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**STATEMENT OF  
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COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
July 12, 2023**

Chairman Tester, Ranking Member Moran and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's legislative hearing for the Senate Committee on Veterans' Affairs. DAV is a congressionally chartered non-profit veterans service organization (VSO) comprised of more than one million wartime service-disabled veterans 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 Committee.

**S. 449, the Veterans Patient Advocacy Act**

This legislation is aimed at improving the assignment of patient advocates at the Department of Veterans Affairs (VA) medical facilities. Specifically, it would direct VA medical center (VAMC) directors to ensure there are no fewer than one patient advocate for every 13,500 veterans enrolled in the system. 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.

The Veterans Health Administration (VHA) has designated patient advocates at each VAMC to receive and document feedback from veterans or their representatives, including requests for information, compliments, complaints and assist with clinical appeals. However, VHA has only 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limited guidance to VAMCs on the governance of patient advocacy programs and its guidance, a program handbook, has been outdated since 2010. VAMCs are still expected to follow the outdated handbook, which does not provide needed details on governance, such as specifying the VAMC department to which patient advocates should report.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 expectations, to receive and address complaints from veteran patients in a convenient and timely manner.

VHA has also only 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.

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.

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. Therefore, we recommend that additional research be conducted to ensure that the ratio of patient advocates to veterans is adequate to meet demand.

#### **S. 495, the Expanding Veterans' Options for Long Term Care Act**

S.495, the Expanding Veterans' Options for Long Term Care Act, would require the VA Secretary to carry out a pilot program to provide assisted living services to a rapidly growing population of aging and/or disabled veterans who are not able to live safely at home, but who do not yet require skilled nursing care.

This legislation would require the VA Secretary to carry out a three-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans in not fewer than six VA Veterans Integrated Service Networks (VISN). Assisted living fills a gap in VA's continuum of care for veterans who require a higher level of support than offered by domiciliaries, but do not need the full complement of skilled nursing care services.

Over the next two decades, an aging veteran population, including a growing number of service-disabled veterans with specialized care needs, will require long-term care and supportive services (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 demand for LTC for veterans in the years ahead, Congress must provide VA the 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.

DAV supports S. 495, in accordance with DAV Resolution No. 016, which calls for legislation to improve the VA's program of long-term services and supports for service-connected disabled veterans irrespective of their disability ratings, and urges the Department to ensure each VA medical facility is able to provide service-connected disabled veterans timely access to a full continuum of institutional and noninstitutional long-term services and supports.

### **S. 853, the VA Zero Suicide Demonstration Project Act of 2023**

S. 853, the VA Zero Suicide Demonstration Project Act of 2023, aims to improve safety and care for suicidal veterans by launching the Zero Suicide Initiative Pilot Program at the VA.

In 2019, there was an average of more than 17 U.S. veterans dying from suicide per day at a rate 52.3% higher than non-veterans. Forty percent of veteran suicides were among active VA patients. For veterans who have served since September 11, 2001, the rate is even more alarming, with 30,117 active-duty service members and veterans dying by suicide, over four times the number of combat deaths over the past two decades. These statistics support the need to pilot alternative intervention methods at VA facilities to improve veteran care, diminish the risk of suicide, and help keep safe those who have sacrificed to serve our nation.

As a nation we have an obligation to ensure that our veterans have timely access to the mental health services they need. Congress and the VA have been working diligently to address the epidemic of veteran suicide and everyone agrees we must work collectively until we get that number down to zero.

This legislation would initiate a pilot program to implement the Zero Suicide Institute curriculum to improve veteran safety and suicide care that stems from the Henry Ford Health Care System—built on the belief that all suicides are preventable through proper care, patient safety, and system-wide efforts. Advocates of the model note it has delivered clear decreases in suicide rates through innovative care pathways to assess and diminish suicide risk for patients across care systems.

The bill would require, in consultation with experts and veteran service organizations, that the VA Secretary select five medical centers to receive special training and support under the pilot program. Provisions in the bill aim to bolster clinical training, assessments, and resources to test the effectiveness of implementing the Zero Suicide Model.

Losing one service member or veteran to suicide is one too many. In conjunction with the White House, the VA has adopted a public health model to decrease service member and veteran suicides. The VA has partnered with the community and offers a vast range of targeted clinical and community-based programs and services aimed at this goal. This legislation would provide an opportunity to test the effectiveness of this alternative care model in combatting veteran suicide; however, we value the opinion of VA mental health experts in this approach to ensure there is not a duplication of services already being offered.

