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**STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
OCTOBER 20, 2021**

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

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Senate Veterans' Affairs Committee. As you are aware, DAV is a non-profit veterans service organization (VSO) comprised of one million wartime service-disabled veterans and dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity.

We are pleased to offer our views on the bills that impact service-disabled veterans, their caregivers and families and the programs administered by the Department of Veterans Affairs (VA) that are under consideration by the Committee.

S. 1342, National Green Alert Act of 2021

S. 1342, 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.

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. No later than two years following the enactment of the bill, the committee would be 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 resolution specific to the proposal outlined in S. 1342 and takes no position on the bill.

S. 1779, Veterans Preventative Health Coverage Fairness Act

S. 1779, the Veterans Preventative Health Coverage Fairness Act, would add preventative medications and services to the list of no-fee treatments that VA covers

and eliminate copayments for such items and services including 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. These same medications and services are provided free of charge to service members, military retirees and many civilians, including those with private insurance plans under the Affordable Care Act.

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

DAV supports S. 1779, in accordance with DAV Resolution No. 019, which calls for the elimination or reduction of VA co-payments for service-disabled veterans.

S. 1937, DOULA for VA Act

The DOULA for VA Act would establish a pilot program within the Veterans Health Administration to provide pregnant and post-partum women veterans access to doula services in an effort to foster better child and maternal health outcomes. Pregnancy, labor and delivery, and the early days of motherhood can be difficult in the best of circumstances, but for women veterans, they can be further complicated by physical and mental health conditions related to military service—this includes anxiety, depression, PTSD due to combat or military sexual trauma, musculoskeletal problems and neurological issues.

Doulas act as advocates before, during and after pregnancy, helping expectant and new mothers navigate their birth experience and empowering them to self-advocate for their care, which can be especially important in instances where health care needs are profound or where veterans do not have strong, established support networks.

This legislation would enhance support services for pregnant women veterans by providing access to doula care within pilot facilities, which is vital as the demand for maternity care services continues to trend upward within VA. By establishing Doula Service Coordinators, this legislation would also help aid in the effort to coordinate care between VA and community providers. In addition, with a focus on health equity, the establishment of the pilot program would be important to addressing poorer maternal health outcomes among minority veteran groups.

We are pleased to support S. 1937, which is consistent with DAV Resolution No. 015, to support enhanced medical services and benefits for women veterans.

S. 1944, Vet Center Improvement Act of 2021

This bill requires the VA to evaluate productivity expectations for counselors of VHA's Readjustment Counseling Service (RCS) Vet Centers. The mandated evaluation

is required to include feedback from counselors regarding the potential effects of productivity expectations on client care, any effect of productivity expectations on the recruitment, retention and welfare of readjustment counselors, and whether productivity expectations provide incentives or add pressure on counselors to inaccurately report client visits. This bill also requires VA to develop and implement a staffing model for Vet Centers, and to standardize position descriptions of Vet Center staff.

In addition, this legislation directs VA to establish a pilot grant program to address food insecurity among veterans and family members of veterans who receive services through Vet Centers or other VA facilities.

According to VA, there was a 90 percent increase in the number of veterans receiving mental health care between 2006 and 2019. As a result, there have been mental health provider staffing shortages within VA and some veterans face challenges in accessing timely mental health services.¹ According to GAO (Government Accounting Office) Report 20-652, shortages of mental health staff within VHA coupled with the increasing veteran demand for mental health services highlight the critical importance of ensuring appropriate Vet Center staffing.²

VHA's RCS Office has set expectations for counselor productivity at Vet Centers however, GAO notes that although most Vet Center counselors met the productivity expectations in fiscal year 2019, some counselors indicated those expectations led them to change work practices in ways that could negatively affect client care.

DAV supports this legislation in accordance with DAV Resolution No. 118, which calls for program improvements VA mental health services and suicide prevention programs.

