S. HRG. 117–745

LEGISLATIVE PRESENTATION OF THE VETERANS OF FOREIGN WARS OF THE UNITED STATES AND MULTI VSOs: IAVA, WWP, VVA, AMVETS, NCHV, SWAN, BVA, BVEC, NASDVA

JOINT HEARING

OF THE

COMMITTEE ON VETERANS' AFFAIRS

BEFORE THE

U.S. HOUSE OF REPRESENTATIVES

AND THE

U.S. SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

SECOND SESSION

MARCH 2, 2022

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MARCH 2, 2022

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LEGISLATIVE PRESENTATION OF THE VETERANS OF FOREIGN WARS OF THE UNITED STATES AND MULTI VSOs: IAVA, WWP, VVA, AMVETS, NCHV, SWAN, BVA, BVEC, NASDVA

WEDNESDAY, MARCH 2, 2022

U.S. HOUSE OF REPRESENTATIVES,
AND U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committees met, pursuant to notice, at 2 p.m., in Room 210, House Visitors Center, Hon. Jon Tester, Chairman of the Senate Committee on Veterans' Affairs, presiding.

Present:

Representatives Takano, Brownley, Lamb, Levin, Pappas, Mrvan, Sablan, Underwood, Allred, Slotkin, Trone, Ruiz, Gallego, Bost, Radewagen, Bergman, Banks, Roy, Cawthorn, Rosendale, Miller-Meeks, and Ellzey.

Senators Tester, Murray, Brown, Blumenthal, Sinema, Hassan, Moran, Boozman, Cassidy, Tillis, and Sullivan.

OPENING STATEMENT OF HON. JON TESTER, CHAIRMAN, U.S. SENATOR FROM MONTANA

Chairman TESTER. I call this Joint Session of the Senate and House Veterans' Affairs Committee to order.

Commander Mihelcic, I want to thank you for being here today. I appreciate your advocacy on behalf of our Nation's veterans and their families.

This is a crucial moment. As the veterans emerge from a year-long pandemic, Congress and VA must not forget the lessons that we have learned. Now we know that, with the right resources, coordination, and authorities, we can accomplish almost anything. That is why going back to normal can't be our goal; we have to do better than normal. That means doing a better job of connecting aging veterans to long-term care options that suit them the best, including the caregivers program. That means ensuring the claims backlog is addressed in a way that doesn't sacrifice quality for speed. And it means doing absolutely everything in our power to ensure veterans are connected to the care and the benefits they deserve in a more timely manner.

Since I introduced the Cost of War Act last year, we have seen a lot of progress. VA has created a new presumptive process that

has added dozens of new presumptions, including the nine announced yesterday by the President.

To put that in perspective, over the previous 8 years, only four conditions were added, and three of those—bladder cancer, hypothyroidism, and Parkinsonism—were only added because of a Tester amendment, interestingly enough, to the 2021 Defense Authorization Act, which forced the Administration to do so.

So, in my view, we can't just rely on the executive branch of Congress because we have a constitutional duty to do our job as the legislative branch on behalf of our veterans.

But for us to get comprehensive toxic exposure legislation done, which we all want, the political games, the political posturing, and the questioning of motives really does need to stop. If we are going to fulfill our obligation to veterans, we need to roll up our sleeves and we need to do our jobs, and we need to work together in a bipartisan and bicameral way to deliver the results that you have earned and that you deserve.

So I look forward to our conversation today and thank you again for being there. We await your marching orders.

I will kick it over to Congressman Levin for the Chairman's response.

HON. MIKE LEVIN,
U.S. REPRESENTATIVE FROM CALIFORNIA

Mr. LEVIN [presiding]. Well, thank you, Senator Tester. It is an honor to join all the members of the House and Senate Committees on Veterans' Affairs in person and virtually to hear directly from the organizations that represent our Nation's veterans about the issues that matter most to them.

I would like to personally welcome Mr. Fritz Mihelcic, Commander in Chief of the VFW, and the leaders of all nine organizations on our second panel. I am grateful for your tireless work on behalf of our Nation's veterans, their families, and survivors.

The opportunity to hear from our VSO partners is incredibly important to me. I was encouraged to see the overwhelming support that VFW and other VSOs provided last Thursday in a letter to House leadership supporting the Honoring Our PACT Act.

Chairman Takano asked me to express his deep regret that he can't be with us today, as he is currently on the House floor, fighting to pass the PACT Act, but he asked that I thank you all for the tremendous support you have provided during this process.

Chairman Tester, I would like to submit the letter from our VSO partners into the record, if there is no objection.

Chairman TESTER. Without objection.

Mr. LEVIN. The bipartisan PACT Act will finally provide access to VA health care to over three and a half million veterans exposed to toxic substances. It requires that VA presume certain veterans were exposed to toxic substances rather than placing the burden on veterans to prove this link themselves.

Vietnam veterans waited more than 40 years for benefits related to Agent Orange exposure because of Congress' piecemeal solutions. We cannot allow this to happen again.

Toxic-exposed veterans have held up their part of the pact and now it is our turn. Today, we are keeping our promise, and we look forward to working with the Senate to make this law.

VSO partners like the VFW, and all those who are joining us today, represent veterans and their families at all stages of life and service. Hearing from these partners allows the committees the opportunity to hear directly about what is most important to your members and how we can be of service to our Nation's veterans.

In the last Congress, together, we secured several important wins for veterans, including passing the Blue Water Navy Vietnam Veterans Act, the Deborah Sampson Act, the Veterans COMPACT Act, the Commander John Scott Hannon Act, and the Isakson-Roe Act.

We are very proud of these accomplishments, but they are only the beginning. We need to build on these achievements and continue our fight for better health care and benefits in this Congress and beyond.

I have read your testimony and it is clear that I share your priorities.

The House Veterans' Affairs Committee's top priorities for this Congress include creating a more inclusive and welcoming VA; building equity for an increasingly diverse veteran community; reducing veteran suicide; addressing toxic exposure; ensuring student veterans receive quality education; advocating for women veterans; modernizing VA; supporting VA's long-term care facilities; improving VA's management and oversight; and ensuring our legislative accomplishments are implemented effectively.

Our diverse veteran community includes higher numbers of women, LGBTQ+, Black, Asian, Hispanic, and Native veterans than ever before. Today, we have the honor of welcoming two new organizations, Service Women's Action Network and the Black Veterans Empowerment Council, to the conversation. This marks the first time that these two organizations have participated in our spring VSO hearings and continues this committee's new tradition of welcoming these voices to the witness table.

It is our country's diversity that strengthens our Armed Forces and veterans communities, and minority veterans deserve to feel safe and welcome when they enter VA's doors, with outreaching, programming, and solutions that address their unique needs.

Additionally, VA must acknowledge the diversity of its workforce to address systemic discrimination in the workplace. We must ensure that health care and benefits are fairly and equitably distributed to all eligible veterans and, to do that, we must ensure a safe and equitable workplace for VA employees.

Our work to prevent veteran suicide also continues. We must relentlessly pursue well-researched and scientifically sound policies that are proven to prevent suicide.

We have big goals, but I know that with your support and insight here today, along with the support of the Biden/Harris administration, we will be able to deliver on them and fulfill the promises we have made to our Nation's veterans.

I look forward to hearing your testimony today and thank you for your continued advocacy and support for the veteran community.

I will yield back.

Chairman TESTER. The outstanding Senator from Kansas, Senator Moran.

OPENING STATEMENT OF HON. JERRY MORAN, RANKING MEMBER, U.S. SENATOR FROM KANSAS

Senator MORAN. Mr. Chairman, thank you very much. I welcome you and us joining our House colleagues for the hearing today. I welcome the Commander in Chief of the Veterans of Foreign Wars, and our panelists that follow this first panel, and I am all ears and interested in hearing what is said, and how we can react and respond to make sure that those requests are honored.

I welcome all of our witnesses and I welcome all of the veterans, and particularly members of veterans service organizations, at home, who are watching today's hearing, and I highlight the number of Kansans who are doing that and I thank them for their input to me on an ongoing basis.

We have accomplished a lot together in recent years: legislation to reduce veteran suicide; improve access and choice in health care; resources to improve disability claims and the appeals process; educational benefit protection expansion; flexibility to assist veterans through the COVID–19 pandemic.

I expect these bipartisan efforts to continue. It gives me pleasure, Chairman Tester, to tell Kansans when I am home and visiting about the partisanship or the divide in the country and in this Congress, that while I prefer to be the chairman of the committee, you can't tell a lot of difference in the outcome and the ability for us to work together whether it is Chairman Tester or Chairman Moran, and I am grateful for that. And Kansans are assured, reassured that there is a circumstance in which maybe the partisanship of this place is set aside—and they want that many more places than it exists, but they are pleased to know that it is true when it comes to caring for our men and women who have served our country, and I appreciate that very much.

And I continue to commit to working with you, Chairman Tester, to see that we get outcomes. I always appreciate being complimented for my efforts, but I would love to be complimented for my results.

We have a lot yet to discuss on how to appropriately address toxic exposure, both on the health care and disability compensation side, and I thank the chairman again and Representative Ranking Member Bost for our work on the Health Care for Burn Pits Veterans Act. And I look forward to working with all House members and Senators in whatever party to find a solution that is in the best interests of all veterans.

We need the VSOs' advocacy, their partnership. I appreciate the relationships I have with each of you and your organizations and your members, and we have a lot that we can do with your information and knowledge. I always indicate that mostly what I know about what should be my job on this committee is what veterans at home tell me should be my job on this committee, and it often, unfortunately, comes through what we call case work, somebody bringing us a problem that they have. We work hard to solve the problem for that veteran, but it also is a reminder that other vet-

erans are in similar circumstances and we need to fix the system as well.

Before I yield back, I want to again, as I did yesterday, thank all of our U.S. service members currently serving in NATO countries, including those from home in the First Infantry Division who are in Poland and Romania, and we have had a lot of folks recently deployed as well from other places across the country. I hope the Ukranian people and I hope that the service men and women of the United States of America know that they are in our thoughts and prayers and, just as they are serving us today, our commitment to them will be the same as those who have served us in the past. We will do everything to honor your service and make sure that the promises that were made to you are kept.

Again, I thank you for being here. I look forward to your testimony.

And I yield back, Mr. Chairman.

Chairman TESTER. Ranking Member Bost.

OPENING STATEMENT OF HON. MIKE BOST, RANKING MEMBER, U.S. REPRESENTATIVE FROM ILLINOIS

Mr. BOST. Thank you, Mr. Chairman. And I want to thank you and Ranking Member Moran, and I know that Chairman Takano is on the floor. I would be on the floor, but the pretest that we had to have before we were to go to the State of Union last night, Monday, when I did that, they discovered COVID. And I feel great, but I am coming to you from a quarantine in a hotel room. But it is good to be with you.

And for those of you that have not met me yet, my name is Mike Bost. I know what it is like to put on the uniform and serve this Nation, I also know what it is like to take it off that uniform and transition back to civilian life. Like many of you, the principles I learned in the Marine Corps still have application today.

I also know what it is like to file a claim for benefits, and to be denied and denied and denied, and that is why it is that I am so passionate. And the other reason I am so passionate is, not only am I a veteran, I have a father who served in Korea and a grandfather who served in Korea; an uncle who served in Vietnam that was a victim of the ultimate oxymoron friendly fire, he is doing well today, but he is 100-percent disabled. And also my son is a Lieutenant Colonel in the Corps, and my grandson is a Lance Corporal in the Corps.

So it is very personal to me the issues that we face and these joint hearings that we are doing annually are vitally important to get your input, so that we can have it to carry your ideas and your concerns to try to correct those problems. And it is vital that we meet with the VSO leaders and the members from across the country like those that we are meeting with today. You understand the complex problems veterans and their families face, and what VA can do better to help them.

Your advocacy here in D.C. and your service throughout the country makes a difference.

The COVID–19 pandemic created a hardship for veterans in all walks of life. Volunteer activities suffered during the past 2 years. VFW and the members of the VSOs represented here today are

needing more than ever to be advocates for the veterans, understanding their needs and helping them navigate the VA bureaucracy.

I want to thank each and every one of you for your service in uniform and your continued service.

I am proud of what we have accomplished together in the first session of this Congress. We expanded VA's ability to offer vaccines to veterans and their families; we improved veterans job training and education; we increased transparency of VA's COVID emergency funds; we provided new mental health resources, especially for rural veterans; we strengthened security in VA medical centers; we passed the largest veterans cost-of-living increase to cushion the impact of rising inflation.

I am also proud that the VA cut through red tape to fill thousands of medical positions. And the veterans suicide rate went down for the first time in years, but we have a lot more to do. But, as you know, our work—and you know our work is never over.

The most important issues we are working on right now is supporting toxic-exposed veterans. Each of us have made improving care and benefits for toxic-exposed veterans our top priority this Congress. I know it is only March, but time is getting painfully short. It is time for us to put our heads together and work across the aisle and across the Capitol to get this done for veterans.

I understand that passage of a single, comprehensive package is preferred by many. I believe we must take action where we can and give toxic-exposed veterans health care now. With the Senate's unanimous passage of the Health Care for Burn Pits Veterans Act in February, we have that opportunity. The House should pass the Health Care for Burn Pits Veterans Act today; it is the right first step. And then we should work together to deliver the other benefits and services toxic-exposed veterans need and deserve as soon as possible.

I again want to thank Senator Tester and Moran for their leadership and for finding a viable path forward to address the health care needs of toxic-exposed veterans. Your organizations have also been a critical advocate on toxic exposures.

I thank you for the work that you have done and I thank you for the work I know you will keep doing until we get to the finish line. I know that all of you will continue to fight for the best interests of this Nation and our veterans, and I promise you that I will do it as well.

And, with that, I will yield back.

Chairman TESTER. Next, I want to introduce Ryan Gallucci, who will introduce the VFW team, and then kick it back to Ranking Member Bost, who will introduce Commander Mihelcic for the opening statement.

You have the floor, Mr. Gallucci.

INTRODUCTION BY RYAN GALLUCCI

Mr. GALLUCCI. Thank you, Mr. Chairman.

Members of the Senate and House Veterans' Affairs Committees, we look forward to the day when once again the VFW and our Auxiliary can pack this room to hear from our National Commander.

But, thankfully, many are still able to join us via video link at the Hyatt, Crystal City, and it is my honor to introduce them.

First, from the VFW Auxiliary, National President Jean Hamil from Florida. Next, our National Officers of the VFW; Senior Vice Commander in Chief Tim Borland from Arizona; Junior Vice Commander in Chief Dwayne Sarmiento from New Jersey; our past Commanders in Chief, our national officers, our National Council of Administration; all our VFW and Auxiliary leaders and staff; as well as the VFW and Auxiliary members watching around the world, especially our comrades like VFW National Staff member Tara Artiaga, our claims representative from San Juan, Puerto Rico, who is currently deployed supporting NATO on the doorstep of the war in Ukraine.

Finally, joining here at the table, to my left, Director of the VFW National Veterans Service, Patrick Murray from Rhode Island; and, to my right, Chairman of the VFW National Legislative Committee, Jason Hoffman from Illinois.

Thank you, Mr. Chairman.

And now to introduce our Commander in Chief of the Veterans of Foreign Wars of the United States, ranking member of the House Veterans' Affairs Committee, Mike Bost, representing Illinois' 12th District.

INTRODUCTION BY THE HONORABLE MIKE BOST

Mr. BOST. Well, thank you. And, once again, it is good to have everybody here.

Yes, I am pleased to introduce my constituent, VFW's new Commander in Chief, Matthew M. Fritz—Mihelcic, who is with us today from Sparta, Illinois.

As a lifetime member of Post 2698 in Sparta, Fritz has been a member of the VFW for more than 30 years. He has long been a leader in our Southern Illinois community and I am grateful that he is now leading our veterans on the national stage.

Fritz served in the United States Air National Guard from 1989 to 1999, with the 131st Tactical Fighter Wing. He deployed overseas from 1990 to 1991, during Desert Shield and Desert Storm, as a security policeman. We like to refer to those as MPs. And he then went on to hold a number of vital leadership positions at the local, State, and national level.

Fritz, thank you for your service then and now. There is a special place for Americans who are willing to dedicate their lives to serving a cause greater than one person or a place. Veterans across the country are lucky to have you at their side, both as an advocate and as a friend, and I am proud to count myself among them.

With that, I will now turn it over to you, Fritz.

PANEL I

STATEMENT OF MATTHEW "FRITZ" MIHELCIC,
ACCOMPANIED BY
PATRICK MURRAY, RYAN GALLUCCI; AND JAY HOFFMAN

Mr. MIHELCIC. Thank you very much.

Before I begin my remarks, I would like to point out my Legislative Chairman, Jay Hoffman, who is sitting next to me. Today, Jay is wearing his Korean War Veteran grandfather's VFW cap, and that is very special to Jay and it shows what the VFW is all about: family, tradition, and generations of service. So, thank you, Jay.

Chairman Tester and Takano, Ranking Members Moran and Bost, members of the Senate and House Committees on Veterans' Affairs, it is my honor to be with you today on behalf of the 1.5 million members of the Veterans of Foreign Wars of the United States and its Auxiliary, America's largest wartime veterans organization.

I would like to thank the members of the committee on your hard work for veterans in the 117th Congress. During a time of divisive partisanship and a global pandemic, you have worked across the aisle and across chambers to pass legislation to improve the care and benefits for America's veterans, families, and caregivers. The House and Senate Committees on Veterans' Affairs continue to remain as shining examples of how work should be conducted in Washington, DC.

For generations, veterans have returned home from war with an array of unexplained health conditions and illnesses associated with the toxic exposures and environmental hazards they encountered in service. Today is no different and toxic exposure has become synonymous with military service. For this reason, the time is now for Congress to change the way veterans receive health care and benefits to help save our lives.

At this joint hearing last year and in hearings in April and May 2021, the VFW called upon Congress to work in a bipartisan manner and with veterans service organizations to develop a comprehensive solution for toxic exposure. You heard our message and you took several pieces of VFW-supported legislation and put them together.

The VFW supports Senate bill S. 3003, Cost of War Act of 2021; and House bill H.R. 3967, Honoring Our PACT Act of 2021.

We are also encouraged by the bipartisan and bicameral efforts to move each component of these larger bills across the finish line, such as H.R. 6659 and S. 3541, but these are just first steps in a long-overdue process.

These historic pieces of legislation would help millions of veterans exposed to toxins. They would address the still-lingering conditions and locations for Vietnam War veterans exposed to Agent Orange. It would take care of atomic veterans and veterans from K–2 base in Uzbekistan. Each has a significant focus on burn pits and improving the Department of Veterans Affairs disability claims process.

The time is now to pass these bills and finally address the needs of sick and disabled veterans.

We must work together to reconcile these two comprehensive legislative packages and pass a final bill swiftly. We must learn from the past and not delay any longer. We must end the piecemeal approach of addressing the problem one disease and one location at a time. We must fix the process now for all veterans of the past, present, and future. This is all the more timely as even now our

troops who guard the gates of freedom face uncertainty in Europe and all around the world.

In order to utilize the care and benefits veterans have earned, they must have faith and confidence in a dependable and veteran-focused claims process.

Due to the chaos of the COVID–19 pandemic, veterans faced unprecedented challenges in accessing and understanding their rights to competent representation for benefits claims. As a result, bad actors seized the opportunity to aggressively target veterans online, seeking to charge predatory fees to assist with benefit claims. While we never stopped working for veterans, the VFW has learned a great deal about how to better communicate the right to no-cost, quality representation. And we look forward to working with VA to clamp down on those bad actors.

Adjudicating certain claims such as toxic exposure, PTSD, and military sexual trauma, also known as MST, requires specialty training and regular oversight.

According to a 2018 VA OIG report, VA incorrectly adjudicated half of the reviewed PTSD claims for MST. The OIG indicated six specific recommendations for VA to review and correct denied claims, and to implement a series of changes needed to improve claims processing for MST. Regrettably, the most recent OIG report just 6 months ago found that VA had not effectively implemented those recommendations.

The time is now to fix this.

VA's national screening program screens all patients enrolled in VA for MST. National data from this program revealed that about one in three women and 1 in 50 men respond affirmatively to having experienced sexual trauma while serving their country. All veterans who screen positive are offered a referral for free MST-related treatment. The VFW believes this should start a similar process that refers veterans who have experienced MST to also begin the claims process immediately.

Forcing these veterans to fight again and again for treatment and benefits they have earned is not only cruel and unnecessary, it creates a duplicative appeals claims process. The best way to ensure veterans receive the care and benefits they have earned is to get it right the first time.

To address the current workload of VA disability claims, the VFW believes that there is only so much more hiring personnel will accomplish, and it will take time to train this new influx of hires.

The VBA also needs significant investment in its IT claims processing infrastructure to move to a single, unified system, and that includes the latest in automation and artificial intelligence technologies. A digital benefits upgrade, similar in scope to the GI Bill, would require a significant investment in VA's IT budget and a strong collaboration with VSOs that provide claims representation.

We commend VA for embracing technology upgrades such as the digital GI Bill, and we look forward to all the positive outcomes this new platform will bring.

Benefits like the GI Bill, VR&E, VA home loans, and VET TEC all set up veterans for success. The transformative benefits under VBA need to be enhanced, protected, and championed at all times, and that is why the VFW calls for the creation of a fourth estate,

a fourth administration, so the C&P benefits and the readjustment benefits currently within VBA can have their own under secretaries who can truly focus and grow each respective set of benefits.

The VFW believes a proper and well-rounded transition from the military is one of the most important things our service members need in order to ease back into our society with minimal hardship. To that extent, the VFW places great emphasis on ensuring veterans receive the best counseling and mentorship before they leave military service.

The VFW is happy to see some changes that have been made in the TAP program in the past years in order to bring a more tailored, personalized experience to transitioning service members, and increasing access to family members. We are pleased to see DOD and VA have finally begun implementing a single, unified electronic health record. However, the VFW sees additional areas for improvement, such as including accredited service officers in the formal TAP curriculum.

Additionally, we want to see, as the law requires, a proper connection between service members and organizations in the community that already receive Federal grant funding for this critical mission.

Separating service members need to be informed about all of the available care and benefits they have earned through their service, and that is difficult to achieve in only 5 days. Transition information needs to be pushed to service members throughout their time in uniform and TAP classes need to be restructured so service members are not, as we have so often heard, drinking from a fire hose.

Specific care and benefits are important for all veterans and it is important we highlight the needs of some who in the past have been overlooked. Minority veterans' health outcomes are affected by real and perceived bias. As the population of minority veterans continues to grow, VA needs to adapt to meet the need for access to both health care and benefits services.

Women, LGBTQ+, racial, and ethnic minorities face barriers and challenges across different life domains. We need to know the specific demographics and needs of that veteran population. The VFW urges VA to ensure that all VA forms and research capture this valuable basic demographic information to correctly track needs, benefits, and services. Until this is corrected, inconsistent data hinders proper and inclusive research.

For years, VFW has come to Congress concerned about veteran suicide. We have all worked together on a number of innovations to try to address this national tragedy. Sadly, without proper demographic data and reporting on all aspects of VA usage to include benefit usage, it is impossible to know which programs are actually helping.

Our veterans should receive first-rate care in our facilities. When COVID–19 hit, the VA health care system was the only health care network in the country to not only withstand the unprecedented challenge, but to also provide help through the fourth mission in towns and U.S. cities across the U.S.

Unfortunately, VA's aging infrastructure needs increased attention. VA's aging infrastructure not only causes many veterans to

wait too long and to travel too far for care, but also potentially endangers the health and lives of veteran patients and VA personnel.

To overcome VA's infrastructure challenges, Congress must not only provide significantly increased funding to fully address these long-standing issues, but also enact comprehensive planning, budgeting, management, and oversight reforms to ensure more effective use of those funds. The VFW recommends VA's construction budget be approximately 3 percent of its overall operating budget annually.

Lastly, the VFW honors our solemn oath to never leave our brothers and sisters, our comrades in arms, behind. We must never leave any missing or unaccounted-for Americans behind on battlefields of the past, the present, or, yes, the future. We urge Congress to continue fully funding and supporting the critical mission of the Defense Personnel Accounting Agency to make sure we bring every American service member home.

Chairman Tester and Takano, Ranking Members Moran and Bost, other distinguished members of these committees, speaking for all of the members of the Veterans of Foreign Wars and its Auxiliary, and on behalf of millions of service members, veterans, and their families around the world, I would like to thank you for your time and attention.

I will leave you with my call to action and remind everybody that the time is now to address these critical issues.

Thank you. This concludes my remarks and I am prepared to answer any questions you may have.

[The prepared statement of Mr. Mihelcic appears on page 69 of the Appendix.]

Chairman TESTER. Commander Mihelcic, thank you very much for those comments.

Before I get to my questions—and, by the way, for the members of the House and the Senate, the questions will be 3 minutes, not 5 as usual—I do want to recognize the VFW members that are viewing this hearing via video, I believe in a hotel in Crystal City, if I am not mistaken. And so welcome to all of the folks that are watching the action here in the hearing room. It is good to have you here.

Commander Mihelcic, thank you very much for your testimony. You wrote that any VA presumptive process should be codified so that future administrations will continue to be held to the same standard. I hear what you are saying and I agree with what you are saying, but could you flesh that out a little more and talk about what could happen if we don't?

Mr. MIHELCIC. Thank you, sir.

When it comes to administrative law, we know things can change easily with a changing administration or a changing viewpoint from the top. When you have that going on, veterans are left in a vacuum, they don't know from day to day what is going to happen. By codifying these ideas, by codifying this, we put it into law, we place it in your capable hands to pass a law, and it will stay there. It will not be open to the vagaries of politics, but it will be open to what the people want, veterans' care.

Chairman TESTER. Thank you very much.

I would like to get the VFW's general views on VA care. Would it be fair to say that most of your members prefer getting their health care from the VA?

Mr. MIHELCIC. Through anecdotal evidence, we have found that, yes, indeed, we do enjoy VA care. When you go to a VA facility for health care, they know you; they know you are a veteran, they want to take care of you, they understand what you have been through. You don't get that in the private sector.

Chairman TESTER. Do you and your members believe that community providers should be held to the same standard as we hold VA providers?

Mr. MIHELCIC. Of course. We have medical standards all over. I would say that, if we have a standard, anyone who provides care to a veteran must uphold that standard.

Chairman TESTER. And then, finally, on the VA care front, is the VA helping veterans make informed decisions about where to get care by comparing quality at the Department and the community?

Mr. MIHELCIC. We do need more outreach. I fear that our veterans don't really know what is available to them or maybe they don't understand, and that is something VFW needs to do a better job about. We can reach out to millions of veterans and let them know what they can do and what they can't do, but it has to be a partnership between the VA, the VFW, and other VSOs.

Chairman TESTER. So, in your testimony, you said that through advocates like the VFW veterans can get free and competent help to file a claim. However, you also warned about bad actors targeting veterans with predatory fees for claim assistance. What should Congress be doing to protect veterans from being exploited?

Mr. MIHELCIC. Well, much like any time when you have bad actors exploiting the population in general, such as usury laws, you can come out and say we will not stand for this. If there is bad advertising, if there is any way that someone comes forward and says, you are a veteran, I can assure you you will get 100 percent, and, if we don't, don't worry, we will take it to appeal, all of this adds up.

Many of our veterans are not as savvy when it comes to law and that is why we come forward and we tell people this is what you can do.

Chairman TESTER. Thank you.

Chairman Takano is now in the house, so I will recognize him for his questions.

HON. MARK TAKANO, CHAIRMAN,
U.S. REPRESENTATIVE FROM CALIFORNIA

Chairman TAKANO. Thank you, Chairman Tester.

Commander Mihelcic, good to see you again, good to see you this morning. I just came off the floor of the House. We concluded debate on the PACT Act. We are going to consider a couple amendments tomorrow, three amendments tomorrow, but we are pretty much done with the debate on the underlying bill, but one of the principal objections that was raised to the bill was its cost. And, as an example, as a corollary to that example, a big sign was posted that veterans are taxpayers too.

You know, I understand that we are all taxpayers, but do you believe, sir, Commander, that—do you believe that your members, your veteran members would be willing to use taxpayer dollars to provide benefits that we make available in the PACT Act to compensate veterans who are ill from exposure to things like burn pits?

Mr. MIHELCIC. Veterans stand united in this. The cost of war includes the cost of peace. Dollars have to be spent to take care of our sick and disabled veterans, and I can assure you that veterans will stand behind you 100 percent to get this PACT Act across the finish line.

Chairman TAKANO. I thank you for that.

What strikes me is that we have both political parties falling over themselves to offer more assistance to Ukraine, which I heartily approve of, I side with and I stand with freedom-loving people who are being besieged by bullies, but I am wondering where is the one-upmanship when it comes to the unfinished business of keeping our promise to our veterans? Can we not expect a political environment or create one in which both political parties fall over themselves to make sure that we take care of our veterans who have been exposed to toxic exposures?

Mr. MIHELCIC. It is unfortunate that, when the peace comes, people forget about veterans. So we have to provide more diligence and get out to our veteran community, but Congress can also do that. You have the larger voice. We saw that last night when the President spent a lot of time talking about veterans and veterans' issues. That will get the public's attention.

So we are fully engaged and fully committed to make everyone aware that veterans' issues are important, they are not going away, and with things going on in Ukraine today, we have our troops stationed nearby. Will they be the next people downwind from a toxic exposure? This will never go away.

Chairman TAKANO. Well, thank you, Commander. I was very proud to see our President mention veterans, the word "veteran" many times over, I guess three times more than the last three State of the Unions. So I was very pleased that so much time was devoted to veterans.

I yield back.

Mr. LEVIN [presiding]. Thank you, Chairman Takano.

I now recognize Senator Moran for questions.

Senator MORAN. Thank you, Congressman.

Commander, hello again. I failed in my comments earlier to thank you for your presence in Kansas City. It is a little bit across the State line, but we are proud to have the headquarters of the VFW so close in our neighborhood. And also the VFW Auxiliary, I should have mentioned their importance and value in serving veterans, and I thank them and their members and their leadership.

The VA provided views on the Cost of War Act in July of last year and Secretary McDonough noted that he has, quote, "authority to establish regulatory presumptions of service connections where no statute expressly provides such presumptions," end quote.

I understand the conversation, the testimony in response to Senator Tester's question about the value of having Congress address these, but I want to again point out that the Secretary admits and it is our view he has—a Secretary has the authority to do so.

In the last year and as recently as yesterday, the VA has taken action on 12 new presumptions, as we heard last night. There are still 20-something diseases across various bills being proposed as additional presumptions. The Biden administration indicated their support, as the chairman just indicated, for the PACT Act. Do you expect the VA to begin the rulemaking process to add these presumptions if they are supportive of the PACT Act and the Secretary admits that he has the authority to do so? While we take care of our legislative business, would it be appropriate for the Department of Veterans Affairs to proceed in their rulemaking to bring these presumptions online as quickly as possible, would that make sense?

Mr. MIHELCIC. Not only do I expect it, I demand it.

Senator MORAN. Thank you.

Do you know any reason that the Administration would be reluctant to do that?

Mr. MIHELCIC. I don't see a reason. We can certainly have two things going at the same time. We can have VA continuing forward, working on new presumptions, which is within their right, it is a regulatory matter, but wouldn't it be better if society as a whole saw not only the VA, one small part of the Government doing that, but also these esteemed bodies in front of me coming out and saying we are on board, we are doing it too.

Senator MORAN. Commander, I appreciate you using the word "esteemed" in front of these bodies. It is not something that is said every day these days. But I also would confirm or affirm to you that I too believe that the legislature, the Congress has a significant role. We are the lawmakers. In fact, I often complain that administrations do things that are in the realm of Congress' responsibility under our Constitution, but in this case we have granted the Secretary that authority to proceed.

Let me ask a slightly different topic, on a different topic. I sent a letter to the President this week regarding the need to fill longstanding vacancies in critical positions at the Department of Veterans Affairs. Could you speak how the absence of an Under Secretary for Health and an Under Secretary for Benefits has impacted veterans and their dependents for health care and benefits?

Mr. MIHELCIC. These positions are leadership positions within the VA. If we don't have leaders, how can we address the needs of our veterans? We are fully on board. If people are coming up, if people need to be confirmed, we should get on that right away, get them in the leadership positions, let them do the job that they have been hired to do, and that is help veterans.

Senator MORAN. I thank you for both of your answers. I would highlight that, in addition to be confirmed, they also need to be nominated.

Thank you.

Mr. LEVIN. Thank you, Senator.

I now recognize Ranking Member Bost.

Mr. BOST. Thank you, Mr. Chairman.

So I am going to go down a little different path, if I could, Fritz. I need to know because—one of the things you brought up that is very much a concern that we have been working on and that is the amount of veterans that are committing suicide. We know that it

held for 20 years—or it has held for many, many years at 20 of those—now, it did fall in 2019 slightly, but it is still way too many. And of those 20 that commit suicide a day, only six of them have ever sought help from the VA.

And I am concerned about something, and I am going to guess you know too and if you have heard it, many of the veterans that I talk with don't seek help quite often because of a rule that has been put in place by the previous administrations and never been corrected, and that is the fact that if you seek help from the VA and you receive a fiduciary, that fiduciary being assigned to you automatically triggers that the veteran would be turned into the NICS program and they would lose their Second Amendment right.

Are you aware of that?

Mr. MIHELCIC. Yes, sir, I am.

Mr. BOST. Okay. Well, I have a bill, because I believe many of our veterans choose not to go to the VA because of that. How is that veterans who served and protect all of our rights in the Constitution can have their rights unconstitutionally removed and without a—what any person who is not a veteran would automatically get the opportunity to go before a judge and that judge would then rule if they were a danger to themselves or others, and that is the only way they can lose it.

I am carrying a bill at this time and I know you are trying to support that, and I would like to have you comment on it, if you can, that basically takes that power away from the VA and allows it to go to the courts just like anybody else and you don't automatically get triggered for a fiduciary taking care of the veteran?

Mr. MIHELCIC. I appreciate that, sir. And of course, coming from southern Illinois, you know, we do enjoy the different rights that are afforded to us and of course the Second Amendment being one of those rights.

We, the VFW, firmly believe that if we do not ask questions, we will not get people coming forward to tell us if they are contemplating or considering suicide. We certainly believe that it is appropriate to ask that question in a non-mandatory, non-binding way, but to simply say, how are you feeling today? Have you had issues? Are there stressors? Is COVID–19 causing—do you have thoughts of harming yourself?

