STATEMENT OF
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BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

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Chairman Tester, Ranking Member Moran, and other Members of the Committee: thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention, Veterans Health Administration (VHA), and Dr. Lawrencia Pierce, Assistant Director, Office of Outreach, Transition, and Economic Development (OTED), Veterans Benefits Administration.

S. 1342 National Green Alert Act

S. 1342 would establish a Green Alert System Advisory and Support Committee, comprised of interagency Federal and private sector personnel, empaneled to outline best practices and provide technical assistance to States for establishing State "Green Alert" systems that would be activated when a Veteran with a history of mental health issues, including neurocognitive disorders, suicide attempts or impulses, or substance use disorders (SUD), goes missing.

VA does not support this bill because we believe the proposed legislation may further stigmatize Veterans with mental health conditions and jeopardize their rights to privacy and confidentiality. Alert systems for missing individuals with cognitive impairment already exist in many jurisdictions, while these systems do not label someone as a veteran, systems exist that could be used to report missing individuals. All missing Veterans, regardless of a physical or mental health condition, may be at risk of harm. For example, a Veteran who requires daily insulin injections, could be at significant risk of health consequences if they were unable to receive or administer those injections as needed; this risk could easily be greater than the risk a Veteran who received treatment for SUD 30 years ago. Further, the bill's focus on mental health issues would mean that any such alert would immediately disclose to the non-medical community the name of a specific Veteran who has a mental health condition. This disclosure raises concerns regarding privacy and autonomy. In addition, VA has concerns regarding the medical ethics associated with disclosure and non-disclosure of information under this authority, as it would involve the disclosure of the fact that a Veteran had a history of mental health issues. The criteria in the bill regarding disclosure are ill-defined and would likely be situational.

S. 1779 Veterans Preventive Health Coverage Fairness Act

The Veterans Preventive Health Coverage Fairness Act would amend 38 U.S.C. §§ 1710 and 1722A(a)(3) to eliminate copayments to VA for hospital care, medical services and medications related to preventive health services. The proposed legislation also would amend 38 U.S.C. § 1701(9) to expand the definition of "preventive health services."

VA supports this bill subject to the availability of additional appropriations to replace lost revenue from the elimination of these copayments. The proposed legislation does not appear to impact VA's authority to assess a copayment when an outpatient visit includes services beyond preventive health services or VA's authority to recover reasonable charges from a third-party under 38 U.S.C. § 1729. VA notes that under existing regulatory provisions at 38 C.F.R. § 17.108, outpatient visits solely consisting of preventive screening and immunizations and laboratory services; flat film radiology services; and electrocardiograms are not subject to copayment requirements and, pursuant to existing 38 C.F.R. § 17.4600(d)(2), an eligible Veteran who receives urgent care consisting solely of an immunization against influenza is not subject to a copayment.

If this bill is enacted, VA would incur a loss of revenues impacting first party pharmacy and outpatient copayment collections. VA estimates that approximately 3% of all outpatient copayments are from services that are included in the expanded definition for preventive health services. This 3% was applied to the 10-year outpatient copayment collections amounts and resulted in a 5-year impact of $24.2 million and a 10-year impact of $49.1 million. For medication copayments, VA estimates the 5-year revenue impact on pharmacy collections would be $193 million and the 10-year impact would be $399 million. The total MCCF collections impact would range from a 5-year impact of $218 million to a 10-year impact of $448 million.

S. 1937 DOULA for VA Act

S. 1937 would require VA to establish, not later than 1 year after the date of enactment, a 5-year pilot program to provide doula services to covered Veterans through eligible entities by expanding VA's Whole Health model. The pilot program would measure the impact that doula support services have on birth and mental health outcomes of pregnant Veterans. The pilot program would have to be carried out in the three Veterans Integrated Service Networks (VISN) that have the highest percentage of female Veteran enrollees and the three VISNs that have the lowest percentage of female Veteran enrollees.

VA is committed to improving maternal and neonatal outcomes among the Veterans it serves. The population of Veterans VA serves with maternity benefits has risk factors for poor maternal and infant outcomes, is racially diverse, has significant rates of mental health comorbidities, and is older when compared to the general population of pregnant people in the United States (see, e.g., Mattocks, K. M. et al. (2010). Pregnancy and

mental health among women Veterans returning from Iraq and Afghanistan. *Journal of Women's Health*, 19(12), 2159-2166. doi:10.1089/jwh.2009.1892; and Combellick, J. L., et al. (2020). Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans*. Journal of Women's Health*, 29(4), 577-584).

VA has established a robust Maternity Care Coordination program with maternity care coordination at every VA facility. Maternity Care Coordinators (MCC) serve as a support and resource to pregnant and postpartum Veterans. MCCs help Veterans navigate health care services inside and outside of VA, access care for their other physical and mental health conditions, connect to community resources, cope with pregnancy loss, connect to needed care after delivery and answer questions about billing for pregnancy care. A key component of the role of MCCs is to screen pregnant Veterans for mental health conditions such as postpartum depression and to provide universal education about intimate partner violence; MCCs also ensure the Veteran is connected to needed resources outside and within VA.

Regarding the bill itself, VA does not support the proposed legislation due to technical concerns with how it is currently written. First, we have several concerns with the timeframes identified in the bill. For example, the bill would only provide 1 year from the date of enactment to establish the program, but we believe this would be a complex process that would take at least 18-24 months to ensure the program is well-designed. That time is necessary to develop a doula pilot program that is best positioned to improve maternal outcomes; we would appreciate the opportunity to discuss these concerns with the Committee in the hope that we might identify ways of improving this bill. VA would conduct a review of the current evidence on benefits of doula care specifically as it may apply to the Veteran population and engage with key stakeholders including established community-based doula programs, female Veterans, reproductive mental health experts and birth workers to establish the characteristics of a successful doula pilot program. VA would need to develop and plan the program, select pilot site and select pregnant women Veterans for participation. Because there may not be a mechanism to pay non-licensed providers through current VA provider structure, VA would have to work to determine the most feasible way to fairly compensate doulas for their work. A hurried implementation schedule would likely result in a poorly designed program that would reduce the likelihood of its success. We also are concerned about the 5-year duration of the pilot program. A shorter pilot would seem to be better from a Veterans' benefit perspective. If the pilot program is successful, then we would like to be able to offer doula support to all Veterans using VA's maternity benefit, and if it is not successful, then there should be no reason to continue a program that is not producing benefits.

Second, we also are concerned about the requirement to include six VISNs in the pilot program, as this would potentially account for one-third of all women Veterans of child-bearing age. Pilot programs generally involve only a handful of facilities to allow them to be developed more quickly and to ensure VA is prudently using its resources in implementing these authorities. For a pilot program, this requirement would involve a significant commitment of human capital and funding to support.

There are other aspects of the bill that make it difficult for us to support as written. The bill would require VA to establish a Doula Service Coordinator within the functions of the MCCs at each site where the pilot programs are implemented to facilitate care between doulas and Veterans. MCCs already are managing significant care coordination activities, and this bill would add to their workload for support of a pilot program, prior to a demonstrated benefit for this program.

VA does not have a cost estimate for this bill. We remain available to provide technical support for proposed legislation to further support pregnant and postpartum Veterans.

S. 1944 Vet Center Improvement Act of 2021

Section 3 of S. 1944 would require VA, not later than 1 year after the date of the enactment of this legislation, to evaluate productivity expectations for readjustment counselors at Vet Centers. Not later than 90 days after the date of the completion of the evaluation of productivity expectations, VA would be required to implement any needed changes to the productivity expectations to ensure the quality of care and access to care for Veterans and the welfare of readjustment counselors. It would further require VA to make every effort to ensure that all Vet Center readjustment counselors are given the opportunity to fully provide feedback on Vet Center operations and productivity expectations to a working group established under section 5 of the bill. Not less frequently than once every year during the 5-year period beginning on the date of enactment, the Comptroller General would be required to audit the feedback obtained from Vet Center readjustment counselors. Not later than 1 year after the date of enactment, VA would be required to develop and implement a plan for reassessing the productivity expectations for Vet Center readjustment counselors and implement any needed changes to such expectations. VA would be required to conduct a reassessment not less frequently than once each year.

Section 4 of the bill would require VA, not later than 1 year after the date of enactment, to develop and implement a staffing model for Vet Centers that incorporates key practices in the design of such staffing model. In developing the staffing model, VA would have to involve key stakeholders, incorporate key work activities, ensure the data used in the model is high quality and incorporate various factors. Not later than 1 year after the date of enactment, VA would have to develop a plan for assessing and updating the staffing model not less frequently than once every 4 years and implementing any needed changes to such model.

Section 5 of the bill would require VA to establish a working group to support the efforts in sections 3 and 4 of the bill. This group would be composed of readjustment counselors, outreach specialists and Vet Center directors. The working group would provide to VA feedback from readjustment counselors, outreach specialists, and Vet Center directors and recommendations on how to improve quality of and access to care for Veterans and the welfare of Vet Center staff.

Section 6 of the bill would require VA, not later than 1 year after the date of enactment, to standardize descriptions of position responsibilities at Vet Centers. In the next two annual reports required by 38, U.S.C. § 7309(e), VA would be required to include a description of VA's actions in this regard. This section of the bill also would amend 38 U.S.C. § 7309(e)(2) to also require a description of actions taken by VA to reduce vacancies in Vet Center counselor positions and the time it takes to hire such counselors.

VA does not support sections 1-6; while we are in agreement with the goals of these sections, we do not believe they are necessary. VA already has the authority to carry out these requirements and has been working to address the issues raised in these sections based on the findings of the September 2020, Government Accountability Office (GAO) Report, "VA Vet Centers: Evaluations Needed of Expectations for Counselor Productivity and Centers' Staffing" (GAO 20-652). VA has developed an action plan to meet these requirements and is on track to complete the actions outlined in GAO's recommendations in accordance with timelines established by VA and accepted by GAO.

Section 7 of the bill would require the Comptroller General to submit to Congress a report, not later than 1 year after the date of enactment, on the physical infrastructure and future investments with respect to Vet Centers. VA defers to the Comptroller General on this section.

Section 8 of the bill would require VA, not later than 1 year after the date of enactment, to establish a pilot program to award grants to eligible entities to support partnerships that address food insecurity among Veterans and their families who receive services through Vet Centers. Eligible entities would include nonprofit organizations, VSOs, public agencies, community-based organizations or an institution of higher education. An eligible entity seeking a grant would have to submit an application for such a grant. VA would have to select applicants using a competitive process taking into account various factors.

VA would have to ensure, to the extent practicable, an equitable geographic distribution of grants under this section. Grants would have to be used to carry out a collaboration between one or more eligible entities and VA for 5 years, to increase participation in nutrition counseling programs and provide educational materials and counseling to Veterans and their families, and to increase access to and enrollment in Federal and other assistance programs. Grantees would have to provide information to VA, at least once each year during the duration of the grant, on the number of Veterans and family members screened for, and enrolled in, education, counseling and assistance programs, as well as other services provided by the grantee to Veterans and their families using grant funds.

Not later than 180 days after the date of enactment, VA would have to submit to Congress a report on the status of the implementation of this section. Not later than 1 year after the date on which the pilot program terminates, the Comptroller General

would have to submit a report to Congress evaluating the effectiveness of the activities carried out under this section in reducing food insecurity among Veterans and their families. This section would authorize to be appropriated $50 million for each fiscal year in which the program is carried out, and not more than 5% of that authorized amount could be used for VA's administrative expenses associated with administering grants.