DAV believes the goal of staffing models and productivity expectations for every VA mental health program must be recovery-oriented and focused on providing veterans the services they need for a positive mental health outcome. Mental health treatment must be patient-centered and tailored to meet the needs and goals of the individual veteran. Therefore, we urge Congress to work in partnership with VHA's RCS Office to create the appropriate statutory mandates that ensure Vet Centers are able to accomplish the mission for which they were established and fully meet the needs of the veterans they serve.

¹ See, GAO, VA Mental Health: Clearer Guidance on Access Policies and Wait-Time Data Needed, GAO-16-24 (Washington, D.C.: Oct. 28, 2015); and VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access, GAO-12-12 (Washington, D.C.: Oct. 14, 2011). See also Department of Veterans Affairs Office of Inspector General, Office of Healthcare Inspections, Veterans Health Administration: OIG Determination of Occupational Staffing Shortages FY2019, #19-00346-241 (Washington, D.C.: Sept. 30, 2019).

² See, GAO, VA VET CENTERS: Evaluations Needed of Expectations for Counselor Productivity and Centers' Staffing, GAO-20-652 (Washington, D.C.: Sept, 2020).

S. 2283, REACH for Veterans Act

The Revising and Expediting Actions for the Crisis Hotline (REACH) for Veterans Act would require a review of training protocols for Veterans Crisis Line (VCL) responders to improve quality management processes. The VA would be required to implement or enhance quality management by: improving staff training; issuing re-training guidelines for call responders who have experienced an adverse event or low performance ratings; establishing monitoring and performance benchmarks for quality review management; ensuring adverse events and close calls are reported; and requiring adequate investigations into VCL callers who die by suicide.

The Act would also require enhanced guidance for managing callers with substance use disorders at risk of overdosing, review of VCL standards for emergency dispatch, and consideration of adapting safety planning for VCL call responders' use. Finally, the bill requires the VA establish a pilot program on the use of crisis line facilitation for the purpose of increasing use of the VCL among veterans at high-risk for suicide and to conduct research on the effectiveness of the VCL and areas for improvement.

Over the past decade, Congress, the VA and the Department of Defense (DOD) have been steadily working to improve prevention efforts to address the epidemic of suicide among service members and veterans. The VCL has proven to be effective and a true lifeline to hundreds of thousands of veterans at risk of self-directed violence. The crisis line takes approximately 650,000 calls a year, but after the expected deployment of the new national 9-8-8 hotline in July 2022, it anticipates a doubling or even tripling of its call volume. While the VCL is an incredibly important resource for veterans who are struggling and has helped hundreds of thousands of veterans access mental health services and mitigate suicide risk—there have been some lapses in quality that led to adverse events for veterans that this legislation could help to resolve.

DAV supports S. 2283 in accordance with DAV Resolution No. 118, which calls for improvement of mental health and suicide prevention programs for veterans and enhanced resources to support increased demand for these critical services.

S. 2386, Veteran Peer Specialist Act of 2021

S. 2386, the Veteran Peer Specialist Act of 2021 would require the VA to make permanent and expand the Veteran Peer Specialist Support program to all medical centers. The bill would require each medical center to have, at a minimum, two peer specialists and expansion of the program would take place over a five-year period including 25 VA medical centers each year until all medical centers have implemented the program. VA would be required to prioritize medical centers in rural and other areas that are underserved by the VA; areas that are not in close proximity to a military base; and areas representing a variety of geographic locations. In hiring peer specialists the bill requires VA to consider women to assist other women veterans treated at the medical center and candidates representing the racial and ethnic groups composing the community the medical center serves.

The bills also requires VA to submit an annual report to Congress for the five-year period of the program containing the following information: an assessment of the benefits of the program to veterans and family members of the veterans; an assessment of the effectiveness of the peer specialists engaging with health care providers in the community; the location of where the new peer specialists were hired; the number of new peer specialists at each medical center and the total number of peer specialists hired overall in the VA; and finally, an assessment of any barriers related to recruitment, training and retention of peer specialists. Once the program has been implemented at all medical centers, the VA would be required to submit a final report on the progress of the program.