DAV supports S. 853, the VA Zero Suicide Demonstration Project Act of 2023, in accordance with DAV Resolution No. 059, which calls for legislation to support program improvements, data collection and reporting on suicide rates among service members and veterans and enhanced resources for VA mental health programs.

### **S. 928, the Not Just a Number Act**

This bill would expand the VA National Veterans Suicide Prevention Annual Report to examine how veterans' suicides correlate with the utilization of VA health care and benefits. Elements of the report would include the findings of the national analysis of veteran suicide rates for the latest year data and include trends and comparisons to previous years. The legislation requires the report's findings be publicly available and also calls for a study of the feasibility and advisability of creating a suicide prevention office separate from the VA's Office of Mental Health.

While the bill requires the VA to disclose important suicide data, it does not require the inclusion of data generated by recipients of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. The grant program was part of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, signed into law on October 17, 2020. This initiative includes non-profit, private, and government groups who are assisting VA in addressing veteran suicide in their local communities. Given the importance of having a comprehensive data set to determine effectiveness of various suicide prevention programs and efforts, we ask the Committee to consider amending the legislation by adding a provision to require the data from the Fox Grants be added to the report.

Additionally, we note the data from the Fox Grant recipients is reflected as information for the whole program and does not provide an opportunity to determine whether a particular organization's services are effective. Therefore, we also request that a provision be added to the bill requiring VA to separate and report information for each Fox grantee to include information on how scores on the five required measures improve for veterans who use the grantee's services. Having this information publicly available will help mental health experts and policymakers determine the effectiveness of all programs and make better decisions on where to focus resources to reduce suicide in the veteran population.

DAV is pleased to support S. 928—the Not Just a Number Act, in accordance with DAV Resolution No. 059 and request the Committee consider our recommendations for amending the bill.

**S. 1037, the Department of Veterans Affairs EHRM Standardization and Accountability Act**

This legislation would require the VA to show that the required improvements to the new electronic health record (EHR) system have been met before it can deploy the system to other VHA facilities. The required improvements include the achievement of a minimum up-time and system-wide stability for the EHR system and a report detailing the completion status of the corrections to the customization and configuration of workflow designs.

VA has engaged in a multibillion-dollar and decade-long rollout of an "off-the shelf" EHR that is interoperable with other health record systems; however, it has experienced significant challenges in the initial phases of the rollout, to include patient safety issues and complaints from staff regarding insufficient training.

A modern EHR is critical to delivering high quality and safe care to veterans and DAV shares Congress' disappointment with the delays, performance challenges, and patient safety issues with VA's EHRM effort.

In accordance with DAV Resolution No. 040, we support S. 1037, to ensure that VA is maintaining patient safety as a priority as the new EHR system is being installed and tested and will not proceed with the roll-out to other facilities until it is safe to do so.

**S. 1040, a bill to prohibit smoking on the premises of any facility of the Veterans Health Administration**

This bill would amend title 38, United States Code, Section 1715 for the purpose of prohibiting smoking on the premises of any facility of the VHA. This mandate would apply to veterans, patients, visitors, contractors and VA employees and include medical centers, community-based clinics, nursing homes and domiciliary facilities. Smoking is defined as the use of cigarettes, pipes, electronic nicotine devices, including e-cigarettes and vape pens.

Currently, tobacco use is allowed by veterans who are hospitalized or reside in a VA domiciliary. The Secretary is required to provide a suitable indoor area in which patients or residents may smoke or an area in a building that is detached from the facility and accessible to patients or residents of the facility.

While the intent of the bill appears to be focused on maintaining the good health of VA patients and employees, we have some concerns that certain veterans addicted to tobacco may forgo needed treatment due to a complete ban on smoking in VA health care facilities if this bill is enacted. However, DAV has no resolution from our members

calling for a complete prohibition of smoking in VA health care facilities and therefore takes no formal position on the bill.

### **S. 1125, the EHR Program RESET Act of 2023**

S. 1125, the EHR RESET Act, would require VA to implement a series of Electronic Health Record Modernization (EHRM) reforms to better serve veterans, medical personnel, and taxpayers.