We support section 8, assuming appropriations are provided for this purpose and some amendments are made to the text. VA currently is unable to offer direct support for Veterans facing food insecurity because appropriated funds cannot be used to purchase groceries or other means of subsistence for Veterans. Food may only be provided concurrent with the provision of medical care or therapy. In addition, VA programs are able to assist only those Veterans who come to VA for care, so there may be Veterans facing food insecurity who could receive support through this section.

We appreciate the Committee's interest in addressing food insecurity among Veterans and their families. For the last 5 years, VA has been working to collaborate with government and nonprofit agencies to focus on the issue of food insecurity. VA has developed and deployed a food insecurity screening tool as part of the regular screenings that occur during VA primary care visits; all Veterans are screened annually unless they reside at a nursing home or long-term care facility. If the Veteran is screened positive for food insecurity, the Veteran is subsequently screened every 3 months thereafter. Veterans who screen positive are offered a referral to a social worker and a dietitian, and VA further assesses the Veteran for clinical risk and complications. Since July 2017, VA has completed more than 10 million screenings. VA social workers can provide information about Supplemental Nutrition Assistance Program (SNAP) eligibility and help Veterans complete a SNAP application. They can also address possible root causes of food insecurity and connect Veterans with community resources. We would welcome the opportunity to meet with the Committee to discuss our current efforts to address Veteran food insecurity.

GAO is currently conducting a review of VA's and USDA's programs regarding food insecurity among Veterans. It may be advisable for the Committee to forbear action on this proposal and in this policy area until that review has been completed. We believe it would be prudent to have GAO's recommendations prior to implementing new programs or authorities to ensure we are using our resources to their greatest effect.

We do note a few technical issues with the bill text. We do not believe 1 year would be enough time to establish a new grant program. VA would need to issue regulations for this new authority, which generally takes between 18 and 24 months. VA also would need funding and staffing to develop the necessary resources to implement this program. Furthermore, this section does not define the duration of the pilot program. Section 8(f)(1) requires grants be used to carry out collaborations "for five years," but grants are typically awarded year-by-year and the length of time for the collaboration may not be the same as the duration of the pilot program. We also note concerns that the language in the bill appears to envision multi-year grants. VA currently awards grants annually, which ensures funding is available and grantees are using funds

responsibly. Particularly for a new program like this, VA recommends adopting this same structure for the proposed grant program. We would be happy to work with the Committee to address these and any other technical issues.

VA developed several potential cost estimates depending upon the size of the program. VA is providing a cost estimate under these scenarios for a 7-year period because this would allow for preparation (in the first year), implementation of a 5-year pilot program (assuming the reference noted previously to 5 years is the limit on the program), and post-program analysis and evaluation (in the final year). On a smaller scale, if we are providing approximately 3.5 million meals during the pilot period, then we estimate this section would cost $0.24 million in FY 2022, $58.25 million over 5 years and $73.41 million over 7 years. On a medium scale, if we are providing approximately 4.9 million meals during the pilot period, then we estimate this section would cost $0.33 million in FY 2022, $81.64 million over 5 years and $102.88 million over 7 years. On the largest scale, if we are providing approximately 6.3 million meals during the pilot period, then we estimate this section would cost $0.43 million in FY 2022, $105.03 million over 5 years and $132.35 million over 7 years. While the bill would authorize up to $50 million per fiscal year for the program, we are uncertain whether obligating that amount would be logistically feasible or advisable given that this program would be a new program with which VA has no relevant experience.

S. 2283 REACH for Veterans Act

Section 101 of S. 2283 would require VA to enter into an agreement with an organization outside VA, such as the American Association of Suicidology (AAS), to review the training for call responders for the Veterans Crisis Line (VCL) on assisting callers in crisis. This review would have to be completed not later than 1 year after the date of the enactment of this legislation. This review would have to consist of a review of the training provided by VA on subjects including risk assessment; lethal means assessment; substance use and overdose risk assessment; safety planning; referrals to care; supervisory consultation; and emergency dispatch. If any deficiencies in the training for VCL call responders are found, then VA would have to update such training and associated standards of practice to correct those deficiencies not later than 1 year after the completion of the review.

VA agrees with the goals of this section but does not believe it is necessary because we already have sufficient authority in this area and our current efforts exceed the requirements of the legislation. Rather than reviewing VCL training standards according to baseline accreditation requirements, VA recommends incorporating a consultative review by the Rocky Mountain Mental Illness Research Education and Clinical Center (MIRECC) for Suicide Prevention to provide recommendations for ongoing training enhancements from the latest research evidence base while we await the next revision of the VA/DOD Clinical Practice Guideline for The Assessment and Management of Patients at Risk for Suicide (2019). Currently, VCL maintains accreditation with the AAS, the Commission on Accreditation of Rehabilitation Facilities, and the International Customer Management Institute. VA currently exceeds the requirements this bill would

impose; for example, AAS expectations are for a minimum of 6 days in precepting, but, on average, VCL responders complete over 85 days of training and precepting before being released for independent work. VA's training for VCL responders include subjects such as military culture; posttraumatic stress disorder (PTSD) and moral injury; military sexual trauma; suicide risk assessment; violence risk assessment; lethal means safety; substance use and overdose risk; crisis intervention; and police perspective.

Section 102 of the bill would require VA, not later than 1 year after the date of enactment, to develop guidelines on retraining and quality management for when a VCL call responder has an adverse event or when a quality review check by a supervisor of such a call responder denotes that the call responder needs improvement. These guidelines would have to specify the subjects and quantity of retraining recommended and how supervisors should implement increased use of silent monitoring or other performance review mechanisms.

VA does not support this section because its requirements would be redundant to current policy. VA already requires supervisor to conduct investigation and oversight after critical incidents or any scenario in which responders need quality review. VA uses data to inform training initiatives through a continuous quality improvement cycle that includes data collection, analysis, feedback and training.

Section 111 of the bill would direct VA to require that no fewer than two calls per month for each VCL call responder be subject to supervisory silent monitoring. VA would have to establish benchmarks for requirements and performance of VCL call responders on supervisory silent monitored calls. Not less frequently than quarterly, VA would have to submit to the Office of Mental Health and Suicide Prevention a report on occurrence and outcomes of supervisory silent monitoring of calls on the VCL.

VA does not support this section because it is unnecessary; we already have sufficient authority in this area, and we do not believe it is prudent to legislate specific methods for quality measurement, as this could limit VA's ability to adopt innovative approaches in the future. VA already has in place three monitors (one performance and two quality assurance) per responder per month, so adding a second supervisory performance monitor is unnecessary. VCL quality assurance monitoring, which includes coaching sessions, is done by quality assurance staff and examines overall VCL quality. VCL performance monitoring is performed by supervisors and can result directly in performance or conduct actions. This section would also direct that quarterly monitoring reports be prepared, but VCL currently generates monthly reports on quality monitoring targets and supervisory monitoring data.

Section 112 of the bill would require that, not later than 1 year after the date of enactment, the leadership of the VCL establish quality management processes and expectations for VCL staff, including reporting of adverse events and close calls.

VA does not support this section because it is unnecessary. In August 2021, VA issued a new policy and standard operating procedures (SOP) that establish the overall policy of reporting adverse events and close calls, as well as expectations for responders, supervisors, quality management staff and others. VCL is monitoring training of all staff in this new SOP with 97.2% of staff completing the training to date. This new SOP has also been incorporated into our new employee orientation. VCL quality assurance is monitoring daily reporting with monthly reviews by VCL leadership to ensure ongoing implementation and adherence.

Section 113 of the bill would require VA, not less than annually, to perform a common cause analysis for all identified callers to the VCL who died by suicide during the 1-year period preceding the conduct of the analysis before the caller received contact with emergency services and in which the VCL was the last point of contact. VA would submit the results of each analysis to the Office of Mental Health and Suicide Prevention. VA would be required to apply any themes or lessons learned under an analysis to update training and standards of practice for VCL staff.

VA does not support this section because it is unnecessary; we already have sufficient authority in this area, and we do not believe it is prudent to legislate specific methods of analysis, as this could limit VA's ability to adopt innovative approaches in the future. The policy VA issued in August 2021 defines the aggregate analysis process that VCL will conduct to identify themes and determine any necessary actions to address quality, continuous improvement or technological solutions.

Section 121 of the bill would require VA, not later than 1 year after the date of enactment, in consultation with VA national experts on SUD and overdose, to (1) develop enhanced guidance and procedures to respond to calls to the VCL related to SUD and overdose risk, (2) update training materials for VCL staff in response to such enhanced guidance and procedures and (3) update criteria for monitoring compliance with such enhanced guidance and procedures.

VA does not support this section because it is unnecessary given VA's actions to implement OIG's recommendations. OIG recommended that VA update SUD and overdose risk policies and staff-wide training; lethal means assessment training and job aides; and communication between staff regarding emergency dispatch and disconnected callers. VA has taken actions in each of these areas. VA's enhanced guidance and training was informed based on consultation with mental health and SUD experts, and consultations occur with Poison Control Centers of America to provide real-time management of potential overdose cases. VA has also developed enhanced criteria for monitoring staff in this area, with coaching completed by silent monitoring staff; VA will be tracking these criteria and will be reporting monitoring data as it becomes available.

Section 122 of the bill would require VA, not later than 1 year after the date of enactment, to review the current emergency dispatch SOPs of the VCL to identify any additions to such procedure to strengthen communication regarding emergency

dispatch for disconnected callers and the role of social service assistants in requesting emergency dispatch and recording such dispatches. VA also would have to update such procedure to include the additions identified previously. VA would be required to ensure that all VCL staff are trained on all updates to VCL's emergency dispatch SOP.

VA does not support this section because it is unnecessary as we already have sufficient authority in this area. VA updated its SOPs for emergency dispatch in June 2021 to include additional steps for responders to take when conducting emergency dispatch requests with VCL customers. Responders are required to communicate status updates with Social Service Assistant (SSA) staff when a call disconnects. The new process also provides guidance to responders to ascertain customer status through VCL resources, such as reviewing incoming calls through caller ID. VA is further evaluating outcomes of VCL emergency dispatches and facility transport plans, and these findings may inform additional process improvements.

Section 131 of the bill would require VA, not later than 1 year after the date of enactment, to establish oversight mechanisms to ensure that SSAs and supervisory SSAs working with the VCL are trained appropriately and implementing VA guidance regarding the VCL. VA also would be required to refine SOPs to delineate rules and responsibilities for all levels of supervisory SSAs working with the VCL.

VA does not support this section because it is unnecessary, as VA has already delivered enhanced training on SSA roles and responsibilities to all SSAs, supervisors and support staff. New SOPs will be released soon for SSA responsibilities regarding facility transportation plans, consult check-ins and carryovers.

Section 201 of the bill would require VA, not later than 180 days after the date of enactment, to carry out a pilot program to determine whether a lengthier, templated safety plan used in clinical settings could be applied in VCL call centers. Not later than 2 years after the date of enactment, VA would be required to brief Congress on its findings, including such recommendations as VA may have for continuation or discontinuation of the pilot program.

VA does not support this section because it is unnecessary as VA has sufficient authority in this area and is already nearing completion of a pilot program where a select group of responders have been trained in implementing VA's standardized six-part safety plans. VCL responders are attempting to complete these plans with any Veteran caller when they identify a need for risk mitigation. VA will review the results of this pilot program to determine next steps for any broader implementation. We would be happy to share the results with the Committee when they are available.

Section 202 of the bill would require VA, not later than 1 year after the date of enactment, to carry out a pilot program on the use of crisis line facilitations to increase use of the VCL among high-risk Veterans. Not later than 2 years after the date of enactment, VA would be required to brief Congress on its findings, including such recommendations as VA may have for continuation or discontinuation of the pilot program.