Peer specialists have been an important addition to VA's programs. This bill helps to ensure that underrepresented veterans including women and ethnic and racial minorities have a point of contact in a system that may seem bureaucratic and unresponsive to their individualized needs. Peer specialists can personalize veterans' care experience helping them establish goals for recovery and increasing their knowledge and engagement in their care. They also help by sharing their own experiences and serving as role models for veterans recovering from similar conditions and help them navigate the complex array of services and benefits that may be available to them. They can also add the cultural and gender sensitivity the VA health care system may lack.

In [testimony](#) on October 13, 2021, before the House Veterans' Affairs Committee Subcommittee on Health, VA noted that expanding peer specialist services in patient-aligned care teams benefited veterans and was associated with increased participation and engagement in care and that their early interactions with veterans yielded lasting, positive relationships with many benefits. VA further noted that peer specialists require initial and ongoing training, supervisory support and dedicated and sustained funding to ensure successful implementation of these positions. VA suggested that a program as outlined in the bill would require extending the bills proposed reporting time-line from 5 to 7 years and additional resources.

DAV supports the expanded use of peer support specialists proposed in S. 2386, in accordance with DAV Resolution No. 028, which calls for a full continuum of health care services to ensure barriers to care for veterans in ethnic, racial and sexual minority groups are addressed, including staff expertise in addressing these groups' needs with sensitivity and gender-specific services necessary to meet the needs of a growing population of women veterans.

S. 2526, a bill to authorize the Secretary of Defense and the Secretary of Veterans Affairs to enter into agreements for the planning, design, and construction of facilities to be operated as shared medical facilities

This legislation would provide broad and consistent authority to the VA and the Department of Defense (DOD) to plan, design and construct shared medical facilities,

which could be a building, multiple buildings or a medical campus. Under the proposed legislation, a shared medical facility could be located either on a military installation or on VA property. The bill would specifically allow both departments to transfer and receive funds from the other and merge those funds into a single account to use for shared major or minor construction projects that have been authorized by Congress.

Given the commonality between the populations served by the VA and DOD health care systems, DAV has long supported efforts to expand the use of shared medical facilities to improve access and better utilize resources for veteran's health care. Unfortunately, longstanding regulatory and bureaucratic obstacles have hindered efforts to undertake and complete joint VA-DOD construction projects. This legislation would provide broad authority for shared medical facility projects and hopefully incentivize leadership in both departments to prioritize such efforts.

DAV supports this legislation in accordance with DAV Resolution No. 115, which calls for modernization of VHA's health care infrastructure, and calls on Congress to examine new models of funding to accomplish this goal.

S. 2533, MAMMO for Veterans Act

S. 2533, the Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act would improve mammography services in the VA by requiring the Secretary to develop a strategic plan for breast imaging services and establishing a tele-mammography pilot program in states without VA mammography services and in locations in which provision of such services is not feasible. The bill would also require VA to upgrade current mammography equipment to three-dimensional imaging and to study the availability of genetic testing for the breast cancer gene to veterans.

In addition, the bill would require that VA determine the accessibility of its mammography services for veterans with disabilities such as spinal cord injuries and dysfunction and collect data on rates at which such veterans receive mammograms. VA would also be required to identify best practices for making these services accessible, assuring that community referral sites are accessible and sharing best practices in accessible breast imagery care with community providers.

The bill would also require that the Inspector General study veterans' access to mammography services in VA or the community, the quality of such services and the documented communication to patients about the results of images. The IG would also assess the performance of the Women's Breast Oncology System of Excellence and the access of veterans diagnosed with breast cancer to a comprehensive breast cancer care team.