The mere fact that we are asking that question, it is going to save lives. If we save one life, we can do that. I am not for automatically taking a person's firearms away because they are being truthful and they are seeking help.

We fully support you in your goal and your effort, but we have to ensure that we still ask the question. A person can certainly decline to answer and that is within their right. But I believe, as you are saying, we need to have something going forward that VA personnel can talk to people. If we talk to them, we can help them.

Mr. BOST. My time is expired, but I do want to say thank you to all of you for what you do because you are that front line that can meet with those. And I do thank you and I will continue to listen to the debate today, and I thank you all for being here.

Mr. LEVIN. I thank the Ranking Member. I will recognize myself.

Commander Mihelcic, thank you again for joining us today. And I want to give a special shout-out to VFW Post 10577 in Oceanside

and 9934 in Dana Point, California, which both do a wonderful job of serving veterans in my district.

As chair of the Economic Opportunity Subcommittee, I share several of the economic priorities you outlined in your testimony, such as ensuring funding for job training programs, extending COVID-related protections for student veterans, and creating parity between active and Reserve component education benefits.

On that last item, I was thrilled that the House passed H.R. 1836, my Guard and Reserve GI Bill Parity Act, in January on an overwhelming bipartisan basis, and I want to thank VFW in particular. Your support was instrumental to achieving the outcome, and I hope that my Senate colleagues will advance the legislation soon.

It is shameful that we have asked Guard and Reserve members to step up in response to natural disasters, the pandemic, and an attack on our democracy without crediting them for each day in uniform, and it is long past time that we provide some basic fairness in the way we allow Guard and Reserve members to accrue GI Bill benefits.

Commander Mihelcic, can you speak to the impact this bill would have on veterans of the reserve components?

Mr. MIHELCIC. Speaking as a former Air Guardsman, this would be a wonderful benefit. When we sign up, we go through the same training, we are deployed at the same rates, we are put in the same situations as our active duty counterparts. To then say you are a second class soldier doesn't sit well. And I think since the Gulf War we have seen in this country that members of the Guard and Reserve are not second class soldiers.

So we applaud your efforts in this. Every day in uniform should count toward a veteran benefit and we thank you for that.

Mr. LEVIN. Thank you.

What would you say to those who might argue that parity is unnecessary because service members know their GI Bill eligibility when joining the Guard or Reserve?

Mr. MIHELCIC. I can speak personally to that. When I enlisted in the Air Guard, I was already a judge in the real world. Nobody told me about GI Bills or benefits.

When I returned from the war and was put back into regular Guard status, even as an attorney, I didn't know my benefits. Back then, we didn't have briefings for Guard, we didn't have TAP for Guard, we were left to our own devices. I say any information we can impart to our service members, whether they are active, Guard, or Reserve, that will make them better capable of understanding their rights and their earned benefits we have to do.

Mr. LEVIN. And what would you say to those who are concerned about the cost of expanding eligibility?

Mr. MIHELCIC. Once again, if someone is willing to put on a uniform and go into harm's way on behalf of their country, what difference does it make whether they are Guard, Reserve, or active? They all go out, they all fight, they all bleed red, why should we not take care of them just as they are? They are all soldiers; whether they are full-time or citizen soldiers, we have to take care of them.

Mr. LEVIN. Well, I am out of time, but, Commander, I look forward to working with you and VFW to get this across the finish line.

And, Mr. Chairman, I will yield back.

Chairman TESTER [presiding]. Senator Cassidy.

HON. SENATOR BILL CASSIDY,
U.S. SENATOR FROM LOUISIANA

Senator CASSIDY. Thank you, Mr. Chairman.

First, let me give a shout-out to all my Louisiana people. You survived Mardi Gras, you are up here the day after. So good to see you and good to see you kind of surviving the celebration.

Commander, thank you all for all you have done and continue to do. I asked the question yesterday, I will ask it again today. I have learned that the majority of suicides among those who—of veterans are within the first 6 months after separating.

Now, we have been pushing DOD and the VA to kind of coordinate their EHRs so that, hopefully, if somebody is identified at risk while in the DOD, there will be just a wraparound bubble, if you will, placed as this person separates.

But I have also learned that the average time between leaving the service and your first appointment at the VA, the minimal time is 6 months, and yet most suicides occur within the first 6 months. I have asked the VA this. The VA says that, listen, they do everything they can to go to that point where somebody is separating and to—as you point out, when you signed up, nobody told you about benefits; when you left, nobody told you about benefits—to do the best they can to tell people about benefits and get them lined up with the services they need.

So I guess my question to you—and maybe you will have to survey your members and get back to me—is to what degree is that working and to what degree—it may not matter what somebody does when they depart the service, they are just going to have a rocky time—or know the VA could do a better job. What are your thoughts on that?

Mr. MIHELCIC. A lot of that is on veterans service organizations. We are out there, we get to people. We want them to come and join us, see us. We can tell them what their benefits are, we can let them know that VA is available. However, in TAP, we do not have our own accredited service officers. So that is missing. That is the one time we can get somebody, right before they leave service, and tell them these VA benefits are available, you need to take advantage of them. And, again, we do it at no cost.

If that is not being taught in TAP, if we have a contractor who is merely reading a piece of paper and saying, yes, your benefits are this, and they drone on and then they go to the next topic, that is not going to stick with a separating troop.

We need to be there, we need to show them that veterans service organizations like the Veterans of Foreign Wars care. Give us a few moments in that 5-day TAP curriculum to tell them we are here, we know what you have been through, we can tell you how you can better help yourself.

So that is on us. Veterans service organizations have to do more, but VA needs to meet with us and allow us to do that.

Senator CASSIDY. Thank you for your perspective, your honesty, and your offer to continue your service.

With that, I yield back, Mr. Chairman.

Chairman TESTER. Representative Radewagen.

HON. AUMUA AMATA COLEMAN RADEWAGEN,
U.S. REPRESENTATIVE FROM AMERICAN SAMOA

Mrs. RADEWAGEN. Thank you, Chairman Tester, Chairman Takano, and Ranking Members Moran and Bost. Thank you all to the VSOs for your testimony. I have been on the Veterans' Affairs Committee for four terms now and I cannot understate how important these regular joint hearings are.

Our VSOs are the gatekeepers for our veterans' voices in Washington. The work you all do to ensure that our veterans are afforded the benefits and services they have earned is so important, and I want to thank you for all you do and for your service to our Nation.

I want to extend a special *mahalo* to the VFW Hawaiian delegation for making the effort each year to reach out to my office and brief my staff on your work. Thank you for all you do on behalf of our Pacific veterans as we move forward with the second session of this Congress and continue to address veterans' issues. I know that your priorities and goals will be at the forefront of our mission to improve the lives of our veterans.

Your priorities are my priorities. We will continue to work on comprehensive toxic exposure reform and ensure veterans are receiving care and compensation for the health conditions and illnesses associated with the toxic exposures and environmental hazards they encountered in service. We also aim to reduce and eventually eliminate veteran suicide, military sexual trauma, and ensure that all of our service members have better access to mental health care.

I hope to continue serving on the Veterans' Affairs Committee, and achieve these and all the other legislative goals on behalf of our veterans.

I want you to know that my colleagues and I, on both sides of the aisle and in both chambers, value your input and hold your efforts in the very highest regard.

Thank you again for being here today and thank you for your service to our grateful Nation.

Thank you, Mr. Chairman. I yield.

Chairman TESTER. Representative Brownley.

HON. JULIA BROWNLEY,
U.S. REPRESENTATIVE FROM CALIFORNIA

Ms. BROWNLEY. Thank you, Chairman Tester. And thank you, Commander, for being here, and thank you and all the men and women that you represent. You know, I thank you for your service and really I thank you for your continued service to reach out in your communities to help and support veterans that need your help. So thank you very, very much for that.

Commander, I recently introduced a bill that we are calling the Elizabeth Dole Act of 2022, and this bill is really about addressing

long-term care for our veterans, for both our senior veterans and for our disabled veterans.

I think within the veteran population, 50 percent of the veteran population is 65 years or older, and still the preponderance of care tends to be institutionalized care, nursing homes. I am trying to move away from that paradigm. I think every veteran, if they can receive care in their home, want to receive care in their home. And I think that is where we need to go and I think it is a win-win solution because I think, by so doing, we can actually save money and provide, I think, better care and better quality care. So that money savings we can reinvest into other—in other needed programs to serve our veterans.

So I don't know if you are familiar with the bill, but I wanted to ask you about it and ask if, you know, you think we are moving in the right direction. Do you support the bill and are we moving in the right direction, and how do you think your members are feeling?

Mr. MIHELCIC. Thank you, ma'am. I am familiar with your bill and the VFW fully supports that bill. It is our opinion that veterans serve with dignity, they have lived with dignity, and they have the right to care with dignity at their home. We really appreciate you putting that forward and our team is to help you in any way to move that bill further.

Ms. BROWNLEY. Well, thank you for that, Commander. That is music to my ears and I look forward—I really look forward to working with you on it. I agree with you, I think it is extremely important and I think we need to make sure we get it through the House and through the Senate, Mr. Chairman, and signed by our President.

So, with that, I will yield back, and thank you for the opportunity.

Chairman TESTER. Senator Boozman.

HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman. And thank you all so much for being here and all you represent.

The last several years, we have been able to enact a lot of legislation, realizing that these are gimmes, these are earned benefits, but we simply wouldn't have gotten that done without our veterans service organizations and nobody does a better job than you all. So give yourselves a pat on the back and we especially thank you.

We also want to thank the Auxiliaries. In reality, we know who does all the work. My wife reminds me also that they are also not only the worker bees, the ones who get all the work done, they are also the brains many times. So we do appreciate them also.

The MISSION Act was essentially essential for providing veterans with timely and quality health care. As I traveled across Arkansas, particularly in rural areas, I have heard that care, being referred and scheduled in community care takes longer than before.

Are you hearing from veterans that care being referred to the community is taking longer to get scheduled and, if so, why do you think that is, Commander?

Mr. MIHELCIC. Empirically, we find that the data show that access to health care times is actually doing quite well. However, anecdotally, we hear from our veterans who are concerned that they are not getting care in a timely manner. I believe that is more, again, on veterans service organizations to properly assist our veterans, to let them know that, if you need something today, if it is not critical, you may not get in today, but nonetheless, when you go through the VA system and you use the MISSION Act, you are going to get care faster than if you went out into the private sector.

So I think it is a matter of changing public opinion and you do that one person at a time by reaching out and explaining what the system is and how it really works.

Senator BOOZMAN. We appreciate that. I am an optometrist by training and it is difficult to access care in the community. So, again, that is very helpful.

One of the most common concerns I also hear from veterans in Arkansas is how long it takes the National Personnel Records Center in St. Louis to respond to requests from veterans for records. I understand some of this was caused by COVID and the workforce capacity limits placed by local officials. Have you heard also that this is an issue among your members and how big of an issue has this become?

As the country returns to its pre-pandemic normalcy, what recommendations do you have for us to try to help expedite the records process and going forward to prevent something like this from happening again?

Mr. MIHELCIC. First, if a veteran can't access military records, then we are all doing a disservice to that veteran. How can they access VA health care and benefits if they can't prove they were in the service? To that end, we are doing everything we can and, because this is a critical thing to me, I would like Mr. Murray to enlighten.

Mr. MURRAY. Senator Boozman, until very recently that center was working at about 25 percent capacity. Some of the veterans who need those records right now are some of our older veterans who don't have the time to wait. It is also continuing to grow the current backlog by not being able to take care of those. We need to make sure that that center is working at all full capacity, obviously, as safely as possible, but we need to get that job done. They need to be working at a hundred percent to take care of the veterans who need it now.

Senator BOOZMAN. Well, I agree totally. Again, thank you all. Thank you so much for all that you represent and just the wonderful work that you do. I appreciate it.

Chairman TESTER. Representative Rosendale.

HON. MATTHEW ROSENDALE,
U.S. REPRESENTATIVE FROM MONTANA

Mr. ROSENDALE. Thank you, Mr. Chair. I appreciate it.

Commander Mihelcic, the bad actors that you were referring to earlier that are taking advantage of our veterans and making these phone calls and getting them to invest in things that probably aren't giving them much of a return, unfortunately, the Veterans

Administration is subject to the same type of deception and lost investment as those veterans are.

For example, are you familiar with the Cerner system that has been contracted by the Veterans Administration for the EHR?

Mr. MIHELCIC. Yes, sir, I am.

Mr. ROSENDALE. Okay. Are you aware that they have been working on this system for approximately 18 months at the Spokane Veterans Hospital?

Mr. MIHELCIC. Yes, sir.

Mr. ROSENDALE. Are you aware that there are 500 safety violation claims that took place there?

Mr. MIHELCIC. I am aware of the violations, yes, sir.

Mr. ROSENDALE. Okay. Are you aware of the poll that was conducted of their entire staff where 80 percent of their staff said they were considering other employment opportunities as a direct result of the Cerner program that is being implemented there?

Mr. MIHELCIC. I have heard that, yes, sir.

Mr. ROSENDALE. Okay. Did you know that after 18 months and $2.7 billion that we still don't have a fully functional system at that one facility, which we were supposed to be rolling out to all 179 VA hospitals across the nation?

Mr. MIHELCIC. Yes, sir.

Mr. ROSENDALE. Okay. It doesn't sound like a great investment. We had assurances from Secretary McDonough that he was not going to move forward until that system was fully functional in Spokane, and yet right now we have a schedule to start rolling this out at the Columbus facility and in Walla Walla. Would you say that, if this is not fully functional, can I receive from you assurances that you would give us in writing your opposition to rolling it out in any other facilities?

Mr. MIHELCIC. At this time, I can't say that, sir. The reason being, a lot of these violations were missed referrals or erroneous medications. We look at that as insufficient training and missed opportunities. The mere fact that this is not working at this one location in Spokane should not hinder us from beginning this at another location. Use the lessons learned, plus and minus, to create another system at another location and we continue to move forward. If we wait on one location to determine whether it is going to pass or fail, we will never get the proper systems in place to help veterans.

Mr. ROSENDALE. So you think that it is wise to roll out a system that is not working, that we have spent $2.7 billion on, on other facilities?

Mr. MIHELCIC. If we look at DOD using the same system, it works there. And that is what I was talking about the training and the missed opportunities. We do not throw the baby out with the bathwater.

We have to look at it holistically. If it is working somewhere else, then it must be working somehow. Let's put that together. Again, best practices from DOD, worst practices from Spokane. Let's move together and get something working. But if we wait and do nothing, people die.

Mr. ROSENDALE. Mr. Chair, I see I am out of time. I yield back.

Chairman TESTER. Representative Pappas.

HON. CHRIS PAPPAS,
U.S. REPRESENTATIVE FROM NEW HAMPSHIRE

Mr. PAPPAS. Thanks very much, Mr. Chairman. And I want to thank, Commander, you and your team for your presentation today and your ongoing partnership, which I think really makes a difference and helps point our committees in the House and Senate in the right direction.

I also want to thank any of my friends from the New Hampshire VFW that are watching in Crystal City. I always appreciate hearing from them.

So, Commander, I wanted to ask you a question. I have heard from some constituents about a really disturbing practice, it is the issue of unaccredited claim consultants, I would refer to them as claim sharks, that are charging veterans thousands of dollars just for filing disability benefits claims, a service that we know otherwise can be free or provided by VSOs or other advocates.

So, because they are unaccredited, these claim sharks aren't subject to VA standards and they avoid regulatory oversight, they target veterans with exploitative practices, financial exploitation, they engage in predatory and other unethical practices.

So I am just curious if VFW shares concerns about these claim sharks and if you think it is a problem that Congress should be addressing?

Mr. MIHELCIC. Well, I thank you very much for that. Again, being an attorney, I see the ads all the time on the television, and it makes me cringe how these predatory practices, they do prey on unsuspecting victims when it comes to unaccredited claims people—I am sorry, I lost track—when it comes to unaccredited claims servicers. Why can't we go after them? Do we have a law that says we will only pull over a person who has a valid driver's license? No. We pull them over. If they don't have a valid driver's license, they can get a penalty. So let's open the aperture. Let's go after anybody, whether they are unaccredited or accredited. If they are involved in predatory practices that involve veterans' claims, we should be able to go after them and put them out of business.

The VFW provides no cost veteran service. That is what we should be shouting from the rooftops.

Mr. PAPPAS. Thanks for highlighting that work, and I know we are planning a hearing in our committee in the House, and we would love to keep you apprised of that, and hopefully can continue to work with you on that issue.

One final thing I have, you talked a little bit about parody. And I just know from my experience in New Hampshire, the Guard has served us in tremendous ways, especially over the last few years, we have seen their sacrifice on full display. And we know that during times of national emergency the are called upon, relied upon, but aren't always credited for those activations as they should be.

I have got a bill I am introducing. It is the Record of Military Service for Members of the Armed Forces Act. It looks to ensure that all members of the Reserve components, including the Guard, are provided the same DD–214 form as other members of the Armed Forces. So just if you have any quick thoughts on, you know, Reserve components without a standardize DD–214 and why this legislation potentially could be important.

Mr. MIHELCIC. I firmly believe that total force means total force, not separate force. We should not have different pieces of paper for different components. If you served, you should get the document. We talked about a DD–214. Whatever we call it, anybody who serves in any capacity should have the same document so when they show it to somebody, they don't have to explain, "Well, I was in this branch. I did this. That is why my form looks different."

Let's standardize. Let's modernize. And let's get with it.

Mr. PAPPAS. Thanks, Commander. I yield back.

Chairman TESTER. Senator Sullivan.

HON. DAN SULLIVAN,
U.S. SENATOR FROM ALASKA

Senator SULLIVAN. Thank you, Mr. Chairman. And, Commander, thank you to you and your team. I really appreciate all the great work and guidance you provide this committee. I want to do a shout-out to some of my fellow veterans from Alaska, who I am sure are watching. You know, we have more veterans per capita than any State in the country. We are very proud of that. The committee knows that because I say it in every hearing. But I am also a proud member of the VFW Post 9785 in Eagle River, Alaska. Any of you gentlemen ever been there? Had a beer there? Yes?

Mr. MIHELCIC. I had a Coke there, sir.

Senator SULLIVAN. Okay.

Mr. MIHELCIC. It is a beautiful post.

Senator SULLIVAN. Well, you know, next time you are in Alaska, come on out. We will have a Coke, or a beer, or whatever you and your team want to have.

So I want to talk about two issues in my time here. I think it was—at the State of the Union last night, I will be honest here, there were some areas that I wasn't fully supportive of the President's vision or ideas. But I will tell you this, I think it was very appreciated the amount of time he spent on the toxic exposure and burn pit issue. This is a topic I have actually discussed at length with the President himself. I know he cares about it. This is something Senator Manchin and I have been working on for quite some time, our bill S. 437, which was one of the first that kind of got out there and looked at the issues of liability.

Can you just explain briefly why you think this is such an important issue for all of our veterans, but the VFW in particular? Not focused on any one particular bill, but the need to get on it, address it, and get in front of it so we don't have an Agent Orange type of situation like we had in Vietnam, you know, a generation ago?

Mr. MIHELCIC. I am going to let Mr. Murray take this one, only because I am not quite sure what you are asking and I don't want to mislead you in any way.

Senator SULLIVAN. Great. Mr. Murray.

Mr. MURRAY. So, Senator, we support that bill, as we do——

Senator SULLIVAN. S. 437?

Mr. MURRAY. Yes, sir. But amongst others. But the reason it is important, and the VFW, I believe, represents it very well. We are a multi-generational organization. Some of these comprehensive bills cover folks from Iraq, and Afghanistan, and K2, and the Gulf War——

Senator SULLIVAN. Right.

Mr. MURRAY [continuing]. And Vietnam. It is needed because this is long overdue. Service and toxic exposure are synonymous. Your service, our service, it is something that every single day we could wake up and be exposed to some kind of nasty substances. That is why these bills—the comprehensive bills that take care of everybody: foreign, domestic, past, present, and future is incredibly important.

Senator SULLIVAN. Great. Thank you for that. Real quick, because I am almost out of time here, but you did mention, Commander, in your testimony the importance of telehealth, particularly serving rural veterans. Our committee has been very focused on that. Can you expand just a bit more on your focus and your testimony on the importance of telehealth for our rural veterans. I think it is a great area of focus for the VFW, because a lot of our veterans live in rural communities, rural States.

Mr. MURRAY. This is the 21st century. Why aren't we using telehealth? The recent pandemic has shown us that we can do things using computers, using telehealth. Why not? People who want to say let's go back to the old ways, they are just wrong. And people who live in rural areas who can't drive 50, 100 miles for a checkup, this is going to save lives. If we can't use technology, then we are lost. There is no reason for us to go back to the way we did things before. Let's learn our lessons from COVID–19. Let's increase the use of telehealth. Let's get more people involved in the VA system who never were able to get involved before because it was too far. This is one way, using outreach, that we can get more people in. They will get their earned health benefits and their earned claims benefits.

Senator SULLIVAN. Great. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Representative Sablan.

HON. GREGORIO KILILI CAMACHO SABLAN, U.S. REPRESENTATIVE FROM NORTHERN MARIANA ISLANDS

Mr. SABLAN. Yes. Thank you very much, Mr. Chairman. I would like to welcome all of our witnesses. I have truly enjoyed this annual convening of hearings to listen to our VSOs because, you know, as a veteran, and many of us at times know what your veterans want, and I am particularly fond of today's hearing because VFW is the only VSO in my district, in the Northern Marianas. And I would like to give a shout-out and a welcome to Washington, DC. to retired lieutenant colonel and former—prisoner of war, Mr. Peter Callahan. So welcome to DC, and I understand you are in Crystal City.

I want to thank again VFW. I have a question, if I may, Commander. You mentioned several times the importance of communicating, whether it is between DOD, VA, or between a veterans and his or her provider, and you may—I think you would agree with me that some of the need for communication rests with those veterans who are in the most remotest part of this world.

So I have introduced a bill, H.R. 3730, that would establish a VA advisory committee for veterans residing in the U.S. territories and the—States. I would appreciate it if you would—you and your colleagues would look over that legislation and see if you could sup-

port it. It really makes a lot of difference for the veterans in these parts of the world.

Mr. MIHELCIC. Thank you, sir. I can tell you that we unequivocally support your bill. This is the 21st century. There is technology. The world is getting smaller. We can reach any portion of this earth using satellites, using communications. There is no reason we can't reach somebody in the Northern Marianas and get them a VA appointment in a timely manner. We do support——

Mr. SABLAN. Thank you, Commander, again. And thank you to VFW for being the first—VSO and the—in the Northern Marianas. Chairman Tester, I yield back.

Chairman TESTER. Representative Slotkin.

HON. ELISSA SLOTKIN,
U.S. REPRESENTATIVE FROM MICHIGAN

Ms. SLOTKIN. Well, thank you for being here. Thank you for addressing both the House and Senate on issues that we know are really important. And in Michigan, we are recovering—I am from Michigan, we are recovering from punch key day, not the New Orleans version, but the Michigan version, which is a very heavy Polish donut that we all eat.

Thank you for all that you all do. I think we were all happy to hear the amount of time the President talked about veterans issues, and the one that is personal to me is burn pits. I am a former CIA officer. I served three tours alongside the military and lived near a burn pit, as we all—almost all of us did in Iraq. And myself and Congressman Meyer, a Republican from Michigan, who also served in Iraq, we have this Veterans Burn Pit Exposure Recognition Act.

And we are basically trying to make sure, I think all of us are trying to make sure, that burn pits don't become the Agent Orange of the post-9/11 generation, right? That we don't wait 40 years to recognize the exposure as we did with our Vietnam veterans, and we do better.

Can you talk to us about what we need to do. Obviously, the legislation is critical. But what else can we do to raise attention, to get the focus on this issue so that we don't have that clock going for 40 years?

Mr. MIHELCIC. First, ma'am, I can tell you we support you and your bill 100 percent. There is no reason that any veteran should have to wait the 40 or 50 years that our Vietnam veterans had to wait. That was a travesty. And we here today can work to say that will never happen again. We know what is going on. We know that it wasn't just Vietnam veterans. It is veterans of all ages, all times.

As far as recognition, I have 1.5 million members of my organization. And it is very easy for me through our VFW action corps to send a notice out, and it reaches all of those veterans instantly and tells them about your bills.

So we, and all of the other VSOs have a captive audience. We will work with you. My colleagues at the table will reach out to you. We will find out the particulars, and we will work with you to get the voice out. When you have a lot of people behind it, we all vote, and we will reach out to our representatives and ask them to support your bill.

Ms. SLOTKIN. I appreciate that. I think the VFW is an amazing organization, and it is just very clear to me. Sometimes I talk to folks who aren't veterans and they just—when I talk about burn pits, they—just a little bit of a blank stare. You know, it hasn't really seeped into the bloodstream the way Agent Orange has.

And anything we can do together collaboratively to get the word out and make it more of a public issue, I would appreciate. With that, Mr. Chairman, I yield back.

Chairman TESTER. Representative Ruiz.

HON. RAUL RUIZ,
U.S. REPRESENTATIVE FROM CALIFORNIA

Mr. RUIZ. Thank you, Mr. Chairman. How long is long enough? How long must our servicemembers wait before their suffering from exposure to burn pits and other toxins is recognized? How long must they shoulder the burden to prove their pain or illness is real and a result of their service.

For our Vietnam veterans, the answer was nearly 20 years before the VA granted a presumption of service connection for many illnesses and diseases. And shockingly, they are still fighting. It has now been over two decades since 9/11, and the VA has estimated that 3.5 million of our post-9/11 veterans served in areas where they may have been exposed to burn pits and other toxic substances. And yet the VA is still not covering the health care veterans who sustained these injuries while serving our country. Why is that? What—have we not learned our lesson?

We cannot afford to repeat history by denying our servicemembers proper benefits and care. Congress must act now. Studies on the health effects of open air waste burning can be traced back to the 1990s, when concerns about health risks began to rise from returning Gulf War veterans. Yet we continue to argue that more studies are needed before we can prove our veterans' illnesses are related to their service.

As a physician and public health expert, I understand the necessity for studies and the importance of understanding the science behind illness and disease, but that has been done here.

The evidence has shown us time and time again that there is a connection between the illnesses veterans are being diagnosed with and their service near burn pits. It doesn't take research to understand that carcinogens cause cancer. And carcinogens are found in the burn pits' toxic smoke. Years later, the veterans are becoming delayed casualties of war, as they develop long term respiratory illnesses and cancers because of their exposure. We don't need more studies to understand where the illness and cancers are coming from. We need service. We need to follow the evidence that presumes service connection for all 23 illnesses listed in the Honoring Our PACT Act.

My first question, Commander Fritz, can you explain why it is imperative that any legislation passed by Congress includes a presumption of service connection, and why anything less is a dereliction of our duty?

Mr. MIHELCIC. Yes, sir. Why should we put the burden on a veteran to show that something they breathed caused them harm? It is so easy for Congress right now, and as a medical professional,

you know, you can tell that causation and effect, you know what is there. If something happens to a veteran, we can tell that. And I say the time is now to pass the PACT Act, so we put these presumptions in, so when a veteran comes forward and says I served in this location, the VA must say we will presume that you have these conditions, and we will take care of you.

Mr. RUIZ. Thank you very much.

Chairman TESTER. Senator Tillis.

HON. THOM TILLIS,
U.S. SENATOR FROM NORTH CAROLINA

Senator TILLIS. Thank you, Mr. Chairman. And thank you for the work, and are committed to get a bill passed out that had elements of the TEAM Act that my office worked on. It was great. Unanimous bill. Glad to get it out of the Senate, and looking forward to getting it to the President's desk.

I think when we are talking—incidentally, I was pleased to hear what President Biden had to say last night about presumptions. I do believe that we need to provide clarity and certainty by codifying some of these presumptions moving forward.

I think most people if they are watching, they don't know what a presumption is. And what people need to understand is when you have got a veteran who is going in, thinks they have got an illness, knows that they had some sort of exposure, they are already in a crisis situation.

We do need to flip the script and make it easier for them to get the care they deserve. So I will continue to work on that.

I want to talk a little bit, first off, about telehealth and what we saw during COVID times. You know, we took emergency measures, expanded access to telehealth, and I for one think that we found some really good uses for it that I believe should be a part of standard operating procedure.

Can you all give me any sense of where you are on that? Any specific areas that we should focus on?

Mr. MIHELCIC. Mr. Gallucci is our expert on that. And I wanted to give him some time to speak.

Mr. GALLUCCI. Thank you, Comrade Commander, and thank you Senator Tillis. This is something that we think a lot about. The VFW is one of the pilot organizations for VA's Project Atlas. All five of our sites are operational and have been for quite some time.

We have seen the most patience through Project Atlas, but we have only seen 100 patients. What we are asking VA now is, is there a more efficient way to deliver this telehealth.

You know, one of our strongest assets in the Veterans of Foreign Wars is the physical infrastructure we have around the country. We truly believe in a program like this, and we want to lean forward with that infrastructure to help deliver telehealth, but is there an easier way to do it? Is there a better way to get that message out to the veterans who can use it?

You know, our posts have leaned forward throughout the pandemic, offering—you know, coming together and sewing masks for veterans, or even hosting VA for things like vaccination clinics and also mobile vet centers, or whatever it took.

I think we can lean forward with that infrastructure similarly to reach veterans where they need that help. But also, there are the broadband deserts for highly rural veterans. And we are really looking forward, VA is convening a meeting of organizations here very shortly about what we can do about that. And the VFW is proud to come to the table there.

Senator TILLIS. Well, hopefully with our bipartisan support of the infrastructure bill and $65 billion going into broadband in particular that will also see some benefit to the unserved or underserved areas across the country. I am about to run out of time. I did want to also say that we are having a hearing, I am the ranking member on personnel subcommittee. And a part of this discussion about toxic exposures, we have got to do better at actually predicting when we are exposing servicemen and women to toxic substances a lot earlier in the life cycle.

So we are having a hearing this week to talk about what we should do to make sure that we are capturing information in the electronic health record, that we are doing a better job of setting up protocols if we even suspect that something could actually result in a bad outcome for a service member, long before they become a veteran. And I think if we do that, we get ahead of the curve, then we are going to be much more likely to be in a position to provide treatment, and then maybe even look out to veterans and identify them as being at risk long before they know they may have been.

And hopefully through that, we cannot have to go through Agent Orange, burn pits, and the next potential disaster for our veterans. And you can count on me to continue to work for it. Thank you, Mr. Chair.

Chairman TESTER. Senator Hassan.

HON. MARGARET WOOD HASSAN,
U.S. SENATOR FROM NEW HAMPSHIRE

Senator HASSAN. Well, thank you, Mr. Chair, and ranking members for this hearing and this panel. And thank you to our witnesses for your service and the work that you do to support our veterans. Before I ask a question, I want to recognize the testimony provided already by our witnesses on veterans exposed to toxic substances, as we have just been talking about.

I was glad to hear the VA announce yesterday that it will propose adding rare respiratory cancers as a presumed service connection condition, a measure that my colleagues and I have pushed for in response to the needs of veterans.

The VA and Congress need to continue to work together so that veterans exposed to toxic substances have the health care and disability benefits that they have earned, and that they deserve, and I will continue with working with my colleagues to ensure that Congress passes bipartisan legislation.

Now, I did want to start with a question, Commander, to you about the home loan guarantee program. This Congress, I led a bipartisan call for improvements to the VA home loan guarantee program. I consistently hear from—State veterans about how the current housing market affects their ability to use this program.

I was certainly glad to see that VFW's written testimony is consistent with my push for conducting further outreach to lenders,

real estate agents, and veterans on how to best utilize the VA home loan guarantee program. But, Commander, what further recommendations does VFW have for Congress so that we can support veterans who want to buy a home using this VA program, but are currently unable to do so?

Mr. MIHELCIC. Well, the first thing, you do need to make it easier.

Senator HASSAN. Yes.

Mr. MIHELCIC. As a recipient of a VA home loan many years ago, I had trouble getting through that. Nobody understood it. There was extra paperwork. Why do we have to do this? Why can't we charge you more? All of those issues are problems.

Senator HASSAN. Yes.

Mr. MIHELCIC. And we can fix this, and it is all a matter of information, enlightening, getting people to understand what is going on. My feeling is there is no problem that can't be solved if you put more information out to people so they can understand what the problem is.

Senator HASSAN. Right. And simplify the process, though, as well. So I appreciate that. One more question in my remaining time, again for you, Commander. A New Hampshire National Guardsman and Reservist swear to defend the constitution and this country, just as their active duty counterparts do, and they deserve the same respect and recognition. That is why I introduced bipartisan legislation with Senators Shaheen, Cramer, and Hoeven to reform the Veterans Cemetery Grants program, to ensure that all members of Reserve components and the National Guard are eligible to be buried in State veterans cemeteries.

I was glad to see the VFW note their support of this legislation in today's written testimony. Commander, can you speak to VFW's support for this bill and why burial eligibility should not restrict State cemeteries from receiving critical VA cemetery grant funding?

Mr. MIHELCIC. Yes, ma'am. We do support you 100 percent. Again, it goes back to total force.

Senator HASSAN. Right.

Mr. MIHELCIC. If someone joins the military, whether they are in the Guard, the Reserve, or the active component, they have served. They deserve all of the rights available to them. And that includes being able to be buried in the hallowed ground of a veteran cemetery. We fully support that. Some people don't get activated. That is great. Thank God they didn't have to go into harm's way. But nonetheless, they put the uniform on and they served. So we need to take care of them, not only in life but in death also.

Senator HASSAN. Thank you very much. Thank you, Mr. Chair.

Chairman TESTER. So we have Representatives Mrvan, Banks, and Gallego. And that will be that for this panel, because we have got another one to get to. So Representative Mrvan, go ahead.

HON. FRANK MRVAN,
U.S. REPRESENTATIVE FROM INDIANA

Mr. MRVAN. Thank you, Chairman. Commander Mihelcic, VFW is a current user of the Veteran Benefits Management System, and

we know from Independent Budget recommendations for VA that modernization of this system is a priority for you.

I have two questions. What is the current state of the system, and how is that impacting your ability to assist veterans with access to benefits? And then secondly, is VBMS technologically equipped to handle the anticipated influx of toxic exposure claims on anticipated congressional action on this issue today?