VA does not support this section because it is unnecessary, as VA completed a pilot study on crisis line facilitation in 2019 and is already considering the possibility of a broader pilot or staged implementation. We would be happy to report to the Committee on this pilot upon request.

Section 211 of the bill would authorize to be appropriated $5 million for VA's Mental Illness Research, Education, and Clinical Centers (MIRECC) to conduct research on the effectiveness of the VCL and areas for improvement for the VCL.

VA does not support this section because it is not needed at this time. Instead, we recommend that Congress could consider appropriating funds to VA to implement recommendations, including ongoing program evaluation projects with the Rocky Mountain MIRECC, and implementing a five-year program evaluation plan with the VA Partnered Evidence-Based Policy Resource Center.

Section 301 of the bill would require VA to solicit feedback from VSOs on how to conduct outreach to members of the Armed Forces, Veterans, their family members and other members of the military and Veterans community on the new, national three-digit suicide and mental health crisis hotline, 988, to minimize confusion and ensure Veterans are aware of their options for reaching the VCL. The Federal Advisory Committee Act (5 U.S.C. App.) would not apply to any feedback solicited under this section.

VA supports the goal of this section, but it is unnecessary because VA's current efforts already meet the requirements of the bill. VA is briefing and soliciting feedback on VA's 988 Communication Plan with federally chartered VSOs during monthly meetings.

For the above reasons, VA does not support this bill as most of the goals of this legislation are already being met. VA would be happy to provide briefings and other details on existing quality assurance measures to the Committee as needed.

S. 2386 Veterans Peer Specialist Act

S. 2386 would amend section 506 of the VA MISSION Act of 2018 (P.L. 115-182; 38 U.S.C. § 1701 note) to insert a new subsection (d) to make permanent and expand the peer specialist program required by section 506. VA would be required to add an additional 25 VA medical centers (VAMC) each year for the 5-year period following the date of the enactment of this legislation until the program is carried out at each VAMC. In selecting additional medical centers, VA would be required to prioritize VAMC's in

rural and underserved areas that are not close to an active-duty military installation, and areas representing different geographic locations, such as census tracts established by the Bureau of the Census.

We support the goals of this proposed legislation, but we do not believe it is necessary because VA already has the authority to appoint peer specialists at VA medical centers. In implementing section 506 of the VA MISSION Act of 2018 (P.L. 115-182), VA found that expanding peer specialist services in patient-aligned care teams benefited Veterans and was associated with increased participation and engagement in care. VA also found that Veterans valued these services. As stated in VA's final report to Congress on its implementation of section 506 of the VA MISSION Act of 2018, peer specialists were highly beneficial to Veterans. They delivered services through individual and group-based interactions that were in-person, over the phone, or by other telehealth technology. Early interactions with Veterans yielded lasting, positive relationships between Veterans and peer specialists with many benefits. Anecdotally, VA heard from family members who expressed their gratitude for the peer services that were provided. Peer specialists provided emotional, tangible, and personalized services. Veterans shared that peer specialists enhance engagement in mental health and other types of care. Peer specialists can bridge gaps between clinical care and behavioral health support outside the clinic as well, while helping Veterans engage with community resources such as food pantries, interfaith and community centers, community colleges, and clothing, housing, and transportation services. VA's Office of Mental Health and Suicide Prevention (OMHSP) and the Center for Integrated Healthcare (CIH) are prepared to share the lessons learned through implementation of section 506 with VA facilities who elect to adapt existing peer support programs or expand such programs through hiring additional peer specialists specifically for work in patient-aligned care teams (PACT). As of the end of August 2021, VA has more than 1,200 peer specialists working in mental health programs across the Nation.

VA's final report to Congress on this authority in November 2020 found that dedicated and sustained funding was essential to ensuring implementation of these specialists at VA facilities. We believe that funding each position for a period of three years is necessary to cover costs and ensure positions are fully functioning prior to the costs for these employees being assumed by the facility or Veterans Integrated Service Networks (VISN). As such, this would require extending the bill's proposed timeline from five years to seven years (to allow a full three years of support for the final phase of peer specialists added in year five). Without additional appropriated funds to support these efforts, we believe VA's current authority, which allows facilities to opt to provide peer specialists, is a better approach. Peer specialists require initial and ongoing training, as well as supervisory support. A program of the scale in the bill would require implementation support and evaluation, which would increase the associated budgetary needs. We do not believe the $5 million authorized for each fiscal year (FY) between FY 2022 and FY 2027 would be sufficient to implement the bill's requirements.

S. 2526 Authorizing VA-Department of Defense Shared Medical Facilities

S. 2526 would allow the transfer of funds between VA and the Department of Defense (DoD) for the planning, designing and constructing of shared medical facilities.

VA supports this bill, which would enable both Departments to realize savings through using existing available capacity at the other's facilities; acquiring and operating a single facility rather than two that are separate; and resulting from a more rapid planning and project execution timetable. The Department designated as lead for a particular project would provide the capital assets (real property) to the other Department and would then be compensated for those assets. The bill would require engagement at the facility level between VA and DoD for the ownership, governance, terms and funding.

S. 2533 MAMMO for Veterans Act

S. 2533 seeks to improve mammography services furnished by VA. We share the Committee's goal of ensuring all Veterans have access to high-quality breast imaging services. We currently are finalizing a strategic plan that will address many of the provisions in this bill, and we believe this plan will further VA's goal to provide excellent access and quality in mammography for Veterans across the Nation.

Section 101 of S. 2533 would require VA, within 1 year of the enactment of this legislation, to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a strategic plan for improving breast imaging services for Veterans. The plan would have to cover the evolving needs of women Veterans; address geographic disparities of breast imaging furnished at VA facilities and the use of breast imaging through non-VA providers; address the use of digital breast tomosynthesis (DBT-3D breast imaging); address the needs of male Veterans who require breast cancer screening services; and provide recommendations on potential expansion of breast imaging services furnished at VA facilities (including infrastructure and staffing needs), on the use of DBT-3D breast imaging, on the use of mobile mammography, and on other access and equity improvements for breast imaging.

We support the goals of this section, but we do not believe it is necessary because VA is already finalizing a strategic plan for the provision of breast imaging services for Veterans. We are already in the process of finalizing a breast imaging strategic plan that addresses the critical elements of this section. We would be happy to brief the Committee when the strategic plan is complete.

Section 102 of the bill would require VA, within 1 year of the date of enactment, to carry out a 3-year pilot program to provide telemammography services for Veterans who live in States where VA does not offer breast imaging services at a VA facility or locations where access to breast imaging services at a VA facility is difficult or not feasible. The pilot program could use community-based outpatient clinics (CBOC), mobile mammography, federally qualified health centers, rural health clinics, critical access hospitals, clinics of the Indian Health Service and other sites as VA determines feasible

to provide mammograms. Under the pilot program, mammography images generated would be sent to VA's centralized telemammography center for interpretation by expert radiologists and results would be shared with the Veteran and their primary care provider. Within 1 year of the conclusion of the pilot program, VA would be required to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report evaluating the pilot program, including an assessment of the quality of mammography provided; feedback from Veterans and providers participating in the pilot program; and a recommendation on the continuation or discontinuation of the pilot program.

While VA supports the goals of this section, we do not support this section as written. VA shares the Committee's goal of ensuring all Veterans have access to high-quality breast imaging services. To this end, VA has established a robust network of community mammography centers to augment services provided by our in-house mammography programs. Independent third-party metrics confirm that women Veterans are more likely to receive timely breast cancer screening than women covered by a commercial health management organization or a preferred provider organization, or by Medicare or Medicaid benefits. We would be happy to brief the Committee or share this research at your request.

Tele-screening mammography (that is, remote electronic interpretation of a screening mammogram by a specially trained physician breast radiologist) may be useful in certain circumstances, but this would be only one component of a comprehensive breast imaging service. For many women, a screening mammogram may be sufficient to exclude breast cancer. However, when an area of concern is identified on a screening exam, additional diagnostic workup (e.g., additional mammogram views, ultrasound, MRI, etc.) is clinically indicated. For optimal patient care, a diagnostic exam (as opposed to a screening exam) requires the physical presence of a breast radiologist to personally direct the workup, perform a physical examination if needed, correlate findings and to counsel the patient. Tele-screening mammography is only useful in areas where referral sites are readily available to provide appropriate follow-up diagnostic imaging care, which may limit the use of the proposed pilot in rural or underserved areas, as these referral sites may not be accessible. Even in areas where diagnostic services are accessible in the community, coordination with a full-service breast imaging center presents challenges to ensuring continuity of care.

Fundamentally, the proposed scope of this section is too broad for a pilot program for logistical reasons. Sustaining high-quality breast imaging services requires enough women Veterans to maintain technical proficiency. Many of the sites VA would be able to select under this section would not meet these minimum requirements. Identifying specific locations where VA in-house mammography programs have limited breast radiologist support could be a useful starting point, and in this regard, a pilot program may identify additional use cases. Mobile screening mammography with remote interpretation may be a consideration in selected areas, specifically where supporting diagnostic and interventional services are available, although mobile screening's utility as a comprehensive service in remote areas is limited. Another barrier for tele-

screening mammography would be the difficulty in obtaining prior mammography examinations for comparison from other imaging centers. Comparison images are helpful to limit patient recalls for follow-up imaging of otherwise indeterminate findings. The section also proposes screening mammography performed by community imaging centers with centralized interpretation by VA providers. While this may prove a viable long-term solution, we are concerned that the technical and cybersecurity requirements may not be feasible within the time constraints of a pilot study. Additionally, we are concerned the proposed one-year timeframe may prove insufficient to implement a pilot. If this section were to become law, we would need to balance the requirements of accreditation, certification and professional competence with the section's requirements to offer these services at additional locations. This could limit the number of sites where the pilot could be implemented.

We would like to discuss our current efforts with the Committee before further actions is taken on this section at this time, and we look forward to working with you to provide the highest quality care for our Veterans.

Section 103 of the bill would require VA, within 2 years of the date of enactment, to upgrade all mammography services at VA facilities that provide such services to use DBT-3D and to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate indicating that the upgrade has been completed and listing the facilities or other VA locations at which DBT-3D is used.

We support the goals of this section, which is consistent with VA's current plans, but we do not believe this section is necessary because we already have sufficient authority in this area. Currently, 62 of the 68 VA mammography programs offer DBT-3D. The six sites that do not offer this technology are in the process of conducting market research or are reviewing construction options to upgrade to the latest technology. We are concerned that the proposed timeline may not be realistic, or could result in additional expenses to VA, as procurement and construction could take longer than this time period. Two years may be inadequate to upgrade all mammography sites without DBT-3D.

Section 104 of the bill would require VA to conduct a study on the availability of access to testing for the breast cancer gene for Veterans diagnosed with breast cancer, as recommended by the guidelines set forth by the National Comprehensive Cancer Network. In conducting the study, VA would have to examine (1) the feasibility of expanding VA's "Joint Medicine Service" to provide genetic testing and counseling for Veterans with breast cancer and (2) access to such testing and counseling for Veterans living in rural or highly rural areas. Section 104 also would require VA to update guidelines or institute new guidelines to increase the use of testing for the breast cancer gene and genetic counseling for Veterans diagnosed with breast cancer; VA could develop clinical decision support tools to facilitate delivery of breast cancer care that is in line with national cancer guidelines. Not later than 2 years after the date of the enactment of this legislation, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on the results of

the study, any updates to guidelines or new guidelines instituted, and any progress by VA in improving access to and usage of testing for the breast cancer gene among Veterans diagnosed with breast cancer, including Veterans in rural or highly rural areas.