Finally, the bill would require VA to enter into an agreement with the National Cancer Institute which would provide access for veterans to services in at least one designated center in each Veterans Integrated Service Network to report on how VA will leverage this agreement to assure women veterans have access to care provided in

clinical trials. In addition, VA would report on additional opportunities to collaborate on breast imagery services with the Department of Defense.

DAV understands that women veterans are a small, but rapidly growing, part of the veterans' population. Because women do not necessarily reside near VA resources, VA does not always have sufficient numbers of women in the population to operate efficient and high quality services to meet their needs, including basic breast health. In many locations, VA has had to rely upon community partners for gender-specific health services—this leads to women veterans using community care at significantly higher rates than male peers.³ VA reports that in FY 2020 a third of all gender-specific cancer treatment and screening took place in the community and VA does not expect that proportion of care to change in the near future.⁴ Anecdotal research indicates that women receiving care in the community are often dissatisfied with communication about scheduling and results of diagnostic work.⁵

One of every eight women will have invasive breast cancer during her lifetime. Breast health is as essential to women's health as prostate health is to men's, yet VA is often operating without providing adequate access to these vital services. There is no doubt that VA continues to make progress with women's health, still, according to the VA's most recent budget summary fewer than half of VA's women patients received gender-specific care in fiscal year 2020—these numbers are particularly low (13%) for the oldest cohort of women veterans who are at the highest risk of breast cancer.⁶ In addition, only about 79% of VA's medical centers had a full or part time breast health coordinator which could hamper access to community care for mammography.⁷

These numbers suggest the need for a more strenuous breast health effort in VA and DAV is pleased to support S. 2533 in accordance with DAV Resolution No. 015, which calls for enhanced medical services and benefits for women veterans.

S. 2624, FY 2022 Veterans Major Medical Facility Authorization Act

This legislation would authorize 12 major construction projects for VA health care facilities for which VA requested funding in its FY 2022 budget submission. The projects authorized include two new spinal cord injury centers in Texas and California; a new research facility in California; a new long-term care community living center (CLC) in New York; and the construction, renovation or repair of medical facilities in California, Kentucky, Mississippi, Missouri, Oklahoma, Texas and Oregon.

³ Vol 4. Sourcebook: Women Veterans in the Veterans Health Administration. P.49.

⁴ Vol. 2 Department of Veterans Affairs Budget Submission, p. VHA-289

⁵ Mattocks, K.M., et al. Examining Women Veterans' Experiences, Perceptions, and Challenges With the Veterans Choice Program, *Med Care*, 2018; 56: 557-560.

⁶ Vol. 2 Department of Veterans Affairs Budget Submission, p. VHA-283

⁷ Vol. 2 Department of Veterans Affairs Budget Submission, p. VHA-286

DAV supports this legislation in accordance with DAV Resolution No. 115, which supports modernization of VA's health care infrastructure and urges VA to request, and Congress to approve sufficient funding to achieve this goal.

We also note that DAV and our partners in *The Independent Budget (IB)* have called for significantly greater funding levels for major and minor construction than VA requested in the FY 2022 budget. According to VA's internal Strategic Capital Investment Planning (SCIP) methodology, it would take at least \$66 billion over the next ten years to meet VA's infrastructure needs, which is a far greater level of funding than has been requested by VA or approved by Congress in recent years. For this reason, DAV also supports the inclusion of \$18 billion for VA health care facilities as part of infrastructure proposals currently being considered by Congress.

S. 2720, Veterans' Prostate Cancer Treatment and Research Act

S. 2720 would require VA to develop, in collaboration with knowledgeable federal stakeholders and partners, a clinical pathway to diagnose and treat prostate cancer at each stage of the disease. Importantly, in creating these pathways, it would require that VA consult with veterans who have received VA care for prostate cancer in addition to multi-disciplinary cancer care providers and clinical researchers. Not later than 180 days after enactment of the legislation, the Secretary would be required to submit a plan for implementing the pathway in its clinical programs which includes a plan for oversight and data-driven program evaluation and describes an educational plan for patients and providers. The plan will also describe means of identifying best practices and bolstering funding to support VA's prostate cancer research efforts.