Specifically, the bill would restructure, enhance, and strengthen the entire EHRM program with a comprehensive and aggressive set of oversight provisions to ensure the VA can reset and course correct this important but challenged modernization program on behalf of veterans, VA's dedicated medical professionals, and taxpayers. It would provide a framework to fix the patient safety, provider efficiency and morale, technology, cost, management and contracting challenges that continue to plague the program and hopefully prevent any future VA modernization project from being initiated without proper planning and controls.

The bill would also mandate specific reporting requirements to Congress to increase oversight, accountability, and transparency following a series of challenges with the system and program, including those found in VA's recent EHRM Sprint Report and a review by the Government Accountability Office report (GAO 23-106685).

The VA's EHRM program has experienced a series of challenges and shortcomings since it was initiated as has been documented in more than four years of Congressional oversight hearings, reports from the VA Office of Inspector General (OIG), GAO, and independent assessments commissioned by VA, as well as VA's own March 2023 Sprint Report and 2021 Strategic Review.

VA and its contractor, Oracle Cerner, made a series of questionable decisions, ignoring clear warning signs and independent oversight reports, selecting to proceed forward without first helping the initial facility in Washington State to recover and stabilize the technology to prevent its frequent crashes and freezes, and resolve how the EHR was designed, which prevented and inhibited VA medical personnel from consistently delivering care safely and efficiently. GAO and independent industry analysts KLAS noted the following troubling results: "KLAS has measured EHR experience in 280 organizations around the world. VHA Cerner currently has the lowest EHR experience score of any organization measured."

While VA's leadership has taken aggressive actions since 2021 and recently established a more stable and engaged management team to overhaul this program, significant challenges remain.

Among its many provisions, this legislation would require VA to:

- Develop clear metrics to guide whether and how VA should go forward with the new EHR at additional VA facilities and require additional resources to support those facilities;
- Require VA and Oracle Cerner to fix the technology features connected to the health safety and delivery issues found in VA's March 2023 Sprint Report;
- Not move forward with the new EHR at other VA health facilities until the data at the existing five facilities shows an ability to deliver health care to veterans at standards that surpass metrics using VA's VistA system or that meet national health operations standards as determined by the Under Secretary for Health;
- Appoint a lead senior negotiator and leverage other federal agencies and independent outside experts to offer advice and strategies for managing aggressive EHR contract negotiations with Oracle Cerner to protect taxpayers and veterans;
- Develop an alternative "Plan B" strategy for a new EHR in the event Oracle Cerner will not agree to new contract terms that protect taxpayers and increase accountability and penalties for poor performance or when VA data shows it cannot get the technology to work to serve veterans efficiently and safely;
- Reform major acquisitions at VA to prevent future programs with poor contracting, oversight, management, and planning from occurring; and
- Require an existing VA Advisory Committee to add health care experts with proven experience implementing EHR deployments to advise VA leaders on potential strategies on how to improve VA EHRM's implementation based on prior lessons learned in the private and non-profit health sectors.

DAV shares Congress' disappointment with the delays, performance challenges, and patient safety issues with VA's EHRM effort. Because a modern EHR is critical to delivering high quality and safe care to veterans, VA must modernize its EHR. The new EHR system is concerning to veterans, medical personnel, and taxpayers, and we agree that more governance is needed along with change management and accountability to right this wrong. Veterans deserve nothing less. In VA's pursuit of a modern EHR system, the Department should look to the GAO report 23-106731 recommendations to address these issues.

DAV supports this legislation in accordance with DAV Resolution No. 040, which recognizes that VA must continue its IT modernization efforts in a manner that ensures that the new system architecture allows it to fulfill all of its core missions, including maintaining patient safety, which should be the foremost concern, along with ensuring personal data is secure but accessible to veterans to allow them to be a partner in their health care.

**S. 1172, the Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act**

The Removing Extraneous Loopholes Insuring Every Veteran Emergency (RELIEVE) Act would allow veterans entitlement to emergency medical treatment within the first 60 days of being enrolled in the VA health care system. Veterans would have up to one year to file claims for reimbursement for emergency treatment services after the enactment of this legislation.

The VA aims to provide enrolled veterans a uniform benefits package that includes access to and coverage for urgent and emergent care. An August 2019 VA Office of Inspector General report found a significant number of emergency care claims were inappropriately denied and many rejected claims were inappropriately processed. As a result, many veterans faced an undue financial hardship.

DAV supports the RELIEVE Act in accordance with Resolution No. 148, which urges the VA to provide a more liberal and consistent interpretation of the law governing payment for urgent and emergency care and reimbursement to veterans who have received emergency care.