Mr. MIHELCIC. I could certainly answer that, but I have an expert sitting right next to me on my left, and he is going to provide you with more information than you could ever want on this topic.

Mr. MURRAY. Thank you, Commander. I will keep the every bit of information possible to a minimum. But the VBMS system is not an entirely comprehensive system to take care of benefits management. It is also about a dozen years old. It is time for a revamp of that system.

In terms of IT, 12-years-old is a lifetime. So it is time that we invest heavily into the IT infrastructure of VA to improve the Benefits Management System. And to your question about is VBMS capable of handling the workload if we were to suddenly flip the switch for the PACT Act, for example, we can't hire enough people to adjudicate those claims in a timely fashion, without also an IT upgrade for that system.

We believe similar to what happened with the digital GI bill, a digital benefits upgrade is necessary in order to make the people that are doing that work more efficient every single day.

Mr. MRVAN. I thank you very much. I appreciate that. And as the chairman of Technology Modernization, the subcommittee chair, we will do everything in our power to make sure that that infrastructure is moving in the right direction to be able to get the tools necessary to be efficient when we come to processing those claims.

I thank you for you opinion, and with that, I yield back.

Chairman TESTER. Representative Banks.

HON. JIM BANKS,
U.S. REPRESENTATIVE FROM INDIANA

Mr. BANKS. Thank you, Mr. Chairman.

Commander, as you know, many of us are concerned about the mental health of our veterans, and I am concerned that the endless COVID lockdowns have forced many of our veterans into isolation, cost them their jobs, and diminished many of their health care opportunities.

Commander Mihelcic, how has COVID affected veteran mental health from your perspective; and what can we do more of to alleviate some of those concerns and problems?

Mr. MIHELCIC. Well, certainly isolation will bring a person down. And if they are not able to get out to get—see a physician, see their doctors, they don't get asked those questions of how you were feeling.

I am very proud to say that our VFW posts are opening now. We are open. We are available. We are pockets of patriotism. We are there for a person to come in, and sit down, and talk to a VFW member about how things are going, because it doesn't make any difference what war you served in or what uniform you wore. The

fact is, we all went through the same thing. And if a person is not feeling right, they can come in and sit down. Maybe they go to Eagle River and have a Coke. But when they do that, they are sharing, and they are talking. And when they can do that, we can help with their mental health. I am not sure what more VA can do, but we can do it on our side of the fence by reaching out to our fellow veterans and say we understand. Come sit down with us. We can help you.

Mr. BANKS. Thank you for that. I think that is very important. Can you also talk for a minute about how COVID has affected veteran employment, and what we can do more generally to support veterans finding employment coming out of the pandemic?

Mr. MIHELCIC. Well, the great program Vet Tech has come about. Instead of them going to a 4-year school and using your GI bill benefits, you can go to a shortened school to learn a quick skill, a digital skill, information technology skill, in a few short months, you can come out and studies have shown that within 7 months of graduating with a certificate, our veterans are making over $60,000 a year on average.

So that is how we come out of the pandemic. That is how we get veterans back into the workforce. Don't force them to go to a 4-year degree. Let them go and take a program that will get them a skill—a life skill that they can use immediately, because when a person works, they have worth. And when they have worth, they don't kill themselves.

Mr. BANKS. Thank you for that. As a proud VFW member, I appreciate your feedback and your attendance here today.

Mr. Chairman, I yield back.

Chairman TESTER. Representative Gallego.

HON. RUBEN GALLEGO,
U.S. REPRESENTATIVE FROM ARIZONA

Mr. GALLEGO. Thank you. Mr. Mihelcic, your testimony discusses the need to improve suicide prevention, not only among veterans, but on active duty servicemembers too. That is why I join my colleague, Representative Miller-Meeks, in introducing the Save Our Servicemember Act, which includes some of the recommendations in your testimony, such as evaluating the effectiveness of DOD's suicide interventions and improving coordination with DOD. Can you expand why it is important for DOD to streamline its own suicide prevention efforts, and how that could help improve outcomes for veterans down the line as well. And also, can you also share any additional recommendations you have in this space?

Mr. MIHELCIC. DOD is the employer of these servicemembers. If we find that our—if our employees, our servicemembers are committing suicide, we owe it to our service members to get better training. I was in the service. I worked as a civilian in the Department of Defense. We did have a lot of suicide awareness training, but it was the same training every 6 months. You just click through. There was nothing new. We need to revamp that training. We need to get people to understand that this is serious, this is not just an oh, I have to get this done. How fast can I push the button?

If we push this to the side and make it just another ancillary training thing, people won't take it seriously. If we take it seriously, we will reduce veteran and active duty suicide.

Mr. GALLEGO. Thank you. As you know, the House is taking up the Honoring Our PACT Act this week to provide comprehensive services to those veterans who were exposed to burn pits and other toxins while serving. I, myself, was exposed to burn pits in Iraq, and I know many of your members have also suffered from this exposure and waited too long for care. I just want to ask you today, what is your message for Members of Congress that are on the fence about this important piece of legislation, or those who say we can't provide this care because it is too expensive?

Mr. MIHELCIC. I will take the last part first. This is not an expense. This is taking care of veterans who have earned their benefits. This is taking care of sick, and wounded, and injured veterans. There is just no sense. How could any right thinking American not vote for this PACT Act? I spoke about it this morning. I spoke about it here. This is what we call the no-brainer. How could you not honor America's veterans?

They went in harm's way for you. They came home. Don't forget them. There is nothing more I can say other than if you are on the fence, you need to get off the fence. You need to pick a side. History does not like people who do not decide. History will recall this week when the House is working on the PACT Act, and history will remember those people who did not vote to pass the PACT Act.

Mr. GALLEGO. I could not have said that any better. Thank you so much. I yield back my time.

Chairman TESTER. That is the end of panel one. I want to thank the VFW for being here. And I want to say, Commander Mihelcic, to my memory, I can't think of a national commander who has done a better job than you did today. So I want to—appreciate you all and your input.

Now, we will introduce the second panel. I will relieve you guys of your spots, and we will set up the second panel, which is an incredibly important panel, where we have multiple veteran services and advocacy organizations who represent and assist the diverse cross-section of veterans from around the country.

I want to tell the presenters here today, you have 5 minutes, and there are nine of you, I believe. And so time is money, as always. But as concise as you can be, the better off it is going to be because we want to hear your input.

And I am going to list these in the speaking order that is there. First, we are going to start with Jeremy Butler, Chief Executive Officer of the Iraq and Afghanistan Veterans of America, otherwise known as IAVA. Jeremy is here in person.

Next up to speak will be Michael Linnington, Chief Executive Officer of the Wounded Warrior Project, who is also here in person.

The third person to speak is going to be Jack McManus, who is here virtually. He is the president of the Vietnam Veterans of America.

Then, Gregory Heun, the National Commander at AMVETS, and he is here in person.

Next up, we have Kathryn Monet, the Chief Executive Officer of the National Coalition of Homeless Veterans, that is here virtually.

Next up is Lory Manning, Director of Government Operations at the Service Women's Action Network, otherwise known as SWAN. She is here in person.

Next up is Joseph D. McNeil, National President of the Blinded Veterans Association, otherwise known as BVA, and Joseph is here virtually.

Next up, we have Victor LaGroon, the Director of the Black Veterans Empowerment Council. And he is here in person.

And last, but certainly not least, we have Thomas Palladino, President of the National Association of State Directors of Veterans Affairs and Executive Director of the Texas Veterans Commission. That is a mouthful. And he is here virtually.

We will start with you, Jeremy, as I said earlier, 5 minutes. We appreciate you guys, appreciate all you guys, and we look forward to your testimony. Go ahead, Jeremy.

PANEL II

STATEMENT OF JEREMY BUTLER, CEO, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Mr. BUTLER. Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and distinguished members of the committees. On behalf of Iraq and Afghanistan Veterans of America, thank you for the opportunity to testify today. My submitted written testimony covers several IAVA priorities, but for my opening statement, I will focus on the one which is literally closest to all of us in terms of a path to success: the overdue need for comprehensive toxic exposure legislation.

This is my fourth year on the road, testifying before this joint body as CEO of IAVA, and every year, I have discussed the needs to address the health issues brought on by 20 years of burn pit usage in Iraq and Afghanistan. Small steps have been made, but like the incremental moves taken to address Agent Orange, we are much too late in the government owning up to this self-inflicted wounds.

Veterans are sick and too many have already died. Even though IAVA has been discussing this for more than 4 years, by no means were we the first or the loudest to raise this issue. In fact, the danger burn pit exposure was raised nearly from the beginning. In 2004, Dr. Robert Miller from Vanderbilt University began one of the first studies into the links between burn pits and illnesses when several seemingly fit soldiers were sent to him from Fort Campbell after failing fitness tests and presenting unexplained respiratory issues on their return from Iraq.

After performing lung biopsies, he found that dozens were suffering from constrictive bronchiolitis, which didn't show up on regular exams. The Army's fix to this problem was to stop sending soldiers to see him.

In 2006, an Air Force officer, back from serving his bio-environmental flight commander for Joint Base Balad wrote, "In my professional opinion, there is an acute health hazard for individuals. There is also the possibility for chronic health hazards associated with the smoke." Another officer, back from serving as chief of

aeromedical services for the 332nd Air Expeditionary wing at Balad wrote, "In my professional opinion, the known carcinogens and respiratory sensitizers released into the atmosphere by the burn pit present both an acute and chronic health hazard to our troops and the local population.

Their writing was in reference to the burn pit at the largest U.S. base in Iraq, home to 25,000 U.S. military personnel and several thousand contractors, where even though the military had three clean burning incinerators operating, officials acknowledge that the burn pit was still taking in 147 tons of waste per day. Significantly more than half the daily output at Balad.

And what was being burned included Styrofoam, unexploded ordinance, petroleum products, plastics, rubber, dining facility trash, paint insolvents, and medical waste that included amputated limbs. All resulting in likely exposure to contaminants that included benzine, arsenic, freon, carbon monoxide, ethyl benzine, formaldehyde, hydrogen cyanide, nitrogen dioxide, sulfuric acid, and xylene.

In 2012, a former epidemiologist for VA testified before Congress that VA officials were manipulating or hiding data that supported veterans' claims of illnesses related to burn pits. We know that the DOD contracted management of the burn pits out to private companies, such as KBR, even though the military's rules prohibited long-term use of burn pits. And when veterans tried to sue KBR because of the illnesses they believed were caused by the burn pits, US judges ruled that KBR had little discretion in how to dispose of the waste, as they were under military control, and the use of the burn pits was a military decision.

The judges further referred to the issue as a "political question" that Congress and the President should resolve, not the courts. And we know that in January 2019, the Supreme Court rejected those veterans' appeals—the circuit court ruling, and decided that more than 60 separate burn pit related lawsuits could not move forward.

Which brings us to today, and this body having the opportunity to do what the court stated Congress needs to do and resolve this political question. Passing the Honoring Our PACT Act in the House and the Cost of War Act in the Senate are how that is accomplished.

Half measures, phased approaches, and anything short of comprehensive toxic exposure legislation would leave this issue unresolved, leave countless veterans responsibility for continuing to fight their own government for what they were promised, and leave a gaping, self-inflicted wound to continue those who served honorably.

We know that we have already lost veterans to toxic exposure induced illnesses. We know that many others are sick. And we know that more will die. What we don't know is how much longer Congress will delay and make excuses. The only reason that comprehensive toxic exposure legislation has not passed is because of the financial cost. But there was virtually no debate by this body during the 20 years that the country sent millions to war, where they were repeatedly exposed to the hazards of burn pits. Burn pits

that were banned from use in the United States as far back as the 1970s.

The Pact Act is not partisan legislation. It was not created by politicians of either party. It was, in fact, a result of a coalition of veterans groups, representing the broad diversity of America's veteran population, who came together to create legislation that would address the unmet needs of those suffering from toxic exposure related illnesses.

So on behalf of the 3.5 million veterans who were exposed to burn pits and other airborne hazards, and on behalf of the veterans behind the nearly 70 percent of burn pit related claims that were denied by the VA, I implore you to pass the comprehensive toxic exposure legislation supported by nearly every veterans' group in the country, and finally keep America's promise to take care of those who fought to defend us. Thank you.

[The prepared statement of Mr. Butler appears on page 103 of the Appendix.]

Chairman TESTER. Wounded Warrior Project, Michael Linnington.

STATEMENT OF MICHAEL LINNINGTON, LIEUTENANT GENERAL, U.S. ARMY (RET.), CEO, WOUNDED WARRIOR PROJECT

Mr. LINNINGTON. Thank you, Chairman Tester. Chairmen, Ranking Members, and distinguished committee members, thank you for today's hearing.

Wounded Warrior Project was founded in 2003 with a simple and clear message: to honor and empower wounded warriors. For nearly 20 years, the servicemembers, veterans, families, and caregivers who we serve have been our inspiration for transforming the way America's veterans are empowered, employed, and engaged in our communities.

And just as so many of us are inspired by the brave spirit of Ukrainians fighting to preserve their freedom, we are reminded of the privilege we have to serve so many Americans who have done the same to protect the liberties we cherish.

Today, we are honoring their service by providing more that a dozen programs that promote mental, physical, and financial health and well being. We challenged ourselves to explore new ways to offer care and support to tens of thousands of wounded veterans, families, and caregivers. We did so through programs like our Warrior Care Network and Project Odyssey, where we connected warriors to more than 43,000 hours of PTSD treatment, find jobs, and social connection at a time when so many people had felt the stress of an uncertain economy and isolation.

We also reached out to more than 33,000 warriors who served in Afghanistan to offer care and support to any who needed it. We are also committed to raising awareness on policies most relevant to those we serve. Last week, that advocacy was delivered to many of you by warriors participating in our virtual operation advocacy. I am here to reinforce their efforts by speaking to those issues.

This year, our top priority is to support legislation that will guarantee access to health care, and improve the disability benefit process for veterans who suffered toxic exposures in service. In our

most recent survey, over 70 percent of warriors who served in Iraq and Afghanistan reported burn pit exposure, and the vast majority say it occurred on a daily basis.

Now, many of them are suffering from serious respiratory conditions, cancers, and other illnesses. Alarmingly, two-thirds of them say their exposure-related disability claims have been denied, and some of them have died because of their illnesses. We cannot let this continue, and we were pleased last night to hear the President announce efforts to address the challenges of toxic exposures.

Providing care and benefits to these warriors must be viewed as part of the cost of sending them to war. For this reason, Wounded Warrior Project strongly supports Chairman Tester's Cost of War Act and Chairman Takano's Honoring Our PACT Act, which would guarantee access to VA health care that does not expire, creates a presumption that certain diseases are related to exposure, and concedes that exposure occurred. Finally, providing post-9/11 veterans parody with what Congress has done for previous generations of exposed veterans. This is the comprehensive solution that warriors need and have earned.

Secondly, I would like to speak to the concerns being shared by many warriors and caregivers who have participated in VA's comprehensive caregiver program. This program recently began its long overdue expansion to pre-9/11 veterans and caregivers, expansion that we were proud to support. But new regulations have put this critical program beyond the reach of many who need it.

As predicted, many post-9/11 veterans and caregivers are expected to be removed from the program. Highly personal reassessments of legacy participants are well underway. And while VA should be commended for ensuring no sudden loss of benefits for these families, this year should invite a candid discussion on whether new regulations and new requirements are set in the right place to extend care and support to our most seriously injured warriors.

We appreciate Secretary McDonough's recent commitment to ensure program decisions are accurate, consistent, and clearly communicated. In the end, our vision is to work with VA to ensure that this critical program continues to support veterans who require great care and attention.

I will close by touching on two other key priorities for the remainder of the 117th Congress. The first is to continue support for the growing population of women veterans. Congress can do this by expanding access to gender-specific care, fostering ongoing connection and support, building safe and welcoming VA environments, and providing coordination of care and benefits for survivors of military sexual trauma.

The other priority is on mental health, which remains one of the most important challenges we face for post-9/11 veterans. Our most recent annual warrior survey shows that nearly 1 in 4 responding warriors had thoughts of suicide in the last year. This is a startling reminder that the VA must be a leader in evidence-based treatment and research, and a champion of wider community efforts to prevent veteran suicide.

The post-9/11 Veteran Mental Health Care Improvement Act and the Strong Veterans Act are two initiatives that have our strong

support. Ladies and gentlemen, it is my distinct honor to be here with you today, and I look forward to your questions.

[The prepared statement of Mr. Linnington appears on page 116 of the Appendix.]

Chairman TESTER. Next, we have Jack McManus from the Vietnam Veterans of America.

STATEMENT OF JACK MCMANUS,
NATIONAL PRESIDENT, VIETNAM VETERANS OF AMERICA

Mr. MCMANUS. Good afternoon. I wanted to thank you all for the good work that you are doing for the American people, particularly for our veterans and their families. This is not VVA's first time presenting the joint hearings of the congressional committees on veterans affairs. We have been the old guys on the hill for a long, long time. We are them old Vietnam vets. You see us walking your halls for many, many years.

You know who we represent, and more importantly, you know what we stand for, as citizens first and for all generations of veterans next. One of our missions is to ensure that the experiences of the Vietnam veteran generation is never repeated by our Nation.

Just as you know all about VVA, let it be said that we know all about you. We know that you work hard on these committees, and you are motivated by your love of our country, and your real and honest concern for those who chose to wear the uniform and sacrificed in so many ways for our still very young country.

It is you, our noble congressional leaders, that will assure the spirit learned from our Vietnam experiences will forever guide consciousness, the respect, and the future way veterans have valued and treated by our country.

There are other organizations who we continue to work with after many years, to help change the perception of the American military service members and their brave families. The Vietnam Veterans Memorial Foundation is celebrating the 40th anniversary of the wall dedication this year. After many years, all of us old Vietnam veterans are long gone, the 58,318 names etched on the big, black marble slab will be there to remind future generations of Americans no, never again.

For over a century, our country has honored our military heroes who made the ultimate sacrifice under combat conditions or during battle. Their families are awarded the privilege of wearing the gold star pin to honor their lost child, lost spouse, or lost parent.

VVA supports Congress in creating a means for recognizing and honoring the families of anyone who was lost during military service. We believe that this goal can be accomplished, and we will work with you to support the creation of a new honor, provided it does not diminish the traditions, criteria, and unique circumstances of the current gold star program.

For four decades, VVA has kept the fullest possible accounting for all POWs, MIA servicemembers as our solemn priority. We continue to support and collaborate with the National League of Families, the DPAA, and the Vietnamese veterans who are also working to identify their missing comrades in arms.

Time is of the essence. The fullest possible accounting of American POWs has long been our solemn priority. We must insist that Congress fund the defense POW/MIA accounting agency was what it is required to investigate all of the potential crash and burial sites, and to recover and identify remains.

We are amazed at the comprehensive way that this Congress has worked—with many of our veterans' wounds caused by exposure to toxic substances while serving our country. Thank you for including Vietnam and Agent Orange issues in the Honoring Our PACT Act. Some of the lingering life and death issues attributable to Agent Orange exposure are still unresolved for so many of our Vietnam vets after more than 50 years.

Obviously, we are delighted with the possibility of seeing some relief and care for those still living toxic-exposed veterans of Thailand, Cambodia, Laos, Guam, and the American Samoas.

The presumption of hypertension as an illness associated with Agent Orange exposure is long overdue, and was previously mandated by previous legislation. VA's own research confirms this presumption, yet it still stonewalls those who are seriously afflicted. Many have died without care or treatment to existing laws, have determined they should have received this care and treatment.

This bill is so remarkable by the inclusion of a real structural process for determining the conditions of presumptive illness. It removes the burden from the shoulders of the individual veteran. It respects them to the point of providing immediate care. And it neither disrespects nor devalues the veteran in need of assistance.

If Congress truly wants to provide solutions to the entire menu of toxic exposure issues, then VVA recommends from both our history and experience that piecemealing through phase legislation will never achieve a comprehensive solution. And unfortunately, many veterans will die waiting for the promise of future legislative phases to be approved or implemented.

Since we are limited to 5 minutes, I want to close up by saying that VVA invites and VVMF invited the honorable members of both committees and fellow VSOs to join us at the wall on National Vietnam Veterans Day, March 29th, for a ceremony and reception to honor Vietnam vets. Thank you very much.

[The prepared statement of Mr. McManus appears on page 152 of the Appendix.]

Chairman TESTER. Thank you. Next, from AMVETS, we have Greg Heun.

STATEMENT OF GREG HEUN,
NATIONAL COMMANDER, AMERICAN VETERANS

Mr. HEUN. Thank you, Chairman, ranking members, and members of this committee. As the largest veteran service organization, representing all of American veterans, AMVETS is honored to provide our legislative priorities for the remainder of the 117th Congress.

Last Memorial Day weekend, AMVETS hosted our first Rolling to Remember pro veterans demonstration ride here in Washington DC. This is the Nation's largest veterans event, which brings to-

gether tens of thousands of veterans and supporters from across the United States.

Riding their motorcycles to demand continued and increased action for the 82,000 servicemembers still missing in action, as well as raising awareness of the many veterans who died by suicide each day. This year's event will take place on May 29, 2022.

We will never forget our POWs and our MIAs, and we won't stop fighting for real solutions to a suicide crisis. 2021 was a tough year for veterans, and we expect it to have lasting repercussions. First, the disastrous withdrawal from Afghanistan increased the number of veterans approaching our heel team for assistance. Second, COVID has continued to kill and sicken many of our population, isolate others, stress our VA medical care employees, and leave many unemployed.

Sexual assault survivors watched as senior senators on the Senate Armed Service Committee stripped language from Military Justice Improvement Act that would have removed sexual assault from the oversight of their chain of command. A betrayal from the leaders who are in positions to protect our troops.

For the first time ever, the Pentagon denied veterans a permit for the annual Rolling to Remember Memorial Day ride. Most recently, our veterans and servicemembers are watching the situation in Ukraine unfold. Our prayers our with the people of Ukraine, our troops, and our NATO allies.

A fellow Kentuckian once said I am a firm believer in the people. If given the truth, they can be depended upon to meet any national crisis. The great point is to bring the real facts. That was Abraham Lincoln.

Here are the facts. We continue to average more than 6,000 veteran suicides every year, despite spending $15 billion a year on VA medical—mental health and suicide programs. 50 to 90 percent of our veterans walk out of VA programs and services never completing the recommended number of visits. No business or nonprofit losing 50 to 90 percent of its customers would call that a success. Nor would they scale that model.

AmVet's number one priority has and continues to be encouraging Congress to create and fund defective programs and services that significantly reduce suicide. Congress worked diligently to pass the John Scott Hannon Veterans Mental Health Care Act—Improvement Act of 2019. Nearly 2 years later, 12,000 veterans lost their lives in nothing but a static VA webpage.

Is this what we call progress? Is this what the VA and Congress calls urgency? With the $15 billion annual budget for mental health, we could fund 60 Wounded Warrior Projects or DAVs. Does anyone feel like this funding is having the impact of 60 of our largest veteran non-profits? We don't.

We have scaled overpriced, underperforming models, tens of thousands of veterans have died. Yet, Congress continues to support scaling broken options. Many Members of Congress have continued to argue on behalf of this broken model, while failing to do due diligence on the available alternatives, failing to look into the extraordinary drop out rates of VA programs and services, failing to hold meaningful hearings that include researchers that have highlighted the poor outcomes occurring at VA, failing to hold hear-

ings that include individuals who have presented robust longitudinal data on new and novel approaches that are resulting in veterans living high quality lives. Failing to conduct significant oversight, travel to better understanding the available alternatives.

Roughly four congressional committee staff are left to tackle this issue that results in more than 6,000 dead every year and 15 billion spent. That is four staff.

Members of this committee, you are the board members that oversees the notoriously underperforming mental health system with a budget of 60 DAVs. Our veterans' lives are counting on you to hold VA to act with a sense of urgency. We need a culture that demands better data-driven outcomes. We need a new model that immediately drives down suicide rates significantly and not marginally. We need a Congress that allocates serious staff and resources to this issue.

In our written testimony, we have outlined numerous approaches that Congress can take to get more proactive. We need you to take serious action.

Chairman, Ranking members, members of these committees, this concludes my testimony, and I am happy to take any questions you may have.

[The prepared statement of Mr. Heun appears on page 192 of the Appendix.]

Chairman TESTER. Thank you. Next up virtually we have from the National Coalition of Homeless Veterans, Kathryn Monet.

STATEMENT OF KATHRYN MONET,
EXECUTIVE DIRECTOR, NATIONAL HEADQUARTERS,
NATIONAL COALITION FOR HOMELESS VETERANS

Ms. MONET. Chairs Tester and Takano, Ranking Members Moran and Bost, and distinguished members of the committees, thank you for the opportunity to share NCHV's priorities with you today. We appreciate your leadership and continuing efforts to focus on the needs of veterans experiencing or at risk of homelessness.

The support Congress provided has resulted in billions of dollars in new resources being utilized nationwide to meet the COVID-related needs of veterans by decompressing shelter spaces, ramping up rapid re-housing capacity, and focusing on individualized housing options in hotels and motels.

I am going to start with the elephant in the room, and that is simply that we know what we know and we don't know what we don't know this year on homelessness.

HUD has recently released 2021—showed a drop of 10 percent in the shelter veteran population. But without good data on unsheltered veteran homelessness, that information is challenging, at best, to interpret. Despite this gap, we remain cautiously optimistic that we can continue to reduce veteran homelessness if we can maintain enhanced current initiatives.

As we turn the corner on COVID, we need to reimagine a system of care that meets the needs of veteran's basic housing and stability and does not leave anyone unsheltered. The pandemic has impacted veterans in unprecedented ways, and transitional housing programs like GBD are a critical component of VA's emergency response capacity for unsheltered veterans.

VA has recently notified grantees that Department of Health and Human Services public health emergency could be lifted as early as April. With many programmatic changes set to sunset at the end of the declared state of emergency, NCHV has identified some program adaptations that should be kept as best practices, and extended even beyond this emergency. These include making permanent and expanding the Section 4201 spending flexibility for SSVF grantees the ability to re-house—rapidly re-house, excuse me, veterans into hotels and motels, allowing VA to continue offering shallow subsidies to veterans in the SSVF program, supporting service providers as they continue to decongregate essential transitional housing capacity via capital grants, and increasing the permanent reimbursement rate for VA's GPD transitional housing program.

Some new legislative priorities that should be considered are creating grant making authority for the HUD-VASH program to address the additional acute needs of elderly, rural, and other priority populations, such as urban Indians, Alaskan natives, and native Hawaiians, expanding HCHV eligibility to veterans with other than honorable discharges and Guard and Reserve members who have not been called up, and improving the quality of HUD-VASH case management and continued congressional oversight over case management vacancies, contracting rates, and voucher utilization.

However, the number one challenge that I hear from NCHV members is related to planning for the over 60 percent decrease in allowable transitional housing reimbursement rates anticipated at the end of the public health emergency, if Congress fails to act.

We request that you address this issue immediately for the following reasons. One, many providers struggle to offer the services required of the program at the rate funded, even before the pandemic. But the 300 percent emergency rate allowed many to request funding that was more aligned with the actual cost of serving the veteran. Two, increases in the rate will better support operating costs for those who are reconfiguring facilities as the program shifts its inventory toward single room options from congregate settings. Three, congregate settings are still considered higher risk than a CDC. So many providers will still be maintaining COVID safety protocols after the end of the public health emergency. Four, non-profit organizations that have a heart for serving homeless veterans should not be subject to congressionally driven unfunded mandates that require the provision of a set menu of services at a rate that doesn't even begin to cover them. And five, many organizations receive a much higher rate from comparable VA transitional housing programs, like HCHV, which is also a program that is dramatically underfunded.

S. 2172 addresses this and other issues. And as such, NCHV and over 60 organizations urge prompt legislative action to reserve and enhance direly needed COVID–19 related improvements. Without a legislative fix, additional VA grantees will be forced to make tough financial decisions about whether to continue prioritizing COVID safety in congregate settings at a financial loss, returning to pre-COVID occupancy levels, or discontinuing essential shelter and treatment program operations all together.

This bill would reduce the regulatory burden on funding for renovations of shelters for all veterans experiencing homelessness, and

it would provide organizations nationwide with the funding and flexibility to provide adequate services to unhoused veterans.

There are other provisions in this bill, and the slew of accompanying House bills that go along with this, that are critical to our ability to address veteran homelessness.

For example, provisions that would allow VA to provide adequate training and technical assistance for its homeless programs, and provisions that would recognize the impact of the Department of Labor's HVRP program in terms of connecting veterans with long term, meaningful jobs. We have a renewed opportunity to continue reducing veteran homelessness nationwide.

In summation, thank you so much for your continued partnership to ensure that every veteran facing the housing crisis has access to safe, decent, and affordable housing, paired with the support services needed to remain stably housed.

[The prepared statement of Ms. Monet appears on page 209 of the Appendix.]

Chairman TESTER. Service Women's Action Network, Lory Manning.

STATEMENT OF LORY MANNING,
CAPTAIN (RET.), DIRECTOR OF GOVERNMENT OPERATIONS,
SERVICE WOMEN'S ACTION NETWORK

Ms. MANNING. Good afternoon. On behalf of the Service Women's Action Network, thank you for the opportunity to share SWAN's legislative agenda for 2022.

Since SWAN members are predominantly women veterans, I am going to concentrate on legislative priorities that we believe will improve the experiences of women veterans, and men too, who use VA services.

Our priorities are: one, ensuring women veterans feel safe, welcome, and well cared for when they visit VA facilities. We thank Congress for passing the Deborah Sampson Act as part of the Johnny Isakson and David Roe Veterans Health Care Act of 2021, which tasked the Secretary of Veterans Affairs with creating a comprehensive plan to eliminate the sexual assault and harassment of women veterans using VA facilities. And we stand by to assist VA in any way we can, and to work with your committees to ensure that this requirement is met.

Number two, fix the Veterans Benefits Administration's broken system for processing compensation and pension disability claims tied to military sexual trauma. Both Congress and VA have been working on this for many years. There have been congressional hearings, GAO reports, and reports from the VA Inspector General. Just over 6 months ago, a VA IG report found that 57 percent of denied MST claims were improperly processed. This broken system must be fixed.

Therefore, SWAN strongly supports the passage of the Servicemembers and Veterans Empowerment and Support Act of 2021, and we thank its sponsors in both houses, including Senators Tester, Murkowsi, and Congresswoman Pingree.

Three, reforming the Veterans Benefits Administration's character of discharge determination process. Over the years, many vet-

erans suffering from post-traumatic stress disorder due to combat, military sexual trauma, or other military experiences, as well as generations of LGBT veterans have been disqualified from VA benefits because they received other than honorable or bad conduct discharges tied to service-connected conditions, or simply because of who they were.

VBA has long had a remedy, the character of discharge determination so veterans unfairly discharged with either OTH or BCDs could receive health care and other benefits, even if they had not received a discharge upgrade from their service.

We would like to see VBA make better use of this process in aid of these veterans, and so we strongly support the passage of the Unlawful Turn-Aways Act, and we thank Senator Blumenthal and Congresswoman Underwood for introducing it.

We, of course, support the PACT Act and the Cost of War Act, and we believe all burn pit and toxic exposure studies must examine the effect of such exposures on the development of breast cancer and infertility in both men and women.

Five, the elimination of copays for contraceptives and widening access to in vitro fertilization. Most VA users are charged a copay for contraception. Considering the provisions of the ACA, that is disgraceful. We thank the House of Representatives for passing the Equal Access to Contraceptives for Veterans Act last June, and we ask the Senate to do the same.

We also ask Congress to expand access to in vitro fertilization treatment for all veterans with service-connected infertility. Right now, there is a rule limiting IVF treatment for veterans suffering from service-connected infertility to those in heterosexual marriages, and only if they can produce their own gametes and carry a fetus to term. Please open IVF treatment to all veterans suffering from service-connected infertility.

I deeply appreciate this opportunity to present SWAN's legislative priorities, which are so important to so many women veterans. Thank you for your time and consideration.

[The prepared statement of Ms. Manning appears on page 216 of the Appendix.]

Chairman TAKANO. Thank you, Ms. Monet. Thank you. I now would like to turn it over to recognize—excuse me, Captain Manning. Excuse me about that. For 5 minutes, Mr. McNeil. Mr. McNeil?

STATEMENT OF JOSEPH D. MCNEIL, SR., NATIONAL PRESIDENT, BLINDED VETERANS ASSOCIATION

Mr. MCNEIL. I am here. Thank you.

I want to present the way a blinded veteran would have to present anything in any [Audio malfunction.] Message content, [Audio malfunction.] Inbox. Message content. Good afternoon, I want to thank the committee for allowing us to present virtually and for the members who are watching.

Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and distinguished members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this opportunity to

present our legislative priorities for 2022. As the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families, BVA first wishes to point out March 28 is our anniversary of our 77th year of our founding by World War II blinded veterans at Avon Old Farms Convalescent Home in Connecticut in 1945.

BVA hopes that this second session of the 117th Congress will productively address the following legislative priorities: One, oversight of VA 508 compliance; two, caregiver benefits for catastrophically disabled blinded veterans; three, renewable VA Auto Grant for service-connected blinded veterans; four, support the continued improvement of programs and services for women veterans; five, support adequate funding of Veterans Health Administration Blind Rehabilitation Service; six, request the enactment of adequate protections for guide dogs and service dogs on Federal properties; seven, Defense Health Agency (DHA)-Blind Rehabilitation Service (BRS) Continuum of Care; eight, support the VA fiscal year 2023 Budget request for prosthetics and sensory aids.

I will highlight three of our priorities. One, oversight of VA 508 compliance. BVA thanks Congress for its continued support of our Nation's blind and visually impaired veterans, demonstrated most by the passage of S. 3587, the VA Website Accessibility Act of 2019. This bipartisan legislation directed VA to report to Congress on the accessibility of VA websites. This report shows that only 7.7 percent of all 812 VA websites are fully 508 compliant, which means they have failed. Uncovering a significant barrier that blind and visually impaired persons—including veterans and VA employees—have known for over two decades, it needs to come down.

