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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 Brownley and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Subcommittee on Health. DAV is a non-profit veterans service organization 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. 913, Build a Better VA Act

H.R. 913—the Build a Better VA Act would change the statutory requirement that major medical facility leases be approved by law to a requirement that such leases must be approved by the Senate and House Veterans' Affairs Committees. The purpose of this legislation is to overcome the recent interpretation of budget scoring rules that require the 10-year cost of a lease to be offset in the first year in order to comply with congressional "pay as you go," or PAYGO rules.

Since PAYGO rules only apply to bills that are considered on the floor of the House and Senate, only requiring approval of a committee resolution instead would properly continue congressional oversight, while avoiding burdensome and unworkable PAYGO rules that have prevented and delayed the leasing of urgently needed Department of Veterans Affairs (VA) health care facilities.

DAV strongly supports this legislation in accordance with DAV Resolution No. 91, which recognizes that "...hundreds of leased VA community-based outpatient clinics are in jeopardy due to a change in congressional budget rules..." and calls for ensuring VA's health care infrastructure adequately meets veterans' needs.

H.R. 2587, SERVE Act

H.R. 2587—the Supporting Education Recognition for Veterans during Emergencies (SERVE) Act would improve the existing credentialing system to allow veterans, who served in a health care capacity during their time of service, to utilize their medical expertise to continue to help their fellow veterans. The SERVE Act would accomplish this by:

- Directing the VA to identify veterans with former military medical occupational specialties and providing documentation of medical training and experience through a web portal, allowing veterans to provide contact information on a voluntary basis;
- Allowing the VA to share volunteered information from veterans with medical backgrounds with state veterans' homes, state Departments of Veterans Affairs and Labor, VSOs, and state-credentialing bodies to facilitate the credentialing process at the state-level for qualified veterans;
- Permanently authorizing the Intermediate Care Technician (ICT) program, which is designed to hire former military corpsmen and medics into positions at VA medical centers; and
- Requiring a study on whether the existing ICT program can be replicated for other military medical specialties to expand pathways for transitioning service members and veterans.

DAV is pleased to support H.R. 2587 in accordance with DAV Resolution No. 77, and appreciates the efforts of Congress to increase the efficiency in the recruitment, hiring, and credentialing of certain health care professionals undergoing separation from the United States Armed Forces.

H.R. 2775, VA Quality Health Care Accountability and Transparency Act

The VA Quality Health Care Accountability and Transparency Act—H.R. 2775—would require the VA to make information on staffing and quality of care data publicly available on one easily accessible internet website.

Specifically, the bill requires VA to include staffing and employee vacancy information on the website required by the VA MISSION Act of 2018 ([Public Law 115–182](#); [38 U.S.C. 301](#) note) and to publish patient wait times and information on patient safety, quality of care and outcome measures required by subsections (a) and (b) of section 206 of the Veterans Access, Choice, and Accountability Act of 2014 ([Public Law 113–146](#); 128 Stat. 1780).

VA would be required to consult with veterans service organizations and ensure the website is easily understandable and usable by the general public. The bill also requires VA to annually assess the accuracy and completeness of the data and provide recommendations for improvement and to ensure standardization of data collection throughout VA.

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 Accountability Office (GAO) 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) has made recommendations about improving data to ensure visibility into quality. Providing accurate, 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.

Both the Veterans Choice Act and the VA MISSION Act promised veterans the opportunity to assess options in the community when VA care was not available or accessible, but the data available from both VA and community providers since that time has often not allowed veterans comparable data to make informed decisions about accessing care. However, unless veterans have access to data on both VA and non-VA providers in the community care networks, it is not possible for them to make a truly informed decision about their health care. Congress and VA must place much greater emphasis on developing tools and methods to measure both access to and quality of care provided to veterans not just by VA, but also by private sector providers, particularly those who are part of VA's community care networks.

While DAV supports increasing transparency, as proposed by H.R. 2775, we believe that much greater attention and effort must be focused on developing and then publicly sharing common access and quality metrics for both VA and non-VA providers participating in veterans' community care networks.

H.R. 2797, National Green Alert Act of 2021

H.R. 2797—the National Green Alert Act of 2021, would establish an interagency advisory and support committee for the development of a green alert system that would be activated when a veteran with a known history of mental health issues—to include suicide attempts or impulses, substance use disorder or neurocognitive disorders—goes missing.