We agree with the goal of this section, but we believe our current efforts are already increasing the availability of access to genetic testing. If VA were required to conduct a study as well, VA would require additional resources (funding for both VA health care and information technology requirements, as well as personnel) beyond those VA has already planned to use to implement improved testing and care. In terms of developing guidelines to increase the use of testing and clinical decision support tools, we anticipate these could be completed with some additional financial support. We note as a technical matter that the bill refers to VA's Joint Medicine Service, but we believe this should instead be to VA's Genomic Medicine Service.

Section 105 would require VA to conduct a study on the accessibility of breast imaging services at VA facilities for Veterans with paralysis; spinal cord injury or disorder (SCI/D); or another disability. The study would have to assess the accessibility of the physical infrastructure at VA breast cancer imaging facilities, including the imaging equipment, transfer assistance and the room in which services will be provided, as well as the adherence to best practices for screening and treating Veterans with SCI/D. The study would have to include a measurement of breast cancer screening rates for Veterans with SCI/D during the 2-year period before the commencement of the study, including a breakout of the screening rates for such Veterans living in rural or highly rural areas. Not later than 2 years after the date of the enactment of this legislation, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on the findings of the study, including the rates of screening among Veterans with SCI/D, including Veterans living in rural or highly rural areas. Furthermore, VA would be required to update VA policies and directives to ensure that, in referring a Veteran with SCI/D for care from a non-VA provider, the Secretary confirms with the provider the accessibility of the breast imaging site, including the imaging equipment, transfer assistance and the room in which the services will be provided, and provide additional information to the provider on best practices for screening and treating Veterans with SCI/D.

We support the goal of this section, but we do not support it as written. VA can assess the physical infrastructure for providing in-house mammography services to paralyzed Veterans or those with SCI/D and other disabilities. We would like to discuss our current efforts and plans with the Committee to determine where we can work together in this regard.

Section 106 would require the VA Inspector General to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on mammography services furnished by VA. The report would be required to include an assessment of the access of Veterans to mammography screenings, including any VA staffing concerns in providing such screenings, the quality of such screenings and reading of the images from such screenings, the communication of the results of such

screening, the performance of VA's Women's Breast Oncology System of Excellence (the System) and the access of Veterans diagnosed with breast cancer to a VA comprehensive breast cancer care team. The System will be comprised of research and partnerships that include precision oncology and tele-oncology that will provide women Veteran oncology patients with cutting edge care and access to potentially lifesaving clinical trials. Within 180 days of the submittal of this report, the Secretary would be required to submit a plan to the Committees on Veterans' Affairs of the House of Representatives and the Senate to address the deficiencies identified in the report.

While VA defers to OIG on this provision, we note that VA's Women's Breast Oncology System of Excellence is focused on care delivery and not mammography screening; additionally, the Center will be implemented in FY 2022 and FY 2023. Consequently, we believe asking the OIG to assess the performance of this Center at this time would be premature.

Section 201 would require VA to enter into partnerships with one or more cancer centers of the National Cancer Institute (NCI) centers in VISN to expand access to high quality cancer care for women Veterans. In carrying out these partnerships, VA would have to ensure that Veterans with breast cancer who reside in rural areas or States without a cancer center in such a partnership with VA are able to receive care through such a partnership via telehealth. Not later than 180 days after the date of the enactment of this legislation, VA would be required to submit a report to the Committees on Veterans' Affairs of the House of Representatives and the Senate on how VA will ensure that the advancements made through the existing partnership between VA and the NCI to provide Veterans with access to clinical cancer research trials are permanently implemented and VA's determination whether expansion of such partnership to more than the original 12 VA facilities that were selected is feasible. Not later than 3 years after the date of enactment, and every 3 years thereafter, VA would be required to submit to the Committees on Veterans' Affairs of the House of Representatives and the Senate a report assessing how the partnerships have impacted access by Veterans to cancer centers of the NCI, including an assessment of the telehealth options made available and used pursuant to such partnerships. The report also would need to describe the advancements made with respect to access by Veterans to clinical cancer research trials through these partnerships, including how many of those Veterans were women Veterans, minority Veterans and rural Veterans, as well as identifying opportunities for further innovation.

VA supports the general goal of this section, but we do not believe it is necessary because we already have sufficient authority in this area, and we have some concerns with it as written. There are nearly 50 NCI-Designated Cancer Centers that have academic affiliations already with a VA facility or are near one, and many of these already support breast cancer care at the affiliated VAMC. VA's Breast Cancer System of Excellence plans to use telehealth to expand access to expert breast cancer care using staff from NCI-Designated Cancer Centers to provide care to Veterans in every VISN, but these experts will not necessarily be located in each VISN. By using tele-oncology, VA can ensure coverage for patients no matter where they live while also

ensuring access to experts that may not be available in specific communities. Cancer treatment is highly specialized, so having a center or an agreement is no guarantee that the center has the expertise to address a particular patient's clinical needs. The System of Excellence being developed by VA will bring this expertise to every community.

Additionally, we have some concerns with the technical language of this section. For example, we note that this section would direct VA to enter into partnerships with cancer centers, but these centers are private entities, and VA cannot compel them to enter into a partnership or agreement. We would be pleased to work with the Committee to address these concerns.

Section 202 would require VA, not later than 180 days after the date of the enactment of this legislation, in collaboration with DoD, to submit to Congress a report on all current research and health care collaborations between VA and DoD on treating Veterans and members of the Armed Forces with breast cancer. The report would have to include a description of potential opportunities for further interagency collaboration between VA and DoD with respect to treating and researching breast cancer and may include a focus on (1) transitions to VA of women members of the Armed Forces who are undergoing screening for breast cancer, (2) collaborative breast cancer research opportunities between VA and DoD, (3) access to clinical trials and (4) such other matters as VA and DoD consider appropriate.

VA is pleased to share information regarding its work and collaborations with DoD, but we do not believe this section is necessary because we already have sufficient authority in this area. VA currently reports regularly on various collaborations, including the Applied Proteogenomics Organizational Learning and Outcomes Network. These collaborations have been useful, and VA and DoD are working closely on several efforts. We would be pleased to brief the Committee on this work in general or any specific projects upon your request.

S. 2624 FY 2022 VA Major Medical Facility Authorization Act

S. 2624 would authorize 12 major construction projects requested in the President's FY 2022 Budget through the available funding provided in this request and in previous years.

VA supports this bill.

S. 2720 Veterans' Prostate Cancer Treatment and Research Act

Section 3 of S. 2720 would require VA, not later than 365 days after the date of enactment, to establish an interdisciplinary clinical pathway for all stages of prostate cancer, from early detection to end of life care. The pathway would be established in the National Surgery Office, which would include a Program Office for Urology in VA's National Surgery Office in close collaboration with the National Program Office of Oncology, the Office of Research and Development (ORD) and other relevant entities in VA.

The national clinical pathway would have to include a diagnosis pathway for prostate cancer that includes early screening and diagnosis protocol; a treatment pathway that details the respective role of each VA office that will interact with Veterans receiving prostate cancer care; treatment recommendations for all stages of prostate cancer that reflect nationally recognized standards for oncology, including the National Comprehensive Cancer Network guidelines; a suggested protocol timeframe for each point of care based on severity and stage of cancer; and a plan that includes, as appropriate, VA and community-based facilities and providers and research centers specializing in prostate cancer. In establishing the clinical pathway, VA could collaborate and coordinate with the National Institutes of Health, NCI, the National Institute on Minority Health and Health Disparities, the Centers for Disease Control and Prevention, the Centers for Medicare and Medicaid Services, the Patient-Centered Outcomes Research Institute, the Food and Drug Administration, DoD and other institutes or centers.

VA would have to consult with, and incorporate feedback from Veterans who have received prostate cancer care at VA medical facilities, as well as experts in multi-disciplinary cancer care and clinical research. VA would have to publish the clinical pathway on an internal website and update the pathway as needed by review of the medical literature and available evidence-based guidelines at least annually.

Not later than 180 days after the date of enactment, VA would have to submit to Congress a plan to establish a prostate cancer program using the comprehensive clinical pathway VA would be required to develop. The comprehensive program would receive direct oversight from the Deputy Under Secretary for Health; include a yearly program implementation evaluation; be metric-drive and include the development of biannual reports on the quality of prostate cancer care; and include an education plan for patients and providers.

VA would be required to establish a program evaluation tool to learn best practices and to inform VA and Congress regarding further use of the disease specific model of care delivery. VA would be required to submit to Congress a plan that provides for continual funding through ORD for supporting prostate cancer research designed to position VA as a national resource for prostate cancer detection and treatment. Finally, VA would be required to submit to Congress a report on the barriers and challenges associated with creating a national prostate cancer registry.

This report would include recommendations for centralizing data about Veterans with prostate cancer for the purpose of improving outcomes and serving as a resource for providers.

VA does not support this bill. While the intent of the draft bill is well aligned with existing VA activities, it is overly prescriptive in details of program implementation, including the internal structure of VA and the prostate cancer clinical pathway. The requirements in the draft bill are not aligned with the current implementation structure and unintentionally risk disrupting progress toward our shared goal of creating a system of excellence for prostate cancer care in VA.

In 2021, VA designed, tested, published and implemented a new prostate clinical pathway. VA's National Oncology Program Office worked with a multidisciplinary team of VA physicians in addition to community-based academic experts and DoD to develop this clinical pathway, which is in use today and is capturing data that are used for monitoring and measuring program performance, pathway utilization, molecular testing and treatment selection that is most clinically appropriate for the Veteran. Key program office collaborators included experts from the VA's National Surgery Office, Pathology and Laboratory Medicine, Pharmacy, Clinical Genetics, Medical Oncology and Radiation Oncology.

Pathway updates are based upon new clinical evidence and occur at least annually, but more frequent updates are considered for major practice changing information. Such management is intended to reduce disparities in health care delivery to Veterans with prostate cancer and is already a part of the current pathway implementation plan. Pathways are published and accessible by VA physicians within the electronic health record as well as on a National Oncology Program internal resource page. A new pathway, as prescribed in the bill, would disrupt patient care and would represent a step backwards in providing high quality prostate cancer care for Veterans. Furthermore, VA already has begun work to enable pathways to be compatible with Cerner to ensure smooth implementation. We are concerned this bill, if enacted, would jeopardize progress toward implementation.

In December 2019, VA announced the launch of an expanded Precision Oncology Initiative with the mission of improving the lives of Veterans with cancer through precision medicine. The initiative is grounded in high reliability principles and a learning health care model in which new knowledge is rapidly transitioned to clinical practice and learning from clinical practice is maximized. This initiative is made possible due to close collaboration among clinical program offices and ORD, facilitated by the Office of Healthcare Transformation.

Key components of the Precision Oncology Initiative are centered around the delivery of cutting edge, high quality, accessible care to Veterans diagnosed with prostate cancer. Clinical Pathways across cancer types are a key component of this effort.

The National Precision Oncology Program (NPOP), which launched in 2016, has implemented national infrastructure in the form of a national contract and metrics around comprehensive genomic profiling using next generation sequencing for all Veterans with metastatic prostate cancer.

In May 2021, national guidelines were implemented, and access to a nationally funded contract made germline testing in metastatic prostate cancer available to VAMCs. Prostate Cancer Foundation funding for Centers of Excellence, which was initiated in 2016, led to the establishment of the Precision Oncology Program for Cancer of the Prostate (POPCaP), and ORD funding for genitourinary sites, which was initiated in 2021, is further expanding these best practices more broadly across VA to provide Veterans with access to precision clinical trials and research across an entire System of Excellence in prostate cancer care.