**S. 1315, the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023**  
**and**  
**Draft bill, the Making Community Care Work for Veterans Act of 2023**

Both S. 1315, the Veterans' Health Empowerment, Access, Leadership, and Transparency for our Heroes (HEALTH) Act of 2023 and the draft bill, Making Community Care Work for Veterans Act of 2023, would change the VA's current community care program, which was established by the VA MISSION Act (Public Law 115-182), to expand access to community care for more veterans, particularly those who live in rural and remote areas of the country. Both bills would also make a number of other changes to the VA health care system to improve access to care for enrolled veterans.

Like most veterans service organizations (VSOs), DAV strongly supported the VA MISSION Act after working for several years with this Committee, your counterparts in the House, VA leaders, and other stakeholders. The resulting legislation was a carefully crafted compromise to improve veterans' access to timely, high-quality, and veteran-focused care. Our support for the legislation, however, was predicated on maintaining a fundamental set of principles underlying the VA MISSION Act to ensure that veterans' health outcomes would be improved. Specifically:

- VA would continue to be the primary provider and coordinator of veterans' care;
- VA's internal capacity to provide care would be expanded through investments in staffing, infrastructure, and IT in order to meet the rising demand for care by enrolled veterans, particularly disabled veterans;



- Veterans who would otherwise have to wait too long or travel too far to get necessary care from VA should have swift and seamless access to high-quality community care options; and
- Community care providers would have to meet the same access *and* quality standards, as well as training and certification requirements, as VA clinicians.

In evaluating this proposed legislation that would make significant changes to VA's community care program, our primary focus is on whether it would improve access and result in better health outcomes for enrolled veterans, particularly service-disabled veterans. The above principles were designed to achieve that goal by balancing the need for greater access to care with the imperative of providing high-quality and veteran-focused care.

Both community care bills would codify existing VA access standards for wait times and travel times, and would limit VA's ability to modify those access standards in response to changing conditions. The VA MISSION Act specifically required VA to regularly review and modify access standards whenever feasible to improve access to high-quality care, however this was to be a clinical and health management decision, not a legislative one. While DAV supports responsible efforts to lower wait and travel times for care, including some provisions in these bills, codifying access standards will not achieve these goals.

Codifying access standards—by itself—will *not* improve veterans' access to care, lower wait times, improve quality, or produce better health outcomes. Investing in VA's health care infrastructure and staffing, however, would directly and measurably improve veterans' access to care. This is particularly true for veterans who live in rural and remote areas where VA is most likely to be a stable, long-term health care option for veterans since private sector medical facilities and practices tend to close more often and without notice, regardless of the needs of veterans who live in those areas.

Investing in VA is also most likely the best way to produce better health outcomes for veteran patients, since studies continue to confirm that VA health care is equal to or better than private sector care, on average. A robust VA health care system also provides vital research, training, and emergency preparedness for veterans and the nation, further justifying such investments.

For these reasons, we do support provisions in the draft Making Community Care Work for Veterans Act that seek to expand VA's capacity to provide care by expanding recruitment and retention programs for critical health care positions. We also support provisions in the draft bill that seek to increase training and compliance by community care providers, though we would like to see greater focus on requiring non-VA providers to meet all the same training requirements as VA providers. We also support the provision to expand reporting of quality metrics by community care providers, though we would also like to see that section strengthened. Further, we support the provision in the draft bill to ensure that community care appointments are more timely scheduled.

We have some questions and concerns about provisions in both bills that would restrict the ability of the Secretary, or his designees, to review "best medical interest" decisions agreed to by veterans and their referring physicians. Would this mean that VA could not review any referral by a non-VA physician, even if that referral went against VA's quality care guidelines? We are concerned that limiting VA's role in overseeing the care of some enrolled veterans could result in less effective care. VA's generous care package, coupled with its specialized veteran-focused treatment programs and wrap-around supportive services are rarely found within a single health system.

We also have questions about provisions in S. 1315 that would mandate the conversion of the VA health care system into a value-based care model. While there have been studies indicating that similar models tested by Medicare and Medicaid can reduce federal spending, there have also been alarming questions raised about whether this comes at the cost of lower quality and worse health outcomes. VA already provides holistic, integrated care for veterans and coordinates care and comprehensive support services for them—services that no other health care system provides. Given the unique nature of the VA system purpose-built for veterans, and recognizing the other missions VA performs, not just to veterans but to the nation at large, we recommend eliciting an opinion from the Secretary's Special Medical Advisory Group (SMAG) regarding the use of value-based care model in the VA health care system.