Members of the committee would be appointed by the president and must include employees from various government agencies—specifically, the VA, the Department of Health and Human Services, the Substance Abuse and Mental Health Services Administration, and at least one veteran and one employee from the Department of Justice who has experience in coordinating the AMBER Alert communications network. The committee would be required to meet at least twice per year and would have the ability to hold hearings, as well as secure and release information from federal agencies to carry out its duties.

The purpose of the committee would be to establish guidelines and best practices to assist states with the development of systems known as “green alerts,” ensuring they adhere to applicable federal and state privacy laws. Finally, no later than two years following the enactment of the bill, the committee is required to provide a report to the president and Congress that contains a detailed statement of its findings, conclusions and recommendations with respect to its charge.

DAV does not have a specific resolution that calls for the “green alert” proposal outlined in H.R. 2797 and takes no formal position on this bill.

H.R. 3027, Veterans Improved Access to Care Act of 2021

H.R. 3027—the Veterans Improved Access to Care Act of 2021, would amend the VA MISSION Act of 2018 to expand reporting requirements on hiring in the Veterans Health Administration (VHA). Quarterly updates to Congress on staffing and vacancies would be required to contain information on the number of employees for which the duration of the hiring process exceeds metrics from VHA’s Time to Hire model or a successor model. It would also require VA to include the percentage of these employees for whom outlined metrics for hiring were not met, and the average time hires and potential hires spent in each phase of the hiring process. The Office of Inspector General (OIG) would be required to report on the findings annually.

H.R. 3027 would also require the VA Secretary to implement a two-year pilot program to reduce the onboarding timeline for new medical providers to be no more than 60 days. This pilot would take place at not fewer than ten VA medical centers selected to reflect regional diversity. At least three sites would be from areas with lower population density and priority would be given to sites with staff shortages in independent medical practitioners. Finally, the bill would require VA to submit to Congress a strategy to reduce the duration of the hiring process no later than 180 days after enactment.

DAV recognizes the significant challenges VHA has faced in meeting its staffing needs. Yet, during crisis periods VA has demonstrated its ability to resolve staffing deficits expediently (for example, meeting the increased staffing needs caused by the COVID-19 pandemic or using special teams to assist in recruitment and onboarding for VA medical centers that are in dire need of staff).

We support favorable consideration of H.R. 3027, in accordance with DAV No. 89, which supports legislation to ensure effective recruitment, retention efforts for development of VA’s health care workforce. However, we note that this bill does not prescribe means for VA medical centers to “reduce the onboarding timeline” under the pilot project, nor does it offer funding or other incentives for participation. While it is possible some VA medical centers will develop new ideas under the pilot without additional guidance or resources, without further specifications, it may not give enough direction to sites that are struggling with managing onboarding.

For these reasons, DAV recommends additional funding or resources be made available for the pilot for selected sites to encourage more sites to address these challenges. We believe that adding these specifications will yield better results from the pilot program, which might then be shared across VA.

H.R. 3452, Veterans Preventative Health Coverage Fairness Act

H.R. 3452 would add preventative medications and services to the list of no-fee treatments that VA covers and eliminate copayments for such items and services.

While service-connected disabled veterans rated higher than 50% do not incur costs for medications, those with lower disability ratings using VA for their health care are currently forced to pay out-of-pocket for many of the prescription drugs, including preventative health medications, and health screenings they require.

This includes immunizations, cancer screenings, vitamin supplements and tobacco cessation products, well-woman visits and other potentially life-saving assessments recommended by the U.S. Preventive Services Task Force. In contrast, these same medications and services are provided to service members, military retirees and many civilians for free through military and private health insurance providers.

DAV believes that asking veterans to pay for part of the benefits they earned in service to the nation is fundamentally contrary to the spirit and principles underlying those benefits. Therefore, we strongly support H.R. 3452, in accordance with DAV Resolution No. 365, which calls for the elimination or reduction of co-payments for service-disabled veterans using VA health care services.

H.R. 3674, Vet Center Support Act

H.R. 3674, the Vet Center Support Act would require the VA to submit a report on mental health care furnished by the department in certain states to the House and Senate Veterans' Affairs Committees. The report must contain information on the ability of the VA to provide assessments and referrals for medical issues, employment and veterans benefits and to deliver certain types of counseling services to include readjustment counseling and therapy for post-traumatic stress; group, bereavement, marriage and family counseling as well as counseling services for military sexual trauma.

The report must also include an analysis of staffing shortages at Vet Centers and an assessment on the feasibility of increasing staff levels at existing Vet Centers to ensure proper coverage, as well as an outreach strategy for various Vet Center community access points to ensure that mental health care services can be provided to veterans residing in underserved areas.