The National TeleOncology service, which was initiated in 2018, provides access to specialized oncology care providers for Veterans in rural and underserved areas through a virtual model and is also a planned foundational infrastructure component to bring decentralized trials to VA. Decentralized trials would allow Veterans to enroll in clinical trials previously inaccessible due to geographical location, which expands access by bringing the trial to the Veteran within VA rather than Veterans to the trial elsewhere.

We appreciate the goals of the legislation and are grateful for the attention that is being given to ensure that our Veterans have access to the highest standard of care for prostate cancer. This area is a high priority for VA, and activities are occurring at an accelerated pace. We would appreciate the opportunity to further discuss prostate cancer related precision oncology initiatives with the Committee.

We do not have a cost estimate for this bill.

S. 2787 Clarifying the Role of VA Podiatrists

S. 2787 would amend 38 U.S.C. § 7306 to establish that the Office of the Under Secretary for Health would include a Podiatric Medical Director who would be a qualified doctor of podiatric medicine and who would be responsible to the Under Secretary for Health for the operation of the Podiatric Service. This change would rename the current role of the Director of Podiatric Service, which is currently included among other Directors in that section of law. It also would provide that for the Assistant Under Secretaries for Health appointed under section 7306(a)(3), not more than two of them may be persons qualified in the administration of health services who are not Doctors of Medicine, podiatric medicine, dental surgery or dental medicines. The bill also would also amend section 7306 to provide that the Secretary’s appointment of the Podiatric Medical Director would be made upon the recommendation of the Under Secretary for Health.

The bill also would amend 38 U.S.C. § 7404 to provide that the pay of podiatrists (along with physicians and dentists) serving in positions to which an Executive Order applies under 38 U.S.C. § 7404(a)(1) would be determined under subchapter III of chapter 74 of title 38, United States Code instead of by such Executive Order. The bill also would make a clarifying edit to the table in section 7404(b) to add "(DPM)" to indicate doctors of podiatric medicine.

VA supports S. 2787, though if enacted, implementation will take some time. The bill would allow the Director of Podiatric Medicine to be paid like other podiatrists in the Veterans Health Administration (VHA). Notably, if enacted, this bill would affect the way Senior Executive Service (SES)-Equivalent podiatrists are paid. Podiatrists appointed under sections 7306 and 7401(4) would receive pay under section 7431, just as physicians and dentists do, because of the changes the bill would make to section 7404(a)(2). Currently, the basic pay of podiatrists appointed under sections 7306 and 7401(4) is set as if it was SES, but market pay assessments and pay for performance would be included in the total compensation of those positions. Of note, 38 U.S.C. § 7404(c) would no longer apply to podiatrists appointed under section 7306.

We estimate the bill would cost $15,000 in FY 2022, approximately $78,000 over 5 years and approximately $163,000 over 10 years.

S. 2852 Long-Term Care Veterans Choice Act

Section 2(a) of the Long-Term Care Veterans Choice Act would amend section 1720 to add a new subsection (h) providing authority for a 5-year period for the Secretary to pay for long-term care for certain Veterans in Medical Foster Homes (MFH) that meet Department standards. Specifically, the bill would allow Veterans, for whom VA is required by law to offer to purchase or provide nursing home care, to be offered placement in homes designed to provide non-institutional long-term supportive care for Veterans who are unable to live independently and prefer to live in a family setting. VA would pay MFH expenses by a contract, agreement or other arrangement with the home. VA could pay for care for a Veteran in an MFH before the date of enactment, if the home meets VA standards, pursuant to a contract, agreement or other arrangement between VA and the MFH. Veterans on whose behalf VA pays for care in an MFH would agree, as a condition of payment, to accept home health services furnished by VA under section 1717. In any year, not more than a daily average of 900 Veterans could receive care in an MFH. The limitations in section 1730(b)(3), which provide that payment of the charges of a community residential care facility to a Veteran whom VA has referred to that facility is not the responsibility of the United States or VA, would not apply. The changes made by this subsection would take effect 90 days after the date of enactment.

VA endorses the concept of using MFHs for Veterans who meet the appropriateness criteria to receive such care in a more personal home setting. VA endorsed this idea in its FY 2018, 2019 and 2020 budget submissions and appreciates the Committee's

consideration of this concept. Our experience has shown that VA-approved MFHs can offer safe, highly Veteran-centric care that is preferred by many Veterans at a lower cost than traditional nursing home care. VA currently manages the MFH program at over two-thirds of our VAMCs, partnering with homes in the community to provide care to nearly 1,000 Veterans every day. However, Veterans are solely responsible for the expenses associated with MFH care today. Of the nearly 800 Veterans in MFHs currently, nearly 200 would be eligible for care at the MFH at VA expense under this bill. Our experience also shows that MFHs can be used to increase access and promote Veteran choice-of-care options. We are concerned with the short period of time to implement this new authority; we believe 1 year would be more appropriate than 90 days to ensure contracts or agreements are in place, and that policies and regulations, if needed, are in effect.

While VA fully supports the MFH concept, we would look forward to working with you to resolve a few technical issues in this bill. For example, the limitation in proposed subsection (h)(3), regarding a limit “in any year” of a “daily average” of 900 or fewer Veterans receiving care, is ambiguous. It is unclear how the limitation to a given year qualifies the daily average and how VA could operationalize this concept effectively. VA would like to work with the Committee to ensure VA can effectively incorporate MFHs into the continuum of authorized long-term services and support available to Veterans. We are happy to provide the Committee with technical assistance on this matter and are available for further discussion.

Section 2(b) of the bill would require VA to create a system to monitor and assess VA’s workload in carrying out this new authority by tracking requests by Veterans to be placed in an MFH; denials of such requests and the reasons for such denials; the total number of MFHs applying to participate (disaggregated by those approved and those denied); Veterans receiving care in an MFH at VA expense; and Veterans receiving care at an MFH at their own expense. VA would be required to identify and report to Congress on such modifications to implementing the new authority as VA considers necessary to ensure the authority is functioning as intended and care is provided to Veterans as intended.

To implement the requirements of section 2(b) and to meet potential demand nationwide VA would have to expand operations and oversight of the existing MFH program to ensure timely placement and payments for Veterans requesting placement. Requirements associated with additional monitoring and data tracking would necessitate additional staff and information technology support.

Section 2(c) of the bill would require the Comptroller General, not later than 3 years and 6 years after the date of enactment, to report to Congress assessing the implementation of the amendments made by this bill; assessing the impact of the monitoring and modifications under subsection (b) on care provided under section 1720(h), as amended; and setting forth recommendations for improvements to the implementation of such section as the Comptroller General considers appropriate.

VA defers to the Comptroller General on this subsection.

We estimate the new costs associated with section 2(b) would be $1.19 million in FY 2022 and $19.10 million over 5 years. We estimate the cost savings of section 2(a), due to the diversion of Veterans from nursing home care to MFHs, would be $15.32 million in FY 2022 and $165.32 million over 5 years. We estimate the total cost savings resulting from the bill, after factoring out the additional costs, would be $14.14 million in FY 2022 and $146.22 million over 5 years.

S. XXXX Vet Center Outreach Act

Section 2 of the draft bill would create a new section, 1730D, in title 38, United States Code, regarding transmittal of information on Veterans transitioning from the Armed Forces to Vet Centers. Specifically, section 1730D would require VA, in consultation with DoD if necessary, to transmit not later than 7 days after the date on which a Veteran separates from the Armed Forces certain information to the personnel of the Vet Center nearest where the Veteran intends to reside permanently after such separation. This information would include the Veteran's name, branch of service, physical address, email address, phone number, service record, marital status and such other information as VA considers relevant. The information would be transmitted electronically in the form of an orderly and easily understood list. Information transmitted would be received and processed by the Readjustment Counseling Service. This information would be available for use to contact members and former members of the Armed Forces transitioning from service to civilian life not more than 14 days after receipt of the information. If it is found, after personnel of a Vet Center contact a Veteran, that another Vet Center is closer to where the Veteran lives, the personnel who initially contacted the Veteran would, only with the consent of the Veteran, directly connect the Veteran to the relevant personnel of the other Vet Center.

VA supports the goals of this section but believes that legislation may be unnecessary. VA currently is working to ensure that Vet Centers have access to this information, currently recorded in the VA-DoD Identity Repository (VADIR), through a data sharing agreement with DoD's Defense Manpower Data Center. We ask that the Committee allow these administrative steps to proceed. If we identify any barriers that would require legislation, we can notify the Committee and recommend action on the bill at that time. VA notes that if the legislation were to move forward, we recommend that the 7-day requirement be modified to the date on which the information is received from DoD. While this information is received within 7 days for many Service members, there are delays in some situations, particularly for members of the Guard and Reserve.

Section 3 of the draft bill would require VA, as part of the Transition Assistance Program (TAP) provided under 10 U.S.C. §§ 1142 and 1144 to provide members of the Armed Forces with information on how to locate Vet Centers and an explanation of how to use Vet Center services. VA would provide this information during instructor-led classroom and virtual courses.

VA supports the provision of information about Vet Centers to transitioning Service members through TAP; however, we do not believe that we require new statutory authority to do this. VA currently discusses Vet Centers in detail as part of the VA Benefits and Services course of TAP. VA redesigned the VA Benefits and Services course in response to section 552 of the National Defense Authorization Act for Fiscal Year 2019 (NDAA FY 2019, P.L. 115-232), which mandated improvements to TAP including providing 1 day of instruction on VA benefits. Through increased interactivity, real-life examples and customizable resources such as checklists and contact lists, the VA Benefits and Services course now provides greater access to information and resources about available VA benefits and services, including VA testimonial videos about Vet Centers. Vet Centers also are discussed in detail during the "Maintaining Your Health" module, which provides instructions on how to locate Vet Centers, describes eligibility requirements and explains how to use Vet Center services.

VA also has launched a Military Life Cycle (MLC) module focused on Vet Centers, which is a voluntary information session available in-person or online at TAPevents.org/courses, available for Service members, Veterans and their families. MLC modules are available at any time throughout a Service member's career. The existing Vet Center MLC module provides information on how to connect with local Vet Centers, on eligibility for Vet Centers and on how Service members, Veterans and their families can use Vet Centers as a free resource. The MLC module emphasizes that Vet Centers are community-based counseling centers that provide a wide range of social, emotional and mental health services for active-duty Service members, members of the reserve components and Veterans and their family members. It notes that all services are confidential and free. It also highlights the Vet Center Call Center, which is an around-the-clock confidential call center where a Service member, Veteran or family member can call to talk about their military experiences or any other issue they may be facing.

VA acknowledges Vet Centers as a valuable resource for Service members, Veterans and their families, and VA plans to continue providing information about Vet Centers under TAP. We ask that the Committee allow VA to take the necessary steps to meet the requirements of this section. If we identify any statutory barriers, we will notify the Committee and recommend action on the bill at that time.

We do not believe this draft bill would require additional resources to implement if enacted.