Prostate cancer is the most common cancer (after skin cancer) among men—one in eight men will be diagnosed with it in their lifetime. Early identification and treatment of the disease is often the key to full recovery. It is particularly important for those veterans at highest risk for the disease, including veterans who may have been exposed to carcinogenic or other toxic materials during military service.

We are pleased to support S. 2720, in accordance with DAV Resolution No. 028, which calls on VA to provide high-quality, responsive, comprehensive health care to all enrolled veterans. Developing a clinical pathway for the treatment of prostate cancer is an important first step in ensuring VA provides best-in-class diagnosis and treatment for this common, often service-related and fatal, disease. This legislation is also in accord with DAV Resolution No. 256, which supports VA's medical research program for the purpose of helping wounded, injured and ill veterans recover and rehabilitate from health conditions related to their military service.

S. 2787, a bill to clarify the role of doctors of podiatric medicine in the VA

S. 2787 aims to clarify the role of doctors of podiatric medicine in the VA and would amend title 38, United States Code, to ensure that directors of the podiatric service are filled by doctors of podiatric medicine and that these professionals are

included in the Veterans Health Administration (VHA) pay scales with doctors of medicine.

Podiatrists or a podiatric physician DPM (doctor of podiatric medicine) is a medical professional who treats disorders of the foot, ankle, and related structures of the leg. While Podiatrists are doctors they do not generally attend a traditional medical school. In the U.S., podiatrists are licensed and regulated by states.

While we understand the important role DPMs play in ensuring the full continuum of health care services are available to serve the needs of service-disabled veterans—DAV has no resolution on the role of podiatrists in VHA as outlined in the bill and takes no position on S. 2787.

S. 2852, Long-Term Care Veterans Choice Act

S. 2852, the Long-Term Care Veterans Choice Act, would provide VA with a new authority to place and pay for veterans in medical foster homes, which are small group homes offering veterans long-term care in more family- and community-oriented settings. Veterans who have a service-connected disability rated at 70% or greater, or who need nursing home care due to a service-connected disability, would be able to request placement into a medical foster home; however, it would remain a discretionary program. The bill would place a limit on the program of 900 veterans based on the annual average daily total.

Medical foster homes can provide a long-term care alternative for veterans who want to have greater independence and remain closer to their families and communities, while receiving a higher level of care than could be sustained in their homes. In VA's fiscal year 2022 budget proposal, the Department requested this legislative authority because VA believes that medical foster homes have "...proven to be safe, preferable to Veterans, highly Veteran-centric..." and cost less than traditional nursing home care.

DAV supports this legislation in accordance with DAV Resolution No. 022, which notes that VA lacks sufficient non-institutional long-term care alternatives, such as medical foster homes, and calls for VA to provide veterans access to a wider range of options to this type of care.

We also note that the proposed legislation provides VA with broad authority to develop regulations to oversee the operation of privately-run medical foster homes, and VA must take special care to ensure these homes all meet strict health and safety standards. In particular, the challenges that every type of long-term care facility faced trying to prevent and mitigate COVID-19 during the pandemic make it especially critical that VA health and safety standards are consistent across all care settings. Veterans and their loved ones should have confidence that all long-term care options offered by VA are safe and offer high quality services.

S. 2924, Vet Center Outreach Act of 2021

S. 2924, the Vet Center Outreach Act of 2021 would require information on members of the Armed Forces who are transitioning to civilian life to be sent to the VA Vet Center nearest to where a veteran resides within seven days of that veteran separating from the military. That information would be used to contact former service members and inform them of the various readjustment services provided through Vet Centers to include, counseling for PTSD and other readjustment challenges, suicide prevention, crisis intervention, marriage and family counseling, and family bereavement counseling. VA would also be required to provide information on how to access such services and how to locate other Vet Center locations if they relocate.