We are pleased to support H.R. 3674 in accordance with DAV Resolution No. 83, which calls for continued support of the VA's readjustment counseling service and Vet Center Program.

H.R. 3693, VA CPE Modernization Act

H.R. 3693, the VA Continuing Professional Education (CPE) Modernization Act would require the Department to reimburse certain health care professionals for the costs of continuing professional education. For physicians and dentists, reimbursements would be capped at \$4000 per year. Other health care professionals—such as podiatrists; chiropractors; optometrists; registered nurses; physician assistants; and other professions including speech and language pathologists; licensed physical therapists; and licensed practical nurses—would be reimbursed for up to \$2000 per year.

Continuing professional education is often required for medical and other professionals to keep their licenses or certifications up to date, and is necessary to ensure that professionals who were trained and licensed or certified decades ago remain abreast of evolving health research and modern practices. Reimbursing medical professionals for these necessary cost outlays is a benefit that many health care providers are likely to appreciate.

We are pleased to support the VA CPE Modernization Act in accordance with DAV Resolution No. 89, which supports the VA's use of effective recruitment and retention incentives and practices to maintain a quality health care workforce to care for our nation's ill and injured veterans. Provisions to reimburse CPE costs included in H.R. 3693 would support that effort and help to ensure VA remains a competitive employer of health professionals.

Draft Bill, VA "VIPER Act" of 2021

The VA's research program plays an invaluable role—not just in terms of enabling the Department to identify breakthroughs in medicine, health services delivery, bio-medical and rehabilitative technology—but in offering its clinicians opportunities to participate in enriched “learning environments” with scientific peers in affiliated academic institutions. These opportunities help VA retain its best and brightest providers and preserve beneficial relationships with academic affiliates. VA's research program is also the only federal program dedicated to exploring veteran-specific care, based on risks unique to this population, and identifying the most effective ways to treat and care for their service-related injuries, illnesses and medical and mental health conditions. VA's office of Research & Development has also made many important scientific discoveries and advances that benefit all [Americans](#). However, many in the VA research community believe the Department's efforts to support a world-class research enterprise are hamstrung by red tape.

This draft bill—VA Infrastructure Powers Exceptional Research Act of 2021, or the VIPER Act—would make the Paperwork Reduction Act requirements inapplicable to VA when it enters certain contracts or agreements for research activities. It would establish the Office of Research and Development under Title 38 of United States Code (USC) to ensure that VA maintains its commitment to a robust research endeavor within the Department. It would also waive requirements that limit an individual's participation

under the intergovernmental mobility program and waive some employees from accepting compensation from other sources (for off-hours work outside of their VA duties), eliminating this financial disincentive to work in VA research for many. The bill would establish a new career-development award grant for universities with smaller research programs and include certain types of non-clinical research employees, such as statisticians and scientists, under Title 38 to ease hiring issues. It would also require a GAO study on VA's use of dedicated time for clinicians and other scientists involved in research efforts.

Importantly, the VIPER Act would authorize resources to help address long-standing infrastructure needs for research labs and facilities, including repairs for life-safety deficiencies to ensure VA researchers are able to perform their work in safe workspaces. The additional funding would also allow VA to purchase "cloud credits" and other information technology necessary to improve manipulation of large health datasets, such as data from its renowned Million Veterans Program, or MVP, genetic initiative.

We are pleased to support this draft measure, the Viper Act, in accordance with DAV Resolution No. 133, which supports efforts to strengthen VA's research programs.

Draft Legislation to Improve the Program of Comprehensive Assistance for Family Caregivers

This draft legislation would make three changes intended to improve VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC), a program that DAV strongly supports. First, the bill would amend the law to prohibit VA decisions on applications for PCAFC from being reviewed by the Board of Veterans Appeals. Second, the bill would change the requirement that the second phase of the PCAFC expansion take place exactly two years after the first phase, and instead provide VA the authority to begin the second phase sooner, but no later than two years. Third, the bill would require VA to provide Congress quarterly reports about denials of PCAFC applications based on "best medical interest" criteria.

Earlier this year, the Court of Appeals for Veterans Claims, in the *Beaudette* decision, ruled that veterans appealing a denial of a VA decision to participate in VA's PCAFC have the right to appeal to the Board of Veterans Appeals, and if necessary, ultimately to the Court itself. DAV has long believed that allowing veterans and caregivers an option to appeal to the Board following the completion of the clinical review/appeals process would be beneficial. Since its beginning, PCAFC has had challenges in the consistency of decision-making, particularly in terms of revocations from the program, as evidenced by VA having to freeze revocations more than once. We think that allowing the Board to play a role in reviewing decisions about eligibility for PCAFC will be an improvement.