S. XXXX Reorganizing the Chaplain Service

The draft bill would add a new section, 324, to title 38, United States Code, establishing within VA a Chaplain Service for the provision of spiritual or religious pastoral services. The Chief of Chaplain Services would be appointed by and directly report to the Secretary. The Chief would oversee the Chaplain Service and be the proponent for, and coordinate with the Secretary on, all guidance pertaining to spiritual or religious pastoral services, faith-based programs and instruction and any policy or guidance pertaining to

religion or religious accommodation. The Secretary would have to ensure that all appropriate VA offices coordinate with the Chief on best practices to implement guidance or policy pertaining to religion or religious accommodation. The Chaplain Service would be collocated with VA Central Office. The Chaplain Service would provide and facilitate spiritual or religious pastoral service across VA as a whole in coordination with the Secretary and VA's three Under Secretaries. Spiritual or religious pastoral services would include the broad facilitation of the free exercise of religion and could include assessment, individual counseling and group counseling. VA would be prohibited from requiring any Chaplain to perform a rite, ritual or ceremony if the Chaplain objects based on the conscience, moral principles or religious beliefs of the Chaplain or the ecclesiastical organization that endorses the Chaplain. VA would be required to promulgate regulations to carry out this section. The bill also would make conforming amendments to 38 U.S.C. §§ 7306 and 7401.

VA does not support this draft bill. In September 2020, VA converted Chaplains from the title 5 excepted service to the hybrid-title 38 excepted service personnel system. It is unclear if the draft bill is intended to provide an additional hybrid-title 38 authority or a separate title 38 authority; we understand this could affect other agencies that also employ chaplains, and we recommend the Committee consult with the Office of Personnel Management regarding these potential effects. The draft addition of a 38 U.S.C. § 7401(5) indicates direct appointments made in VHA, though, as read with the other changes, the intent is unclear, especially as to the proposed Chief of Chaplain Services. If the intent is for all Chaplains to be aligned under the Secretary and not in VHA then further statutory changes would be needed for any pay to be available under Chapter 74 of title 38,United States Code. If Chaplains are aligned under the Secretary, they would have to be covered by the title 5 personnel system absent additional statutory changes. However, to continue to be recognized as clinical providers, Chaplains would need to remain under the hybrid-title 38 authority, which is critical to ensuring that the Chaplains' clinical workload continues to align with the three approved Centers for Medicare and Medicaid Services Healthcare Common Procedural Coding System codes, as implemented in October 2020. Clinical workload for the Chaplain Service also is reported already through the Veterans Equitable Resource Allocation model, which informs VA's budget requests. The bill would require the Chaplain Service to be collocated with VA Central Office, but a memorandum in January 2020 already established that the Director of the National Chaplain Service is physically located in VA Central Office. The current status and placement of Chaplains allows them access across the Department, including in the Veterans Benefits Administration (VBA) and the National Cemetery Administration.

VA also notes as a technical matter that the amendment striking 38 U.S.C. § 7306(e) does not have a corresponding amendment to 38 U.S.C. § 7306(d), which references that paragraph.

S. XXXX Dental Care Expansion and Enhancement Act

Sections 3 and 4 of the draft bill would require VA to provide dental care in the same manner as medical services in the VA medical benefits package phased in by priority group over an 8-year period following enactment, thereby requiring that VA provide all necessary dental services to any Veteran enrolled in VA health care. The changes made by section 3 would take effect on the date that is 1 year after the date of the enactment of this legislation.

These sections are aligned with the mission of VA Dentistry, which is to honor America's Veterans by contributing to whole health through the provision of exceptional oral health care. Veterans who are ineligible for dental care through VA may purchase dental insurance at a reduced cost through the VA Dental Insurance Program or may be eligible to participate in the Community Provider Collaborations for Veterans Pilot Program.

If these sections were enacted, VA expects an initial surge in demand for dental care that would stabilize over time. Only 1.35 million Veterans of the 9.28 million Veterans enrolled for VA health care are currently eligible for dental care. This bill would increase the number of eligible Veterans by 678%, which would create a significant spike in the need for resources to meet the increased demand. While we would expect that demand would level off after this initial spike, the sheer number of newly eligible Veterans would mean that a tremendous increase in the number of available resources would be needed in the long-term as well. Current statutes and regulations do not define any limitations to dental benefits for those eligible for them. The proposed bill defines the dental benefit as comprehensive and, as such, would have no limitations. VA's existing resources to provide dental care are at or near full capacity, with some regional variation. As a result, VA does not believe it could provide all this care internally, even with the phased implementation period. Therefore, VA would require an increased use of community resources, which would have associated administrative costs, as well as the direct cost of paying community providers to provide dental care to all enrolled Veterans. We also believe an expansion of this magnitude would require building new dental clinics and hiring new staff to meet demand.

VA estimates that in the first year of implementation (FY 2023), the cost of expanding dental care would be more than $4.1 billion. Our estimated costs only reflect the additional costs associated with purchased care ($3.77 billion) and costs to the dental program within VA, but we note that this expansion would also increase VA's costs for associated services like sterile processing. We have not had an opportunity to calculate those costs. The cost for VA's dental program and community care over 5 years is estimated to be more than $34 billion, and the cost to VA's dental program and community care over 10 years would be more than $109.3 billion. Given these estimates, VA does not believe that it would have the necessary resources to successfully complete the expansion required by the bill and, therefore, does not support these sections of the bill.

Section 5 of the draft bill would require VA to ensure that each State has a VA dental clinic to meet the needs of the Veterans within that State. This section would take effect on the date that is 1 year after the date of enactment.

We support the intent of this section, but we do not believe it is necessary. There is currently only one State, Vermont, that does not have a dental clinic, but VA is planning to include such a clinic in a new CBOC location.

Section 6 would require VA to carry out a program of education to promote dental health for enrolled Veterans. The program would need to include specific information on various matters. These materials would have to be provided through a variety of mechanisms. This section would take effect on the date that is 1 year after the date of enactment.

We support the intent of this requirement, but we do not believe this is necessary because VA already provides and promotes dental health education information for enrolled Veterans, including options for obtaining access to dental care. We would be happy to brief the Committee on these efforts.

Section 7 would require VA to ensure that it has sufficient staff to provide dental services to Veterans by implementing a loan reimbursement program for qualified dentists, dental hygienists and oral surgeons who agree to work at VA for a period of not less than 5 years. VA could not reimburse more than $75,000 for each participating dentist, $10,000 for each participating dental hygienist and $20,000 for each oral surgeon. VA would have to monitor demand among Veterans for dental care and require participants in the loan reimbursement program to choose from VA dental clinics with the greatest need for dentists, dental hygienists or oral surgeons according to facility enrollment and patient demand.

We appreciate the intent of this section, but we do not support this section as written. We believe the amounts specified in this draft section would not provide an incentive for dentists, dental hygienists and oral surgeons given the average student loan obligations of graduates in these professions. VA has not had a challenge in hiring these specialties to meet current demand. If sections 3 and 4 of the bill were enacted, VA would need significantly more staff, but we would be unable to hire for these positions, simply because there would be insufficient supply.

Section 8 would require VA to enter into educational and training partnerships with dental schools to provide training and employment opportunities for dentists, dental hygienists and oral surgeons.

We support the goal of section 8, but we do not believe this is necessary. VA currently maintains a robust network of partnerships with dental schools. We currently have 360 dental resident positions authorized around the country. We would be happy to brief the Committee on these efforts.

Section 9 would authorize to be appropriated such sums as necessary to carry out this legislation. The amount authorized to be appropriated would be available for obligation for the 8-year period beginning on the date that is 1 year after the date of enactment.

As noted previously, we believe the total costs of this bill would be prohibitive.

S. XXXX Veterans State Eligibility Standardization Act

This draft bill would require VA to modify the areas in which Veterans reside as specified for purposes of determining whether Veterans qualify for treatment as low-income families for enrollment in VA health care. VA would have to modify these areas so that any area so specified would be within only one State, and any area so specified would be coextensive with one or more counties (or similar political subdivisions) in the State concerned. VA also would have to modify the thresholds for income for determining eligibility for enrollment so that there would be one income threshold for each State, which would be equal to 100%t of the highest threshold among the counties or metropolitan statistical area within each State and any metropolitan statistical area that encompasses territory of such State and one or more States. The calculation of the highest income threshold would be consistent with the calculation used for section 3(b) of the United States Housing Act of 1937 (42 U.S.C. § 1437a(b)). The timing and methodology for implementing these changes would be determined by VA in such a manner as to permit VA to build capacity for enrolling such additional Veterans in the patient enrollment system as they become eligible based on these changes, except that all required modifications would have to be completed not later than 5 years after the date of the enactment of this legislation.

VA appreciates the Committee's interest in considering updates to eligibility criteria, but as is the case with any proposals to changes affecting enrollment for care, VA is concerned about potential adverse or inequitable consequences that might result from this legislation. We have not had an opportunity to conduct a full State-by-State analysis, but the draft bill would have very different results across States. In States with diverse economic statuses that include both lower income areas and cities with much higher median incomes, there could be a significant change in the geographic means-test threshold for those in lower income areas. In States with more homogenous income levels, not as many Veterans may be affected by this legislation. This variance could introduce unintentional inequities across the Nation, as Veterans in States with even a single high-income area would benefit more. We also are concerned about the potential effect this legislation could have on Veterans who reside in one State but regularly receive services in another State; because the bill limits eligibility based on income to State borders, Veterans living near these borders could be uniquely affected. We would welcome the opportunity to discuss this proposal in greater detail with the Committee.

We have not had an opportunity to develop a cost estimate for this draft bill.

S. XXXX Servicemembers and Veterans Empowerment and Support Act

Section 101 of the draft bill would require VA within 1 year of the date of enactment to begin to revise its regulations for the definition of military sexual trauma (MST) for purposes of access to VA health care and compensation. VA would have to ensure that its revised regulations include matters relating to technological abuse (further defined in the draft bill) to reflect sexual harassment in the digital age. VA would be required to collaborate with DoD and to consult with VSOs, military service organizations and other stakeholders. Not later than 1 year after the date of enactment, VA would have to submit to Congress a report on its progress in revising its regulations. Final regulations would have to be issued within 2 years of the date of enactment, and VA would have to update training aids, manuals and information materials to reflect these changes.

VA recognizes the unique challenges and difficulties that Veterans may experience because of technological abuse, and we commend the Committee for looking at this issue. We welcome further discussion given that the goals of section 101 are commendable. However, there are several complexities that make it difficult for us to support the bill as written, and we would welcome the opportunity to discuss these further with the Committee.

Initially, for benefits purposes, many of the examples of technological abuse in this section do not appear to require a sexual component or context, and it is unclear that the definition of MST should be expanded in this way. The bill language suggests, but does not specifically state, that the “private information, photographs, or videos” must be of a sexual nature. If that is the intent, VA believes that its current authority accounts for these actions as sexual harassment, and we support Congress’ intent to ensure eligibility for benefits and health care for Veterans who experienced MST consisting of (1) technology-facilitated sexual harassment, (2) online sexual abuse and harassment form an intimate partner (as defined in the Uniform Code of Military Justice Article 117a), (3) online retaliation related to a sexual assault, or (4) violation of a military protection order via sexual threats or non-consensual distribution of intimate digital images and DoD sexual harassment policies. Similarly, the existing definition of MST in 38 U.S.C. § 1166(c)(2), which includes sexual harassment, does not preclude that harassment occurring through technological means. VA is concerned that becoming overly specific in defining specific behaviors that establish eligibility for benefits could be problematic if it ultimately becomes more limiting than inclusive by omitting (likely inadvertently) circumstances that should be included. We also have some reservations about our ability to implement this authority in a consistent and fair way for claims processing, and we would be happy to discuss these in detail with the Committee.

From the health care perspective, the concern about the concept of “technological abuse” is reasonable and experiences of this sort can affect victims’ health and well-being. However, we are concerned that the proposed changes in section 101 may not be necessary and may result in regulations that are ambiguous and difficult to implement.