Vet Centers have proven to be an effective resource to assist veterans of all eras who seek care for readjustment issues associated with exposure to combat, military sexual trauma and reintegration challenges with families and communities. DAV supports this legislation in accordance with DAV Resolution No. 106, which encourages Vet Center outreach to inform eligible veterans about these critical community-based readjustment services.

Draft bill, Servicemembers and Veterans Empowerment and Support Act of 2021

The draft Servicemembers and Veterans Empowerment Act addresses existing shortfalls in the military sexual trauma (MST) claims process to help ensure veterans are aware of and have adequate access to care and services for conditions related to their trauma, and that they do not face unnecessary hardships throughout the claims process. Specifically, this law would expand the definition of MST to include more technologically modern forms of harassment and abuse; codify evidentiary standards and requirements within the review process; enhance outreach and communication with veterans regarding the claims process for MST-related conditions; mandate studies on the quality of both training and procedures of Veterans Benefits Administration (VBA) staff responsible for reviewing and processing these cases; access to inpatient mental health care for MST survivors; and authorize a pilot program to provide intensive outpatient mental health care services for MST survivors unable to access inpatient mental health care at VA medical center within a 14-day window.

This bill stands as a much-needed compilation of provisions that address many of the long-standing issues DAV has noted within the claims process for MST-related conditions. In fact, many of the recommendations DAV made at the hearing before this Committee on May 12 of this year are reflected in this bill, and we appreciate the dedication shown to listening directly to MST survivors and those who advocate for them, and incorporating their feedback into this proposed legislation.

One such recommendation was to relax the evidentiary standards for “stressor” requirements in claims for conditions related to MST. For many survivors, establishing service connection for mental and/or physical injuries caused by MST represents personal validation as well as recognition of and gratitude for their honorable service.

DAV supports lessening the evidentiary burden for MST cases, more closely in line with what is currently required for combat veterans—as this bill seeks to do through the addition of provisions outlined in Section 1167.

As we address this long-standing issue, DAV believes it is also important to protect the integrity of the claims process and to prioritize the best interest of veterans by putting accuracy before speed. The proposed new section—Section 1167, Evaluation of claims involving military sexual trauma, Subsection (f), Paragraphs (2) and (3)—calls for a veterans' lay statement (a personal statement of the event, for example) to be considered adequate for VA to provide both an exam and medical opinion, without waiting for other evidence to be presented. While we believe this provision is well-intentioned, the bill text indicates there may be times in which this results in the veteran not receiving a supporting medical opinion for diagnosis of a covered mental health condition linked to the MST. In such cases, VA would need to request additional evidence and order a new exam. Enduring unnecessary exams throughout this process can be re-traumatizing for MST survivors. As such, DAV strongly recommends veterans complete the full claims development process (in such instances where evidence exists and stressors can be documented) prior to undergoing any exam to ensure they are presenting the strongest and most thorough case to the VA for evaluation and adjudication. It is important to get this first step right to avoid possible premature denials and putting veterans in the position of undue emotional stress.

Beginning in 1992, with the enactment of Public Law 102-585 and in the years since, VHA began offering veterans counseling and services to address physical and mental health issues related to MST, without requiring a service-connected rating or proof of the event. However, a lack of consistent coordination between VBA and VHA often results in MST survivors filing for disability claims without any guidance on the immediate health services available to them through VA. This bill includes provisions that would initiate automatic written communications—guided by experts and mental health professionals—to MST claimants, providing information on resources and contact information for MST coordinators in both VBA and VHA. DAV believes this is a positive step forward in synchronizing efforts to serve the same veteran between the two administrations. We would further recommend VA consider requiring its MST coordinators provide initial outreach by phone once a claim has been filed, something that has shown to be beneficial in making pregnant women veterans aware of available VA services through maternity care coordinators.

