from advertising the use by the member of a space within a facility of the Department.

Prohibited activities include:

- Campaigning in support of or opposition to any political office;
- Statements or actions that solicit, support, or oppose any change to federal law or policy;
- Any activity that interferes with security or normal operation of the facility;
- Photographing or recording a veteran patient at such facility;
- Photographing or recording a patient, visitor to the facility, or employee of the Department without the consent of such individual;
- Photography or recording for the purpose of political campaign materials;
- Using a facility during the 60-day period preceding an election for federal office in the jurisdiction in which such facility is located; and
- Unreasonably restricting use of a facility of the Department by a member if:

- there is space in such facility not in regular use by personnel of the Department; and
- use of such space shall not impede operations of the Department in such facility.

DAV does not have a specific resolution that directs the Secretary of Veterans Affairs to permit members of Congress to use VA facilities as proposed in H.R. 562 and takes no formal position on this bill.

H.R. 693, the VACANT Act

H.R. 693, the VA Medical Center Absence and Notification Timeline Act or the VACANT Act, would limit the detailing of VA medical center directors to different positions within the Department.

Over the past several years, the GAO added VA health care and acquisition management to its High-Risk List. This list identifies areas that are most vulnerable to fraud, waste, abuse, mismanagement, or the need for transformation. VA has made marked progress recently in addressing these high-risk issues by identifying root causes of the deficiencies and establishing action plans to address them. However, these are only the initial steps of the long-term commitment required to achieve transformational change.

The total number of veterans enrolled in VA's health care system increased from 7.9 million to about 9.2 million from FY 2006 through FY 2022. GAO has identified challenges related to VA's management and oversight of its health care system, including:

- Ensuring veterans' health care appointments are scheduled in a timely manner;
- Having complete information to determine if it has an adequate number of health care providers to meet veterans' needs;
- Effectively identifying and meeting the demand for mental health and other behavioral health services among veterans; and
- Ensuring timely implementation while addressing data quality issues as it works to modernize its electronic health record system.

Addressing each of these longstanding challenges requires sustained leadership and strong management and would help ensure veterans receive the care and benefits they deserve. Given the scope of VA's responsibility to serve veterans, effectively addressing its management challenges will require sustained commitment from VA leadership.

This legislation would require the VA Secretary to appoint a VA Medical Center director as acting director after detailing that director to a different position within the Department. The individual appointed as acting director would be afforded all of the authority and responsibilities of the detailed director. The VA Secretary would also be

required to notify the House and Senate Veterans' Affairs Committees of such detail, including the location at which the director is detailed; the position title of the detail; the estimated time the director is expected to be absent from their duties at the medical center; and any other information as the Secretary may determine appropriate.

Lastly, this bill requires, not later than 180 days after such detail with limited exception, that the Secretary return the individual as director of the medical center or reassign the individual from the position as director of the medical center and begin the process of hiring a new director for such position.

This legislation would help improve accountability to sustain needed leadership to ensure the VA health care system runs seamlessly during a period of transition and that veterans' continuity of care and benefits are not disrupted.

DAV supports this legislation in accordance with DAV Resolution No. 056, which recognizes that staffing shortages and vacancies at every level of the VA health care system, especially for critical management positions, can impede the delivery of care for service-disabled veterans who rely on the VA to receive timely, high-quality, veteran-centric medical care.

H.R. 754, the Modernizing Veterans Health Care Eligibility Act

This legislation would establish a Commission on Eligibility to examine policies guiding veterans' health care eligibility and make recommendations, if feasible and advisable, to change them. The Commission would be composed of 15 members appointed by the President; Senate Majority Leader; Senate Minority Leader; House Speaker and House Minority Leader (three each, at least one of whom would be a veteran). The President would designate the chair of the Commission and at least one member must be appointed from a veterans service organization; one member that has worked for a large private health care system; one representative with experience in a government health care system; and one individual familiar with the VHA, but not currently employed there.