The law requires that all VA websites, medical center check-in kiosks, and the new Cerner Electronic Health Record, be fully 508 compliant. BVA requests stronger congressional oversight and agency transparency on VA's progress of updating websites, files, and applications that are still inaccessible. BVA urges VA to create an Under Secretary of Accessibility to champion with the authority and subject matter expertise to lead VA's 508 compliance efforts.

Two: Caregiver benefits for catastrophically disabled blinded veterans. VA reported that 80 percent of all PCAFC applications for fiscal year 2021 were denied. BVA is concerned that blinded veterans are being discriminated against. Denied fair, adequate reasons and bases for PCAFC decisions and being denied access to their files has been unfairly and unlawfully inhibited their ability to appeal. There are gross violations of—[Audio malfunction.] And veterans face an ambiguous eligibility standard based on VA's rulemaking, which has made them cryptic and—I'm sorry, excuse me.

1620. Alert. Turn off airplane mode or use settings. OK. Button. Seven defense health agency—deep—this bipartisan—the law requires that all—The law requires that all VA websites, medical center check-in kiosks, and the new Cerner Electronic Health Record, be fully 508 compliant. BVA requests stronger congressional oversight and agency transparency on VA's progress of updating websites, files, and applications that are still inaccessible. BVA urges VA to create an Under Secretary of Accessibility to champion with the authority and subject matter expertise to lead VA's 508 compliance efforts.

Two: Caregiver benefits for catastrophically disabled blinded veterans. VA reported that 80 percent of all PCAFC applications for Fiscal Year 2021 were denied. BVA is concerned that blinded veterans are being discriminated against. Denied fair, adequate reasons and bases for PCAFC decisions and being denied access to their files has been unfairly and unlawfully inhibited their ability to appeal. These are gross violations of due process.

Further, blinded veterans face an ambiguous eligibility standard based on VA's rulemaking, which has made them cryptic at most. The subjectivity in the evaluation of their disabilities further complicates the adjudication process of blinded veteran applications causing their denial.

Caregivers are the most important component of rehabilitation and maintenance for veterans with catastrophic injuries and the welfare of their caregiver has a direct impact on the quality of care and quality of life they can sustain.

BVA urges that Congress provide further clarification on eligibility standards such as a clear definition of the need for supervision, protection, or instruction in order for the individual to maintain personal safety on a daily basis, and a definition of activities of daily living, which the VA has failed to provide in its rulemaking process.

BVA strongly supports modification of PCAFC eligibility criteria regarding activities of daily living to include catastrophically disabled blinded veterans. Blinded veterans want a fair opportunity to be considered for the PCAFC program.

Three: Renewable VA auto grant for service-connected blinded veterans. Accessible transportation options remain a persistent problem for blinded veterans. Public transportation is not equal across the country, especially in rural areas. This causes issues when veterans are trying to pursue employment or reach medical appointments.

The VA Automobile Allowance makes healthcare and employment more accessible to blinded veterans who have a spouse or other person who can drive for them. To mitigate this hardship, BVA supports the IBVSO recommendation of a renewable Automobile Grant for eligible veterans equal to 100 percent of the grant maximum amount at the time the grant is renewed. BVA strongly supports H.R. 1361 and S. 444, AUTO for Veterans Act.

Conclusion: Once again, Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and all committee members, thank you for the opportunity to present to you today the legislative priorities of the Blinded Veterans Association. We look forward to furthering our relationships and working with you productively during these challenging times.

I stand ready to answer. Thank you for giving us the opportunity to present. I did this in the virtual way so that you understand how a blind veteran has to read or see documents. I stand ready for any questions.

[The prepared statement of Mr. McNeil appears on page 226 of the Appendix.]

Chairman TAKANO. Thank you, Mr. McNeil.

Mr. LaGroon, you are recognized for 5 minutes.

STATEMENT OF VICTOR LAGROON,
DIRECTOR, BLACK VETERANS EMPOWERMENT COUNCIL

Mr. LAGROON. Chairmen Takano, Tester and Ranking Members Bost and Moran, I am pleased to speak before the Joint House and Senate Veterans Service Organizations hearing today on behalf of the Black Veterans Empowerment Council.

BVEC is a non-partisan coalition of national, State and local veterans organizations seeking to shift long-standing racial inequities suffered by Black veterans in the United States. Since its inception, BVEC has grown to represent 15-plus organizations nationally, representing more than 20,000 members with the ability to reach hundreds of thousands more in communities across our Nation, as well as in bases internationally.

The BVEC has been greatly appreciative of the opportunity to collaborate robustly with the HVAC, as well as the SVAC in advancing sensible and sustainable solutions to the issues affecting all veterans.

As the work of the 117th Congress progresses, we understand that that country is at a nexus of crises. Political discourse and discord and unrest, rising military conflicts, economic recessions, and the tail end of a 2-year pandemic. We must all work to ensure no veteran is left behind during these difficult times.

Under benefits and usage, Black veterans disproportionately hail from at-risk, low-income, and underserved communities, joining the military in the hopes of serving our Nation while seeking economic mobility and access to housing, education and healthcare benefits often lacking in their respective environments.

Though underserved communities are heavily recruited, many Black veterans return to resource-poor neighborhoods and withstand frequent denials, deterrence, and misinformation on how to appropriately utilize and access the veterans benefits they have earned. To that end, BVEC is piloting an initiative to train 500 Black service officers across the country to ensure veterans benefits are widely understood and adequately accessed.

To address historical disparities, VA must contend with the ways dishonorable discharges have adversely affected Black servicemembers, impeding their ability to attain crucial veterans benefits and job placement post-service. A legacy of stark disparities in punishment under the Uniform Code of Military Justice continues to fuel a pipeline of Black veterans who fall victim to homelessness, joblessness, and mental health crises which place undue burden on under-resourced municipalities and nonprofits.

The BVEC calls for the convening of a task force to formulate recommendations to confront the legacy of discriminatory bad paper discharges with an emphasis on disproportionate impact on Black and minority veterans to ascertain and codify VA's role in mitigating this harm moving forward.

To fulfill its commitment to diversity, equity, and inclusion, VA must also improve micro-targeting outreach across the Black veterans community. BVEC and its affiliated partners and organizations stand—excuse me—crisis coupled with persistent unemployment and underemployment reflect a bleak series of crises on the horizon.

As a host of factors complicate benefit utilization, BVEC supports the work of the Black Veterans Project in advancing research on racial disparities in access to veterans benefits across the Department of Veterans Affairs. The BVP's findings to date reveal statistically significant racial disparities in disability rates and denials suffered by Black veterans and highlights a need for redress and reform. For example, Black veterans suffer from a 30 percent disparity in mental health benefits approval.

As it pertains to Black women, the BVEC commends the passage of the Deborah Sampson Act which provides much needed reforms to VA accommodations to care for women veterans. We also applaud the implementation of a zero-tolerance policy around sexual harassment at VA facilities championed by Chairman Tester.

Women of color continue to be the fastest growing segment of our homeless veteran community. We ask that the VA prioritize a plan centered on preventing and aiding our women members with stable housing, suitable for them and when applicable, their children.

As it pertains to the 6888 congressional Gold Medal, the BVEC commends the passage of a bipartisan legislation to award the congressional Gold Medal to the members of the Women's Auxiliary Corps, who were assigned to the 6888th Central Postal Directory Battalion, the "Six-Triple-Eight" during World War II. Given the increasing age of surviving 6888 veterans, this historic and groundbreaking women's organization deserves to be addressed and recognized for their sacrifices and commitments.

And, finally, under the G.I. Bill Repair Act, the introduction of the G.I. Bill Repair Act by U.S. House Majority Whip James E. Clyburn and Congressman Seth Moulton, which seeks to provide GI Bill benefits to the surviving spouse and descendants of Black World War II veterans alive, and those who have passed, this bill's enactment is profoundly necessary legislation that begins with the process of amending that over 900,0000 Black World War II veterans and their families who were denied access and utilization to those benefits at their time of separation from war. I appreciate the opportunity to serve before you today and I stand ready to answer any questions that you have. Thank you.

[The prepared statement of Mr. LaGroon appears on page 235 of the Appendix.]

Chairman TAKANO. Thank you, Mr. LaGroon.

Mr. Palladino, you are now recognized for 5 minutes.

STATEMENT OF THOMAS PALLADINO, PRESIDENT AND EXECUTIVE DIRECTOR OF THE TEXAS VETERANS COMMISSION, NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS (NASDVA)

Mr. PALLADINO. Thank you very much.

Chairman Tester, Chairman Takano, Ranking Members Bost and Moran, and distinguished members of the joint committee, my name is Tom Palladino, President of National Association of State Directors of Veterans Affairs, otherwise known as NASDVA, and the Executive Director of the Texas Veterans Commission.

Our association is comprised of the executive leaders representing the Veterans Affairs agencies in all 50 States, five terri-

tories, and the District of Columbia. We are tasked by our respective Governors and legislatures to address the needs and improve the lives of our veterans, their families, and survivors, and to ensure they receive the services and benefits they have earned.

Nationally, we are the second largest provider of veterans services after the Federal VA and our roles continue to expand. NASDVA, through its members, States, and territories, is the single organization that represents and serves all of America's 19 million veterans and their families. We collectively contribute nearly $10 billion each year in support of our Nation's veterans.

NASDVA has a longstanding partnership with the United States Department of Veterans Affairs. Since 2012, we have entered into a formal memorandum of agreement between the VA and NASDVA to increase our direct services to our veterans and their families. Last week, VA Secretary Denis McDonough and I updated the memorandum of agreement on behalf of our organizations, enhancing our cooperative relationship.

Our written testimony covers a wide range of items, so, due to time limitations, I will focus only on a few. So, NASDVA requests full congressional support of the President's fiscal year 2022 VA budget in order to deliver services to meet the needs of our veterans.

Second, NASDVA fully supports efforts to increase veterans' access to VA healthcare under the provisions of the MISSION Act.

While the VA continues to place emphasis on suicide prevention, there is still much work to be done, given that the rate of suicide is still too high. It is vital that the Veterans Health Administration work with the States to address this critical issue. NASDVA proposes a creation of outreach grants from the VA to the States to increase veteran suicide prevention and awareness.

Third, NASDVA, along with the National Association of State Veterans Homes supports a continued commitment to substantial funding of the VA's State Veterans Home Construction Grant Program, which is the largest provider of long-term care to America's veterans.

We request full funding support for all Priority 1 projects, increasing the VA budget for State Veterans Homes from 90 to $500 million.

Fourth, regarding veterans benefits services, States and territories continue to take on a greater role representing veterans filing disability claims and pension. Regardless of whether States view State employees, veteran service organizations, or county veteran service officers, collectively, we are essentially in advocating for veterans and working with the Veterans Benefits Administration to effectively manage the claims process.

Given the claims backlog and the number of claims on appeal, NASDVA recommends making Federal funding available to States for claims, advocacy, and to further reduce the backlog and maintain progress on expediting existing and new claims.

One of the results of the Appeals Modernization Act is an increase in veterans choosing hearings at the Board of Veterans' Appeals. We commend the VBA for increasing the number of virtual hearings; however, the VBA still uses manual procedures in the appeal process, so NASDVA supports BVA's request for additional

funding to automate their processes, which will result in an increased number of timely Board decisions.

Fifth, the VA National Cemetery Administration partners with States, territories, and tribal governments to manage the Veterans Cemetery Grant Program. NASDVA recommends that that the Construction Grant Program [Audio malfunction.]

[The prepared statement of Mr. Palladino appears on page 238 of the Appendix.]

Chairman TAKANO. Senator Moran, I am going to call on you for your 5 minutes of questioning.

Senator Moran, go ahead.

Senator MORAN. Chairman Takano, thank you very much.

Let me begin with, well, first of all, I want to make certain that I express my gratitude for your remarks, Mr. LaGroon in regard to the 6888. There was a monument built at Fort Leavenworth in honor of these African-American women and it caused me to have a knowledge and an interest, and I am pleased to have a House Bill—have the House now pass a Senate bill that is on its way to the President and allowing a Congressional Medal to honor the survivors. And I thank you for recognizing their service to our Nation in difficult circumstances and I am grateful for that.

Let me talk to Mr. Butler about our withdrawal from Afghanistan. Mr. Butler, let me find you. There you are.

I have spoken certainly at home and here on the Senate floor about my concerns about how we left Afghanistan last year and I know that there are many veterans who continue to bear the brunt of that, the manner by which we withdrew. We know that there were consequences to their mental health and well-being and concerns about suicide ideation, not just for Iraq and Afghanistan veterans; for others, as well.

Tell me what your experience is in regard, consequences in regard to this circumstance, and if you can then, in addition, to what it meant to those who served there, what about the efforts that you know about or any continuing efforts to get others out of Afghanistan.

Mr. BUTLER. Yes, sir. Thank you for the question.

It is something we want to address. It is a priority. I touch on it in our written comments. A few things. I don't think that there is a more galvanizing issue around which the veteran community has rallied with one single voice. Toxic exposure, frankly, might be the other one. But the withdrawal from Afghanistan, the following effects, the need to get our Afghan allies out, that has been something where the veteran community has spoken with one voice.

We saw the response from the military and veteran community, the desire to get them out. We saw the impact that it had on the military and veteran community. Our program that IAVA has a Quick Reaction Force, where it provides direct support to veterans. We saw a massive increase in folks reaching out for help, mental health care, support, and things like that, because of how it was affecting them.

We applaud Congress for including the Afghan War Commission Act in the NDAA. That is going to go a long way to addressing the

things that went wrong, not just with the withdrawal, but, frankly, throughout the 20 years that we were in Afghanistan.

One of the big things we are pushing for now is the Afghan Adjustment Act to make sure that we are taking care of our Afghan allies and we continue to coalesce around the need, the absolute need to focus on those who are still left behind. The situation in Afghanistan is deteriorating. It seems very evidence that the Taliban is taking advantage of the fact that the world has shifted their attention to Ukraine to do things like, literally, not allowing women to leave the country anymore. That is something that was just announced by the Taliban within the last few days, obviously, because the world is not paying attention anymore and we have to make sure that that isn't allowed to happen. That we continue to focus to not only get our allies out, but then to make sure that they are taken care of when they get to the U.S. or whatever country they are going to settle in.

Senator MORAN. Just in Kansas alone or at least in our office, Kansans provided us with the names of a thousand individuals, a thousand-plus individuals of individuals who were still in Afghanistan asking for our help for their departure and I don't want the focus to not shine as well Ukraine is an important issue at the moment, important and tragic, but there are people who are still in need of our help. And if there are ways that we can help you or you can help us in that regard, we volunteer. Thank you.

Thank you, Mr. Chairman.

I turn to Ranking Member Bost.

Mr. BOST. Thank you. You know, this could—whoever would want the answer to this, you know, we are hearing concerns in our office both, in district and then here, also, through other members that know of the position I have with the Veterans Affairs' Committee that people are still having trouble getting appointments in the VA. We are also hearing that many of them, and I will give you an example of one particular legislator that brought this to us and tried to deal with this, there was a—and, basically, it is not fulfilling the MISSION Act like we put it in place to do. We had one veteran who was actually in the middle of receiving chemotherapy and received a letter from the VA that they need to return to get that chemotherapy at the VA, and when they got to the VA, the VA said they didn't have room for them and they didn't—wouldn't understand why they interrupted that.

Are you hearing concerns like this, where many of your members that might be in rural areas around the Nation, are having these same types of problems of still getting care and service?

Mr. LINNINGTON. Ranking Member Bost, this is Lieutenant General Linnington from Wounded Warrior Project. Continuing—we believe the VA is the best place to get care for veterans and that is, as evidenced in our annual warrior survey where the majority of our veterans get their healthcare from the VA. And even during the period of COVID, 7 in 10 got telemedical support, telemedicine from the VA and 81 percent were happy with that.

That said, we do need to continue to provide access to veterans in more robust manners through the Community Care Program. That was part of the MISSION Act that still needs to be enacted in areas where veterans are having difficulty.

I will tell you that the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, as part of the Commander Scott Hannon Act needs to be implemented quickly because there are a lot of community-based programs where veterans aren't able to get care, that they can get care utilizing that grant program.

Mr. MCNEIL. Ranking Member Bost?

Mr. BOST. Yes.

Mr. MCNEIL. This is McNeil for the BVA.

There is an issue with the Community Care base program, which part of it may relate with the VA. The fact that we identify a veteran that is in crisis by a flag when he checks in, but when you have an MST veteran or a blinded veteran, you can't identify them when they go to the VA or to community-based plan.

There was with a recent where a female veteran, an MST, went to a C&P and it was a male clinician that was going to do the exam. And she ran out of there and I thought it was something that should have been looked at.

If you can identify a troubled veteran that has PTSD, why can you not flag the MST ones so they are aware that they are there and a blinded veteran that [inaudible] instead of asking the question.

Mr. BOST. Sure.

Others? Because we don't have much time, let me just say thank you to all of you and for the services that you provide. You are our front line and you give us the information that we need. I appreciate each and every one of you.

And with that, Chairman, I yield back.

Chairman TAKANO. Ms. Underwood?

HON. LAUREN UNDERWOOD,
U.S. REPRESENTATIVE FROM ILLINOIS

Ms. UNDERWOOD. Thank you so much.

And thank you to our representatives from the VSOs who are here with us today. It has been an honor to work alongside you on behalf of our Nation's veterans, including via my Protecting Moms Who Served Act, which President Biden signed into law last November. The Protecting Moms Who Served Act is a historic step to provide our veterans with the world-class maternal healthcare they have earned and the bill commissions the first-ever comprehensive study of maternal mortality, morbidity, and disparities among veterans, and it also authorizes $15 million in new funding to strengthen VA's Maternity Care Coordination Programs.

The Wounded Warrior Project not only endorsed this bill, but also worked tirelessly to build momentum for the legislation to pass in the House and the Senate, and I am so glad that we have Lieutenant General Michael Linnington, the CEO of the Wounded Warrior Project with us today.

Lieutenant General Linnington, as we prepare for the fiscal year 2023 appropriations process, can you describe why it is so important to fully fund the Protecting Moms Who Served Act authorization and ensure that VA's Maternity Care Coordination Programs have the staff and resources they need.

Mr. LINNINGTON. Representative Underwood, first of all, let me just say thank you for championing that legislation, Protecting

Moms Who Served Act. It was a critical piece of the legislation. We are very proud to support it.

And we know that comprehensive maternity care is absolutely critical for all women veterans that choose to become moms. We also know that women veterans using VA maternity care are more likely to experience pregnancy complications and for a variety of reasons, because they have been deployed, have PTSD, have MST in their background, et cetera.

I can't think of something more important, next year, as to extend that $15 million funding into subsequent years. So, we appreciate you letting us know about that legislation. It is certainly welcomed, not just from our women veterans, but from all of our veterans want to support our women alumni.

Ms. UNDERWOOD. Well, thank you, sir.

We are looking forward to working with you on that appropriations process.

This week, the House of Representatives is preparing to vote on Honoring Our PACT Act, a bipartisan bill that will finally provide access to VA healthcare for more than 3 and a half million veterans exposed to toxic substances. I am proud to be an original co-sponsor of the Honoring Our PACT Act, which is a full accounting of the true cost of war. And I appreciate the recent comments from Jeremy Butler, the CEO of the Iraq and Afghanistan Veterans of America who emphasized the need for the Senate to follow the lead of the House and take comprehensive action of toxic exposure legislation.

Mr. Butler, last month you explained on CNN that the piecemeal legislation passed by the Senate basically does about a third—that is a quote—of what VSOs have been calling for in legislation to address toxic exposures. Can you describe why it is so important that the Senate pass comprehensive legislation like the Honoring Our PACT Act.

Mr. BUTLER. Yes, thank you for the question.

I mean, really, it is for two reasons. One, it is completely overdue, and, two, the statistics that I cited in my testimony, 70 percent of veterans who are applying for burn pit and other toxic-related benefits from the VA are getting denied. We need to get beyond this point where we are forcing veterans, sometimes literally on their death beds, for VA benefits that they were guaranteed when they signed up for service.

The Cost of War Act, the Honoring Our PACT Act, that does everything that veterans got together and put down in legislation, handed to the VA committees and saying, this is what we need to do. That legislation gets this done.

A piecemeal effort just means we are going to continue to have to be back here, not just year after year, but month after month, to tell you that the job is not done, veterans are still dying, and we are still waiting on you to do what we told you needed to be done.

So, now is the time. Literally, tomorrow, the House of Representatives has the opportunity to pass the comprehensive bill, send it to the Senate, and get things done.

Ms. UNDERWOOD. Get things done; that is what we are here to do.

Thank you all so much for being here and I am so pleased that we have had the opportunity to hear from so many of you.

I would like to yield 2 minutes to Thomas Palladino in order for him to be able to complete his testimony.

Mr. PALLADINO. Thank you very much. I really appreciate that, Congresswoman. My power went out and I don't know what it was, but I got back on and so I will complete the testimony.

So, I was talking about the VA National Cemetery Administration partnering with the States, territories, and tribal governments to manage the veteran cemetery program. And so, NASDVA recommends the Construction Grant Program budget be increased from 45 to $60 million. This modest increase to the budget would allow funding of new State cemeteries to bring burial benefits to the growing needs of eligible veterans, spouses, and families.

Six. Women now comprise nearly 20 percent of the Armed Forces and are the fastest growing veteran cohort. There are several areas NASDVA believes VA can work on to close gaps in service, ensure continuity of care, and better address the needs of women veterans. One is a disproportionate and nonstandard availability to access gender-specific healthcare. The decision-making and planning for new services must be data-driven and veteran-centric to ensure all veterans, regardless of gender, receive the care they have earned.

Seven, and the last issue, is the Transition Assistance Program, TAP, is a cooperative effort among DoD, DOL, and the VA; however, there is no mandate to include the States in the TAP curriculum. It is a major challenge for transitioning servicemembers to connect with State benefits and services that are available to them. This lack of connectivity between transitioning servicemembers and the States is not only a significant barrier to their employment, but increases their mental stress associated with their transition.

So, NASDVA recommends that all State Department of Veterans Affairs be included the TAP at military installation in their State and be allowed to connect with transitioning servicemembers who are moving to their State, prior to separation, to inform them of their specific benefits in each particular State.

Mr. Chairman, distinguishing members of the House and Senate Veterans Affairs Committee, with your continued support, we can ensure that the needs of our veterans and their families are addressed, adequately resourced and remain a priority.

Thank you for your work on behalf of our Nation's veterans, and for including the National Association of State Directors of Veterans Affairs in this hearing and allowing me to come back online after our EMP disaster down here. So, thank you very much. I welcome any questions you have or comments on behalf of those we serve. Thank you.

Ms. UNDERWOOD. Well, Mr. Palladino, thank you so much. And thank you to the VSO witnesses that have joined us.

Subject to the call of the chair, this hearing is in recess for votes.

[Recess.]

Mr. MRVAN [presiding]. I bring the meeting back to order.

I recognize myself for 5 minutes. I have a question for General Linnington. You mentioned the importance of VA's successful implementation of the electronic health modernization program. Are

there any capabilities and services that VA is not able to provide veterans with their current system that you would like to see provided?

Mr. LINNINGTON. Representative Mrvan, you know, I am going to have to get back with you on that. If you don't mind, I will take that one for the record. I am not an expert on VBMS or the EHR. I do know that it is 20 years' overdue. I really applaud the work of DoD and VA and the Congress to finally collaborate on a single solution. But I do not know of any capabilities that we would like to add to the current system.

Mr. MRVAN. Okay.

Mr. MCNEIL. Mr. Chair?

Mr. MRVAN. Yes?

Mr. MCNEIL. Joe McNeil, Blinded Veterans Association. Our main concern is the accessibility of the systems, getting into them. The fact that they are going to create a system that is not accessible to blind veterans, it is like kicking the can down the road, which we have been doing for 20 years. They say they are going to fix it and they keep promising to fix it and this is year over year over year. This becomes a decision. They have not consciously fixed it so that blinded veterans can use kiosks, this new system they have coming out, Cerner, none of this helps a blinded veteran.

You are going to put a system out that you are going to turn around and come back and have patches for it. That is job security for the people that are creating the system. That is not helping us.

Mr. MRVAN. Thank you very much, Joe.

If I might follow up with what are some systematic cures for what you have seen as it is missing?

Mr. MCNEIL. Well, we start with the kiosks. The kiosks are not accessible at all. We do everything with audible listening, as by my presentation, which was audible. I can't read a written document. Most of the veterans that are visually impaired or blind can't, so because of that, you have to listen to what is going on. If it is not talking to us, we can't do anything with it.

And when you are looking at checking in for a kiosk or trying to access a website, if a website is not accessible to us, how are we supposed to fill out a form or even process something that we can't get to?

Mr. MRVAN. Okay. Thank you very much, Mr. McNeil.

At this time, Mr. LaGroon, the promise of the interoperability between the Department of Defense and the VA health records is the core goal of electronic health record modernization. How are the current delays and deployment of a new system impacting veteran's care?

Mr. LAGROON. Well, sir, to be honest with you and frank, any delay is significant. Wait lines and wait times for veterans have been substantially impacted by COVID and the shift of attention and resources to address those needs and I think they are extremely important; however, we also see significant delays in people having access to mental health being qualified, being certified, getting competent care, and it also has impacted how people can get not just primary care, but specialty care.

So, if you were a veteran and you were seeking care for cancer, for example, and you wanted to get a referral to someone who was

an oncologist and you were deferred because of COVID and some of the other factors, being processed through the system has been slagged, it has been dragged down, but it also has been delayed, which has further delayed many people getting the access that they need in a timely fashion.

Mr. MRVAN. Okay. Mr. Butler, the Secretary has taken several important steps during this past year to—to ensure that the Department is welcoming to all veterans. No matter what their gender, race, sexual orientation, or background, last summer, VA completed the Department-wide review by the Inclusion, Diversity, Equity, and Access Task Force, or IDEA Task Force, which came up with a number of very useful recommendations toward improved inclusion and equity.

My question for the witness is, how is VA doing? How well has the Department been doing in creating a welcoming place for all veterans and would you like to see more collaboration and coordination between the Department and the VSO community, regarding equity and inclusion?

Mr. BUTLER. Yes, sir. Thank you for the question.

And the short answer and to start, really, with your last question is, absolutely, yes; more collaboration is the key. We were actually talking about that, in between here on the panel, and we look forward to not only having more of an inclusive panel, as you have done this year, continuing that to give more organizations the opportunity to speak directly to you. I think Secretary McDonough has been doing a great job of opening things up, communicating directly with more of us. We welcome more of that.

One of the things that we have been pushing for, and it was great to see an email coming out from the VA just last week was on changing the motto to something more inclusive. So, that is something that we have been pushing for, for a long time. So, there is still always more work to be done, but I think we are moving in the right direction.

Mr. MRVAN. Thank you, Mr. Butler.

At this time, I would like to recognize Congressman Bergman for 5 minutes.

HON. JACK BERGMAN,
U.S. REPRESENTATIVE FROM MICHIGAN

Mr. BERGMAN. Thank you, Mr. Chairman.

First of all, thank you to all of you veterans. Welcome home. I can't say that often enough.

Thank you to all the VSOs present today and, especially anyone who might have traveled from Michigan here to DC. We are having a wonderfully nice spring day, which we are not in Michigan, but that is a different story.

Commander Heun, I have read your testimony and have heard you loud and clear today. I share your frustration. We cannot continue to fund the same types of programs and expect a different result. We know that is the absolute definition of nuttiness, okay.

I champion the grant program that you are referencing in your testimony, because I believe we have to be more innovative with veterans' mental health and as you mentioned in your testimony, we have to move forward toward an outcomes-based model. Fund

what works. Fund what leads our veterans toward happier, healthier, more productive lives. It seems simple, but as you know, the VA seems to really not have a sense of urgency in implementing what could be life-saving measures.

So, what can we do to put pressure on the VA in a positive way, hopefully, to act with some sense of urgency?

Mr. HEUN. AMVETS would like to see a roundtable set up in the very near future, March or April would be very good, to monitor and set goals for the VA. And we would also ask the VA to be invited to that roundtable to share of the failures and the successes they have seen and, if you would, put a metrics on them and, you know, put their feet in the fire, so to say.

We need to change the goals and the principles of what we are doing with veteran suicide. Six thousand a year is just too many. It hasn't gone down significantly for the $15 billion that we throw into veteran suicide. I believe that, and AMVETS believes that if we start monitoring the VA and their successes and their failures in this and start outreaching to programs that actually work and succeed, because there are programs out there, and learn from their successes and their failures, and I just don't see that that is happening right now.

Mr. BERGMAN. Yes, it is not a simple question and not a simple answer. But for at least 5-plus years now with my membership on the committee, we have pressed continually, the VA to show us some sense of urgency. And there are good folks working at the VA, but they need to be led in such a way that they know that if they have a good idea, we can get it implemented.

You know, when you mentioned the roundtable, subject-specific roundtables, back in 115th Congress, we started doing roundtables under Chairman Roe's direction and it worked very well because we had all the VSOs on one side of the table. We had the VA on the other side of the table. And there was a subject. And we, as members, just kind of sat there, didn't say much; we just listened to the conversation and learned from the dialogue between all of you and Veterans Administration.

So, whatever we can do, especially when it comes to rural veterans, and I would suggest to you, rural is not, at least in my district, you have got—we don't have any urban in our district. We have some, maybe a couple small towns that would be considered suburban, but we are rural and remote. So, anything that, suggestions that you might have, whether it be, you know, procedures, capabilities for the blind veterans, especially, when you get into a teleworking situation or, a, you know, where you are tapping it out there a synthetic voice, or whatever it happens to be, we need those kinds of solutions that will work for our veterans who live remotely, because the good news is they do. The bad news is when you are remote, you are out of contact, which makes you potentially more susceptible to suicidal ideations because you don't have that human interaction.

And I just, you know, I appreciate all that you all do. Let's keep the dialogue going.

And with that, Mr. Chairman, I yield back.

Mr. MRVAN. Thank you, Congressman.

At this time, I recognize myself for 5 minutes.

Captain Manning, members of our committee have introduced legislation to examine the lasting effects on veterans due to past discriminatory Pentagon policies regarding the discharge of servicemembers. In past decades, too many servicemembers were unfairly discharged under "Don't Ask, Don't Tell," because they were suffering from PTSD, due to pregnancy, or due to other antiquated reasons, and received "other than honorable" discharge.

This has too often resulted in veterans being denied access to the benefit that they have earned and need. Can you provide your thoughts on the lasting effects of these past and unfair discharge policies.

Ms. MANNING. Yes, thank you for that question.

The first is, particularly when there is an OTH or a BCD involved, there are no veterans benefits. There is no G.I. Bill. There is no employment and training. There is no healthcare, unless you have MST and you can get some minimum for that.

The services right now on the DoD side are doing a lot to upgrade some of those discharges, but a lot of these veterans have totally lost touch with VA and they don't even know that if they have an OTH and if it was military sexual trauma or PSD or pregnancy back in the 1950s or 1960s involved, that they can even ask for a service discharge upgrade through their service.

Also, there are a lot of discharges that the services are looking at for upgrade and one of the things that we talk about a lot is the character of discharge power that VA has. It allows them to look at somebody with an OTH discharge or a BCD and decide that there were circumstances there and allow them to begin to get, at least, some of their benefits. So, even if they have tried to get an upgrade through the services, they may have to wait a year or two now because they are so backlogged and that character discharge power that VA has is wasted.

Most people don't know it exists and there are very few statistics on it. When I have looked for statistics on that, they seem to do about 3 percent are granted. That is ridiculous. And there is no—they don't seem to have any transparency, not much that I can find out about the training or even what the procedure is.

So, that whole thing needs to be looked at, and that is why we support the bill that Senator Blumenthal and Congresswoman Underwood have proposed. That would help.

Mr. MRVAN. Okay. And I have a follow-up question. Last session, we passed the Isakson and Roe Veterans Health Care and Benefits Improvement Act of 2020, included the Deborah Sampson Act.

How satisfied are you, thus far, with the VA's implementation of these measures and where is there room for improvement?

Ms. MANNING. Well, the main thing that VA was charged with—well, they were charged with a lot of things on that—but specifically, all the best care in the world isn't going to help women veterans if they get harassed by their fellow veterans or staff members when they go. So, it is clearing up that veteran-on-veteran sexual assault and sexual harassment that happens at VA. And that is part of the Deborah Sampson Act; VA is charged with fixing that.

You know, Secretary McDonough participated in the Independent Review Committee Commission that the Secretary of Defense did,

but most of the VA participation in that seemed to fall away over time. And I think they—I am hoping that they will come out with something like an IRC for VA. They need, first of all, a system so that a veteran can even report that he or she is being sexually harassed or assaulted. It's this great stuff laid out if you are a staff member at VA, but there is nothing in writing about what a veteran who is a customer should do.

So, they need, and I know they have things going on over there, but it is hard to figure out at what stage they are in. They do have a special group that meets with the Secretary and his staff, but it is hard to get any feedback from where they are standing and what they are planning to do. So, transparency is the first thing we need and then we can make judgments from there.

Mr. MRVAN. Thank you, Captain.

At this time, I would like to recognize Representative Cawthorn for 5 minutes.

HON. MADISON CAWTHORN,
U.S. REPRESENTATIVE FROM NORTH CAROLINA

Mr. CAWTHORN. Thank you very much, Mr. Chairman.

And to all of our witness, thank you all very much for being here.

Lieutenant General, in your testimony, you mentioned that supporting the expansion of telehealth and telemental health would be a net positive. But in Western North Carolina there is a dire need for broadband access and it being such a rural area, there are so few places. Such a long drive for them to get to the VA.

Do you mind expanding on what Congress can do to ensure that we have access for all veterans to telemedicine?

Mr. LINNINGTON. I can't speak to the broadband issue. I will tell you that telemedicine, especially during COVID, was something that, I mean, it threw us all on our heels. But we quickly translated a lot of our programs to virtual delivery, especially in the areas of mental health and our wounded warriors did the same. And a large majority of them that took advantage of that were women veterans.

So, that really opened our eyes to the importance of not just offering in-person programming, but also offering virtual offerings. And as I mentioned in my written testimony, and from our recent annual warriors survey, 7 in 10 of our alumni that took part in the survey representing all 160,000, took advantage of VA telemedicine opportunities during COVID. And it had a very high success rate; 81 percent noted that the therapy they had received through telemedicine was good, was acceptable.