VA's authority to provide MST-related treatment already includes a broad definition of "sexual harassment" in 38 U.S.C. § 1720D(f). Any verbal contact (spoken or online) of a sexual nature that is unsolicited and threatening in character is qualifying for health care. VA already is taking steps to call more attention to technology-based harassment. For example, the sexual harassment question used in VA's universal MST screening program currently is being updated to include "sexual texts and online messages" as one of the examples offered to patients. Also, for purposes of health care, VA has adopted an expansive evidentiary policy: MST survivors are not required to provide documentation or otherwise prove that their harassment experiences meet specific legal criteria to gain access to care.

Furthermore, efforts to regulate access to MST-related care using rules that include all behaviors listed in section 101 would likely result in legal difficulties and definitional conflicts that would complicate, rather than facilitate, greater access. VA's treatment authority under 38 U.S.C. § 1720D(a) is specific to conditions that resulted from physical assault of a sexual nature, battery of a sexual nature or sexual harassment. Several behaviors listed in section 101 do not have a clear sexual nature, but to provide care, VA would be obligated to develop regulatory criteria defining when these behaviors do and do not have a sexual nature. VA providers and staff would, in turn, be obligated to attempt to apply these criteria to decide eligibility in individual cases. We note that if Congress intends for VA to treat conditions related to technology-based harassment that is not clearly of a sexual nature, the remedy is to grant additional authority through legislation; VA cannot on its own regulate more expansive access to care than what its statutory authorities permit. As noted before, we support Congress' intent to ensure Veterans who experienced MST consisting of those four categories identified above are able to access benefits and health care. We would welcome the opportunity to discuss where our statutes could be clarified to recognize qualifying online behavior and technology-facilitated behavior to support victims of MST.

We are aware that Congress has an interest in expanding health care eligibility to include experiences such as those which were part of the Marines United scandal in 2017, where explicit photos taken of women Service members were later posted on Facebook. VA concurs with this intent but notes that VA's authority under 38 U.S.C. § 1720D is specific to sexual harassment experienced while a former Service member was serving on duty. The regulations prescribed by section 101 would not and could not authorize care for sexual harassment experienced after leaving the military (such as in the Marines United case), even if the content of the abuse is related to the individual's military service. As noted previously, if Congress intends for VA to provide care related to these types of circumstances, additional legislative change to VA's statutory authorities would be required. Again, we would welcome the opportunity to discuss specific areas of concern with the Committee.

We estimate section 101 would result in mandatory costs of $12.7 million in FY 2022, $192.3 million over 5 years and $716.4 million over 10 years. We also estimate this section would result in discretionary costs of $7.0 million in FY 2022, $23.4 million over 5 years and $51.0 million over 10 years.

We believe a robust discussion of how this section might affect Veterans and VA would be appropriate to ensure that any changes made preserve VA's ability to furnish care and services to MST survivors while also supporting their applications for compensation benefits.

Section 201 would adopt the definition of military sexual trauma set forth in 38 U.S.C. § 1167(j), as added by section 203(a) of this legislation, for purposes of sections 201-207 of this draft bill.

VA has no objection to this section.

Section 202 would amend 38 U.S.C. § 1166(c) to adopt the definitions of covered mental health condition and military sexual trauma set forth in section 1167(j), as added by section 203(a) of this legislation.

VA has no objection to this section.

Section 203 would add a new section, 1167, to title 38, United States Code, to accept as sufficient proof of service connection a diagnosis of a covered mental health condition by a mental health professional together with satisfactory lay or other evidence for claims that a covered mental health condition was based on MST that was incurred in or aggravated by active military, naval or air service. This acceptance would be required notwithstanding the fact that there is no official record of such incurrence or aggravation in such service, and VA would be required to resolve every reasonable doubt in favor of the Veteran. Service connection of such covered mental health conditions could be rebutted by clear and convincing evidence to the contrary.

VA would be required to ensure that if a disability compensation claim is received for a covered mental health condition based on MST, evidence from sources other than DoD's official records regarding the Veteran's service or evidence of a behavior change following the MST event may be considered to corroborate the Veteran's account of the trauma. VA would be prohibited from denying an MST-related disability compensation claim for a covered mental health condition without first advising the Veteran about evidence that may constitute credible corroborating evidence of MST and allowing the Veteran an opportunity to furnish such evidence or advise VA of potential sources of such evidence. In a case where non-military sources of evidence or evidence of behavior changes are unavailable, and the only evidence of the occurrence of MST is the Veteran's own lay statement, VA would have to accept a lay statement that was consistent with the places, types and circumstances of the Veteran's service as credible evidence the event occurred, which would lower the evidentiary standard in contrast to the evidentiary standard for other PTSD claims

In reviewing claims for compensation for covered mental health conditions, VA would have to submit evidence to appropriate medical or mental health professionals to obtain a nexus opinion whether it is at least as likely as not there is a nexus between the MST

and any diagnosed covered mental health condition. If a Veteran submitted a lay statement describing the MST, the Veteran would have to be provided with a medical examination and opinion, without delay to request records from the Veteran. VA would have to request records regarding non-military sources of evidence and evidence of behavior changes if the medical examination and opinion do not result in a diagnosis of a covered mental health condition and a positive opinion that the MST was related to the diagnosis. VA would be required to provide a subsequent medical examination and opinion following receipt of evidence. The bill also would require VA to ensure that each document provided to a Veteran related to an MST-related disability compensation claim includes contact information for an appropriate point of contact within VA. Furthermore, VA would have to ensure that all MST-related disability compensation claims are reviewed and processed by a specialized team established under section 1166. Finally, within 180 days of the date of the enactment of this legislation, VA, with input from the Veteran community, would have to implement an informative outreach program for Veterans regarding the standard of proof for evaluation of MST-related claims.

Section 203 of the bill would include a rule of construction prohibiting VA from construing this section as supplanting the standard of proof or evidence required for claims for PTSD based on non-sexual personal assault. Covered mental health conditions would include PTSD, anxiety, depression or other mental health diagnoses described in the current version of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that VA determines to be related to MST and which may be service connected. Military sexual trauma would be defined to mean, with respect to a Veteran, a physical assault of a sexual nature, battery of a sexual nature or sexual harassment that occurred while the Veteran was serving in the active military, naval or air service.

VA cannot support section 203 unless certain provisions in proposed section 1167 are removed.

VA does not object to the expansion of the lowered evidentiary standard contained in current regulations to cover mental health conditions listed in proposed section 1167. However, VA opposes provisions in proposed section 1167 that would further lower the evidentiary threshold for MST claims. VA is concerned the bill’s language would require VA to accept for benefits purposes all allegations of an MST stressor and potentially award service connection based on a single lay statement from the Veteran without any other evidence verifying the existence of the stressor. VA acknowledges that the circumstances of service make the claimed MST stressor more difficult to corroborate, and to that end, VA has promulgated regulations at 38 C.F.R. §§ 3.303 and 3.304(f)(5), which establish equitable standards of proof and provide examples of the types of evidence that may corroborate an in-service injury, disease or event for purposes of service connection.

Proposed section 1167, as written, would substantively create new standards for verifying a stressor and establishing a nexus between a claimed mental health condition and a claimed MST stressor when adjudicating a claim for service connection for MST-related conditions. VA believes some level of corroboration is necessary to maintain the integrity of the claims process. The bill would essentially require VA to award service connection if there is a current diagnosis of a covered mental health condition and a mental health professional is willing to speculate that the claimant's symptoms are related to an event in military service reported by the Veteran. This situation would occur in the absence of corroborating evidence to substantiate the occurrence of the stressor.

To be clear, VA does not object to the codification of certain MST evidentiary standards that are already included in VA regulations that necessarily lower the evidentiary threshold based on the sensitive and challenging nature of MST claims. This method allows adjudicators to process MST claims in a fair and equitable manner, for example, by considering alternative sources of evidence (i.e., non-military evidence and markers) to corroborate the Veteran's account of the stressor incident.

In addition to these concerns, VA has several technical comments and concerns with section 203, and we would appreciate the opportunity to discuss these with the Committee. For example, we are concerned about the definition of "covered mental health conditions", which would include mental health diagnoses described in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), as VA establishes service connection for disabilities using the VA Schedule for Rating Disabilities, and not every DSM-V disability is in the Schedule for Rating Disabilities.

We estimate this section would result in mandatory costs of $323.6 million in FY 2022, $4.2 billion over 5 years and $11.4 billion over 10 years. We also estimate this section would result in discretionary costs of $38.5 million in FY 2022, $215.1 million over 5 years and $447.4 million over 10 years.

Section 204 would amend 38 U.S.C. § 1165 to require VA to ensure that Veterans who require a medical examination in support of a disability compensation claim for a mental or physical health condition that resulted from a physical assault of a sexual nature, battery of a sexual nature or sexual harassment may request the medical examination take place at a VA facility of choice and be performed by a qualified VA employee. VA would be required to grant any such request and could not issue a decision on such a claim before the requested examination is completed.

VA would support this section if amended to state that Veterans requiring a medical examination may request such an examination take place at a facility within 100 miles of the Veteran, which is consistent with VA's current contractual requirements for specialist examinations or diagnostics. In addition, we recommend that the references to "a facility of the Department" be revised to "a medical facility of the Department" and that the reference to "a qualified employee of the Department" be removed.

We do not believe this provision, if amended as we recommend, would result in any additional costs to VA.

Section 205 would require VA to establish a board to review correspondence relating to MST. The board would have to include experts in MST and mental health, including VA mental health providers, experts on sexual assault and sexual harassment and MST coordinators from VHA and VBA. The board would be responsible for the review of all standard correspondence and other materials, as well as outreach materials and Veteran-facing website content from VA to survivors of MST for sensitivity and to ensure that communications treat survivors with dignity and respect while not re-traumatizing survivors. VA would have to ensure that any written communication to an MST survivor includes contact information for VBA and VHA MST coordinators, the Veterans Crisis Line and the VA health care facility closest to where the survivor resides.

Although VA supports ensuring that communications and care for MST survivors is sensitive and appropriate, we do not believe this section is necessary. VA already prioritizes ensuring that the entire environment of care, including correspondence, outreach and staff interactions, as well as health care delivery, communicates respect and safeguards the dignity and autonomy of MST survivors. This emphasis has been a driving factor in VA's outreach and staff awareness training efforts for many years. We are concerned with the specific requirements in subsection (b) that any written communication to an MST survivor must include certain information, such as the nearest facility and that facility's MST Coordinator. This requirement could create confusion and miscommunication. For example, VA can provide MST-related care to certain former Service members who are pending eligibility determinations, but if such a person were found ineligible based on further review, VA would need to correspond with that person to state they are no longer eligible. While VA has taken steps to ensure this correspondence is sensitive and respectful, including contact information may suggest that the person is eligible for services from these facilities. Further, VA sends out broad communications to many Veterans, some of whom are MST survivors and some of whom are not. The requirement that "any" written communication from VA to an MST survivor must include certain information would complicate VA's general outreach efforts and could require two separate sets of information and documents be prepared and shared. This requirement would increase costs to VA and increase the likelihood for errors in distribution. It is also unclear how broad-based online communication through social medial or email distribution lists would comply with these requirements. There also is no guarantee that, even with extra measures taken, some Veterans will not experience re-traumatization. We note that some may find the term "survivor" troublesome and object to its use, so adoption of an alternative with a less sensitive connotation might be appropriate. Finally, we recommend that the review board established under section 205 also include representatives from the Board of Veterans' Appeals.