The Commission would be required to hold its first meeting no later than 15 days after a majority of its members are appointed and issue a preliminary report with findings and recommendations no later than 90 days after its first meeting and a final report and recommendations no later than one year from its initial meeting. The President would then be required to submit a report to Congress on the advisability and feasibility of each recommendation, along with the executive actions and legislation necessary to implement them. DAV believes these proposed timelines would not allow individuals selected for the Commission, who may have little familiarity with the VA, its mission, and the specialized programs it has created for the veterans it serves, enough time to undertake a comprehensive evaluation and assessment of the eligibility system and to understand the nuanced policy decisions Congress has legislated since the establishment of the VA health care system.

Additionally, we do have concern about previous efforts proposing to diminish the size and scope of the veterans' health care system, whether by proposing changes in eligibility to limit the number of veterans who may receive care or by pressing for privatization of VA medical services. Congress has made thoughtful decisions about assigned priority for care and eligibility for various groups of veterans outlined in this bill—including service-disabled veterans and most recently expanding eligibility for veterans exposed to combat and or toxic exposures or radiation, under the PACT Act and veterans in mental health crisis, under the Compact Act. These two pieces of bipartisan legislation that became law, are good examples of Congress maintaining an eligibility system that meets the needs of our nation's veterans including our newest generation of wartime veterans. We appreciate Congress' oversight in providing VA the authority to exercise and implement new requirements of eligibility to veterans who have rightly earned access to VA health care.

Veterans' health care eligibility and VA's medical benefits package for enrolled veterans are clearly defined in title 38, United States Code, and accompanying federal regulation and continue to be modified in accordance with the needs of veterans at Congress' and the Administration's discretion. Because Congress has full authority to modify eligibility requirements or VA's medical care benefits package through the legislative process, it is unclear why a special outside commission is necessary.

We prefer that Congress continue to make decisions in the best interests of veterans by conducting oversight of VA health care eligibility and legislating the changes it deems necessary.

H.R. 808, the Veterans Patient Advocacy Act

H.R. 808, the Veterans Patient Advocacy Act, would improve the assignment of patient advocates at VA medical facilities.

The Veterans Health Administration (VHA) has designated patient advocates at each VA medical center (VAMC) to receive and document feedback from veterans or their representatives, including requests for information, compliments, complaints and assist with clinical appeals. In recent years, the importance of a strong patient advocacy program has taken on new significance given concerns with VHA's ability to provide veterans timely access to health care, among other issues.

VHA provided limited guidance to VAMCs on the governance of patient advocacy programs and its guidance, a program handbook, has been outdated since 2010. VAMCs are still expected to follow the outdated handbook, which does not provide needed details on governance, such as specifying the VAMC department to which patient advocates should report. Officials from most of the VA facilities that the Government Accounting Office (GAO Report 18-356) reviewed noted that the department to which patient advocates report can have a direct effect on the ability of staff to resolve veterans' complaints. The lack of updated and complete guidance may

impede the patient advocacy program from meeting its expectations, to receive and address complaints from veterans in a convenient and timely manner.

VHA also has provided limited guidance to VAMCs on staffing levels for the patient advocacy program. VHA's handbook states that every VAMC should have at least one patient advocate and appropriate support staff; however, it did not provide guidance on how to determine the number and type of staff needed. Officials at all but one of the eight VAMCs in GAO's review stated that their patient advocacy program staff had more work to do than they could realistically accomplish. This limited guidance on staffing does not support good practices to ensure there are an appropriate number of patient advocates and support staff to address veterans' complaints in a timely manner.

This legislation would direct VAMC directors to ensure there is no fewer than one patient advocate for every 13,500 veterans enrolled in the system. Additionally, it would also address the need for highly rural veterans to have access to the services of patient advocates assigned to rural community-based outpatient clinics.

DAV supports this legislation in accordance with DAV Resolution No. 056, which recognizes that staffing shortages and vacancies in the VA health care system including critical positions like patient advocates can hamper the ability of veterans, who rely on the VA, to overcome barriers to accessing the care they need and deserve.