The broadband issue is a big issue. I am hopeful that, you know, some of the infrastructure investments that I see coming out now with, you know, with the bipartisan infrastructure bill will help with some of the rural areas, establishing those broadband areas. And we are working with some of the internet providers that are also establishing a broadband islands, a thousand of them around the country, to help provide broadband access, specifically for veterans, that can allow them to tap into some of these virtual offerings.

Mr. CAWTHORN. That is fantastic. Thank you, sir.

And Lieutenant General, just one follow-up question. You know, veterans have ensured that we can all pursue The American Dream and I think having the VA loan for veterans to be able to achieve The American Dream, to own their own home, it is incredible, but what in your opinion can Congress do to make entrepreneurship more accessible to veterans with things like loans or grant programs or, really, just what are your thoughts on that?

Mr. LINNINGTON. Yes, I think it comes down to training and opportunity that the VA and DoD provide at the transition point and I think that is key.

I also know that for veterans to take advantage of an entrepreneur program or start their own business, they have to have some financial stability to do so and have the availability, have the resources to do that. We have found that, especially over the past 2 years many of our veterans, especially those we serve, wounded, ill, and injured, are in financial jeopardy and it is hard to start a business or start your own entrepreneurship when you are having trouble putting groceries on the table.

So, I think we have to look at, how do we continue to inspire those that can to transition quickly into meaningful careers, and then for those that want to pursue the entrepreneurship, then you do it with help from the VA, through the entrepreneurship program and with organizations like ours that can support some of that.

Mr. CAWTHORN. That is fantastic.

To all of our witnesses, thank you all so much for supporting our veteran community so much. It truly means a lot. I have got a lot of veterans in my district, and so I really appreciate all of your work.

And with that, Chairman, I yield back.

Mr. MRVAN. Thank you.

At this time, I recognize Representative Trone for 5 minutes.

HON. DAVID TRONE,
U.S. REPRESENTATIVE FROM MARYLAND

Mr. TRONE. Mr. Chairman, thank you very much.

Last night, I know I was thrilled, and I am sure all of you were, to hear President Biden announce his plan for more mental health resources during the Save the Union address. I am looking forward to working with the VSOs to ensure we can meet our promise to provide mental health resources and that they are tailored to meet the unique needs of our vets.

I would like to focus my remarks on the new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program, which was signed into law in 2020. It is part of a broader mental health package. Through the important advocacy of the Wounded Warrior Project, veterans from across the country have shared how this mental health program will support their local communities.

Right here in my community, Ms. Angela Waller from Germantown, Maryland, told us how the increased collaboration will help Maryland veterans receive mental health care faster in a more coordinated manner.

When our veterans need care, they need it now and they can't be asked to jump through unlimited hoops. So, my first question is to Lieutenant General Linnington. It is clear this grant program

has fantastic potential. What kind of services stand out for WWP and what does WWP have any advice for what type of programs should be targeted?

Mr. LINNINGTON. Congressman, first of all, thanks for meeting with Angela. I know she was thrilled for having the visit with you as part of Operation Advocacy and speaking to the issues that we addressed both, in our written statement and in our opening comments.

The grant program under the Staff Sergeant Parker Gordon Fox Act is very important to provide communities and community programs, community organizations that can provide programs and services to veterans to help them connect and heal; heal, both physically and mentally, and get back into their jobs.

Many of these community-based programs don't have the resources that government programs have. Certainly, they don't have the resources that Wounded Warrior Project has, so providing these $750,000 grants as part of the $170 million program that was recently approved is very important for those organizations to provide community-based programs that help that veteran regain the connections and the comradery they had when they were in uniform.

I will also tell you that the best programs are those that refer the veteran back into carry-on care at the VA, wherever that care is available, because if you don't have that continuity of care, then the question is, you know, why?

So, I am a huge fan of this legislation. Thank you for sponsoring it and thanks for getting it off the ground and implemented across our country.

Mr. TRONE. It is really important that we handle and deal with this area directly and this legislation is one of the great first steps. So, thanks for sharing your thoughts.

I have one last question, which is open to any of the panelists. What models of collaboration do you think we can create the biggest impact for mental health services? Where should be we collaborating to get the most bang for our buck?

Mr. LINNINGTON. I hate to steal the mike again, but, Congressman, I will tell you, we have one right now that we are very proud of that we have in partnership with the VA and that is our Warrior Care Network. That program is a comprehensive, PTSD, intensive outpatient program where any Post–9/11 veteran or active-duty servicemembers can go and get 2 weeks of intensive outpatient care, individual therapy, group therapy, alternate therapy, yoga, tai chi, nutrition. It includes the family, includes the service dogs.

And the VA has a partnership with Wounded Warrior Project so that the VA employees are at the site of these four academic medical centers at Mass General, Emery, UCLA Health, and Rush University. And that, to me, is the best model of collaboration in the mental health arena where nonprofit, government, non-government organizations can work together to get the veteran into care and then ensure the continuity of care after the veteran completes the program.

Mr. TRONE. Perfect. Well, thank you for your feedback on this topic. We have to keep expanding our mental health resources for our vets. We owe it to them.

And with that, I will yield back. Thank you, Mr. Chairman.

Mr. MRVAN. Thank you, Congressman.

At this time, I recognize Senator Blumenthal for 5 minutes.

HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you so much, Mr. Chairman.

And thank you to the wonderful representatives of these great organizations who are with us on this panel and to the earlier panel, the Veterans of Foreign War panel that testified so well. I'm sorry, I wasn't able to ask questions then, but I was going to mention, as a matter-of-fact, the need or more investment in VA infrastructure, which affects all of your groups and the veterans we represent.

There have been a number of incidents that have really [inaudible] called for action. One incident related to the tragic deaths of a VA employee and a contractor in [inaudible] West Haven VA Medical Center and the infrastructure that we have at the facility in West Haven desperately needs replacement. I suspect that the same is true of your infrastructure in many other parts of the country. The kinds of structural changes that need to be made, and in some cases, rebuilding, are an absolute imperative. And the statement made by the VFW and many of you support that point.

I want to turn to the issue that has concerned many of you, and I appreciate your leadership on it from the VSO community, we have seen the devastating impact veterans communities from invisible wounds of war, including post-traumatic stress, military sexual trauma, traumatic brain injuries. We have all talked about it. The President did last night.

Veterans struggling with these burdens really deserve a fair opportunity for the character of their discharge to be reviewed if they have been discharged without honorable status, a bad-paper discharge, so they can receive support and treatment for these wounds. In the meantime, they need and deserve access to mental health care at the VA, which is guaranteed under law.

My office, my guess is many of your offices, and my colleagues have almost all received complaints about unlawful turn-away of veterans with "other than honorable" discharges who are seeking mental health care at the VA.

I have introduced a measure called the Unlawful Turn-Aways Act of 2021 earlier this session to eliminate and remedy unlawful turn-aways. I submitted comments and proposed regulations to the Federal Register regarding the VA's request for information updating [inaudible] discharge regulation in this submission. I outline specific ways to close the regulatory gaps that allowed too many veterans to fall through the cracks, in effect, without the kind of mental health care they need and deserve.

Many of them were discharged less than honorably because of the behavioral results of their invisible wounds; the traumatic effects of their injuries caused them to act out. So, let me ask Ms. Manning, because I know your organization, the Service Women's Action Connection Network, SWAN, are supporters of this legislation and others are, as well.

I thank, particularly, organizations that have contributed to my understanding of like the Iraq and Afghanistan Veterans of America, Jeremy Butler, thank you for being on this panel; the Wounded Warrior Project, Lieutenant General Linnington; and, of course, I work closely with Jack McManus and those at Vietnam Veterans of America.

But Captain Manning, if you could respond to this question, how would this legislation assist women and men veterans who have traumatic injuries?

Ms. MANNING. Thank you for asking, Senator.

And, in fact, I was talking to one of your staff members, well, typing with them just yesterday about this legislation. We are strong supporters of it. We think of it mainly from the military sexual trauma point of view, but, as you said, it has a much wider application.

There are many men and women who have suffered military sexual trauma back through the years and we are picking up some of them now, some of the younger ones through service discharge upgrades and that sort of thing so they can get help from VA, but there are two generations of people who suffered this sort of trauma that don't know that they can even go to VA for some basic mental health care.

I think one of the problems is that VA is a huge organization and they use the VISNs and the regional offices have an awful lot of independence, which is necessary in a lot of cases, but for something like this, they need a general set of procedures laid out when somebody with an OTH, for instance, comes and asks for help, you don't just turn them away. You do a character of discharge assessment and you have to take into account the circumstances under which they were discharged.

And I don't think that VA is training people properly how to do that. You might go to the regional offices and find out a lot of people have never even heard of character discharge and it should happen anytime an OTH person asks.

And on the other hand, the people out there, who have been out there since the Vietnam War, perhaps, with an OTH discharge, don't even know that they can go and ask. So, we need a lot of, not just within VA channels, but a lot of outreach to veterans who don't use VA so they can learn this is a possibility.

But we would love to work with you on this. We are very supportive of it.

Senator BLUMENTHAL. Excellent answer. Thank you so much, Captain Manning.

Thanks, Mr. Chairman.

Mr. MRVAN. Thank you, Senator.

I have one last question for Captain Manning. It was a scenario that I had faced as a local elected official. A veteran who was assaulted or a survivor of military sexual trauma turned to alcohol and drugs to hide from that trauma and then was dishonorably discharged based on getting caught on that scenario.

My question to you is, what process is in place for that veteran to successfully be able to receive the treatment necessary and what recourse might they have going forward?

Ms. MANNING. And there may be something I don't know, but if it is a dishonorable discharge, which is awarded by a general court marshal, I don't think there is much of anything in place, besides getting an appeal up through the court system and revoking the discharge.

Mr. MRVAN. Well, it was discharged based on, and I don't remember the facts, based on the alcohol and the drug use.

Ms. MANNING. Then, if it was an OTH discharge or a bad-conduct discharge, there are processes. They can either go back through their service—each service has a discharge review board—and Congress has changed the laws over the past 4 or 5 years, particularly with respect to PTSD and military sexual trauma, telling these service boards over at the DoD that they have to take that into consideration when they are doing a discharge review. And if they get the discharge review done and the discharge is upgraded, then they are eligible for a lot that they are not eligible for right now.

The other possibility is to go directly to VA and ask for a character of discharge review, what Senator Blumenthal was just talking about.

Mr. MRVAN. Right.

Ms. MANNING. That doesn't upgrade their discharge, but if it is granted, they begin to be able to be eligible for VA healthcare and can enter into the VA programs for alcohol or drug addiction kinds of things.

Mr. MRVAN. Okay.

Mr. LINNINGTON. Congressman, if I can jump in real quick both, for you and Senator Blumenthal, we have a small team at Wounded Warrior Project called a complex case coordination team and they handle exactly these cases. And these are largely veterans who have suffered trauma, gotten in trouble, and discharged because of it and turned to alcohol, drugs. They all have issues that need to be addressed through psychiatric counseling or traumatic brain injury treatment.

And we have very close coordination with the VA to get these warriors back into care. So, for either you or the senator, we take those cases on.

Our team started out as a team of three and I think we are over 15 now, full-time individuals that manage these cases, so we would be happy to talk with your staff about how we can help.

Mr. MRVAN. And I welcome that, and the simple fact is making sure that there is policy that takes these scenarios that are welcoming to make sure that veterans receive the mental health care that they need based on those facts. So, I do welcome that information.

With that, I want to thank all of you for being here today and for your service and your testimony today. It has been enlightening and deeply appreciate your commitment to our Nation's veterans, their families and survivors.

We look forward to working with you and your organizations and your members throughout this Congress to make sure that we continue to honor their service and sacrifice. Again, I want to thank for your commitment to the veterans, to our country, and I want to thank you for being here today.

And with that, all members will have 5 legislative days to revise and extend their remarks and include any extraneous materials.

Again, thank you for your presentation and this hearing is now adjourned.

[Whereupon, at 5:49 p.m., the hearing was adjourned.]

A P P E N D I X

Prepared Statements

STATEMENT OF
MATTHEW "FRITZ" MIHELCIC
COMMANDER-IN-CHIEF
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

JOINT HEARING
COMMITTEES ON VETERANS' AFFAIRS
UNITED STATES SENATE AND UNITED STATES HOUSE OF REPRESENTATIVES

WEDNESDAY, MARCH 2, 2022, WASHINGTON, D.C.

Chairmen Tester and Takano, Ranking Members Moran and Bost, members of the Senate and House Committees on Veterans' Affairs, it is my honor to be with you today on behalf of the more than 1.5 million members of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary—America's largest war veterans organization.

I would like to begin by thanking the members of the committees on your hard work for veterans in the 117th Congress. During a time of divisive partisanship and a global pandemic you have worked across the aisle and across chambers to pass legislation to improve care and benefits for America's veterans and our families. The House and Senate Committees on Veterans' Affairs continue to remain as examples of how work should be conducted in Washington, D.C.

For decades, veterans have returned home from war with an array of unexplained health conditions and illnesses associated with the toxic exposures and environmental hazards they encountered in service. Today is no different, and toxic exposure has become synonymous with military service. For this reason, THE TIME IS NOW for Congress to change the way veterans receive health care and benefits to help save lives.

Toxic Exposures

At this joint hearing last year and in hearings in April and May of 2021, the VFW called upon Congress to work in a bipartisan manner and with Veterans Service Organizations (VSOs) to develop a comprehensive solution for toxic exposure. You heard our message and took several pieces of VFW-supported legislation and put them together. The VFW supports Senate bill, S. 3003, *COST of War Act of 2021*, and House bill, H.R. 3967, *Honoring our PACT Act of 2021*. We are also encouraged by the bipartisan and bicameral efforts to move each section of these larger bills across the finish line.

These are historic pieces of legislation that would help millions of toxic-exposed veterans. They would address the still lingering conditions and locations for Vietnam War veterans exposed to Agent Orange and take care of Atomic veterans and veterans from the K2 base in Uzbekistan. Each has a significant focus on burn pits and improving the Department of Veterans Affairs

(VA) disability claims process. The time is now to pass these bills and finally address the needs of sick and disabled veterans.

Both the *COST of War Act* and the *Honoring our PACT Act* focus on the following key areas: health care for toxic-exposed veterans, a concession of exposure to burn pits for veterans who served in certain locations, a list of presumptive conditions related to burn pit exposure, and a framework for VA to review and grant new presumptive conditions for any toxic exposure in the future. Additionally, the bills include critical training necessary for VA health care providers to better diagnose and treat veterans with conditions related to toxic exposures and for VA disability claims processors to understand how to properly rate and adjudicate toxic exposure claims.

Health Care

The health care expansion within these two bills is vital for toxic-exposed veterans who need treatment for current conditions and for preventive care. In the same way that Vietnam era veterans have access to VA health care, so should the Post-9/11 era of veterans who were exposed to burn pits and other environmental toxins. Veterans today have earned access to health care and compensation.

This shift would indeed increase the number of users of the VA medical system, but this is certainly necessary after more than twenty years of conflict and is something VA should have anticipated. By providing veterans care now, VA could deliver lifesaving, early detection for serious and rare conditions. Delaying access to medical care will only create a larger and potentially more costly problem in the future as some veterans will require significant care as their conditions worsen.

Concession of Exposure

VA reporting indicates that nearly eighty percent of toxic exposure disability claims related to burn pits are denied. The most difficult aspect veterans face in applying for these benefits is the inability to prove that an exposure took place. Without documentation from their service records, veterans often lack evidence that provides a nexus to their health condition and the in-service event, which is a requirement to be granted service-connection.

In 1991, after decades of advocacy, Vietnam War veterans were finally presumed to have been exposed to herbicides such as Agent Orange. This is a "concession of exposure." It is important because it is an acknowledgement that service members at certain locations during certain time periods were exposed to particular toxins, removing the burden of proof from the veteran. The *COST of War Act* and the *Honoring our PACT Act*, both include a concession of exposure to burn pits for those who served in Iraq, Afghanistan, and other key locations during the Global War on Terrorism. This would help veterans with serious health conditions more easily access the care and benefits they so desperately need.

Presumptive Conditions

Another important aspect of these comprehensive bills is that they include lists of presumptive conditions related to burn pit exposure. While the number of conditions in each bill differs, they both consider scientific findings which relate serious cancers and respiratory conditions to the burning of waste. It will always be difficult to fully replicate and study the exact components of every burn pit that was used over the last twenty years of conflict. There already exists a large body of research pointing to the health effects of humans exposed to burning trash where jet fuel is the most common accelerant. The conditions listed in the bills address some of the most serious conditions that veterans are facing and are an integral part of accessing vital care and benefits in a timely manner.

Framework

The process in which VA reviews and considers new presumptive conditions is fundamentally broken. Under the authority of the *Agent Orange Act of 1991*, VA entered into an agreement with the National Academy of Sciences (NAS)— now part of the National Academies of Sciences, Engineering, and Medicine (NASEM)— which assessed the strength of association between herbicide exposure and various health conditions. The legislation also provided VA with timelines to review the findings of NAS, determine whether a presumption of service connection was warranted for each condition, and issue proposed regulations. Under this framework, the majority of Agent Orange presumptive conditions were determined, but the two conditions of hypertension and monoclonal gammopathy of undetermined significance (MGUS) remain. NASEM determined in 2018 that there was sufficient evidence of an association for these two conditions, which is a level of association higher than some of the other conditions on the Agent Orange list. The fact that VA still has not added those conditions to the list points to the now-expired authority of the legislation and VA's unwillingness to adhere to this scientific body, or any other on its own, without the passage of new legislation.

The VFW supports adding hypertension and MGUS to the Agent Orange list of presumptive conditions. In addition, we strongly believe that a new presumptive process is needed at VA. This framework should use what worked well from the past—a transparent process with timelines, an independent scientific review board, and a decision-making model based on positive association.

The VFW acknowledges that VA is currently in the process of developing a new presumptive pilot program, with the expressed goal "to lower the burden of proof for Veterans impacted by exposures and speed up the delivery of health care and benefits they need." We have not yet been presented with the full details of the pilot, nor have Veterans Service Organizations (VSOs) been included in its development, so we cannot assess its merits at this stage. This does not change the fact that we believe a new and effective framework must be codified by statute so that future administrations will continue to be held to the same standard.

Training

Toxic exposure claims can be extremely complex and difficult for VA claims processors to accurately process. In a September 2021 VA Office of Inspector General (OIG) report, it was assessed that VA had made inaccurate rating decisions in nearly half of Blue Water Navy claims. The report indicates that claims processors did not fully understand how to apply the changes made through the *Blue Water Navy Vietnam Veterans Act of 2019*, nor were the established procedures followed correctly.

Training on these complex toxic exposure claims will be critical for VA staff to ensure accuracy and prevent veterans from having to go through the lengthy appeals process. Training will also be necessary for VA medical providers, in order to for them to properly identify and treat conditions related to toxic exposures, as most do not have any specific training in this area.

Ending the Piecemeal Approach

The components of the *COST of War Act* and the *Honoring our PACT Act* are necessary as a complete package to fix the broken system at VA regarding toxic exposures. Without one part, the process will continue to create significant barriers for suffering veterans. Without health care access, veterans may lose the opportunity for early detection and preventive care. Without a concession of exposure, veterans with conditions not on a presumptive list may still be denied their benefits. Without proper training for VA staff, the delivery of both health care and benefits are at risk.

We must work together to reconcile these two comprehensive legislative packages and pass a final bill swiftly. We must learn from the past and not delay any longer. It is time to end the piecemeal approach of addressing the problem one disease and one location at a time. The time is now to fix the process for veterans of the past, present, and future.

VA Benefits Issues

Veterans faced unprecedented challenges in accessing and understanding their rights to competent representation for the preparation, presentation, and prosecution of benefit claims before VA due to the chaos of the COVID-19 pandemic. As a result, bad actors seized the opportunity to aggressively target veterans online, seeking to charge predatory fees to assist with benefit claims. Organizations like the VFW continue to serve our veterans unabated by leveraging technology to overcome the challenges of reaching veterans during the COVID-19 pandemic. We have learned a great deal about how to better communicate the right to no-cost, competent, accredited representation in the claims process. We are grateful for the attention that the current Veterans Benefits Administration (VBA) team has paid to this issue alongside the VFW and our accredited partners to help veterans access their earned benefits and weed out predators.

Recently, VBA has worked to improve its consumer resources to better inform veterans of the right to accredited representation and what to expect from the process, including working closely with states to weed out bad actors seeking to exploit veterans and, in some cases, defraud VA.

Furthermore, the VFW is working closely with the Veterans Experience Office, VA Office of General Counsel, and VBA's Office of Transition and Economic Development to better communicate the right to representation and how to select an accredited representative as part of the military transition process.

The VFW and our partner VSOs know that there is plenty of accredited help for veterans in communities across the country, whether they seek the help of a VFW representative or from another VSO, a state or county representative, or an accredited agent or attorney. Veterans can experience challenges when finding the right representative who carries VA accreditation and is mandated to abide by the laws and regulations that govern the process. We look forward to continuing to work with VBA and other business lines across VA to spread this message and ensure veterans can choose the highly trained and accredited representatives that are right for them.

We are thankful that Congress and Secretary McDonough have been listening to the VFW and our partners, and are willing to work together to hold VA accountable, institute key policy changes, and reinstate veteran-centric business processes. The VFW looks forward to continued collaboration with VA and your committees to implement these critical reforms, offering our veterans reliable access to the benefits they have rightly earned.

Reinstate Pre-Decisional Review

On April 30, 2020, VA informed VSOs that it would eliminate the 48-hour, pre-decisional review process for claims. The VFW continues to be vocal in our opposition to the elimination of this decades-old practice and insists on its restoration. To address this, we have pursued litigation, which is currently underway. This review served as the final quality check that our advocates could perform on behalf of our clients to ensure that their rating decisions were correct the first time, as they rightfully deserve.

Appeals Modernization Act Implementation

As a collaborative partner in the development of the *Appeals Modernization Act* (AMA), the VFW is encouraged by VA's efforts to seek congressional support and include VSOs at multiple levels. To be clear, the VFW believes that AMA is largely working as intended. We believe that the framework for veterans to seek review of decisions remains sound and we have been encouraged by the timeliness with which VBA has recently adjudicated Higher Level Reviews under AMA. Moreover, the changes to the Board of Veterans Appeals (BVA) business processes under AMA have allowed organizations like the VFW to reimagine ways in which we serve the needs of our clients, improving efficiency and clarity in how veterans can seek review of their decisions.

We thank VBA for leaning forward on the Claims Accuracy Review (CAR) pilot program, which is made possible through the AMA framework. We have seen some success in quickly correcting decisions, but accredited representatives are skeptical that CAR is the best solution in its current form. Thankfully, this is an iterative process and we look forward to working with VBA to continually improve this process to meet the needs of veterans.

The VFW understands that legacy appeals will continue to demand our team's attention as VBA handles its remand workload and as appeals resulting from the Beaudette v. McDonough decision arrive at BVA for adjudication. The VFW stands ready to ensure that VBA administers these remands in a timely manner and that BVA has the business processes in place to handle the influx of Beaudette appeals.

Supplemental Claims and Intent to File

The VFW continues to have concerns with VA's interpretation of AMA language on Supplemental Claims. In the time since the AMA was enacted, the VFW and other VSOs have had numerous discussions with VA on the matters of prohibiting Intent to File (ITF) on Supplemental Claims and the requirement to submit anything that VA considers to be a supplemental on the required VA Form 20-0995.

Thankfully, the courts threw out VA's regulations restricting ITF, but to fully resolve this issue, VA must start to accept Supplemental Claims on any complete application for VA benefits, as Congress intended when it passed the AMA. We truly believe that this is a commonsense solution that will not only improve access to benefits for veterans, but also simplify VBA business processes, resulting in more timely and accurate benefits delivery.

The AMA was designed to simplify the claims process for veterans, and in most instances, we believe that it has succeeded. If we can work together to resolve this final Supplemental Claim issue, we believe we will have achieved the solid framework for benefits delivery that your committees, VA leaders, and the VSO community worked so hard to build.

21st Century Tools to Access Benefits

VA should be applauded for quickly migrating from a paper-based benefits system to a digital claims environment through the implementation of the Veterans Benefits Management System (VBMS). Since the introduction of this system, the VFW has sought to work with VA on new and innovative ways to provide quality advocacy for our veterans by leveraging technology.

In 2016, the VFW laid out a strategic vision for our global network of accredited representatives through which we would be able to provide quality claims assistance anytime, anywhere, through a reliable internet connection. When the COVID-19 pandemic hit, the objective to provide real-time claims service via the internet took on a whole new significance. Fortunately, the VFW was prepared to meet this challenge, and we continue to provide high quality claims assistance to our veterans even when we cannot always meet with them face-to-face.

As we navigate this changing world and the shifting manner in which we all deliver our services, it is imperative that VA works with its trusted partners like the VFW to ensure we can provide access to earned benefits regardless of the obstacles. For years, we worked in lockstep with VA to stand up systems like Stakeholder Enterprise Portal (SEP), Digits 2 Digits, Claims Management Portal, and others to allow our advocates and our clients to navigate their benefits electronically. VA also worked closely with accredited representatives to issue the required

electronic credentials to access VA information systems to provide the quality advocacy that our clients expect.

The VFW participated in a roundtable discussion with the House Veterans' Affairs Subcommittee on Technology Modernization in late 2019 and articulated our vision for a 21st century claims process. Since this meeting, our plans to improve our digital connection with claimants has continued to grow, with the VFW looking at ways to better link our claims management database directly with VA systems. The VFW also seeks to create a client-facing portal that allows claimants to interact with our accredited representatives in a secure manner, allowing us to more efficiently share and submit the information necessary to advance a benefit claim in partnership with VBA and our vendor, Tyler Technologies.

Current VA leadership has invited dialogue on improving digital tools for accredited representatives and veterans. The most substantial collaboration to date is the creation of VBMS. To the VFW, this is a game-changer on how we advocate for our claimants. In the past, we had to rely on cumbersome printed paper decisions. Keeping track of notifications was unwieldy and inefficient for both VA and our accredited representatives. For years the VFW has asked for electronic notification and we are grateful that VBA was finally able to deliver. We look forward to working with VBA on next steps in this process, to include simplifying VA systems access by moving away from the antiquated PIV badge system and building modern multifactor authentication for accredited representatives to access the systems we need.

Last summer, VBA surveyed VSOs on the needs of our accredited representatives in accessing VA systems. The goal of this survey was to build a new service provider system on VA.gov for accredited representatives. Our understanding is that VBA has taken this feedback and is looking to build a new system in 2022. We believe this system will help move VSOs closer to providing quality, real-time claims assistance to veterans from any reliable internet connection, and we look forward to working with VBA on this project.

Veterans are entitled by law to competent representation in the VA benefits process. Through continued collaboration and by accomplishing the VFW's objectives, VA is moving closer to providing veterans advocates with the same advocacy rights in the digital environment as were allowed in the paper-based claims process, and hopefully beyond. Aside from satisfying these statutory obligations, the VFW believes that VA will also achieve greater efficiency in the delivery of benefits to veterans.

Separation Documents

The Reserve Component does not have a single, comprehensive separation document like the DD Form 214 (DD-214). As the widely accepted standard form proving military service, only the Active Component receives a DD-214 on a predictable basis. Reserve Component members receive a DD-214 only under certain conditions and can receive many throughout a career, thereby increasing chances of lost forms and potentially lost access to benefits. Moreover, a 2019 RAND Corporation study found that the DD-214 neither captures cumulative service for these members nor includes Reserve-Component-specific data, complicating access to the full breadth of their earned benefits.

The VFW believes the Department of Defense (DOD) should adopt a uniform separation document that fully captures military members' unique service characteristics, regardless of the component in which they served. Accordingly, we urge Congress to pass S. 1291, *Record of Military Service for Members of the Armed Forces Act of 2021.* Moreover, the document must be available and accessible to service members to retrieve as needed, similar to a certificate of eligibility that a veteran would receive from VA to use their education benefits.

C&P Exams

Compensation and Pension (C&P) exams are a critical part of the VA disability claims process. The VFW supports S. 3163, *RURAL Exams Act of 2021*, which would improve data collection of C&P exams to better track timeliness, quality, and veteran satisfaction. The VFW has asked for this information to better understand the quality of both VA and contract exams in all parts of the country. It would also provide performance-based incentives for contractors to provide high quality exams in rural areas and would require inspections of contractor facilities to ensure exams are conducted in safe and appropriate locations.

VBA IT Upgrades

The COVID-19 pandemic continues to impact disability compensation claims processing resulting in a current backlog of over 260,000 claims. Some veterans who missed their C&P exams in 2020 were still able to reschedule and attend either in-person or virtual appointments during 2021, while others were hesitant to attend in-person exams as infection rates fluctuated throughout the country. The backup of exams continues to contribute to the growing backlog of pending claims.

During 2021, pressure intensified from VSOs, veterans, and the public on the need for VA to recognize presumptive conditions related to burn pits, Agent Orange, and a range of other toxic and environmental exposures due to military service. In August, VA added three new presumptive conditions associated with particulate matter exposure and has since hired 2,100 personnel to address the growing number of claims.

To address the growing backlog of disability claims, the VFW believes that there are limits to hiring more personnel and it will take time to train the new influx of hires. VBA also needs significant investment in its information technology (IT) claims processing infrastructure to move to a single, unified system that includes the latest in automation and artificial intelligence technologies. A digital benefits upgrade, similar in scope to the Digital GI Bill modernization in Education Services, would first require a significant investment in VA's budget, followed by strong collaboration with private industry peers and VSOs that provide claims representation, to build, iterate, and test a true 21st century claims system. VBA needs these critical IT improvements to increase efficiency in processing large numbers of claims in a timely manner as well as providing resources to accredited representatives to more efficiently assist claimants.

Improvements to Survivor Claims Process and DIC Increase

Part of VA's mission is to assist surviving spouses and children following the death of their

service member or veteran. The VFW finds that survivors are usually not prepared for the dramatic financial impact and have difficulty understanding the benefits to which they are entitled. While VFW Service Officers do assist survivors, improvements are needed from DOD and VA to better prepare, educate, and communicate with survivors during their time of need.

Dependency and Indemnity Compensation (DIC) is paid to the survivors of service members who died in the line of duty or to veterans who died from service-connected injuries or illnesses. This benefit has only minimally increased since it was created in 1993. Currently, DIC is paid at forty-three percent of one hundred percent permanent and total disability while all other federal survivor programs are paid at fifty-five percent. The VFW supports H.R. 3402 / S. 976, *Caring for Survivors Act of 2021*, to finally increase DIC payments to survivors, reaching parity with other federal agencies.

Health Care Issues

The COVID-19 pandemic changed the dynamic of the American health care system. As Veterans Health Administration (VHA) facilities and other health care systems throughout the nation applied a public health response, health care providers converted patient appointments to communication through telephone or video. The COVID-19 pandemic highlighted critical issues like expedited staff hiring and telehealth appointment platforms that the VFW hopes VHA continues beyond the pandemic. The VFW continues to monitor the safety and effectiveness of VA care at major medical facilities, outpatient clinics, and VA nursing homes to ensure the best possible care for those who have earned it.

Before the pandemic, VA had roughly 45,000 unfilled vacancies, including approximately 2,500 primary care physicians, more than 700 psychologists, and 1,900 social workers. Over the last two years VHA relaxed hiring policies, and *Coronavirus Aid, Relief, and Economic Security (CARES)Act* funding allowed VHA to hire new employees by the thousands. Although, as of the fourth quarter of fiscal year (FY) 2021, VHA had 47,310 vacancies for full-time employees, which is 16,732 more than the same quarter last year. The top five occupations with the most vacancies in VHA are nurses, medical support assistants, medical officers, social workers, and housekeeping aids. As the pandemic continues, the VFW urges Congress to pass *VA Nurse and Physician Assistant RAISE Act*, which would increase the pay rate to retain and incentivize these valuable health care professionals.

As new variants appear and COVID-19 cases surge, telehealth continues to play a critical role in maintaining veterans' mental and physical well-being during a time of social distancing and quarantine. Forty-one percent of veterans who responded to the VFW's COVID-19 survey in April 2021 stated their routine care appointments were converted to telehealth, which is slightly lower than the forty-seven percent from our 2020 survey. Telehealth appointments allowed veterans to gain access to their care in the safety and comfort of their own homes. By retaining telehealth as a tool to access, barriers such as transportation, inconvenience, unpaid time off from work, and child care were decreased. However, new issues arose such as limited access to high-speed internet, technology illiteracy, or lack of access to smartphones, tablets, or computers.

As COVID-19 vaccinations and boosters are given, veterans and their caregivers hear conflicting messages about who can receive the vaccination and how, or they receive no information from their VA medical centers. The first 133 VA facilities to receive the vaccination for distribution were VA medical centers and a few outpatient clinics. Many rural veterans rely on outpatient clinics as they are closer than the nearest VA medical center, which may be hours away by car. The VFW urges VA to keep the line of communication open regarding the COVID-19 pandemic, vaccination supplies, and scheduling appointments.

We would like to thank Congress for the swift passage of the *SAVE LIVES Act*. The VFW knows we cannot come out of this global pandemic until herd immunity is achieved, and we cannot accomplish that without whole households being vaccinated. Expanding VA's vaccination authority to immunize all veterans and their caregivers, will protect individuals and their communities. As of the end of January 2022, VA has fully vaccinated over 4.3 million individuals. Almost eighty-nine percent of the 2021 VFW COVID-19 survey respondents received at least one dose of the COVID-19 vaccine, and most were given at VA.

Mental Health and Suicide

The critical issue of suicide and mental health remains a priority for the VFW. Veteran suicide prevention requires a multi-faceted approach. An upstream perspective can examine root causes and support protective factors before mental health reaches a breaking point. This social-ecological model brings together the individuals, family and friends, and communities to create connectedness, strengthen life and coping skills, empower a purpose, and address social determinants of health to improve outcomes and reduce the risk of suicide.

VA's 2021 National Veteran Suicide Prevention Annual Report stated a decrease of 7.2 percent in the veteran suicide rate between 2018 and 2019. The report needs to include VBA information that can truly inform our decision-making on VA programming that affects social determinants of health. The VFW believes that VBA has significant data regarding recipients of these benefit programs, and that VA should easily be able to cross reference this data as it already has with VHA and now the National Cemetery Administration (NCA) to produce the annual suicide prevention report that provides a complete picture of how this change occurred.