Mr. Chairman, we applaud you, Ranking Member Moran and other Senators for your continued interest and efforts to improve veterans' health care. We would welcome the opportunity to work with you and your staffs to address the concerns we and others have raised, and collaborate with you to develop a balanced package of legislation that would improve the quality of, and access to, health care for all enrolled veterans, particularly those who were wounded, injured, made ill and disabled from their service.

### **S. 1436, the Critical Health Access Resource and Grant Extensions (CHARGE) Act**

This bill would restore essential programs and authorities for homeless veterans, caregivers and State Veterans Homes that expired May 11, 2023.

Specifically, it would increase VA reimbursement rates for transitional housing facilities furnished to homeless veterans from 115% to 200% for a three-year period. The bill would also extend for three years the current authority for the VA Secretary to provide homeless veterans direct assistance when other resources through the homeless program office grantees are not available. Specifically, VA could provide safety and survival items such as food, shelter, clothing and hygiene items and transportation to health care appointments and other service providers, for food and supplies, along with communication equipment such as tablets, smart phones and related service plans.

The bill would also authorize veterans and caregivers to elect virtual home visits under the VA's caregiver programs through September 30, 2023, or until VA finalizes its new regulations for its comprehensive caregiver program. In addition, it would extend a

waiver of bed hold occupancy rate requirements for receipt of per diem payments for State Veterans Homes that was implemented at the outset of the COVID pandemic and makes permanent the authority for VA to provide State Veterans Homes medicines, personal protective equipment, and various supplies in similar health emergencies.

DAV supports S. 1436 in accordance with DAV Resolution No. 060, which calls for sustained and sufficient funding to improve services for homeless veterans to include improved access to specialized health and benefits services and Resolution No. 330, which calls on Congress to support State Veterans Home programs through adequate per diem payments for skilled nursing care, domiciliary and adult day care.

### **S. 1545, the Veterans Health Care Freedom Act**

This bill would require the Center for Innovation for Care and Payment to carry out a three-year pilot program in four VISNs to allow enrolled veterans in those VISNs to choose any VA or non-VA health care provider they prefer, using no access standards for eligibility for community care. Four years after enactment of the legislation, this pilot would automatically be rolled out to the entire country, all VA access standards would be eliminated, and all enrolled veterans could choose any primary, specialty, or mental health care provider in VA or in the community care network.

The legislation would require VA to develop systems to coordinate veterans' medical care with private providers. However, the bill includes a provision stating that no additional funding will be authorized for VA to implement and carry out any provisions of the legislation.

This legislation would unravel the carefully crafted VA MISSION Act, which created VA's current community care program, while simultaneously expanding access to care by increasing VA's internal capacity. Based on similar bills introduced and analyzed in prior Congresses, the additional cost of this legislation could run into the hundreds of billions of dollars. However, by specifically stating that no additional appropriations are authorized, enactment of this legislation would likely result in funding shortfalls for the VA health care system, threatening its viability, and severely limiting the options for veterans – particularly disabled veterans – who choose to get their care from VA.

For the above reasons, and in accordance with DAV Resolution 149, DAV opposes this legislation. DAV will oppose any recommendation or proposal that could lead to weakening, diminishing or dismantling of the VA health care system that millions of veterans have chosen and rely upon, or that would weaken VA research or medical education programs.

### **S. 1612, the Reimburse Veterans for Domiciliary Care Act**

The Reimburse Veterans for Domiciliary Care Act would require VA to publish a proposed rule to implement the requirement under section 3007(a) of Public Law 116-

315, which authorizes the VA to waive existing eligibility requirements for a veteran to receive per diem payments for domiciliary care at a State Veterans Home if the veteran meets at least four of those requirements (e.g., can feed himself or herself), or the waiver is in the best interest of the veteran. The bill requires VA reimburse State Veterans Homes retroactively to January 5, 2021.

DAV supports S. 1612 in accordance with DAV resolution 330, which calls on Congress and the VA to provide sufficient funding to support State Veterans Homes, including adequate per diem payments for skilled nursing care, domiciliary care and adult day health care.