Section 206 would require VA to conduct a study on the quality of training provided to VA personnel who review MST-related disability compensation claims and the quality of VA's procedures for reviewing the accuracy of the processing of such claims. VA would have to submit to Congress a report detailing its findings with respect to this study not later than one year after the date of enactment.

VA has no objection to this section.

Section 207 would require the Under Secretary for Benefits to conduct annually a special focus review on the accuracy of the processing of MST-related disability compensation claims. If the Under Secretary found, pursuant to the review, that an error had been made with respect to a Veteran's entitlement to a benefit, VA would return the claim to the appropriate regional office for reprocessing to ensure the Veteran receives an accurate decision. If the Under Secretary found, pursuant to a special focus review, that the accuracy rate was less than 90%, VA would conduct a review of each MST-related claim filed during the fiscal year preceding the fiscal year in which the report was submitted. Finally, section 207 would amend section 5501 of P.L. 116-315 to include as a requirement in the report required by that section the findings of the most recent special focus review.

VA has no objection to section 207.

Section 301 would amend 38 U.S.C. § 1720D, to expand the population of eligible persons to include former members of the Armed Forces who served on active-duty, active duty for training or inactive duty training, and who were discharged or released therefrom under any condition that is not a discharge by court-martial or a discharge subject to a bar to benefits under 38 U.S.C. § 5303. It would also define the term "military sexual trauma" to mean, with respect to a former member of the Armed Forces, a physical assault of a sexual nature, battery of a sexual nature or sexual harassment which occurred while the former member of the Armed Forces was serving on duty, regardless of duty status or line of duty determination.

VA would support section 301 if amended. Former members of the National Guard and Reserve face additional barriers to accessing MST-related care relative to the active-duty components. Under current authority, VA is authorized only to provide this care to former Service members who served on "active military, naval, or air service", which is defined in 38 U.S.C. § 101(24) as inclusive of active duty and any period of reservist duty where the individual incurred a service-connected disability. Former National Guard and Reserve members could satisfy only the active-duty component if they served in active duty before entering the Guard or Reserve or were federally activated under 10 U.S.C. § 12301, and most members do not meet these requirements. Former members of the Guard and Reserve who are ineligible for VA care may have few to no alternatives to access comparable care in their communities. VA providers have unique clinical expertise in MST and other health concerns specific to Veterans. MST survivors often face both physical and mental health effects from their experiences and benefit from VA's ability to coordinate care seamlessly across multiple specialties.

VA also supports defining military sexual trauma in 38 U.S.C. § 1720D(f), as this health care-oriented definition would facilitate future rulemaking, avoid technical implementation issues, and improve the clarity and conciseness of communication materials on the topic. We do have one technical concern with the definition, as it would not apply to VA's authority to provide care to current members of the Armed Forces under section 1720D(a)(2). VA historically has referred to care provided under sections 1720D(a)(1) and (a)(2) as "MST-related care", but having that term limited in statute to one patient cohort (Veterans) and not the other (current Service members) would be counterproductive. We recommend the proposed definition of military sexual trauma be inclusive of former and current members of the Armed Forces, and we further recommend that subsection (a)(1) be amended to refer to this definition.

VA estimates this section would cost $2.97 million in FY 2022, $28.82 million over 5 years and $82.26 million over 10 years.

Section 302 would require VA, not later than 14 days after the date on which a Veteran submits an MST-related disability compensation claim, to send a communication to the Veteran with contact information for the nearest VBA and VHA MST coordinator, the types of services that MST survivors may receive from VA, contact information for the Veterans Crisis Line and other such information VA considers appropriate.

VA supports the intent of section 302, but we do not believe it is necessary because our current authority is sufficient. Timely, consistent and comprehensive communication with the goal of connecting claimants to key points of contact is critical to supporting Veterans during the claims process. Furthermore, we note as a technical matter that the section, as written, would apply only for claims related to sexual assault or sexual harassment experienced during "active military, naval, or air service" under section 101(24). This point would exclude certain former members of Reserve components, who are eligible to file a disability claim.

Section 303 would require VA conduct a study on access to inpatient mental health care for current and former members of the Armed Forces who are MST survivors. The study would have to assess several factors, and VA would be required to submit a report to Congress, not later than 1 year after the date of enactment, detailing the findings of the study.

VA supports in principle efforts to better understand access to care for MST survivors, but we do not support this section because it is unnecessary as VA already has authority to carry out such a study. Further, we are concerned that the references in this section (as well as in sections 304 and 305) to "inpatient" programs should instead refer to "residential" programs. VA's inpatient mental health units treat Veterans with severe and acute treatment needs, such as suicidal behavior, and the focus is on crisis stabilization. These are not considered residential treatment programs.

We also are concerned about the reference to current Service members in section 303(a). To protect privacy and confidentiality related to DoD open health care record sharing, current Service members receiving treatment at VA are not screened for experiences of MST, and VA cannot reliably identify whether current Service members receiving VA mental health residential rehabilitation treatment have experienced MST.

In addition, due to the COVID-19 pandemic, mental health residential treatment programs have seen significant reductions in utilization and capacity. We are concerned that a study at this moment would not reflect the typical care provided by these residential treatment programs; in particular, we believe the satisfaction data may be adversely affected by the COVID-19 pandemic and necessary requirements for mitigation of the virus and related reductions in services. If Congress intends to move forward with such a requirement, we believe commencing the study at a later point in time, after the COVID-19 pandemic, and for a longer period, such as 3 years, would be appropriate.

Further, no VA mental health residential rehabilitation treatment programs are officially designated as MST-treatment programs, although there are a small number of such programs that only serve Veterans who have experienced MST. It would seem more appropriate to instead focus on the needs of all Veterans who have experienced MST who require residential treatment. VA does not capture the level of detail in the proposed legislation at the national level from Veterans receiving care in a mental health residential treatment program, so to complete the study as written would require significant time to develop and implement a means of capturing such information.

We estimate section 303 would cost more than $156,000 in FY 2022, $1.55 million over 5 years and $3.6 million over 10 years.

Section 304 would require VA commence, not later than 1 year after the date of enactment, a 3-year pilot program to provide intensive outpatient mental health care to current and former members of the Armed Forces who are MST survivors when the wait times for inpatient mental health care from VA are more than 14 days. VA would be required to carry out the pilot program at not fewer than four VISNs, and VA would have to select locations that have the longest wait times for inpatient mental health care, particularly for MST survivors. VA would be required to notify Congress of the locations selected for the pilot program before commencing the program. VA could provide services, subject to the preference of the participant, through telehealth or at a VA community-based outpatient clinic. Participation in the pilot program would be during the period in which the survivor is waiting for an inpatient bed opening and would not disqualify the survivor from receiving inpatient mental health care following their participation in the pilot program. Decisions about participation in the pilot program would be made by the survivor and their health care provider. Not later than 180 days after the conclusion of the pilot program, VA would be required to submit a report to Congress on participation in the pilot program, clinical outcomes under the pilot program and recommendations for the continuation or termination of the program, along with recommendations for legislative or administrative action.

While VA appreciates the intent of this section, we do not support it because the implementation of a pilot program to develop an intensive outpatient program to provide interim services for Veterans pending residential admission is not warranted. VA currently provides a broad continuum of mental health services that include intensive outpatient services for mental health and SUD concerns. These services are available in-person and by telehealth. VA policy requires support for Veterans pending residential admission including at a minimum weekly contact with a focus on ensuring all emergent needs are met. We also are concerned about the reference to “inpatient” programs instead of residential programs, as noted in our discussion of section 303.

More significantly, we are concerned that the proposed program may not be aligned with existing programs that have self-identified as providing specific treatment related to MST. Intensive outpatient treatment programs represent a level of care distinct from residential treatment, and an intensive outpatient program may not be beneficial to all Veterans who would benefit from residential services. Even more concerning, participation in an intensive outpatient program could result in further delays in care as Veterans may not be willing to stop treatment mid-course and may bypass an available residential treatment bed.

Section 305 would require the Comptroller General to conduct a study on access to mental health care for MST survivors at VA facilities. Not later than 2 years after the date of enactment, the Comptroller General would be required to submit to Congress a report on the findings of this study.

VA defers to the Comptroller General on this section. However, we do note that the proposed study overlaps with, and may be partially redundant with, other GAO investigations, such as “Review of Servicemember Trauma and Experiences with Unwanted Sexual Behavior”. Also, as previously noted, we are concerned with the references to “inpatient” care as opposed to residential treatment programs. Finally, we note that one of the required elements, assessing the role of VHA MST coordinators in coordinating and providing care for MST survivors at VA facilities, may be inapplicable, as these positions are administrative by design. Although MST coordinators may provide care to MST survivors as part of other job roles, there is no designated responsibility or expectation these coordinators be involved in care delivery.

S. XXXX State Veterans Home Requirements

This draft bill would add a new section, 1741A, to title 38, United States Code, establishing conditions on the receipt of per diem payments to State Veterans Homes (SVHs) under subchapter V of chapter 17, title 38, United States Code. These conditions would require SVHs to have a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the SVH, consists of more than one person, and appoints an administrator or deputy superintendent who is licensed by the State (if required by State law) and who meets standards established by the Secretary of Health and Human Services under sections 1819(f)(4) and 1919(f)(4) of the Social Security Act (42 U.S.C. §§ 1395i-3(f)(4) and 1396r(f)(4)).

SVH also would have to employ an infection preventionist and include in the annual report to VA the name of this preventionist and an emergency plan, updated annually, in case of a public health emergency or other disaster. The draft bill also would add a new section, 1744A, requiring VA to make payments to States for assisting SVHs in the hiring and retention of infection preventionists. Payment to SVHs would be made, subject to submission of an application, to any State that during the fiscal year receives per diem payments under this subchapter. Payments under this section could not be used to provide more than 50% of the salary or wages for an infection preventionist for a fiscal year.

Payments could only be made upon an application submitted by the State seeking such payment. Each such application would have to describe the salary or wages of the infection preventionist. Payments under this section would be made as part of the disbursement of payments under section 1741. VA would have to require, as a condition of any payment under this section, that in any case in which the SVH receives a refund payment made by an employee in breach of the terms of an agreement for employee assistance that used funds provided under this section, the payment must be returned to the incentive program account for the SVH and credited as a non-Federal funding source.

Any SVH receiving a payment under this section would be required to provide VA with a report setting forth in detail the use of funds received through the payment. VA would be required to prescribe regulations necessary to carry out this authority, including the establishment of criteria for the award of payments under this section.

VA would support the draft bill if amended and subject to the availability of appropriations. In terms of our recommended changes, first, we recommend the bill be revised to require that all SVHs hire a licensed Nursing Home Administrator, as this would establish a core knowledge level for such persons. Second, we recommend the role of the infection preventionist be standardized for all SVHs. We would be happy to share specific elements or requirements of this position we think might be appropriate. We further recommend the emergency plan in case of a public health emergency or other disaster have standardized components across all SVHs. Areas of the plan should

focus on the prevention, control and monitoring of infectious disease outbreaks. We also recommend establishment of infection prevention committees and members be standardized across the SVHs. We also recommend the annual reporting requirement for SVHs to the Secretary be updated to a quarterly report, and we further recommend submission of these reports be a condition of receiving payments under this section. Finally, we recommend that all SVHs be required to obtain CMS certification and be held to the current edition of the State Operations Manual.

We estimate this bill would cost $23.47 million in FY 2022, $124.60 million over 5 years and $266.53 million over 10 years.

Conclusion

This concludes my statement. We would be happy to answer any questions you or other Members of the Committee may have.