Additionally, DAV appreciates the inclusion of provisions to allow MST survivors the opportunity to request their compensation and pension exam be done at a VA facility by a VA provider. However, based on the unique nature of these cases, the often-complex health needs of survivors and the expertise within VA regarding veterans' mental health and impacts of trauma, DAV recommends all original mental health claims be handled by VA providers, rather than directed to the community.

Caring for disabled veterans, and specifically MST survivors, must begin at the very beginning of the claims process. This type of trauma is uniquely personal and

sensitive, and the approach to address it cannot always be standardized. An August 2021 VA Office of Inspector General (OIG) report, showed clear challenges remaining in the MST claims process. The report's concerning findings make the bill's provisions for studies on VA staff training and processing of claims particularly important moving forward, especially as VBA effectively creates MST rating specialists across a limited number of regional offices to handle the entire volume of these cases. DAV is also in favor of the bill's provisions for studies on access to inpatient mental health care and the pilot program on interim access to more intensive outpatient care, which could help to ensure care is available to veterans when they need it.

DAV supports the draft Servicemembers and Veterans Empowerment Act in accordance with DAV Resolution Nos. 116 and 074, which call for ensuring that all MST survivors gain access to the specialized treatment programs and services they need to fully recover and that VA conducts rigorous oversight of claims adjudication personnel and review of data to ensure the policies for processing claims for conditions due to MST is being faithfully followed and standardized in all VA regional offices.

Draft bill, State Veterans Homes

This draft legislation would establish several new requirements that State Veterans Homes (SVHs) must meet to remain eligible to receive VA per diem payments for the provision of long-term care to eligible veterans. Specifically, the legislation would require every SVH to have a governing body consisting of two or more people that would be legally responsible for establishing and implementing policies regarding the management and operation of the SVH. Under current VA regulations, a SVH can have either a governing body or a "designated person functioning as a governing body," such as a state director of veterans affairs. It is unclear whether this legislation would prohibit a state from having a director of veterans affairs or similar state official be responsible for overseeing its SVHs.

The draft bill would also require SVHs to have an administrator or deputy superintendent who is licensed by the State or meets federal standards, and to employ an infection preventionist with appropriate education, training and licensing. Currently, most SVHs meet these requirements. Finally, the bill would create a VA program to provide up to 50% of the salary or wages for the infection preventionist to help with recruitment and retention for this position.

The State Veterans Homes program is a partnership between the federal government and state governments. SVHs receive per diem payments from VA for providing skilled nursing care, domiciliary care, and adult day health care (ADHC) to eligible veterans. VA also provides State Home Construction Grants, covering up to 65% of the cost to build, renovate and maintain SVHs. Although VA has significant regulatory and oversight authority for State Veteran Homes, each state is responsible for the operation and management of its homes.

Although DAV Resolution No. 017 supports the State Veteran Homes program and calls for sufficient funding, we have no specific resolution concerning changes to the management or oversight of SVHs proposed in this draft bill and take position on the legislation.

Draft bill, Veterans Dental Care Eligibility Expansion and Enhancement Act

This discussion draft, the Veterans Dental Care Eligibility Expansion and Enhancement Act, would include dental care as currently provided to certain veterans under title 38, United States Code (USC), Section 1712 in the definition of medical services. Currently, VA is only authorized to provide outpatient dental services to a limited number of veterans. Specifically veterans rated 100% service connected, veterans who were held prisoner-of-war or to those who have sustained dental trauma in performance of military service and in some cases to other veterans the Secretary determines require such care to provide effective preventative health care.