### **S. 1828, the Veterans Homecare Choice Act**

S. 1828, the Veterans Homecare Choice Act, would direct the VA Secretary to recognize nurse registries for purposes of the veterans community care program and the ability to procure contracts or other agreements on behalf of registered nurses, licensed practical nurses, certified nursing assistants, home health aides, companions, or homemakers, under which such individuals may provide health care-related or assistive services (including such services provided directly to veteran patients or in support of health care facilities) and receive compensation for such services; and satisfy any applicable State licensure requirements.

Veterans deserve to live independently in their own homes but sometimes need extra assistance to do so. Veterans need care options to include home care professionals for everything from occupational therapy to housekeeping. However, finding the right home care professional can be a challenge, and for some, a daunting task. Many veterans have to search on their own to seek appropriate caregivers. It appears this legislation would help connect them with caregiver support options.

However, we do have some questions with regard to the bill's intent and definition of the "nurse registry," being that it includes more than skilled nursing positions, i.e., companion and homemaker. Likewise, should the program fall under community care versus VA's care giver program. Therefore, we ask the Committee to work with the bill's author to clarify these questions.

### **S. 1951, the Department of Veterans Affairs Income Eligibility Standardization Act**

This legislation would expand entitlement to health care for certain veterans and require the VA Secretary to eliminate all subcategories of priority for enrollment established by the VA under paragraph (8) of section 1705(a) of title 38, United States Code.

One hurdle in getting new veterans' access to care and services through the VA is the enrollment process. Veterans face complex eligibility requirements to determine whether they can receive VA health care.

Currently, veterans are placed in Priority Group 8 if they do not have a compensable service-connected disability, their gross household income is above the VA national income threshold (\$43,834) (including geographically adjusted income threshold for their resident location) and they agree to pay copays for care. Because of budgetary constraints, VA ended the enrollment of veterans in priority group 8 in 2003. However, veterans who were enrolled at that time were allowed to remain in VA's health care system with access to care.

The Veterans Affairs Income Eligibility Standardization Act would reduce the complexity of eligibility requirements in Priority Group 8 and open the aperture for more veterans to access care regardless of income or service-connected status.

DAV does not have a resolution calling for the removal of Priority Group 8 subcategories and therefore takes no position on the bill. However, if Congress intends to expand eligibility to all veterans, it must be accompanied by sufficient funding to ensure the VA health care system is able to provide timely, high-quality, and veteran-focused care to all enrolled veterans.

### **S. 1954, the Improving Whole Health for Veterans with Chronic Conditions Act**

S. 1954, the Improving Whole Health for Veterans with Chronic Conditions Act, would authorize dental care services to be provided by the VA to enrolled veterans diagnosed with diabetes and heart disease.

These chronic conditions are closely linked with poor dental health. Lack of dental care exacerbates these conditions, worsening their progression and increasing medical costs. However, only 15% of veterans are eligible for dental care through the VA system. Many of the remaining 85% of veterans who are not eligible for dental care struggle with access to affordable, quality dental care that meets their physical and oral health needs.

The regulations governing dental care eligibility for veterans using VA health care, outlined in title 38, Section 17 of the United States Code, have not been substantively updated since 1948—with nearly the same guidelines governing which veterans can access oral health care for the past 70 years. Expanding dental care to this group of veterans would help to improve the cost of managing chronic diseases.

In fiscal year 2021, the VHA reported 3.3 million enrollees were treated for diabetes and just over 640,000 were treated for ischemic heart disease. In 2020, the VHA reported spending \$86,079 per veteran treating ischemic heart disease and \$10,777 per veteran treating diabetes compared to \$1,132 per veteran for comprehensive dental care.

Based on these projections, the VHA could save an estimated \$3.4 billion dollars in medical costs—almost 1.5 times the annual VHA budget for dental care—by expanding access to dental care for veterans with heart disease and diabetes.

According to CareQuest Institute of Oral Health for every \$1 spent on dental care, the VHA could save \$1 in medical expenses for veterans with diabetes and \$2 for veterans with heart disease.

Additionally, on average, veterans with heart disease and diabetes miss more workdays and lose 42% more income than nonveterans with these chronic disease conditions. Veterans who don't get dental care face increased health concerns and are also more likely to experience prolonged pain, resulting in missed workdays and less productivity. Veterans cannot maintain their overall health without good oral health. The inadequate dental care most veterans have experienced has created a costly and painful crisis for many veterans.