All VFW members are eligible to use Vet Centers, and yet they are often overlooked as points of care offering various services such as individual and family counseling, benefits explanation, substance abuse assessment and referral, and many others. The VFW urges Congress to pass the *Vet Center Improvement Act of 2021*, which would require VA to develop and implement a staffing model and assess the productivity of Vet Centers.

The COVID-19 pandemic forced us to shelter in place, isolate, and social distance from each other, thereby increasing loneliness, anxiety, depression, and other mental health concerns. Telehealth played a large part in accessibility and timeliness of connecting veterans with mental health professionals. The continuum of care could carry on in the virtual world and build on existing trust between a veteran and their mental health provider. The VFW was the first partner with VA and Philips to roll out our five ATLAS sites, which provide telehealth services including mental health counseling to rural veterans. As of the beginning of February 2022,

VFW ALTAS sites hosted over ninety-four VA appointments at VFW Posts in Eureka, Montana; Linesville, Pennsylvania; Los Banos, California; Gowanda, New York; and Athens, Texas.

Although the data recently released from VA show a slight decline in veteran suicides, the number must be reduced to zero and remain there. There is movement in the right direction, but more needs to be done. The VFW urges Congress to pass the *STRONG Veterans Act of 2022*, which would improve substance use disorder treatment programs, increase Vet Center workforces, and provide oversight of the Veterans Crisis Line. Expanding VA mental health resources and research will support the comprehensive public health approach to suicide prevention. Additionally, the VFW urges strong oversight for all VA prescribing practices, to avoid overreliance on pharmaceuticals, specifically mental health related prescriptions is properly administered.

Veteran suicide prevention awareness is not just a VA, congressional, or veteran organization issue, it is an everyone issue. The VFW commends the members of these committees for their commitment to passing legislation such as the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019,* and ensuring VA implements the law as written and intended.

Mental Health and Suicide in Service

The issue of suicide and mental health in service also remains a priority for the VFW. In 2020, DOD found that the suicide rate within the Active Component has increased since 2015, while the Reserve Component experienced no change. Moreover, the study found that service members who are enlisted and young remain at heightened risk for suicide. While 2020 U.S. population suicide data were not yet available at the time of reporting, 2019 data indicated that, after correcting for sex and age, suicide rates for all service members were on par with the U.S. population. Many programs currently exist within DOD to mitigate suicide. However, it is unclear to what extent they are effective in decreasing the incidence of suicide within the ranks. Moreover, suicide-related definitions are not necessarily consistent across the services, which challenges accurate data collection, analysis, and reporting.

The VFW was pleased to see important steps being taken on these matters as part of the *National Defense Authorization Act (NDAA) for FY 2022*. We are eager to see the effect of improved suicide-related definitions on our understanding of the underlying causes of suicide among service members. Similarly, we look forward to the outcomes of the independent review of suicide prevention and response programs on military installations and urge Congress to implement associated recommendations. Finally, the VFW calls on Congress to pass the *Ensuring Veterans' Smooth Transition (EVEST) Act*, which would help ensure continuity of health care and decrease financial uncertainty in obtaining health care after service.

Military Sexual Trauma

Sexual assaults and harassment that occur during military service, known as military sexual trauma (MST), affect service members of all backgrounds, gender, and sexual orientation, and continue to be a problem that VA and DOD fall short in properly addressing. In 2018, DOD

estimated that nearly 20,500 service members had experienced some type of assault. An estimated 6.3 percent of active duty service women and 0.7 percent of service men have been sexually assaulted, while an estimated 25 percent of service women and 6.3 percent of service men have been sexually harassed. From FY 2012 to FY 2020, reported sexual assault cases increased from 2,828 cases to 6,290 cases. In 2019, sexual harassment complaints in the military were at just 1,600, while a 2018 survey of active duty troops indicated roughly 119,000 instances of harassment. The discrepancy between estimated prevalence and actual reporting of sexual assault and harassment among service members indicates MST is more pervasive than reporting alone would suggest. While DOD has continued to increase its efforts to reduce or eliminate sexual trauma within the ranks, the number of service members affected by MST has been slow to decline.

The VFW applauds Congress' inclusion of provisions in the FY 2022 NDAA that will substantially change how sexual assaults are handled under the Uniform Code of Military Justice (UCMJ). We are also relieved to see President Biden signed an executive order making sexual harassment a crime under the UCMJ. However, we believe there is still more to be done with regard to sexual harassment. While the FY 2022 NDAA made sexual harassment an offense punishable under the UCMJ and directs independent investigation, the definition for what constitutes "independent" is more loosely defined than for sexual assault. In the eyes of the UCMJ, the VFW believes sexual harassment should be handled in the same manner as sexual assault without room for interpretation. The VFW also urges Congress to ensure all recommendations of the 2021 Independent Review Commission on Sexual Assault in the Military are implemented with urgency and fidelity across DOD, regardless of component.

VA's national screening program screens all patients enrolled in VA for MST. National data from this program reveal about one in three women, and one in fifty men, respond affirmatively to having experienced sexual trauma while serving their country. All veterans who screen positive are offered a referral for free MST-related treatment, which notably does not trigger the VBA disability claims process. The VFW believes this should start an automatic process that allows veterans who have experienced MST to begin the claims process immediately. In addition to VA medical centers, VHA offers MST-related treatment at community-based and mobile Vet Centers.

VA's aim to end sexual harassment and abuse within its own walls falls short. Veterans and VA employees continue to experience some form of sexual harassment. Congress must provide oversight on programs and initiatives that were introduced in the *Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020*. In September 2021, VA announced the release of the Online Bystander Intervention Training for veterans, which provides tools and techniques on how to respond if a veteran witnesses harassment or sexual assault at a VA medical facility. The VFW recommends promoting this training more widely through all communication channels, but also suggests that posters and flyers be displayed throughout all VA facilities, so it is clear to veterans where to report inappropriate behavior.

Military Sexual Trauma Claims

Sexual assault in the military directly affects the lives of service members once they transition out of the military. However, VA disability claims related to MST are incredibly complex. According to an August 2018 VA OIG report, VA incorrectly adjudicated half of the reviewed post-traumatic stress disorder (PTSD) claims for MST. The OIG indicated six specific recommendations for VA to review and correct denied claims and implement a series of changes needed to improve claims processing for MST. Regrettably, the most recent OIG report from August 2021 found that VA had not effectively implemented those recommendations, did not ensure adequate governance over MST claims processing, and that fifty-seven percent of the previously denied claims reviewed by VA had still not been processed correctly. This is incredibly troubling. The VFW is concerned that VA's lack of improvement to accurately process MST claims has unfairly denied veterans their benefits, forcing those willing to continue the process to go through unnecessary and emotionally distressing appeals.

It can take many years for survivors to even acknowledge a trauma occurred, and sharing details with advocates and care providers can be extremely difficult. Survivors of sexual assault often report feeling retraumatized when they must recount their experiences to disability compensation examiners. Therefore, we encourage VBA to employ the clinical and counseling expertise of sexual trauma experts within VHA or other specialized providers during the compensation examination phase.

The VFW supports H.R. 5666 / S. 3025, *Servicemembers and Veterans Empowerment and Support Act of 2021*, which would require VA to modernize the MST definition to include technological abuse, update the standard of proof for MST disability claims, review VBA's MST training for quality, and examine barriers and challenges MST survivors experience for inpatient mental health service. This bill is a necessary step to ensure veterans' MST claims are handled respectfully and veterans are given the much-needed support services from VA.

Caregiver Support Program

2021 marked the first full year of phase one applicants to VA's Program of Comprehensive Assistance for Family Caregivers (PCAFC). Since October 2020, VA received over 127,500 applications and approved thirteen percent of them. The majority of denied applications were because of program ineligibility or eligibility during phase two. As in any program expansion, there have been bumps along the way. VA met with VSOs to announce updates and created a VA Caregiver VSO Toolkit.

The VFW believes a veteran has the right to appeal non-medical determination by PCAFC. This is the right thing to do. Over a six-month period starting in November 2021, almost 450,000 letters will be mailed to veterans and their caregivers who received PCAFC denial decisions to explain the process to appeal. The VFW urges Congress to oppose any legislation that would overturn the Beaudette decision and remove the rights of veterans and their caregivers. With phase two PCAFC expansion this year, the VFW urges Congress to maintain oversight and ensure VA opens phase two applications on or before October 1, 2022.

Minority Veterans

Minority veterans' health outcomes are affected by real or perceived biases. As the population of minority veterans continues to grow, VA needs to adapt to meet the need for access to both health care and benefits services. Women, LGBT, and racial and ethnic minority veterans face barriers and challenges across different life domains. VA's "Minority Veterans Report: Military Service History and VA Benefit Utilization Statistics" from March 2017 states that in 2014 less than a quarter of the total veteran population was comprised of minorities, and this number is expected to increase to 35.7 percent in 2040. Nothing has been updated and published on the public-facing website since.

Gathering a veteran's background characteristics, such as race, ethnicity, sexual orientation, and self-identified gender identity, brings awareness to the veteran population and provides a clear picture of disparities in health care access and outcomes affecting them. Understanding a veteran's race and ethnicity can help health care providers address specific health care concerns for which the veteran may be at a higher risk. The VFW urges VA to ensure all VA forms and research captures this valuable information to correctly track needs, benefits, and services. Until this is corrected, inconsistent data hinders proper and inclusive research. VA recently included gender identifier in the medical record. By understanding a veteran's sexual orientation or self-identified gender identity, the health care provider's ability to provide appropriate care increases and LGBT veterans' risk of discrimination decreases.

Racial and ethnic disparities affect veterans' health care outcomes. According to the Government Accountability Office (GAO) report "Opportunities Exist for VA to Better Identify and Address Racial and Ethnic Disparities," VA's action plan and advancing health equity is lacking performance measures and accountability. The VFW believes that VA should adopt a culture of trust and action to achieve positive health outcomes for minority veterans. To begin this process, VHA must first consistently collect the correct race, ethnic, and sexual orientation data in the electronic health record system. Collecting basic demographic information is the first step in understanding the needs of a diverse veteran population.

Women Veterans Issues

Reproductive health follows a woman veteran throughout the seasons of her life. Women veterans will soon account for almost eleven percent of the national veteran population, and they comprise twenty percent of the veteran population ages 18-35. The average age of women veterans is fifty-one years old, which is almost fifteen years younger than for male veterans. Presumably, a significant portion of women veterans require family planning resources, prenatal and maternity care, or premenopausal and perimenopausal care.

Our VFW women veterans have routinely stated that VA must improve privacy at women's health clinics, access to gender-specific health care, prenatal and maternity care, mental health care to treat MST and postpartum depression, and targeted outreach to women to ensure that no veteran is left to wonder what benefits she is eligible to receive. Reproductive health services, family planning counseling, and contraception must be available as a matter of principle. There is absolutely no room for debate on providing in vitro fertilization to treat service-connected reproductive difficulties for younger female veterans. Military service has been linked to lower fertility rates, and genitourinary injuries, particularly from blast exposures, are a signature

battlefield trauma of operations in the Global War on Terrorism. Service-connected injuries, toxic exposures, and other health issues can destroy a veteran's dream of having a family. The VFW urges Congress to pass legislation that would expand VA services to include fertility preservation, and reproductive, adoption and child care assistance.

Mammography and other services to address health conditions that are more prevalent in women must be readily accessible. The VFW urges Congress to pass the *Making Advances in Mammography and Medical Options for Veterans Act*, which would require VA to develop a breast imagining strategic plan and upgrade to 3D digital mammography. In addition, this bill would create a telemammography pilot program, which would centrally locate radiologists in an adequately equipped room to read mammograms and digitally enter their diagnoses into veterans' electronic medical records.

The *Isakson-Roe Act of 2020* contains the majority of the *Deborah Sampson Act*. This forward-looking legislation will break the cultural barriers impacting women veterans by requiring VA to address privacy concerns and improve access, expand the amount of time new mothers are given to find health care coverage for their newborns, increase staff cultural competency, eliminate harassment and assault, and make other much-needed improvements to women veterans' health care. Understanding barriers and challenges to care, gap analysis on services for homeless women veterans, the availability of prosthetics for women, and research and studies specifically tailored toward women veterans will create a path to meet the future needs of women veterans. However, there is more work to be done. The VFW also urges congressional oversight of the Deborah Sampson portion of the *Isakson-Roe Act of 2020* to ensure proper implementation of this critical provision.

More and more women veterans are admitted to treatment programs and the number continues to rise. A majority of women veterans in treatment programs are there due to alcohol abuse, and use of cocaine and opiates. Women veterans with substance use disorders (SUD) have distinct needs and barriers to treatment. The VFW supports the *Women Veterans Transitional Residence Utilizing Support and Treatment (TRUST) Act*. The VFW also supports the *STRONG Act of 2021*, which would require VA to conduct a study on veteran access to inpatient mental health and substance abuse treatment programs.

Parity of Health Care Services

From the VFW's research and member feedback, as well as studies by RAND Corporation, NASEM, and other leading institutions, we know that VA provides high-quality health care. We also know that veterans tend to prefer treatment from VA, once they are eligible. A VA study published in August 2020 concluded that VA care ranked higher than community care in overall provider rating, communication, and coordination. DOD care, through both the direct care system and TRICARE, offers state-of-the-art treatment options at an extremely reasonable cost. Research done by VA and DOD has and continues to yield innovative new therapies and research that contribute to amazing advances in medical science, making health care better not just for service members and veterans but for all Americans and people the world over. Parity with the best options of civilian treatments, however, is often an issue in both VA and DOD.

The rapid innovation of research and development means that therapies and diagnostics, such as in vitro and laboratory-developed tests that focus on specific diseases, are available to the general public and are reimbursed by commercial insurance but are not covered by VA or DOD. Some reproductive health services that are readily available and are a common standard of care from civilian providers and commercial insurers are not covered by VA or DOD. Conversely, VA rehabilitation programs, prosthetics, and inpatient mental health and substance abuse treatment lead the way for the nation.

VA and DOD should develop more agility in their certification and procurement processes to take full advantage of changing standard-of-care treatments. VA and DOD health care is first-class and must remain responsive to ensure that America's service members and veterans do not receive lesser care or fewer options than other Americans.

The VA formulary currently carries all categories of pharmaceuticals deemed preventive by the U.S. Preventive Services Task Force. However, VA is exempt from requirements to provide preventive care and services without cost shares. Cost is a significant barrier for veterans who use VA health care, who have been found to have a lower income on average than veterans who do not use VA health care.

There are currently eleven categories of preventive medications found to be effective, such as aspirin to lower the risk of cardiovascular disease. Cardiovascular disease is the number one cause of death in the United States and is highly prevalent among the veteran population. Additionally, folic acid is recommended for pregnant women to prevent neural tube defects. It is unjust to require women veterans to pay for the cost of preventive medication to prevent such birth defects. Vitamin D is another preventive medicine that is often prescribed to prevent bone fractures, which benefits traumatic brain injury patients with hindbrain injuries. There is also breast cancer prevention medication that is useful not just for individuals with a family medical history of breast cancer, but for Camp Lejeune toxic water survivors who have been found to suffer from increased rates of breast cancer. These pharmaceuticals have been found to prevent possible disease and to be health care cost savers.

Preventive dental care can significantly impact veterans' health and quality of life, including job security. However, only veterans who are one hundred percent service-connected disabled, certain homeless veterans, and those who have a service-connected dental condition are eligible for VA dental care. The majority of veterans enrolled in VA health care are unjustly denied access to VA dental care. Instead, they are offered the ability to purchase dental insurance through VA, which has high costs and poor coverage. The VFW urges Congress to expand eligibility and resources regarding the VA Dental Insurance Program.

Women veterans who use VA health care for family planning services are also concerned that VA requires copayments for preventive prescription drugs, such as contraceptives. This is counter to industry standards for private health insurance plans, which do not require out-of-pocket costs for preventive care prescriptions. The VFW supports the House-passed *Equal Access to Contraception for Veterans Act.*

VA Infrastructure

Over the past decade, the VA health care system has faced significant challenges and undergone historic reforms to improve veterans' access to timely and high-quality health care. The *VA MISSION Act of 2018* was enacted to improve veterans' access to medical care by expanding VA's internal capacity to deliver care, and by developing new community care networks to integrate within the VA health care system to serve as a supplemental source of care if VA were unable to provide needed services or do so in a timely manner. The law also established an Asset and Infrastructure Review (AIR) process to modernize, realign, and rebuild VA's health care facilities. VA is also currently engaged in a ten-year, sixteen-billion-dollar modernization of its Electronic Health Record Management (EHRM) system. As these truly pivotal transformations continue during the COVID-19 pandemic, it is important for VA to incorporate critical lessons about how to safely and effectively expand and improve the delivery of care today and in the future.

While VA has received increased funding levels to support the veterans' health care system and an increasing number of veterans are seeking VA care, the lack of resources for facilities management and modernization, sufficient health personnel to meet demand for care and benefits, and replacement of aging systems of support continues to negatively impact accessibility. VA's aging infrastructure not only causes many veterans to wait too long and travel too far care, but also potentially endangers the health and lives of veteran patients and VA personnel.

The past year has shown VA's strengths and weaknesses, and has spotlighted areas where VA needs improvement. As a result, the VFW is closely monitoring the progress of the VA Market Assessments and the upcoming AIR process. We believe the AIR commission is vital to the future of VA care and must be administered correctly. The bipartisan work that took place to ensure a proper AIR process should not be undermined by hasty partisan efforts. The VFW recommends that the AIR commission implements a methodical review process and produces a report detailing the future needs of VA assets and infrastructure. We urge Congress to immediately provide funding for all necessary changes and recommendations resulting from the AIR commission's report, separate from the other outstanding infrastructure needs.

Problems with VA's Planning, Budgeting, Management and Oversight of Infrastructure

While VA's Strategic Capitol Investment Planning (SCIP) process ostensibly provides a consolidated and prioritized list of all VA major construction, minor construction, non-recurring maintenance (NRM), and lease projects, VA's budget request regularly fails to include the full SCIP funding estimates or priorities. The SCIP process does not provide a chronological list of anticipated repairs, renovations, and replacements of facilities necessary to develop an actuarial schedule of facility lifecycle repair and replacement costs. At best, SCIP provides nonbinding suggestions to the VA budget process, which are regularly ignored, resulting in an ever-increasing backlog of overdue maintenance and construction projects. Furthermore, as long as funding for VA infrastructure remains part of its discretionary budget, it must compete with other VA health care and benefit delivery priorities in an era of rising deficits and debt, budget caps and sequestration. In this limited fiscal environment, VA is forced to choose between properly funding the maintenance of existing facilities or making overdue modernizations and

expansions to meet veterans' future health care needs. As a result, the annual discretionary appropriations process has resulted in more than two decades of inadequate funding and a rising backlog of critical VA health care construction projects and leasing requirements. This underprioritizing has led to some of the needs of the AIR commission, and we hope this committee stands ready to remedy all VA infrastructure needs.

Inefficient VA construction management and congressional oversight procedures are obstacles to timely and cost-effective infrastructure maintenance and construction. Neither VA's Office of Construction and Facilities Management nor individual VA facilities have the manpower or expertise required to plan or oversee VA's infrastructure. VA's multi-step planning, contracting, funding, and approval process is consistently plagued by delays and cost overruns, and low funding thresholds for minor construction and NRM, as well as PAYGO scoring rules, have unnecessarily limited clinical treatment.

To overcome VA's infrastructure challenges, Congress must not only provide significantly increased funding to fully address these long-standing issues, but also enact comprehensive planning, budgeting, management, and oversight reforms to ensure more effective use of those funds. The VFW recommends VA's construction budget should be approximately three percent of its overall operating budget, which would be between six and seven billion dollars annually. This three percent should also be separate from the AIR recommendations. We also recommend partnering with the Army Corps of Engineers to help reduce the SCIP backlog.

Electronic Health Record Modernization

VA is transitioning to a new EHRM system that would store all health information and track all aspects of patient care. EHRM is planned to take ten years to be fully implemented and is scheduled to be completed in 2028. Once fully implemented, the new system will connect VA medical facilities with DOD, the U.S. Coast Guard, and participating community care providers, allowing clinicians to easily access a veteran's full medical history in one location. This new platform will improve quality of care, patient safety, the ability to connect medical systems, and will streamline workflows through multiple connection technologies. Data acquired from medical devices will be directly populated into the record for verification, reducing data entry. The VFW has been working closely with VA and Cerner Corporation to inform veterans of the new changes, help them navigate the new online service, and monitor the implementation.

The VFW understands the high cost and challenges associated with implementing this new health care system and recognizes that this is a necessary step to improving the overall quality of VA health care. However, recent OIG reports revealed significant costs were unreported, underreported, or unknown. Findings from the OIG indicate possibly as much as fifteen percent of total costs were not identified due to inadequate physical infrastructure conditions, such as heating, ventilation and cooling, electrical work, and cabling. Moreover, the OIG found that other critical success factors, such as key stakeholder inclusion and proper user training were not prioritized in the initial EHRM rollout at Mann-Grandstaff VA Medical Center in Spokane, Washington. This misidentification of infrastructure needs combined with inadequate emphasis on VA staff could jeopardize the overall success of the modernization program.

The VFW supports the *VA Electronic Health Record Transparency Act of 2021*, which would require VA to identify any amount expended on infrastructure projects necessitated by this program. In addition to authorizing and appropriating funds to upgrade infrastructure, we urge Congress to ensure marked improvements are realized with each subsequent EHRM rollout. Moreover, the VFW recommends full funding of the joint program office to oversee the implementation of the two programs. Making sure there is seamless coordination between DOD and VA is integral to the development of this program, and proper funding for the entirety of the process is critical to its success.

Employment And Education Issues

The first year of the COVID-19 pandemic had significant impact on employment nationwide, including veterans, as our country saw a halt to the longest period of economic growth since the end of World War II. At its peak, the unemployment rate for veterans has nearly doubled from 3.1 percent in 2019 to 5.5 percent during the pandemic. Over the past year, veteran unemployment rates have recovered as unemployed veterans have seen relief through passage of legislation such as the *Isakson-Roe Act of 2020* and the *American Rescue Plan Act of 2021*, which expanded programs such as Veterans Rapid Retraining Assistance Program (VRRAP) and Veteran Employment Through Technology Education Courses (VET TEC). The education and training provided via VET TEC has allowed over 3,200 veterans to reskill and gain certifications in high-demand technology fields, with education providers held accountable to support gainful employment. Congress must pass legislation to ensure funding for programs such as VRRAP and VET TEC that show measurable outcomes and help put veterans in high-demand jobs.

The success of graduates in the VET TEC program for subsequent job placement has demonstrated the value short-term job training and credentialing has for veteran economic security. The VFW is interested in improving private sector and civilian credentialing for certain military occupational specialties and ensuring veterans can leverage their miliary skillsets to the maximum extent possible. For decades, DOD has had difficulty translating military training and professional development education into civilian terms in ways that were easily communicated to service members. The VFW is encouraged by new initiatives to revamp DOD's Credentialing Opportunities Online (COOL) programs through the launch of the new MilGears platform in 2021. This tool, which finally aggregates military training in a centralized location for tailored assessment for future career opportunities, will allow a better chance to seamlessly apply for a professional license after transition from military service—a solution the VFW has long called for. We are eager to learn outcomes from DOD regarding the success of this launch and urge Congress to require reporting and data collection on the use of MilGears and opportunities for expanded outreach or partnerships on a regional level to provide the most tailored experience possible.

Additionally, we are happy to see strides made by the Army in recognizing the importance of credentialing pathways and establishing Credentialing Assistance in addition to Tuition Assistance, expanding opportunities for soldiers to pursue credentials that lead to high-demand jobs. The VFW hopes to learn outcomes from the Army's program and how DOD might implement this broadly across services. As VBA expands its training opportunities to align with current employment opportunities through programs such as VET TEC, it is critical that DOD

Voluntary Education (VolED) programs are paralleled to ensure a seamless transition for service members.
The VFW continues to be concerned about military spouse unemployment. DOD estimates the spouse unemployment rate to be one in four, or twenty-five percent, which is nearly seven times the national average. Underemployment estimates among military spouses are as high as fifty-one percent. Several factors influence spouses' ability to maintain gainful employment including frequent relocations, as well as affordable and timely access to quality child care. Bolstering interstate agreements for licensing portability and expanding child care programs and facilities would help support access to stable and qualification-appropriate employment for military spouses. Military spouses were already operating at this deficit before the COVID-19 pandemic hit, when an additional thirty-four percent who were previously employed lost their jobs due to the pandemic. Despite some economic recovery, military spouse employment and child care stability challenges remain. The VFW is happy to see comprehensive research of military spouse employment funded within the FY 2022 NDAA, and we look forward to meaningful action and policy changes made in accordance with subsequent findings.

Additionally, we urge Congress to move forward with legislation to expand tax incentives for businesses to hire both veterans and military spouses who offer unique skillsets that can be overlooked by employers. We seek innovative ways to encourage businesses to bolster workforce and best highlight their valuable skills. The VFW supports and hopes for quick action to pass H.R. 3582, *Veteran Employment Recovery Act*, and H.R. 2914, *Military Spouse Hiring Act*, both which would expand Work Opportunity Tax Credits (WOTC) for the military and veteran community in ways needed in the wake of the pandemic.

Veteran Readiness and Employment (VR&E) Services

Vocational rehabilitation for disabled veterans has been part of this nation's commitment to veterans since Congress first established a system of veterans' benefits upon entry of the United States into World War I in 1917. Today, Veteran Readiness and Employment (VR&E) is charged with providing wounded, ill, and injured veterans with an array of services designed to enable them to obtain and maintain suitable and gainful employment. In the case of those veterans with more serious service-related disabilities, VR&E is authorized to provide independent living services. Veterans are eligible for VR&E services and programs if their military discharge is other-than dishonorable and they have a VA service-connected disability rating of at least ten percent or, a VA memorandum rating of twenty percent or more. The VR&E program is also accessible to active duty military personnel expecting to be medically discharged with the anticipated disability rating of at least twenty percent or more from DOD and VA.

The 116th Congress passed legislation to expand VR&E eligibility. Previously, all eligible veterans were required to apply for VR&E benefits within twelve years of the date of separation from active duty or the date a veteran was notified by VA of a service-connected disability rating. The *Isakson-Roe Act of 2020* removed the twelve-year delimiting period for veterans who separated on or after January 1, 2013. The twelve-year application eligibility deadline can be extended, however, if vocational rehabilitation counselors determine veterans have a serious employment handicap. Service-connected disabilities usually get worse with time, and veterans should not be at the mercy of counselors to determine if their disabilities are severe enough to

waive the twelve-year limitation. The VFW calls on Congress to eliminate the twelve-year delimiting period for VA Chapter 31 VR&E services for veterans who separated before January 1, 2013, to ensure disabled veterans with employment handicaps, including those who qualify for independent living services, qualify for VR&E services for the entirety of their employable lives.

Congress must provide proper oversight of the VR&E program. After years of stagnant funding levels, the VR&E office was finally given enough resources to achieve a 1:125 counselor-to-client ratio at the national level and underwent IT modernization upgrades to allow for increased counselor-to-client interaction. Despite these improvements, veterans using VR&E still consistently report difficulty contacting their VR&E counselors and a general lack of responsiveness. Veterans also report they are often stonewalled by their counselor regarding their desired career path and that decisions regarding approval for education programs are not consistent from counselor to counselor for veterans with similar disabilities and career goals. The VFW asks Congress to perform periodic oversight of the recent changes to the VR&E program to determine if the resources are sufficient or if further changes are necessary, including the 1:125 counselor-to-client ratio and further codifying policy for program approvals. The VFW also recommends a change to the reporting of the ratio to reflect the VA Regional Offices (VAROs), instead of a nationwide counselor-to-client ratio. This will help address the needs of specific offices and more directly help veterans.

In concert with this oversight, the VFW asks Congress to require reporting on the effectiveness of VR&E counselors at VetSuccess on Campus (VSOC) centers and data on institutional requests and approvals. The VSOC program is designed to help veterans, service members, and their qualified dependents thrive on campus through on-campus benefits assistance and counseling. In part, this is accomplished by having a VR&E counselor assigned to each VSOC. Many veterans report that despite having a VSOC on their campus, the VSOC counselor may still be assigned to multiple VSOCs and not as dedicated support. The VFW asks Congress to incorporate VSOC use and implementation into comprehensive VR&E oversight, to include the number and type of institutions requesting and being approved for VSOC establishment.

A GAO report in July 2021 found that many veterans are unaware of their eligibility for VR&E when making decisions about using their GI Bill benefit or seeking employment. GAO recommended VA conduct further outreach to ensure eligible veterans are aware of all their options. In April 2021, VA also announced a change to its interpretation of the "48-month rule," which would now allow veterans pursuing education through VR&E to keep their Post-9/11 GI Bill eligibility, instead of this time consuming their eligible GI Bill months. The VFW recommends that Congress requires VA to provide outreach in line with GAO recommendations to ensure all veterans are aware of VR&E eligibility and the changes to the 48-month rule, and that VA measures the impact of this rule change on veteran choice and outcomes through VR&E and Post-9/11 GI Bill use.

GI Bill

Despite the extreme value of the Post-9/11 GI Bill and its correlation to upward mobility, VA reports there has been a seventeen percent decline in GI Bill use over the past six years, with

barriers to obtaining financial support cited as a major factor in this decline. The VFW recommends a thorough re-evaluation of Monthly Housing Allowance (MHA) and adjustments made so this allowance is comprehensive of the cost of attendance beyond tuition, to include housing and other costs such as child care. Student veterans oftentimes bear responsibilities not shared by their non-military counterparts. VA data indicate that roughly forty-seven percent of student veterans have children, whereas approximately only twenty percent of non-veteran students are parents. Securing consistent and affordable child care is a barrier to degree completion and can result in poor academic performance.

The VFW believes the current scale for GI Bill Monthly Housing Allowance (MHA) does not offer parity for students attending school online. The current payment rate of GI Bill MHA for students attending school exclusively through Online Training is half the national average. In 2020, the COVID-19 pandemic pushed most education classes to an online-only format for certain periods of time. The *REMOTE Act* that passed in December 2021 extended existing protections to allow students enrolled in courses that were intended to be on campus but had been pushed online due to the pandemic to still receive the higher-paying MHA for resident courses. As these protections have now extended beyond two years, the inequity for students enrolled in online courses prior to the pandemic is that much more glaring. As these changes to campus programs push into a third year, some changes will no longer be temporary, and some elements of higher education and student choice will be forever altered. With that, the support allowances provided along with GI Bill use must also be altered to support the needs of current students and allow them to persist to graduation.

The need for this legislation to extend protection for student veterans, which also included protection for associated delimiting dates based on school closures resulting from the COVID-19 pandemic, has also highlighted the need for permanent policy addressing the GI Bill during times of national emergency. The VFW believes Congress must pass legislation that would immediately extend these protections to students using GI Bill and VBA education benefits during a time of national emergency that impacts the ability to participate in coursework as intended.

Furthermore, we would like to ensure that members of the National Guard and Reserve are credited for all activations in support of federal service missions. Within the past few years, members of the National Guard and Reserve have been activated to assist during events of national urgency. The VFW was pleased to see the House pass the *Guard and Reserve GI Bill Parity Act*, and urges this legislation to quickly pass the Senate so these service members can begin to see this long-overdue equity.

Lagging IT infrastructure has been a consistent barrier to VA efficiency that different business lines need to work around daily. The VFW has been pleased to hear of the consistent meeting of milestones as VBA continues making strides toward automation to enhance user experience when executing GI Bill benefits following the reallocation of the *Coronavirus Aid, Relief, and Economic Security Act* funding for the Digital GI Bill. The VFW urges Congress to track and remedy any deficiencies in funding to achieve Digital GI Bill success to ensure this project stays on course to completion. Additionally, Congress must ensure that additional funding for the

Digital GI Bill is accounted for in concert with any legislation related to the GI Bill, such as the *Guard and Reserve GI Bill Parity Act.*

The VFW also supports proposals to set limits on federal funds that may be received by for-profit institutions. The 90/10 loophole has existed for years, and the VFW believes closing this loophole is a great step in the right direction to help protect service members, veterans, and their families. Currently, schools accepting Title IV Pell Grants must abide by the 90/10 ratio of funding from students using federal funds versus students paying on their own. Closing the 90/10 loophole by defining federal funds to include payments from VBA and DOD, such as GI Bill and military tuition assistance, is the correct course of action. The VFW believes this is a straightforward change that aligns all federal funding for the purpose of the 90/10 ratio. This step to protect student veterans and active duty service members from predatory schools is not meant as a measure against for-profit institutions. The VFW recognizes the value certain institutions provide for student veterans and would not want this loophole closure to negatively impact students due to the nature of their institution. That is why we recommend a waiver clause placed in any 90/10 GI Bill proposal to ensure good schools are not categorized with predatory institutions.

In addition to closing the 90/10 loophole, the VFW believes a critical element in protecting GI Bill users against predatory institutions is to ensure information in the GI Bill Comparison Tool is comprehensive, accurate, up to date, and user friendly so veterans can make informed decisions regarding education programs of choice. The Digital GI Bill has begun to make strides toward the user interface of the GI Bill Comparison Tool. However, the VFW urges Congress to pass commonsense legislation that would provide practical updates to content and enhance transparency for service members and veterans, to include passing the *Student Veterans Transparency and Protection Act of 2021.*

Public Service Loan Forgiveness

The VFW has been very encouraged by the Department of Education (ED) action in October 2021 to fix years of a broken Public Service Loan Forgiveness (PSLF) program. For many years, service members and veterans who rightfully believed their time on active duty would allow them to have their federal loans forgiven were shocked when they were denied approval due to the nature of their repayment plan. Additionally, many service members and veterans were never even made aware that their active duty service would qualify for them to eliminate this financial burden. Under the current PSLF overhaul, loan borrowers will have a limited time through October 2022 to request a waiver that will allow all repayment types to count toward PSLF. The VFW asks Congress to provide oversight to ED that would ensure there is sufficient outreach to all eligible loan borrowers, that these borrowers have adequate time to complete these waivers, and that all eligible service members and veterans are granted the PSLF to which they are entitled. Additionally, we request Congress to determine if any funding is needed to provide automation between DOD and ED to ensure that eligible service members are provided this relief without unnecessary red tape.