The bill would phase in provision of dental services to all enrolled veterans starting with veterans with service-connected conditions rated at least 30% or greater (priority groups 1 and 2 under title 38 USC, Section 1705(a)) at locations including VA medical centers with existing dental clinics; at least four military treatment facilities with dental clinics as agreed upon with the Secretary of Defense; at least four community based outpatient clinics with space available; at least four federally qualified health centers; and at least four Indian Health Service facilities with dental clinics. In choosing locations for participation in phase 1, VA must consider locations in rural areas; those distant from military treatment facilities and those from different geographic areas. The Secretary could also consider mobile clinics and home services for care delivery. The VA Secretary must increase the sites of dental services at each phase of implementation commensurate with the growth in the eligible veterans' population.

- Phase 1 would begin one year after the date of enactment and continue for two years;
- Phase 2 would begin 90 days after the completion of Phase 1 and continue for two years;
- Phase 2 would include veterans from Phase 1 in addition to veterans in enrollment priority groups 3 and 4;
- Phase 3 would begin 90 days after completion of Phase 2 and continue for two years, including veterans authorized for care in Phases 1 and 2 and adding veterans in priority groups 5 and 6;
- Phase 4 would begin 90 days after completion of Phase 3 for a duration of two years and include all other enrolled veterans.

DAV believes that the long phased in implementation schedule outlined in the bill would allow VA the appropriate time to develop program capacity, obtain the necessary resources to hire dental staff or contract with dentists in the community for such services, and make any adjustments necessary to support this new proposed dental benefit for veterans using VA care.

Oral health is integral to overall general health and well-being and is part of comprehensive health care coverage for most private, federal and state health care plans. Veterans who are medically compromised or who have chronic disabilities can be at greater risk for oral diseases which has the potential to jeopardize their overall health, compromise their ability to work and significantly diminish their quality of life. A recent study of Medicaid beneficiaries with a high burden of disease indicated that, for this large cohort of publicly insured individuals in New York State, preventive dental care was associated with better health care outcomes, most notably for the rates and costs of inpatient medical care admissions.⁸ Certain associations with poor nutrition, diabetes, obesity and other chronic health conditions have also been made.

We support this draft legislation in accordance with DAV Resolution No. 018, which recognizes the importance of oral health as part of basic health care and calls on VA to provide comprehensive dental care to all enrolled service-connected veterans.

Draft bill, Veterans State Eligibility Standardization Act

This draft legislation would change the methodology that VA uses to calculate low-income thresholds for the purpose of providing veterans eligibility to VA health care under Priority Group 5. Currently, VA uses geographic low-income limits calculated by the Department of Housing and Urban Development (HUD) based upon metropolitan statistical areas (MSAs), which can consist of one or more contiguous cities or counties located in one or more states. As a result, veterans living in a state can be subject to different income thresholds depending on what part of the state they reside in.

This draft legislation would require that VA establish one single income threshold for all veterans residing throughout the entire state, which would be based on the highest of the HUD low-income thresholds for any city or county in the state. As a result, more veterans would become eligible for VA health care under Priority Group 5 based on their income levels.

DAV does not have a specific resolution that addresses changes to Priority Group 5 eligibility requirements for low-income thresholds and takes no position on the draft legislation.

Draft bill to reorganize the Chaplain Service of the VA

This bill would reorganize and establish a Department-wide Chaplain Service in the VA, to provide guidance and spiritual or religious pastoral services to all 3 administrations within the Department—VHA, VBA and the National Cemetery Administration. This service would be overseen by a new Chief of Chaplain Services appointed by the Secretary and report directly to the Secretary. Currently, Chaplain

⁸ Lamster IB, Malloy KP, DiMura PM, et al. Dental Services and Health Outcomes in the New York State Medicaid Program. *Journal of Dental Research*. 2021;100(9):928-934. doi:10.1177/00220345211007448.

services are overseen by the National Director of VA Chaplain Service who reports directly to the Under Secretary for Health.

DAV does not have a resolution that pertains to this legislation and takes no position on this draft bill.

Mr. Chairman, again thank you for inviting DAV to provide testimony on the bills under consideration and I am happy to address any questions you or members of the Committee may have.