We recommend that additional research be conducted to ensure that the ratio of patient advocate to veterans is adequate and balanced. Veterans want and need a proactive patient advocacy program. Patient advocacy offices should be staffed appropriately to provide timely assistance to veteran patients in accessing health care and clinical appeals. A consistent system-wide organizational structure for patient advocates will help to facilitate best practices and improve patient satisfaction.

H.R. 1089, the VA Medical Center Facility Transparency Act

H.R. 1089, the VA Medical Center Transparency Act, would require the Secretary to ensure VA medical center directors submit an annual easy-to-read fact sheet to the Secretary, the House and Senate Veterans' Affairs Committees, and certain members of Congress.

The fact sheet would be required to be made publicly available and provide statistics regarding:

- Number of veterans treated;
- Average wait time for veterans to receive treatment;
- Number of appointments conducted;
- Most common illness or conditions treated;
- Veterans' satisfaction rates;
- How veterans' satisfaction compares with other facilities; and

- Other matters the director determines appropriately.

The bill would also require that the fact sheet provide data and highlight special areas of emphasis or specialized care programs at each VA facility that are aimed at meeting the needs of women veterans, homeless veterans, suicide prevention and other mental health initiatives to include opioid abuse prevention and pain management services, or actions taken to improve the facility or quality of care.

Accurate and effective data collection is at the heart of assuring quality care. Without it, veterans, stakeholders and VA officials can be blindsided by crises that are otherwise difficult to identify, such as the access crisis in 2014, that led to major VA reforms under the Veterans Choice Act, and subsequently, the VA MISSION Act.

The Government Accounting Office (GAO Reports; 21-169, 22-103718, 22-105522, and 23-106665) has made a number of recommendations to improve this type of information to allow for greater program accountability and transparency in areas from assessing the quality of care provided to LGBTQ veterans, to understanding staffing needs for suicide prevention efforts and Vet Centers, to improving its electronic health record management system. Similarly, the Office of Inspector General (OIG Reports; 19-08658-153, 20-02186-78, 21-03020-168, and 21-00175-19) has made recommendations for improving data to ensure visibility into quality. Providing accurate, easily accessible, and up-to-date information to veterans will help to improve their care experience, as well as better inform policy makers overseeing the VA health care system. We suggest the Subcommittee consider adding a provision to the bill requiring VA to also provide comparable access and quality metrics for VHA providers and providers in VA's community care network.

DAV supports H.R. 1089, the VA Medical Center Facility Transparency Act, in accordance with DAV Resolution No. 121, which calls for greater attention and effort to be focused on developing and publicly sharing common access and quality metrics for both VA and non-VA providers participating in the VA's community care network. This information is essential for veterans to make fully informed decisions about their care.

H.R. 1256, the Veterans Health Administration Leadership Transformation Act

H.R. 1256, the Veterans Health Administration Leadership Transformation Act, would make certain changes to the laws pertaining to the appointment of the VA Under Secretary of Health (USH) and Assistant Under Secretaries of Health (AUSH).

Currently, Section 305 of title 38, United States Code (USC), states that in the VA, an Under Secretary for Health is appointed by the President, by and with the advice and consent of the Senate. Whenever a vacancy in the position of Under Secretary for Health occurs or is anticipated, the VA Secretary is required to establish a commission to recommend individuals to the President for appointment to the position.

This legislation would extend the term of appointment for the Under Secretary for Health to 5 years and remove restrictions for the number of Assistant Under Secretaries for Health that can be appointed (currently not to exceed eight). Lastly, the bill would eliminate the requirement that all but two AUSHs be physicians or dentists.

We understand the intent of this bill is to provide greater leadership stability at VHA and believe the proposed changes would help address identified governance challenges that have at times impeded oversight and accountability within the health care system. It would also empower the USH to more effectively manage and carry out their responsibilities to ensure veterans' health care needs are met. While DAV does not have a specific resolution that calls for changes to the laws relating to the appointment of these positions, we have no objection to the Subcommittee moving this bill forward.

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