We were also extraordinarily pleased by ED's decision as part of the 2021 PSLF overhaul to remove a barrier for military loan borrowers and allow deferral months while active duty service members are deployed to count toward eligible repayments. Given this current rule change, the

VFW urges Congress to codify these policies and ensure these protections stand the test of time by passing H.R. 3486, *Recognizing Military Service in PSLF Act.*

Fourth Administration

VA is currently comprised of three administrations—the National Cemetery Administration, the Veterans Benefits Administration, and the Veterans Health Administration. VBA oversees not only compensation and pension, but also the GI Bill, vocational rehabilitation, housing and business loans, and the broadly defined transition assistance program, which is shared with the Departments of Labor (DOL), Defense, and Homeland Security.

The VFW believes our nation's focus on the economic opportunities of our veterans must be permanent. In reality, not all veterans seek VA health care when they are discharged, they do not need assistance from NCA, and they do not all seek disability compensation. However, the vast majority are looking for gainful employment and/or education. Congress should recognize the value of these programs by separating them into their own administration focused solely on their utilization and growth.

The VFW has long proposed that Congress creates a fourth administration under VA with its own under secretary whose sole responsibility is the economic opportunity programs. This new Under Secretary for Economic Opportunity would refocus resources, provide a champion for these programs, and create that central point of contact for veterans, VSOs, and Congress within VA to oversee benefits such as the GI Bill, VR&E, home loan, transition, and other economic-opportunity-centered benefits. The VFW was pleased in 2021 when the House passed H. R. 2494 to establish this fourth administration, and we urge the Senate to also move this legislation quickly into law.

Adaptive Automobile Grants

The current adaptive automobile grant for disabled veterans is an incredible benefit for those who need this program. VA is authorized to provide a one-time grant of $21,488.29 to veterans who are unable to drive due to a service-connected disability. This grant may be used for the purchase of a specially equipped automobile. However, the one-time use of this grant does not take into account modern vehicular needs for veterans and vehicles in the 21st century. A one-time grant for vehicle adaptations is not enough considering the average American buys multiple vehicles in their lifetime. Veterans who have previously received a grant must pay any expenses associated with the purchase of a new vehicle themselves. The cost of replacing a modified automobile with a used or new vehicle ranges from $21,000 to $65,000, which is a substantial sum for most consumers. These substantial costs, coupled with inflation, present a financial hardship for many disabled veterans who need to replace their primary mode of transportation once it reaches its life of service. The VFW urges Congress to pass the *Advancing Uniform Transportation Opportunities (AUTO) for Veterans Act*, which would permit veterans to receive an automobile grant every ten years in an amount equal to the grant maximum at the time of vehicle replacement.

Homelessness and Food Insecurity

The VFW commends VA and the Department of Housing and Urban Development (HUD) for making significant strides toward ending veteran homelessness. Temporary legislative measures during the COVID-19 pandemic to alleviate homelessness and housing insecurity among veterans were successful and impactful. However, as these issues continue to plague veterans, as well as the service providers, permanent legislation is needed to ensure continuity of these services. The VFW strongly supports and urges Congress to quickly pass the *Building Solutions for Veterans Experiencing Homelessness Act.*

A homeless person is federally defined under the *McKinney-Vento Homeless Assistance Act of 1987* as an individual or family lacking fixed, regular, and adequate nighttime residence, as well as those fleeing domestic violence or other dangerous or life-threatening conditions. VA is not precluded from assisting veterans who are temporarily living with friends or family, commonly referred to as "couch surfing." Yet, it has elected not to do so. This is particularly burdensome for women veterans who often do not feel safe due to violence or sexual assault in a homeless shelter, as well as for veterans with dependent children. The VFW urges Congress and VA to expand this definition so VA can provide more benefits and services to homeless veterans who are in intermediary situations, especially in the current housing crisis from the fallout of the COVID-19 pandemic.

Veterans with dependent children face diverse challenges with access to their earned benefits, including child care. Currently, VA has four pilot programs that offer on-site child care, which have been successful in increasing access to care and benefits. The VFW also encourages Congress to work with VA to provide more separate living arrangements for veterans with children and veterans who have survived sexual trauma. Congress and VA must work together to better understand that individuals face homelessness for different reasons, and their needs to overcome homelessness are equally unique.

VA's homeless programs are holistic in nature and include medical, dental, and mental health services, as well as specialized programs for PTSD, MST, SUD, and vocational rehabilitation. VA adopted a model of housing veterans first, rather than requiring them to be in recovery or treatment for mental health or SUDs prior to receiving housing assistance. Homeless prevention coordinators and peer mentors are imperative to the success of the program by helping veterans navigate the system and receive the services they need. The VFW urges Congress and VA to consider increasing the use of peer specialists, particularly for veterans who are in recovery for SUDs and/or have experienced homelessness. Peers who have had similar experiences are often able to connect on a more personal level and can help homeless veterans overcome challenges they face in maintaining housing and sobriety.

For veterans on the verge of homelessness, there is currently little VA can do. Several benefits require veterans to literally be living on the streets before they are deemed eligible. Many veterans who are on the verge of homelessness know they are being evicted, and nearly half of homeless veterans report temporarily staying with friends or family. This is why the VFW recommends Congress works with VA and HUD to ensure veterans who are facing eviction or are temporarily staying in another person's home are allowed to obtain assistance. The VFW also strongly urges Congress to pass a bill to provide cost-free child care to veterans living below the

poverty line, or who are already homeless while using VA and the DOL Veterans' Employment and Training Service (VETS). If a veteran is not able to afford rent or is working to avoid homelessness, then it is impractical to assume the veteran can afford child care services.

Veterans fortunate enough to obtain HUD-VA Supportive Housing (VASH) vouchers also face difficulties. VFW Service Officers have reported in various cities that homeless veterans sometimes prefer sleeping under a bridge rather than living in the unsafe neighborhoods for which their vouchers are eligible. The VFW urges Congress, VA, and HUD to work together with local VA facilities to ensure HUD-VASH vouchers put veterans in safe and secure housing.

An estimated 160,000 enlisted active duty troops have difficulty feeding themselves and their families. While affecting all enlisted ranks, food insecurity is predominantly experienced by junior enlisted families (E1–E4) and is influenced by factors such as low pay, spouse unemployment, child care challenges, and inconsistent eligibility for programs like the Supplemental Nutrition Assistance Program (SNAP). Accordingly, even though military readiness is paramount, many service members cannot fully engage their missions since their families struggle to eat and satisfy other basic necessities. To help combat this problem, the VFW has partnered with Humana to provide one million meals to service members and veterans in need.

The VFW believes Congress' creation of a Basic Needs Allowance (BNA) via the FY 2022 NDAA was a vital step in the right direction, as it will bring needed relief to many military families. We believe there is still room for improvement, however. Congress should work to exempt Basic Allowance for Housing (BAH) from the federal calculation for SNAP eligibility, which would enable wider access to this lifeline program. Moreover, the VFW believes Congress must continue to identify and remove barriers to gainful spouse employment and strengthen access to quality child care. Last, we call on Congress to pass legislation to ensure an acceptable living wage.

VA Home Loan

The VA home loan guaranty service has long been providing opportunities for upward economic mobility to the military community by opening the door to homeownership. The unique elements of the VA home loan program, which include allowing veterans to purchase a home without a down payment and to save thousands of dollars by not requiring mortgage insurance, make it invaluable among the benefits provided to veterans. Through this program, VA guarantees to over 1,500 nationwide approved lenders that it will back at least twenty-five percent of loans if the loans were to default. This has made these loans some of the safest in the market and allowed veterans to gain access to a housing market from which they may otherwise have been excluded. However, the competitive housing market that arose in 2021 showed many veterans the barriers to using these loans. This housing market highlighted both misconceptions and realities surrounding how difficult and time consuming accepting a VA-guaranteed loan can be. The VFW recommends that Congress passes legislation that would fund and require VBA to conduct outreach and marketing to lenders, real estate agents, and the general population on the benefits of accepting and using VA-guaranteed loans and the reality of how closely the timeline for these loans match that of conventional loans.

Additionally, the VFW recommends Congress conduct oversight over VA-guaranteed home loan use to determine where true pain points may exist, to include analysis of the Minimum Property Requirements waiver use and rates of approval and denial. The VFW also recommends that Congress conducts analysis of the use of the Energy Efficient Mortgage program, and fund VA to conduct outreach and marketing to promote the program, as well as provide funds to increase maximum loan dollars to match current market prices for the most effective eligible energy-efficient upgrades.

Transition Assistance

The VFW believes a proper and well-rounded transition from the military is one of the most important things our service members need to ease back into our society with minimal hardships. To that extent, the VFW places great emphasis on ensuring service members receive the best counseling and mentorship before they leave military service. Veterans who make smooth transitions by properly utilizing the tools and programs available will face less uncertainty regarding their moves from military to civilian life.

Today's military has experienced two decades of continuous war, and this extended time of conflict has shaped the experiences of all men and women who have worn the uniform defending our country. This reality of heightened conflict makes successful transition back to the civilian world that much more important. Only a small percentage of Americans serve their country in the armed forces, so transitioning from military service can bring its own set of trials and tribulations.

Transitioning service members (TSMs) face many hardships that include unemployment, financial difficulty, lack of purpose, separation anxiety, and many unknowns. There are programs set in place to ease the hardship of this change, and the VFW believes these programs are paramount. Transition programs such as the Transition Assistance Program (TAP) and Soldier For Life are key stepping stones to a seamless transition to civilian life. The information provided to service members on VA benefits, financial management, higher education, employment, and entrepreneurship is invaluable.

We were pleased the five-day TAP classes were restructured and enhanced as part of the *National Defense Authorization Act for Fiscal Year 2019*, and we are eager to see what benefits the more efficient and holistic approach has generated. However, the VFW sees additional areas for improvement, such as including accredited service officers in the formal TAP curriculum. As the law requires, we would like a connection made between TSMs and resources in the community to which they are transitioning, with an emphasis on specialized transition service organizations that receive grant funding. We would also like the timely return of TAP classes to an in-person format across DOD, while ensuring adherence to COVID-19 precautions. Such provisions would help ensure veterans are equipped to succeed after leaving military service.

The VFW is happy to see changes that have been made in TAP in the past few years to bring a more tailored, personalized experience to TSMs and increase access to family members. We believe TAP is a critical program that should be accessed as early and as often as needed by

service members and by their family members. We are excited to learn this year of outcomes from DOL's newly launched Employment Navigator (EN) and Partnership Pilot (ENPP) and discover the impact of providing individualized counseling to help TSMs find their paths. We look forward to data on these results, and recommendations for improvement of this program and expansion beyond its current eighteen locations.

In 2019, DOD established a tiered evaluation system to allow for a one-on-one analysis of an individual's readiness for transition. As a byproduct of these evaluations, if a service member were deemed ready for transition and had a transition plan for success, the individual could choose to forgo the previously required two-day track focused on accessing higher education, career training, entrepreneurship, or employment. In the most recent VFW Benefits Delivery at Discharge (BDD) survey for TSMs, over sixty percent reported not having completed a two-day focused track. While the VFW is pleased that TAP is providing a more individualized approach and increasing overall access, we are concerned that service members may be waived of track requirements to their detriment. We ask Congress to require in-depth reporting on the use of this tier system, its impact on track participation, and its overall effect on outcomes following transition. Additionally, we ask for reporting on military spouse and dependent participation and overall outcomes to assess any needed improvements to programming tailored to family members.

The VFW is also encouraged by significant changes that have been made by DOL to revamp transition programming available for veterans and those without installation access. We are excited by the newly launched Off-Base Transition Training Program (OBTT), which will allow both in-person and virtual opportunities in key geographic transition hubs. We are also pleased to learn that the VFW's recommendations have been heard, and these resources will be interactive and provided under a facilitator. The VFW believes that access to transition resources and support is integral throughout a veteran's journey and should not and cannot be limited to just their time in service. Like ENPP, we look forward to learning from DOL and veterans about the successes and challenges of the pilot, and how it can best be expanded and improved.

VFW Service Officers have been a resource for TSMs since 2001, and they continue to aid these men and women during this difficult time of change. We provide pre-discharge claims representation at twenty-four bases around the country and are available for TSMs at the same time they receive their training in TAP. While the primary role for the VFW staff in the BDD program is to help service members navigate their VA disability claims, we are also able to assist with many other benefits and available opportunities.

Our BDD representatives offer guidance and information for many different transition opportunities that may not be covered in the TAP classes. They are trained in education, employment, and other benefit eligibility, and can be additional resources to the ones offered during TAP classes. Service members who utilize additional resources such as BDD representatives are likely to face fewer unknown hurdles during transition.

Though the BDD program is critical to post-military success for many veterans, the VFW remains concerned that VA's decision to compress the time in which a TSM may file a BDD claim remains problematic. Prior to 2017, TSMs could file BDD claims between 180-60 days

before leaving the military. Service members with fewer than sixty days could file claims through the Quick Start program. In 2017, VA arbitrarily moved the goalposts back for BDD, allowing service members to file only between 180-90 days and eliminating the Quick Start program altogether. In the years since this policy was changed, the VFW has seen problems in delivering benefits for TSMs. Of note, some service members, particularly those who work in high-intensity military occupations, have trouble meeting this timeline due to the constraints of their jobs. A 90-day window also creates compliance issues with military treatment facilities in furnishing service members with their full health records in a timely manner to satisfy the requirements of the BDD program. Complicating matters, some locations can take up to thirty days to provide records after service members request them.

These hurdles have only been exacerbated by the sunset of the Quick Start program. While it remains true that service members can still technically file regular claims before separation, many times VA intake sites on military installations turn these BDD-excluded claims away, or VA fails to act on them in a timely manner due to a future effective date showing in VBMS. Though affected service members lose no benefits because of this bureaucratic hurdle, it can significantly delay the delivery of benefits until long after members have transitioned.

VA's changes were an unnecessary step backward all in the name of efficiency on paper. However, these reported efficiencies come at the expense of the needs of TSMs. The VFW urges Congress to direct VA to revert to the old parameters of its BDD program and reinstitute Quick Start so that VA can once again ensure TSMs have a smooth experience accessing their earned VA benefits.

Full Concurrent Receipt

The VFW has long argued that DOD retired pay and VA service-connected disability compensation are fundamentally different benefits, earned for different reasons. Military retired pay is earned through twenty or more years of service in the United States Armed Forces, allowing retirees to maintain their standard of living while attempting to enter the civilian job market for the first time in the middle of their prime working years. Service-connected disability compensation is a benefit meant to supplement a veteran's lost earning potential as a result of the disabilities he or she incurred during service. However, military retirees who are less than fifty percent service-connected disabled are required to offset their retiree pay with the amount of VA disability compensation they receive.

The *National Defense Authorization Act for Fiscal Year 2004* allowed for the gradual phase-in over ten years of full concurrent receipt for certain military retirees who have a service-connected disability rating of fifty percent or more. The phase-in period ended in 2014, which means military retirees with at least twenty years of service and a VA disability rating of at least fifty percent no longer have their military retirement pay offset by the amount of VA disability compensation they receive. However, service-connected disabled military retirees with VA ratings of forty percent and below, and service members who were medically retired with less than twenty years of military service, are not provided the same benefits. The only purpose for this offset is to balance the federal budget on the backs of America's disabled veterans. They are different benefits paid by two separate government entities for separate reasons.

The VFW acknowledges that eliminating full concurrent receipt would be a costly endeavor. However, Congress should chip away at the unjust practice by first eliminating the offset for medical disability retirees who served less than twenty years and receive Combat Related Special Compensation (CRSC). Service members found to be unfit for continued service due to physical disability may be retired if the condition is permanent and stable, and the disability is rated by DOD as thirty percent or greater. These veterans are referred to as Chapter 61 retirees. Furthermore, retirees who have combat-related disabilities can receive CRSC from their respective branches of service, provided they waive their VA disability compensation from their retired pay. CRSC is afforded to combat injured retirees to make up for lost retirement pay, but often does not fully replace it. There are currently over 50,000 veterans affected by this unjust practice. The VFW thanks our supporters for introducing the *Major Richard Star Act*, and we continue to call on Congress to pass this important legislation immediately.

Guard and Reserve Burial Equity

Only certain veterans are eligible for burial at cemeteries managed by VA's National Cemetery Administration. This includes service members who died on active duty, those who served on active duty and received an other than dishonorable discharge, and those who served in the National Guard or Reserve for at least twenty years and received an other than dishonorable discharge. Service members of the National Guard and Reserve who serve for less than twenty years and have no time on active duty, even if discharged under honorable conditions, do not qualify.

Service members of the National Guard and Reserve, many of whom also have access to VA health care, education benefits, and VA home loan, should have the right to be buried in a state veterans cemetery. States that choose to broaden the eligibility of veterans beyond what NCA currently allows should not be restricted from receiving critical VA cemetery grant funding.

The VFW supports H.R. 3944 / S. 2089, *Burial Equity for Guards and Reserves Act of 2021*, which would ensure state cemeteries that choose to bury veterans from the National Guard and Reserve with honorable discharges remain eligible for funding through the Veterans Cemetery Grants Program.

DOD Health Care

Many of our members utilize the Military Health System (MHS) for their health care. Just like our preference with VA's health care system, we believe DOD should be the primary provider of health care. We believe community care is an important supplement to the system, but it should never be used as a replacement for DOD- or VA-provided care. We are seeing too much of a shift toward the community for care provided to DOD beneficiaries, and we urge Congress to shift the primary role back to DOD.

Additionally, many members of the Guard and Reserve utilize MHS. Switching back and forth between private health coverage and MHS during periods of active duty can be stressful and leave gaps in coverage. The VFW would like to increase the availability of full-time MHS

coverage for those individuals because proper health care is a readiness issue for our Reserve Component troops.

Military Housing

Military housing has been plagued with issues for years. In the past few months disturbing reports about housing at Joint Base Pearl Harbor-Hickam and Walter Reed have highlighted some of the problems our troops face with housing. Most service members' housing is either Government-owned and Government-controlled (GO-GC) or privatized. Unaccompanied and overseas family housing is largely GO-GC, while continental United States family housing is primarily privatized. GO-GC housing is the ultimate responsibility of base commanders, with day-to-day oversight generally falling to individual units. Conversely, in 1996, the Military Housing Privatization Initiative (MHPI) began as a result of DOD's struggle to build and maintain adequate housing. Under MHPI, contractors signed a fifty-year leasing agreement with the government that gave them custody of existing base housing and the responsibility to build and maintain military homes. Currently, over 200,000 military family housing units across the United States are controlled by a handful of private corporations.

In recent years, the MHPI program has been plagued with widespread complaints of neglected or careless repairs and unsafe conditions including mold, lead-based paint, asbestos, poor water quality, and sewage. Moreover, one of the primary contractors, Balfour Beatty Communities, was recently convicted of rampant fraud across many military housing communities, marking a stark example of corporations' strong financial incentives not to hold units vacant for lengthy repairs or renovations. Similarly, reports of mold persist in GO-GC housing, among other safety issues. In response, DOD implemented a bill of rights to ensure tenants receive quality housing and fair treatment, but this only applies to service members and families in MHPI housing. There have also been reports of contractors circumventing elements of the bill of rights. Complicating matters, Congress and service members do not have a centralized tool that allows for feedback and provides information about all base housing and related housing company performance, making proactive oversight and informed housing decisions difficult for those who are eligible.

As a result, the VFW proposes that DOD develop a base housing feedback tool that acts as a central information center for Congress and service members. Based on the model of the GI Bill Comparison Tool, it would enable military members and families to submit direct feedback about their housing conditions, while helping eligible service members make informed decisions about whether to live on or off base. Additionally, it would allow for oversight of both GO-GC and MHPI housing situations at each base around the country, so problems could be addressed in an appropriate and timely manner. The VFW calls on Congress to direct DOD to develop and implement a feedback tool for base housing.

Defense POW/MIA Accounting Agency

Currently, over 81,600 DOD personnel are unaccounted-for from WWII to Operation Iraqi Freedom, seventy-five percent of whom are in the Indo-Pacific area, and more than 41,000 are presumed lost at sea. For decades the VFW has been intimately involved in the fullest possible accounting mission, and since 1991 we have been traveling to sites across the world to assist in

this noble endeavor. It has been the mission of the Defense POW/MIA Accounting Agency (DPAA) to recover missing personnel who are listed as a prisoner of war (POW) or missing in action (MIA), from past wars and conflicts and countries around the world. Within that mission, DPAA coordinates with hundreds of countries and municipalities around the world in search of missing personnel.

Our nation's ability to bring our fallen heroes home is not guaranteed and is extremely limited by the lack of funding and the dwindling numbers of eyewitnesses who can assist in identifying possible recovery sites, among other factors. That is why the VFW has been partnering with DPAA to work with foreign governments to help American researchers gain access to foreign military archives and past battlefields. Since 1991, the VFW is the only VSO to return to Southeast Asia annually, and Russia and China periodically, and we have made it our goal to not rest until we achieve the fullest possible accounting of all missing American military service members from all wars.

The process to bring a missing service member home often takes years and requires predictable funding. Before a recovery team is deployed to a potential site, researchers and historians examine host nation archives, investigate leads in Last Known Alive cases, and obtain oral histories from foreign military and government officials that may have broad information about a particular region or a specific battle. Investigative Teams follow up on leads by interviewing potential witnesses, conducting on-site reconnaissance, and surveying terrain for safety and logistical concerns.

Once a site has been located, recovery teams that include civilian anthropologists and military service members are deployed to conduct an excavation. Each mission is unique, but there are certain processes each recovery has in common. Depending on the location and recovery methods used on site, the standard recovery missions last thirty-five to sixty days. Recovery sites can be as small as a few meters for individual burials to areas exceeding the size of a football field for aircraft crashes. Artifacts and remains discovered during excavations are transported to one of DPAA's two forensic laboratories. The main laboratory is located at DPAA's facility on Joint Base Pearl Harbor–Hickam. The Hawaii laboratory is responsible for forensic analysis of all evidence associated with service members unaccounted-for from conflicts in the Indo-Pacific region. The other laboratory is found on Offutt Air Force Base in Nebraska. The Offutt laboratory is primarily responsible for analyzing remains and material evidence associated with The USS Oklahoma, and specific European losses such as the 92nd Infantry Division, known as the "Buffalo Soldiers."

DPAA has the largest and most diverse skeletal identification laboratory in the world and is staffed by over thirty anthropologists, archaeologists, and forensic odontologists. Due to DPAA's efforts, the remains of 142 Americans were accounted for in FY 2021. However, government budgetary uncertainty in the past interrupted DPAA operations, as it did for many DOD organizations.

Congress must continue to support full mission funding and personnel staffing for DPAA, as well as its supporting agencies, such as the Armed Forces DNA Identification Laboratory and the military service casualty offices. The fullest possible accounting mission remains a top priority

for the VFW, and we will not rest until every possible missing American military service member is brought home.

Chairmen Tester and Takano, Ranking Members Moran and Bost, and other distinguished members of these committees, speaking for all the members of the Veterans of Foreign Wars and its Auxiliary, and on behalf of millions of service members, veterans, and their families around the world, I would like to thank you for your time and attention to these critical issues. I will conclude with my call to action, and remind everybody that the TIME IS NOW to take care of these critical issues for those on whose behalf we are here to advocate.

Thank you, this concludes my remarks, and I am prepared to answer any questions you may have.

Information Required by Rule XI2(g)(4) of the House of Representatives

Pursuant to Rule XI2(g)(4) of the House of Representatives, the VFW has not received any federal grants in fiscal year 2022, nor has it received any federal grants in the two previous fiscal years.

The VFW has not received payments or contracts from any foreign governments in the current year or preceding two calendar years.

Statement of Jeremy Butler
Chief Executive Officer
of
Iraq and Afghanistan Veterans Of America
before the
Senate & House Veterans Affairs Committee

March 2, 2022

Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and distinguished members of the Committees, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members, I would like to thank you for the opportunity to testify here today.

This is my fourth year in a row testifying before this joint body as CEO of IAVA and every year I have discussed the need to address the health issues brought on by 20 years of military toxic exposures, including from burn pit usage in Iraq and Afghanistan. Small steps have been made but, like the incremental moves taken to address Agent Orange, we are decades too late in the government owning up to this self-inflicted wound. Veterans are sick and too many have already died. Even though IAVA has been discussing this for more than 4 years, by no means were we the first or loudest to raise this issue. In fact, and quite frustratingly for the many who have been harmed, the danger of burn pit exposure was raised nearly from the beginning.

We know that we have already lost veterans to toxic exposure induced illnesses, we know that many others are sick and we know that more will die. What we don't know is how much longer Congress will delay and make excuses. The only reason that comprehensive toxic exposure legislation has not passed is because of the financial cost. But there was virtually no debate by this body during the 20 years that the country sent millions to war where they were repeatedly exposed to the hazards of burn pits. Burn pits that were banned from use in the United States as far back as the 1970's.

So, on behalf of the 3.5 million veterans who were exposed to burn pits and other airborne hazards. And on behalf of the veterans behind the nearly 70% of burn pit related claims that were denied by the VA, I implore you to pass the comprehensive toxic exposure legislation supported by nearly every veterans group in the country and finally keep America's promise to take care of those who fought to defend us.

2021 was another incredibly impactful year for the veteran community, largely thanks to Members of both the House and Senate Veterans Affairs Committees. Coming off of the momentum of 116th Congress, and the passage of two landmark IAVA-backed bills, the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act*, and the *Deborah Sampson Act*, we continued our work to improve the lives of veterans. In 2021 we built on the momentum of the 116th Congress to pass critical reforms within the military justice system, create a commission to account for the last 20 years of war in Afghanistan, create opportunities for veterans who lost jobs due to the pandemic, ensured that those who sacrificed in support of the Global War on Terror will have a memorial on the National Mall, and finally closed a loophole in the law that made military-connected students the target of predatory schools.

In 2021 IAVA continued to fight tirelessly for servicemembers, veterans, and their families, conducting over 200 Capitol Hill meetings by our staff, speaking directly with leaders of VA, and other agencies impacting our community, and executing robust traditional and social media outreach nationwide to highlight the needs and concerns of post-9/11 veterans and military families. We conducted a soon-to-be-released comprehensive membership survey in order to understand the pressing issues facing the post-9/11 generation of veterans.

We must recognize that the COVID-19 pandemic continues, and the effects of this unprecedented event are long lasting. IAVA is proud to be part of the Veterans Coalition for Vaccination, which is helping to combat COVID-19 to raise awareness, expand access, and ensure that all Americans have equitable access to COVID-19 vaccines. According to our 11th Member Survey, 85% of IAVA members reported being vaccinated. However, we must also continue to address issues caused by this pandemic, such as veteran unemployment and homelessness. Veterans were not immune to the damage that COVID-19 caused to the American economy and the effects of our recovery are still ongoing. While there has been progress, we will remain vigilant that veteran unemployment remains at pre-pandemic levels.

I thank all the Committee members that worked tirelessly to ensure that pressing issues facing our nation's veterans were not forgotten. As we look to 2022 and the remaining time in the 117th Congress we must continue to press forward.

Burn Pits and Toxic Exposures

According to IAVA's latest member survey, over 80% of IAVA members were exposed to burn pits during their deployments and a shocking 90% of those exposed believe they already have or may have symptoms. IAVA and our allies within the VSO community have spent years educating Congress, national leaders, and the public on the enormous scope of these injuries faced by our community.

Year after year, the concern grows surrounding the health impacts of burn pits and other toxic exposures in recent conflicts. Burn pits were a common way to get rid of waste at military sites in Iraq and Afghanistan. The effect of toxic exposure is not just the chemicals in the smoke, but the particulate matter, dust, ashes and other pollutants these men and women breathed in. Approximately 3.5 million veterans were exposed to burn pits and other airborne hazards. Yet VA continues to deny approximately 70% of burn pit-related claims. Much-needed legislation would finally take the burden of proof off the veteran by creating a presumption of service connection for a list of illnesses and diseases, including cancer, as well as allowing veterans to receive health care from VA.

While VA has made many strides forward in the past year, creating presumptives of three illnesses due to toxic exposure, it is simply not enough. Veterans are looking towards Congress for bold action and leadership. The time to pass critical, comprehensive legislation to ensure that veterans have the healthcare, benefits, and a new framework for how presumptive illnesses are handled, is now.

It is for these reasons that IAVA will continue to tirelessly advocate for the *Honoring Our PACT Act* (H.R. 3967). This critical piece of legislation is a culmination of years of work, to finally address veterans that have suffered from their exposures. The *PACT Act* is moving to the House floor for a vote and IAVA has urged all House Members to vote for its passage and we call on the Senate to swiftly pick up this landmark legislation. We understand that there have been a number of bills introduced in both the House and the Senate, yet the *PACT Act* is the legislation that will provide the most comprehensive solution. Veterans that have been exposed and are now sick can not wait any longer for the healthcare and benefits that they have earned through their service. We must ensure that the 117th Congress is when veterans finally receive comprehensive legislation that addresses one of the signature injuries of the post-9/11 wars.

Combat Suicide Among Troops and Veterans

For nearly a decade, IAVA and the veteran community have called for immediate action by our nation's leaders to combat the crisis suicide among our servicemembers and veterans. In the last two years, we made groundbreaking strides towards addressing this epidemic.

Despite our progress through legislation, more can and must be done. According to the most recent VA data, veterans aged 18 to 34 have the highest rate of suicide. And while not always an indicator of suicide, mental health injuries continue to impact the post-9/11 generation. In our latest member survey, a stunning 61% of IAVA members have a service connected mental health injury. Meanwhile, the nation and VA struggle to keep up with the demand for mental health care and mental health care providers such as psychiatrists and psychologists, both of which are in the top 5 for VA staffing shortages. Despite these shortages, IAVA members overwhelmingly seek care for their mental health injuries from VA professionals, with 73% of those receiving care for their injuries choosing to do so at VA. Despite additional funding and scrutiny, VA still faces a shortage of mental health care professionals, specifically in rural areas.

It is for these reasons that IAVA will continue to advocate for the *Post-9/11 Veterans Mental Health Care Improvement Act* (S. 3293), which we were pleased to see included in the *Supporting The Resiliency of Our Nation's Great (STRONG) Veterans Act* (H.R. 6411), which has recently passed out of the House Committee. This legislation will address a number of key issues regarding mental health and suicide prevention by increasing access to care, strengthen VA's workforce, and continuing to increase mental health research. We look forward to working with your Committees for a timely passage of this crucial legislation.

2020 was a significant year in mental health and suicide prevention. The *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* resulted in critical reforms in how America combats the suicide crisis. Key provisions included the creation of a community grant program to help identify isolated veterans and provide mental health services, modeled after the extremely successful Supportive Services for Veteran Families (SSVF) program. These targeted programs are designed to identify the veterans who die by suicide that are not currently participating in VA services and connect them to lifesaving resources. Additionally, this legislation expanded VA's tele-health services at a time when veterans may be feeling more disconnected than ever before. These are critical improvements to VA care. But the work is not done. Now that the *Commander Hannon Act* has been successfully passed into law, it is our responsibility to ensure its successful implementation. Oversight of the execution of this new law is a top priority for IAVA, especially considering its 34 separate provisions. Staffing

improvement plans for mental health professionals, increased tracking metrics, and funding for numerous studies are just a few of the disparate sections of this comprehensive legislation.

We will also continue to spread public awareness for the suicide crisis as thought leaders forums with policymakers, and through the media. Sobering statistics on suicide continue to be released, identifying women veterans at especially high risk of suicide. IAVA's groundbreaking Quick Reaction Force (QRF) is a safety net for veterans and families and provides comprehensive care management, resource connections and 24/7 peer-to-peer support for any veteran or family member in need. QRF's services are free and confidential and are available regardless of era, discharge status or location, making the barrier of entry very low. The needs of veterans remain high, particularly in light of the pandemic and in 2020, QRF saw a 400% increase in clients served from 2019, and we continued to see steady increases in 2021. QRF is built to address all aspects of a veteran's life that are in need of intervention and support and we do this by providing holistic and comprehensive care for all of our clients. In 2021 more than 15% of all client requests were directly related to mental health needs, and 59% were related to emergency financial assistance or the threat of homelessness, or both, which directly impacts an individual's overall well-being and stability. IAVA continues to have a strong working relationship with the Veterans Crisis Line (VCL) and also has 24/7 in-house clinical support for clients that reach out to the program and are at risk for suicide.

Women Veterans

Women veterans and servicemembers are currently the fastest-growing populations in the military and veteran communities. Despite these numbers consistently growing since the 1970s, veteran services and benefits for women often fall behind. Over the past few years, there has been a groundswell of support for women veterans' issues. From health care access to reproductive health services to a seismic culture change within the veteran community, women veterans have rightly been focused on and elevated on Capitol Hill, inside VA, and nationally. While this growing interest has been encouraging, VA continues to have a motto that explicitly leaves women veterans out. It is past time that we recognize the service of all veterans from the moment they walk through the doors of a VA. This change must start at the top. At the end of the 116th Congress, we were encouraged when the House unanimously passed legislation to approve the motto change; however, the Senate was not able to take it up before the Congress ended. IAVA will continue to call for changing the current VA motto to be gender-neutral and we encourage your committees to pass the *Honoring All Veterans Act* (H.R. 2806/S. 1313) soon.

At the end of 2020, we celebrated as the *Deborah Sampson Act*, the cornerstone of IAVA's #SheWhoBorneTheBattle campaign for four years, officially passed Congress. It was a historic

year for women veterans and will ensure that VA is a place for all veterans. We thank all those that were relentless in their efforts to push this instrumental piece of legislation over the finish line. The *Deborah Sampson Act* includes provisions that will address sexual harassment and assault in VA facilities, establish an Office of Women's Health directly under the Undersecretary of VA for Health, and improve access to care and benefits for survivors of Military Sexual Trauma (MST). We should most certainly celebrate this historic win but recognize that our work is far from over. We will continue to work with Congress and VA to ensure that this monumental legislation is properly implemented.