Finally, allowing Board review could help increase the transparency of VA's decision making, particularly notification letters, which would help to increase confidence in the fairness of VA's decision-making process among veterans and caregivers, and likely reduce appeals. While we understand this action could result in

additional work and cost for both VA and the Board, DAV believes it must be done to assure veterans fair access to family caregiver support. If necessary to implement the *Beaudette* decision, VA should request and Congress should approve the necessary resources, which DAV would strongly support. For these reasons, we oppose subsection (a) of the draft bill.

DAV worked closely with Congress to add provisions to the VA MISSION Act of 2018, that would expand PCAFC to all generations of severely disabled veterans, not just those who were injured on or after Sept. 11, 2001, as was the case under the previous eligibility criteria. The law required PCAFC to be expanded in two phases: the first phase of the expansion, which included eligible veterans injured or made ill prior to May 7, 1975, was to begin October 1, 2019; and the second phase, which included veterans injured or made ill after May 7, 1975, was planned to start two years later, beginning October 2, 2021. However, when VA failed to complete the information technology (IT) upgrades required under the law for phase one expansion, the certification was delayed until October 1, 2020.

While we are pleased the first phase rollout took place, the initial delays that occurred with implementing and certifying the new IT system subsequently delayed the second phase of the rollout, causing the second group of veterans and their caregivers to wait until October 1, 2022—a year longer than originally anticipated—for access to the program and benefits. We believe this delay is unnecessary and unjustified. While the VA indicated it would be necessary to increase staff levels prior to phase 2 expansion to properly manage the program, caregiver program officials have confirmed that no additional IT upgrades would be needed to accommodate new enrollees. As such, DAV believes there should be no further delays in expanding the program to all remaining veterans and their caregivers. We have called on VA to begin hiring additional caregiver program personnel now in order to expand PCAFC to phase 2 veterans and caregivers as soon as possible, but no later than the original intended date of Oct. 1, 2021.

For the above reasons, DAV strongly supports subsection (b) of the draft legislation. In addition, we recommend that additional language be included requiring VA to report to Congress within 30 days, and then every 90 days thereafter, whether it intends to begin phase 2 sooner than October 1, 2022, and if not, the specific reasons why it is unable to do so, and what resources it would need to move forward.

DAV generally supports subsection (c) of the legislation to require quarterly reporting on the number of PCAFC applications denied due to the “best medical interest” criteria, however we believe that VA should be required to regularly and publicly report on many other aspects of the program. Since the first phase of the expansion, VA has reported that approximately 75% of applications have been denied, however it has not publicly provided meaningful data or explanations for why the denial rate is so high. We recommend that in any quarterly reporting, VA should also provide the total number of applications, approvals, denials, appeals, outcomes of appeals, removals and reassessments, with breakdowns for the reasons and categories of each. Only with full, accurate and public data can veterans, caregivers, VSO stakeholders and

Congress determine how well the program is operating and whether changes are needed.

Draft Bill to Require an Independent Assessment of VHA

This draft bill would require a comprehensive independent assessment of health care delivery systems and management processes of the VHA, largely mirroring the independent assessment required under Section 201 of the Veterans Access Choice and Accountability Act of 2014 (P.L. 113-146). The original independent assessment, and the Choice Act as a whole, were adopted in response to an access crisis and waiting list scandal that erupted in 2014 as hundreds of thousands of veterans were waiting months to receive necessary medical care. The Choice Act created a new process for veterans to more easily receive non-VA care when wait times and travel distances to VA were too great. The independent assessment, as well as an independent commission (Commission on Care), were established to help determine the cause of the access crisis and offer recommendations to improve VA health care delivery. Both concluded that the lack of adequate resources to meet veterans' increasing demand for care was the primary driver of VA's access problems.

Four years later, Congress passed the VA MISSION Act of 2018 (P.L. 115-182) which created a new community care program based in part on findings and recommendations from both the independent assessment and the Commission on Care. Although the key elements of the VA MISSION Act were mandated to be fully implemented by June 6, 2019, due to a slow VA contracting process, and later the impact of the COVID-19 pandemic, creation of VA's new community care networks were significantly delayed and have only been fully operational for less than a year.