DAV supports this legislation in accordance with DAV Resolution No. 013, which recognizes the need for routine dental care to be afforded all enrolled service-connected disabled veterans to ensure their whole health needs are met.

### **S. 2067, the Service Dogs Assisting Veterans (SAVES) Act**

The Service Dogs Assisting Veterans (SAVES) Act would require the VA Under Secretary for Health to establish a program to award grants, on a competitive basis, to nonprofit organizations to assist such organizations in carrying out programs to provide service dogs to eligible veterans.

Groups who are accredited to train and work with service dogs could apply for grants to cover the costs of training the service dogs, as well as providing ongoing support to both veteran and service animal after they are matched.

While we understand the value a service animal brings to many service-disabled veterans, DAV has no resolution calling for VA to provide grants to nonprofit organizations training service dogs. Therefore, we take no position on the bill, but noting the potential benefit for certain disabled veterans, would not object to its passage.

### **Draft bill, the Leveraging Networks in Communities for Veterans Act**

This draft legislation, the Leveraging Integrated Networks in Communities for Veterans Act, would require the VA Secretary to create a pilot program for the purpose of establishing a community integration network infrastructure for services for veterans, and require the collection of information from veterans related to social determinants of health.

This legislation would establish a new or enhance an existing interoperable technology network that enables the coordination of public and private providers and payors of services for veterans, including services such as:

- nutritional assistance;
- housing;

- health care, including preventive health intervention, chronic disease management, and behavioral health care;
- transportation;
- job training;
- child development or care;
- caregiving and respite care;
- disability assistance; and
- other services, as determined by the Secretary.

The bill also, prioritizes connectivity with appropriate existing technology networks developed by public or private organizations that comply with, as applicable, standards adopted by the Secretary of Health and Human Services (HHS) under section 3004 of the Public Health Service Act (42 U.S.C. 300jj–14).

Further, it would require the collection of information from veterans served under the pilot program regarding social determinants of health using a standardized risk assessment or screening tool, which shall include standardized definitions for identifying social determinants of health needs identified in the International Classification of Disease that incorporate measures for quantifying the relative severity of any such social determinant of health need identified in a veteran; and incorporate screenings used to collect information into routine care provided to veterans under the laws administered by the Secretary.

In carrying out the pilot program the Secretary of Health and Human Services, in consultation with the VA Secretary, shall issue guidance to states that includes options for State Medicaid programs to coordinate and integrate medical assistance provided under a state plan or waiver under title XIX of the Social Security Act (42 U.S.C. 1396a et seq.) with services for veterans.

Adequate representation is an important social determinant of health, ensuring the special needs and preferences of a subgroup are voiced, understood, and addressed. Many veterans with service-connected disabilities using the VA belong to subpopulations, including racial or ethnic minorities; LBGTQ+ groups, women, or reside in geographically remote areas (rural, underserved or outlying areas) and these subgroups are gradually making up greater portions of the veterans' population.

DAV supports this legislation in accordance with DAV Resolution No. 433, which recognizes the need to advocate for holistic programming to address social and economic determinants (related to income, employment, education, and family and community support), health behaviors (substance use, sexual behavior, diet and exercise) and physical environment (access to nutritional food, housing and transit) in addition to culturally relevant and personalized clinical care necessary to address health disparities among service-connected veterans.

## **Draft bill, the Rural Vital Emergency Transportation Services (VETS) Act**

The Rural Vital Emergency Transportation Services (VETS) Act would require the VA to reimburse highly rural veterans for the cost of ambulance service, to include air ambulance service to either VA or non-VA facilities for care regardless of whether the veteran qualifies for payment or allowances for beneficiary travel.

The VA aims to provide enrolled veterans a uniform benefits package that includes access to and coverage for urgent and emergent care, including veterans in rural and highly rural areas. Fifty-six percent of all rural veterans are enrolled in the VHA and rural veterans are older, poorer, sicker and less likely to have internet access. VA's Office of Rural Health has funded 450 projects in rural areas to improve access, care and services to this population, including transportation programs.

DAV supports the VETS Act, in accordance with Resolution No. 014, which supports rural and remote veterans' sufficient access to care and legislation to overcome barriers to care by assisting such veterans with transportation and travel needs.

This concludes my testimony on behalf of the DAV. Again, we appreciate the opportunity to comment on the bills before the Committee and I am happy to address any questions members of the Committee may have.