In addition, the VA MISSION Act mandated an Asset and Infrastructure Review (AIR) to assess VA's hospitals, clinics and other health care facilities, and to make comprehensive recommendations for change, realignment and/or modernization to meet veterans' health care needs in the future. The AIR process started this year and will culminate in 2023 with either approval or disapproval of recommendations by the President and Congress. The VA MISSION Act also required VA to produce a "Strategic Plan to Meet Health Care Demand," which was due in 2019, but has yet to be produced. In addition, VA is required to perform a quadrennial VHA review every four years to ensure VA has the health care capacity, resources and authorities necessary to deliver care to all enrolled veterans.

The draft bill under consideration would require VA to contract for an independent assessment of VHA not less than every ten years, with the initial assessment to be completed no later than December 31, 2024. The draft measure includes most of same requirements for the independent assessment as had been mandated by the Choice Act: specifically, current and projected demographics; budgetary trends for health care and accuracy of projection and budgetary models used; access standards; workflow processes, staffing, case-load, and productivity levels

at each medical center; clinical staffing support tools; recruitment and retention efforts and incentives; information technology strategies for clinical documentation; business processes for collections and vendor reimbursements; and detailed information on the purchase and distribution of medical supplies, health care devices and pharmaceuticals.

Currently, the VA health care system receives oversight and reviews from the GAO, the VA OIG, congressional committees such as this one, VSO stakeholders, and other interested academic, professional and media organizations, as well as VA's quadrennial review described above. While DAV sees the value and generally supports independent reviews of VA to help identify problems and offer solutions, we believe at this time an independent assessment is premature and is not sufficiently focused on current and future challenges.

As discussed above, VA is still in the process of major transformations of its health care system that stem from the 2014 access crisis. The VA MISSION Act has yet to be fully implemented, particularly the new community care networks. Further, the COVID-19 pandemic has distorted normal health care usage over the past 16 months, making it difficult to understand the impact of the VA MISSION Act changes until the pandemic has fully subsided. At the same time, changes in health care delivery, such as telehealth, have been accelerated by the pandemic and it will take some time to determine health outcomes and how this model of care will be integrated into health services in the future.

The ongoing AIR process will have a significant impact on the future of VA health care delivery, but will not be completed for several more years. In addition, VA is presently in the process of comprehensively transforming its electronic health records (EHR) system to provide more seamless data alignment with systems used by the Department of Defense and the private sector. With all these major VA health care transformations taking place over the next several years, we believe it is too soon to mandate a comprehensive assessment.

In addition, the challenges that veterans and the VA health care system faced in 2014 have significantly changed due to Congressional action discussed above, internal reforms and the impact of the COVID-19 pandemic. As a result, we recommend a broader scope for any future assessments of VA health care. In order to be meaningful, a review of the VA health care system must look holistically at the (quality of care provided by) the entire spectrum of providers, both VA and non-VA, who are delivering medical services to veterans paid for by VA.

For these reasons, DAV does not support the draft legislation at this time, but would consider supporting an independent assessment that more comprehensively examines both VA and non-VA health care systems serving veterans once the current transformations have been completed (are closer to completion).

**Draft Legislation to Furnish Vet Center Readjustment Counseling and Related
Mental Health Services to Veterans and Members of the Armed Forces**

This draft bill would expand eligibility for readjustment counseling and related mental health services in VA's Vet Centers for veterans or members of the Armed Forces from various service eras who are pursuing a course of education using certain veteran and military educational assistance benefits. Specifically, this bill pertains to educational assistance programs provided pursuant to Chapters 30-33 of Title 38, USC and Chapters 1606 or 1607 of Title 10, USC; Section 116 of Public Law 115-48 or Section 8006 of Public Law 117-2.

The bill would also require GAO to complete a report on the mental health needs of veterans using their educational assistance benefits and the efforts of VA to address those mental health needs.

VA's Vet Center program provides veterans easy access to readjustment counseling and mental health services at more than 300 community-based facilities. Veterans pursuing an education should have every opportunity to succeed in that endeavor and many may benefit from access to the peer-based mental health services Vet Centers offer, especially veterans dealing with service-connected disabilities.

DAV supports this draft measure in accordance with DAV Resolution Nos. 83 and 370, which support veteran's access to VA mental health services, including Vet Centers and effective mental health care programs for all enrolled veterans needing such services. We do however, ask the Subcommittee to consider adding provisions to ensure funding levels are commensurate with the expected growth in demand for Vet Center services, increases in staff and outreach efforts by Vet Centers that may be necessary.

Madame Chair, this completes my testimony and I am happy to address any questions you or Members of the Subcommittee may have regarding DAV's position on the bills under consideration.