For years, VA has faced scrutiny for sexual harassment and assault within their medical centers, and the lack of action by top leadership. While not solely a women veterans issue, it is known that these issues disproportionately affect women and the lack of action by VA furthers the problem of women veterans feeling unwelcome at their facilities. Of the 3.5% of IAVA Members that reported having experienced sexual harassment while seeking care at a VA facility, 77% of them are women, and women veterans are less likely to feel safe while at a VA facility. We know that this issue of sexual assault and harassment stems from a larger issue within the military community. While this is a hearing to address issues within the veteran community, I am underscoring the need to address the problem of sexual assault and harassment within our military as some of you also sit on the Armed Services Committee.

In IAVA's 11th Member Survey, 58% of our female members stated that they are survivors of military sexual trauma. Of those, only 34% reported the crime, and 63% reported experiencing some sort of retaliation as a result of their report. Those who did not report listed their reasons for not reporting as fear of retaliation by their peers or commander, concern about the impact on their career, and doubt that their commander would believe them or nothing would be done. We also found that women reported being retaliated against 67% of the time, as opposed to 47% of men that reported. Our survey data, and the recent stories that have made this issue impossible to ignore. This is why IAVA fought for years to ensure a trained military prosecutor will have the authority to decide to move forward with a sexual assault case, instead of a commander. We thank Congress for the inclusion of some critical components of the *Military Justice Increasing Prevention & Improvement Act (MJIIPA)* (S. 1520) within this year's NDAA. We will continue to work alongside our Congressional allies for the full implementation of MJIPPA and urge Congress to take up the legislation for a full floor vote.

The VA reports that about 1 in 4 women veterans and 1 in 100 male veterans report experiencing MST while serving in the military. For years, the claims process has received a fair amount of criticism due to the gruesome process a veteran must go through to prove their experienced MST. This past August, the VA OIG released a glaring report detailing that VA potentially denied

thousands of veterans benefits related to their MST claims due to errors during claims processing. The report also found that VA failed to implement recommendations made by OIG back in 2018 that had resulted in similar issues. The lack of implementation resulted in an increase from 49% of claims being improperly processed to 57%. Additionally, VA's claims process for MST is already a difficult road for a survivor. It is imperative that VA does not further traumatize and instead make veterans feel safe and secure as they embark on the difficult process of filing their claim.

IAVA strongly supports the *Servicemembers and Veterans Empowerment and Support Act* (H.R. 5666/S. 3025) that will greatly improve the MST claims process and adjust the standard of proof a veteran has to provide, lessening the potential for re-traumatizing any veteran. It also would require VA to review the claims process yearly to ensure accuracy. Finally, the legislation would require VA to study the training and accuracy of VBA's disability claims process for MST.

Defend and Expand Veterans Education and Economic Opportunities

The effects of the COVID-19 pandemic on the American economy will be long lasting. Veterans, and especially the post-9/11 generation of veterans, have been hit extremely hard by unemployment. Younger veterans have consistently had higher rates of unemployment than their older veteran peers, and their civilian counterparts. It is clear that we need bold, aggressive legislation to confront these challenges. This is why IAVA worked hard to pass the *Veterans Economic Recovery Act* as part of the *American Rescue Plan*. This critically important legislation provides up to 12 months of retraining assistance for veterans who are unemployed due to the pandemic.

To further address employment and to fight the pandemic, IAVA worked with Rep. Conor Lamb and Sen. Gary Peters to develop the *Supporting Education Recognition for Veterans during Emergencies (SERVE) Act* (H.R. 2587) to ensure veterans' service-connected medical qualifications and expertise are utilized by the VA and civilian healthcare facilities to meet the challenges of the Coronavirus.

Veterans who gained critical medical skills in the military are an under-tapped source, and we need to get them into the fight and help alleviate medical staffing shortfalls across the country. The *SERVE Act* is an easy, impactful solution that Congress should immediately enact to address the continuing crisis.

The Post-9/11 GI Bill has now sent more than one million veterans and dependents to school, and remains one of the military's best retention and recruiting tools. In IAVA's latest member

survey, 73% of IAVA members reported that they would have been unable to go to school without the GI Bill. 79% agree that the Post-9/11 GI Bill is essential to military recruitment and 84% believe it is extremely or very important to transition to civilian life. This is why IAVA is proud of the work done to finally close a loophole in the law that allowed underperforming actors to take advantage of military-connected students burdening them with unnecessary debt and a subpar education. Additionally, IAVA is currently working with the Department of Education directly to ensure that this loophole is closed for all military-connected students. We thank all the Members of both Committees that worked hard to ensure the 90/10 loophole was closed once and for all and ask that you continue to remain vigilant, as will IAVA and the VSO community, to ensure that military-connected students are protected from predatory actors within higher education.

While we must always protect students that have been taken advantage of by predatory schools, we can also look forward and ensure that these schools are not able to access veterans benefits without providing a quality education. We must strengthen protections surrounding how VA approves schools to receive taxpayer dollars. Veterans rely on VA to approve schools for GI Bill with an understanding that they are only approving quality schools. The current regulations are outdated and have a low standard of entry. IAVA looks forward to working with the Committees and our VSO allies to ensure that standards of quality are increased to ensure that schools approved for the GI Bill are giving military-connected students a quality education and are being good stewards of taxpayer dollars.

In 2020 and beyond, many military-connected students had to quickly adjust to 100% online classes, and the uncertainty of what that would mean for their housing allowance. IAVA was quick to work with our VSO and Congressional partners to ensure that military-connected students would continue receiving their full housing allowance if their school shifted online. While these protections were crucial for students that were forced into an online-only environment, there remains concerns with making this a permanent change going forward. Stronger protections for military-connected students attending online-only classes may be needed to help safeguard these students from predatory institutions, while ensuring students that are online due to the pandemic are protected.

Afghanistan Withdrawal and War Commission

IAVA's 11th Member Survey opened on September 8, just over a week following the official withdrawal of U.S troops from Afghanistan. In our 2020 survey, 62% of our members stated that our engagement in Afghanistan was worth it or somewhat worth it and the data for our current survey shows now only 52% of our members feel that way, a 10% decrease. The recent data also showed that, although 59% agreed with the need to withdraw troops, only 21% of respondents approve of the way President Biden withdrew from Afghanistan and 85% of IAVA respondents agreed that more should have been done to support the evacuation of Afghan allies during the withdrawal.

War affects every veteran differently and the circumstances that took place late last year will no doubt have caused a lasting effect. IAVA's Quick Reaction Force saw an 80% increase in mental health inquiries from August 16-31, 2021 when compared to those dates in 2020. This speaks to the high level of connection our generation of veterans have with regards to Afghanistan.

IAVA fought hard alongside our allies in order to ensure the *Afghanistan War Commission Act* was included within the FY22 NDAA. This commission will be responsible for a thorough investigation of every aspect of US involvement in Afghanistan and must include examining top level strategic decisions, combat operations, efforts to train Afghan forces, intelligence work, diplomatic efforts, congressional oversight, corruption in the US-backed Kabul government, the development and execution of the Special Immigration Visa (SIV) program, the failure to evacuate our Afghan wartime allies prior to the withdrawal of US troops; the entirety of Operation Allies Refuge; and the collapse of the Afghan government and security forces after 20 years of American aid and investment.

Additionally, tens of thousands of US-affiliated and at-risk Afghans have been or will soon be welcomed into the United States via humanitarian parole. Unlike immigrant visa or refugee programs, humanitarian parole is not a pathway to permanent status; it is a temporary allowance to enter and remain in the United States.

The *Afghan Adjustment Act*, patterned after similar legislation such as the Cuban Adjustment Act following the Cuban Revolution, offers an important correction by allowing these Afghan refugees to apply for lawful permanent resident status, the same legal status they would have received had they been admitted as refugees. Rather than punishing Afghan arrivals for being evacuated, Congress has an urgent obligation to ensure they have a chance to become lawful permanent residents. We urge all Members of this Committee to support this legislation.

Veterans suffered a profound moral injury when our country failed to keep its promise to evacuate all of the Afghan wartime allies who stood shoulder to shoulder with us throughout the war. Currently, an estimated 80,000+ Afghan wartime allies - interpreters and their immediate family - remain left behind. Veterans bear the brunt of this failure - we continue to field the daily pleas for rescue from the Afghans whose lives are at risk under Taliban rule because of their support for the US and our NATO allies. Should we fail to pass the *Afghan Adjustment Act* and adequately provide for the Afghans we were able to evacuate, the moral injury suffered by many veterans will be exacerbated. We already suffer from an epidemic of veteran suicides in this country - we fear what additional moral injuries will do to our veteran community as it still comes to terms with the fiasco of last August. We urge Congress to pass the *Afghan Adjustment Act* and streamline the resettlement of the thousands of our Afghans who placed themselves in danger to stand with us when we needed them most.

Support for Veterans Who Want to Utilize Medical Cannabis

Support for the use of medical cannabis to treat the wounds of war has been growing among the veteran population for years, and IAVA members have repeatedly voiced their support. Veterans consistently and passionately have communicated that cannabis offers effective help in tackling some of the most pressing injuries we face when returning from war. In our latest Member Survey, over 80% of IAVA members supported legalization for medicinal use. Across party lines, medicinal cannabis has been rapidly increasing in support, yet our national policies are outdated, research is lacking, and stigma persists.

Over the past few years, IAVA members have set out to change the national conversation around cannabis and underscore the need for bipartisan, evidence-based, common-sense solutions that can bring relief to millions, save taxpayers billions and create thousands of jobs for veterans nationwide.

In 2022, IAVA will continue our fight on behalf of veterans who want to use medicinal cannabis and we remain committed to the goal of VA conducting research into the efficacy of medical cannabis as a treatment for veterans with chronic pain, PTSD, and other conditions. However, as a Schedule I drug under the FDA, research into the effects and efficacy of cannabis has been stagnant, cumbersome, and convoluted. While not impossible, federal research into cannabis faces many bureaucratic hurdles that hinder good research. A January 2017 National Academy of Sciences study found "conclusive or substantial" evidence that cannabis is effective in treating chronic pain, moderate evidence that cannabis helps with sleep, and the science is inconclusive on cannabis as an anxiety and PTSD treatment option. However, federal bureaucratic hurdles continue to halt the system and stymie good research. We will never get a definitive answer on

the efficacy of cannabis as a treatment option while federal regulations that actively undermine solid research studies remain in place. The system is antiquated and must be adjusted to match state laws and research needs. For these reasons, in the 117th Congress IAVA will continue our work to remove these barriers to research and usage to those veterans where it is already legal by advocating to remove cannabis as a Schedule I drug.

Extremism Within the Veteran Community

Last Fall, IAVA was asked to join the first of what we hope will be more hearings on the important topic of extremism within the military and veteran community. Due to many of the conversations that followed the tragic events of January 6, this year for the first time ever we surveyed our membership on extremism within the military and veteran communities. Survey data shows about 3 in 10 participants reported personally witnessing extremism in the military ranks and among post-9/11 veterans, but while that number presents a problem, a third say it is not a problem, and a third say they do not have enough information to determine. This speaks to the need not only for DoD to continue educating servicemembers about the dangers of extremism, but also for the need for all of leadership, including within Congress, to take this issue seriously.

IAVA applauded the efforts of Defense Secretary Austin conducting a 'stand-down' to address extremism in the ranks. However, we were also concerned with reports that some units and commanders treated this training as just another check in the box. This training, much like suicide prevention training, must be robust and have the full support of all levels of leadership in order to ensure it is effectively educating servicemembers on the dangers of extremism within the military and veteran communities. This training must extend through the Transition Assistance Program, as servicemembers transition to the civilian world. Leadership must be held accountable to ensure that their servicemembers are receiving the best possible training to combat attempts from any extremist group to take advantage of servicemembers.

We also surveyed our membership on trust in different news sources. When asked if they trust political news from elected officials and political figures, 36% of IAVA membership reported "not at all," with less than 7% reporting "a great deal" or "a lot." Any work by VSOs, DoD, and VA could easily be outdone if elected officials use their positions to spread misinformation.

One of the most stressful times for a veteran is their transition out of the military. Almost 80% of IAVA members cited having at least "some challenges" during their transition. Many veterans fill this void and disconnect by continued service to their communities in positive ways. Approximately half of IAVA members report volunteering, mostly in service to other veterans

and servicemembers, youth, and the elderly. Half of our members that do report volunteering, do so at least five hours per week. It is clear that many veterans seek a larger connection with their communities after the transition out of the military.

One veteran participating in an extremist organization is one too many. However, veterans are a microcosm of society. Like many other problems within American society, those problems will also exist within the veteran community. If there is an extremism problem within society, it will exist within the veteran community. And like many other problems it cannot be solved by the veteran community alone. This will require efforts across Congress, federal agencies, law enforcement, and the VSO community. We look forward to working with leaders across all spectrums of government to address this issue.

Members of both Committees, thank you again for the opportunity to share IAVA's views on the pressing issues of 2022. I look forward to answering any questions you may have and working with the Committees in the future.

Biography of Jeremy Butler

Jeremy Butler serves as IAVA's Chief Executive Officer. Jeremy joined IAVA with 15+ years of experience providing substantive and strategic counsel to leaders in high-profile government and private sector offices, including the Departments of Defense and Homeland Security. He is a graduate of Knox College and the U.S. Naval War College. Butler has recently contributed to NPR, Fox News, CNN, C-SPAN, Sirius XM, and other veteran and military media outlets. He is also a Surface Warfare Officer in the Navy Reserves with 20 years of uniformed service.

Wounded Warrior Project
4899 Belfort Road, Suite 300
Jacksonville, Florida 32256
O 904.296.7350
F 904.296.7347

WOUNDED WARRIOR PROJECT

STATEMENT OF
LT. GEN. MICHAEL S. LINNINGTON (RET.)
CHIEF EXECUTIVE OFFICER

ON

WOUNDED WARRIOR PROJECT'S 2022 LEGISLATIVE PRIORITIES

March 2, 2022

Chairmen Takano and Tester, Ranking Members Bost and Moran, distinguished members of the House and Senate Committees on Veterans' Affairs – thank you for inviting Wounded Warrior Project (WWP) to submit the following written statement to highlight our legislative priorities for 2022.

As your committees move toward completion of the 117th Congress and our nation continues to navigate the stressors associated with the COVID-19 public health emergency, WWP remains firmly committed to delivering on our mission to honor and empower wounded warriors. We continue to carry out our vision to foster the most successful, well-adjusted generation of wounded service members in our nation's history by providing more than a dozen programs and services that promote mental, physical, and financial health and well-being. Although the pandemic continues to present challenges and hardships experienced by all Americans, it has created opportunities for WWP to explore new and innovative ways to offer care and support to more than 163,000 veterans and Service members, and more than 40,000 of their family support members and caregivers. In Fiscal Year 2021 (October 1, 2020, to September 30, 2021), WWP:

- Connected warriors to more than **43,900** hours of post-traumatic stress disorder (PTSD) treatment;
- Placed more than **22,000** emotional support calls to warriors and their families to help mitigate psychological stress and improve quality of life and resilience;
- Delivered over **190,000** hours of in-home and local care through our Independence Program to the most severely injured warriors, helping them reach and maintain a level of autonomy that would not otherwise be possible;
- Helped place over **2,100** warriors and family members with new employers;
- Secured over **$159 million** in Department of Veterans Affairs (VA) disability compensation benefits for warriors;
- Hosted more than **8,600** virtual and in-person events, keeping warriors and their families connected and out of isolation; and

- Reached out to over **33,000** warriors who served in Afghanistan to offer care and support to any who expressed a need for it[i].

In addition to these lifesaving programs, an integral part of WWP's impact has been our robust network of partner organizations which amplify, augment, and broaden the reach of our own programs and services. In 2021, WWP granted more than $52 million to 60 organizations – including more than $34 million to our academic medical center partners in the Warrior Care Network[ii] – operating in communities across the country. These investments are far more than financial fuel; they are conduits to meaningful partnerships that enable information sharing, coalition-building, and most importantly, greater access to resources for our nation's wounded warriors and their families. Through our role as a community integrator, every dollar generously donated by the American public goes farther to provide holistic support in high-need areas such as suicide prevention, support for the Special Operations community, brain health, women veterans, caregiver support, and improvements to quality of life[iii].

Lastly, WWP remains resolved to identify, develop, and pursue public policy changes that will have the biggest impact on the wounded warriors we serve. In 2022, we are committed to the same areas of need that we brought to the committees' attention during our testimony before you in March 2021. Our advocacy over the remainder of the 117th Congress will build upon momentum your committees have given to these initiatives over the past 12 months. We hope that together our work will deliver large scale impact in the following areas:

- **Toxic Exposure**: Our aim is to grant health care eligibility and improve the disability benefits process for all veterans who served in areas of known toxic exposures.
    - As many as 3.5 million post-9/11 veterans served in areas where they may have been exposed to burn pits or other toxic substances, and 97.9% of warriors responding to WWP's *Annual Warrior Survey*[iv] reported exposure to environmental hazards during military service.
    - **Key Legislation**: The *Comprehensive and Overdue Support for Troops (COST) of War Act* (S. 3003) and the *Honoring our Promise to Address Comprehensive Toxics (PACT) Act* (H.R. 3967)

- **Mental Health**: We will strive to ensure that VA is a leader in evidence-based treatment and research, and an indispensable coordinator of wider community efforts to prevent veteran suicide.
    - Approximately 29% of Veterans Health Administration (VHA) health care users have been seen for a mental health condition, and 88.5% of WWP's *Annual Warrior Survey* respondents reported having at least one mental health injury or condition.

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[i] For more insight on WWP programmatic impact, see Appendix 1.
[ii] For more insight on Warrior Care Network and our Mental Health Continuum of Support, see Appendix 2.
[iii] For more insight on WWP partnerships, see Appendix 3.
[iv] Unless otherwise noted, the *Annual Warrior Survey* reference corresponds to the twelfth edition of the survey, which was published in 2022 and reflects data gathered in 2021. To learn more, please visit https://www.woundedwarriorproject.org/mission/annual-warrior-survey.

  - **Key Oversight**: The *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* (P.L. 116-171)
  - **Key Legislation**: The *Post-9/11 Veterans' Mental Health Care Improvement Act* (S. 3293) and the *Support The Resiliency of Our Nation's Great Veterans Act of 2022* (H.R. 6411)

- **Women Warriors**: We must continue to support the growing population of women veterans by expanding access to gender-specific care, fostering ongoing connection and support, building safe and welcoming VA environments, and improving coordination of care and benefits for survivors of military sexual trauma (MST).
  - Seven in 10 women who responded to WWP's *Annual Warrior Survey* reported experiencing MST, and only half (49%) of women warriors agreed that VA was able to meet their needs after military service[v].
  - **Key Oversight**: The *Deborah Sampson Act* (P.L. 116-315 §§ 5101-5503)
  - **Key Legislation**: The *Women Veterans TRUST Act* (H.R. 1957), the *VA Peer Support Enhancement for MST Survivors Act* (H.R. 2754), the *Making Advances in Mammography and Medical Options for Veterans Act* (S. 2533, H.R. 4794), and the *Servicemembers and Veterans Empowerment and Support Act* (S. 3025)

- **Long Term Care and Support**: We support policies to promote the utilization and success of VA's long term care programs for younger veterans, including those who have suffered traumatic brain injuries in service.
  - In 2020, 27% of VA's Geriatrics and Extended Care program users were veterans under the age of 65. With more than 430,000 TBIs reported by Service members since 2000, recent research indicates that 1 in 4 veterans who have been hospitalized with TBI will develop long-term disability[1].
  - **Key Legislation**: The *Elizabeth Dole Act of 2022* (House draft) and the *Long-Term Care Veterans Choice Act* (S. 2852)

- **Caregivers**: We seek to ensure that the Program of Comprehensive Assistance for Family Caregivers (PCAFC) continues to support veterans who require great care and attention, even if they are not completely dependent on their caregivers.
  - As the PCAFC expands to support veterans and caregivers of all generations, many post-9/11 households are expected to be removed from the program. Warriors participating in the program made up nearly 1 in 4 (23.6%) of *Annual Warrior Survey* respondents, yet 30.5% reported needing more than 40 hours of aid or assistance each week and the average warrior reported needing 21 to 30 hours of assistance per week.
  - **Key Implementation Oversight**: The *VA MISSION Act* (P.L. 115-182 §§ 161-163)

[v] This data is reflected in WWP's Women Warriors Initiative Report available at https://www.woundedwarriorproject.org/media/tt0ftq4a/wwp-women-warriors-initiative-report-2021.pdf.

- **Financial Security**: We aim to modernize and improve VA's systems of support for wounded warriors in recognition of how financial security is an important factor in overall wellness and a key component to a veteran's success after service.
    - Nine in 10 Warriors (92.5%) reported debt other than mortgage debt, of which, nearly half (49.8%) have at least $20,000 in total debt. Forty-two percent of those who participated in our *Annual Warrior Survey* indicated that they experienced financial strain in the last year.
    - **Key Legislation**: The *Major Richard Star Act* (S. 344, H.R. 1282); the *Brian Neuman* and *Mark O'Brien VA Clothing Allowance Improvement Acts* (S. 2513, H.R. 4772)

The sections that follow will explain why each of these issues have become a priority for WWP, how our organization is addressing these issues programmatically, and what public policy initiatives we are pursuing to improve the health and well-being of the wounded, ill, and injured veterans we serve. We are confident these recommendations will help the lives of our nation's wounded warriors, their families, caregivers, and those who will come after them.

TOXIC EXPOSURE

Last year, our nation marked the 20th anniversary of the beginning of the Global War on Terrorism. Throughout this period, young Americans volunteered for service in the U.S. Military, understanding the risk that they would be deployed to combat in places like Iraq, Afghanistan, Uzbekistan, and elsewhere. They did so with some understanding of the danger to life and limb posed by enemy fire and roadside bombs. Less understood was the very real possibility that they would experience prolonged and pervasive exposure to toxic fumes from burn pits and other dangerous chemicals that they would not be able to avoid, resulting in serious illnesses that would follow them long after they returned home.

Just as our nation has a responsibility to provide health care and benefits to veterans who suffer physical and mental injuries in service, we must also meet the needs of those who suffer from illnesses associated with toxic exposures, both on the battlefield and in peacetime. VA estimates that as many as 3.5 million post-9/11 veterans served in areas where they may have been exposed to burn pits and other toxic substances. Now, many of them have developed rare and early onset diseases like cancers, respiratory conditions, and other serious illnesses, which we strongly suspect are associated with their exposures. WWP is committed to addressing their toxic wounds with the same urgency which we address the physical and invisible wounds of war.

Results from WWP's 2021 *Annual Warrior Survey* illustrate the extent to which our population suffered toxic exposure during their service and the health conditions they are now facing. Among those deployed in support of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND), 72.8% reported serving near a burn pit, meaning a burn pit was located either on their base or close enough that they could see smoke. Of those, 67.4% report being near a burn pit on a daily basis. Additionally, nearly all warriors (97.9%) reported some exposure to hazardous or toxic substances during military service, which include desert sands, petrochemicals, and powerful solvents.

Historically, Congress has dealt with military toxic exposures with era-specific legislation. Vietnam veterans' exposures were addressed with the *Agent Orange Act of 1991* (P.L. 102-4), and Desert Storm/Desert Shield veterans' exposures were addressed by the *Persian Gulf War Veterans Act of 1998* (P.L. 105-368 §§ 101-107). However, no comprehensive legislation has been enacted to specifically address the toxic exposure concerns of current and future generations of veterans.

Multiple pieces of legislation introduced in the 117th Congress would address individual challenges faced by current-era veterans who were exposed to toxic substances. Recognizing that many of these bills were complementary, they were combined into omnibus legislation offering comprehensive solutions: Chairman Tester's *Comprehensive and Overdue Support for Troops (COST) of War Act* (S. 3003), and Chairman Takano's *Honoring our Promise to Address Comprehensive Toxics (PACT) Act* (H.R. 3967). WWP strongly supports these landmark pieces of legislation, which would accomplish all of our legislative priorities regarding toxic exposures as outlined below.

Health Care Eligibility for All Exposed Veterans

Wounded Warrior Project strongly believes that VA health care enrollment eligibility should be granted to any veteran who suffered toxic exposures while in service, regardless of their service-connected disability claim status. Context proves that this is an exceedingly difficult task for those seeking treatment for toxic-exposure related conditions. According to VA, from June 2007 to July 2020, only 2,828 of the 12,582 veterans (22%) who claimed conditions related to burn pit exposure were granted service connection.[2] This is generally consistent with findings from our *Annual Warrior Survey*, which revealed that warriors who filed claims for conditions related to toxic exposures were successful only 31.9% of the time. One critical consequence of a denied disability claim is delayed access to VA care.

Our call for guaranteed health care access is not unprecedented. Legislation enacted over the course of several decades has provided health care eligibility to previous generations of veterans with toxic exposure concerns. Veterans who served in the Republic of Vietnam between January 9, 1962, and May 7, 1975, and the Persian Gulf War between August 2, 1990, and November 11, 1998, are eligible for permanent Priority Group 6 VA health care enrollment without the need to establish a service-connected disability. Those who served on active duty at Camp Lejeune for at least 30 days between August 1, 1953, and December 31, 1987, where they were exposed to contaminated drinking water are also guaranteed permanent Priority Group 6 enrollment eligibility. In contrast, veterans who served in combat and were discharged after January 27, 2003, all of whom were potentially exposed to burn pits or other toxic substances, are only eligible for enrollment on this basis for a period of five years after separation.[3]

To illustrate the impact of the five-year policy, we point to VA data showing that as of June 30, 2015, there were 1,965,534 separated veterans of OEF, OIF, and OND,[4] all of whom are now outside the five-year enrollment eligibility period. Taken together with the fact that only 62 percent of deployed post-9/11 veterans have established a service-connected disability as of March 2021,[5] it can be reasonably estimated that nearly 750,000 current-era veterans who served in areas of known exposure are presently ineligible for VA health care if they have not

established a service-connected disability. Should any of them become ill with a condition they suspect is related to their exposure and seek care at a VA facility, they would be turned away and told to return only after they are service connected.

If enacted, the *COST of War Act* and the *Honoring Our PACT Act* would expand permanent Priority Group 6 enrollment eligibility to any veteran who served in an area of known exposure, regardless of era or location. This would include any veteran identified by the Department of Defense (DoD) as having been possibly exposed to a toxic substance inside or outside the United States as reflected by the Individual Longitudinal Exposure Record (ILER). The *COST of War Act* would also include any veteran who earned certain medals associated with current-era deployments, while the *Honoring Our PACT Act* would include any veteran who served after certain dates in locations of current-era deployments. This would finally provide parity to current and future generations by granting them the same access to VA care that Congress has established for previous generations of exposed veterans. WWP strongly supports these provisions and believes their enactment would provide lifesaving treatment and preventative care to all those who were exposed to toxic substances, now and in the future.

A Scientific Framework

In recognition of the challenges associated with establishing direct service connection for toxic exposure-related conditions, Congress has historically created mechanisms that require VA to make determinations on whether to establish presumptive service connection when scientific data show a link between specific exposures and associated illnesses, as it did for Vietnam veterans with the *Agent Orange Act of 1991*. However, no law currently exists to require VA determinations on illnesses associated with all toxic exposures, regardless of location or period of service.

The *COST of War Act* would address this by establishing an independent Toxic Exposure Review Commission comprised of scientists, health care professionals, and veteran service organizations (VSOs). This commission would collect information and hold public meetings to identify all possible military toxic exposures and make recommendations on whether scientific reviews by the National Academies of Science, Engineering, and Medicine (NASEM) are warranted. Upon receiving a report from NASEM, VA would be required to respond within an established timeframe and the Secretary would be authorized to grant presumptive service connection for diseases by reason of having a positive association with exposure to a toxic substance.

The *Honoring Our PACT Act* would create a Formal Advisory Committee, the majority of whom would be appointed by the VA Secretary, to review scientific data on potential exposure-related conditions. They would then have the option to advance recommendations to an Independent Science Review Board, all of whom would be appointed by the Secretary, to determine the likelihood of association. This would generate reports to the Toxic Exposure Working Group, comprised of VA employees, which would make recommendations to the Secretary to establish a presumption of service connection within established timetables.

We recognize that VA is also piloting its own internal presumptive decision-making model. WWP praises VA for taking this proactive step to formalize the Secretary's broad authority to establish presumptive disabilities when warranted by scientific data. The pilot is scheduled to conclude in April 2022, and we will assist VA in any way we can to support this process. Beyond the potential paths of arrival, we look forward to supporting the establishment of a scientific framework that maintains a level of independence, adheres to an evidentiary standard of positive association, and requires decisions within established timeframes.

Concession of Exposure

Traditionally, VA disability claims are granted by establishing direct service connection through a medical nexus that links a veteran's current diagnosis to an in-service event. In the case of toxic exposure-related claims, however, the in-service event, such as burn pit exposure, can be nearly impossible to prove since these events were often never documented. Since the veteran has no documentation of burn pit exposure (e.g., time and location), no in-service event is established, and VA often rejects the claim without providing additional consideration of whether the claimed illness is connected to the veteran's service.

Both the *COST of War Act* and the *Honoring Our PACT Act* would solve this problem by conceding exposure to burn pits and other toxic substances currently accepted by the VA adjudication manual for any veteran who was deployed to locations of known exposure, to include Iraq, Afghanistan, and surrounding areas. It would also require VA to request a medical opinion on the link between illness and exposure when the underlying facts do not provide prima facie evidence to grant the claim.

While VA's grant rate of 22 percent for burn pit-related claims is discouragingly low, we believe that claims will be more likely to succeed if burn pit exposure is conceded for veterans who served in areas where burn pits are known to have been used. Current law grants a concession of exposure to herbicide agents for Vietnam veterans (38 U.S.C. § 1116(f)), in recognition of that fact that many lack documentation of where and when they were exposed to Agent Orange. Current era veterans deserve concession of exposure for the same reason. We note that even if a list of presumptive disabilities was established in connection with burn pit exposure, proving exposure would still be necessary for veterans who wish to claim direct service connection for any illness that is not presumed to be related to exposure.

Presumptive Disabilities

Recognizing the possible relationship between in-service exposure and illnesses, the U.S. has invested resources in scientific studies to determine if there is an association. Still, after two decades of war, the science is disappointingly inconclusive. In its most recent report on the topic, released on September 11, 2020, National Academies of Science, Engineering, and Medicine (NASEM) stated that its analysis of the previous epidemiologic studies found them inadequate to determine an association, largely due to a lack of good exposure characterization. However, they stated, "this should not be interpreted as meaning that there is no association between respiratory health outcomes and deployment to Southwest Asia, but rather that the available data are, on the whole, of insufficient quality to make a scientific determination."

Consequently, NASEM recommends that new epidemiologic studies should be conducted.[6] Unfortunately, new studies could take years without the promise of more conclusive outcomes.

The *COST of War Act* and the *Honoring Our PACT Act* would bypass this scientific gridlock by establishing a presumption of service connection for any veteran who served on current-era deployments to areas of known exposure and is now suffering from certain cancers or serious respiratory conditions. While both bills include the same list of non-cancerous respiratory diseases and the *COST of War Act* includes respiratory cancers and glioblastoma, WWP strongly prefers the list of conditions in the *Honoring Our PACT Act*, which also includes eight additional cancers of various body systems, as well as granulomatous disease. WWP urges Congress to include all of these diseases in its final bill.

In August 2021, VA announced that it would begin processing claims for asthma, rhinitis, and sinusitis on a presumptive basis for veterans who served in Southwest Asia, Afghanistan, Uzbekistan, and surrounding areas due to presumed exposure to particulate matter. While WWP applauded the Secretary for using his rulemaking authority to establish these presumptive conditions, we opposed VA's decision to only include veterans who can produce evidence that their conditions manifested within 10 years of discharge. We believe that this unfairly excludes many veterans who were discharged over 10 years ago and may have chosen to self-treat for these conditions. Since they had no reason to believe they had a reasonable chance of being granted direct service connection, they may have never gathered evidence to file a claim or sought a formal diagnosis of their symptoms. Consequently, they have no way to prove when their conditions first manifested, even if they have been experiencing symptoms ever since returning from deployment. For this reason, we also urge Congress to codify these presumptive conditions without the 10-year time limitation.

Additional Legislation

The *Health Care for Burn Pit Veterans Act* (S. 3541, H.R. 6659) – introduced by Chairman Tester and Ranking Member Moran in the Senate and by Ranking Member Bost in the House – would extend eligibility for Priority Group 6 enrollment for recently discharged combat veterans from five years to 10 years. For those who were discharged over 10 years ago, it would establish a one-year enrollment period, beginning on October 1, 2022. An outreach plan by VA would be required to inform veterans of these new eligibility rules. The bill also contains various requirements for toxic exposure-related reporting, studies, screening, and training for VA employees. The sponsors of this legislation state that it is "the first of a three-step approach to expand access to health care for toxic-exposed veterans, establish a new process through which VA will determine future presumptive conditions, and provide overdue benefits to thousands of toxic-exposed veterans who have been long-ignored or forgotten."

Although WWP has publicly stated that the *Health Care for Burn Pit Veterans Act* represents a first step towards expanding access to care for recently discharged combat veterans, all of whom served in areas of known exposure, it is only a short-term solution. We continue to support passage of the *COST of War Act* and the *Honoring Our PACT Act* to provide a long-term health care solution for veterans exposed to toxic substances. Our commitment from the start of the 117th Congress has been to establish permanent access to VA health care for any veteran

who suffered toxic exposures while in service, regardless of his or her service-connected disability claim status.

No veteran who served in an area where they were forced to inhale fumes from burn pits or endure exposure to other dangerous toxic substances should be turned away from VA care, regardless of how many years ago they were discharged. Extending the special combat eligibility rule to 10 years only delays the point at which they will be denied access to care. The brief one-year enrollment provision for those discharged over 10 years ago does not alleviate our concerns. Previous generations of exposed veterans are not limited by arbitrary deadlines, and we see no reason why the post-9/11 generation should face this barrier to care.

Wounded Warrior Project is also concerned that those who have been discharged for more than 10 years may remain unenrolled at the end of the special 12-month enrollment period offered by the *Health Care for Burn Pit Veterans Act*. We believe that those who are presently ill but have been denied service-connection will likely enroll. In contrast, veterans who chose not to enroll during the initial five years following discharge and never filed a disability claim likely consider themselves healthy and will continue not to seek enrollment until their health status changes. We also recognize some adhere to a principle of not seeking care when others "more deserving" of the care should find needed care sooner. Others may be completely disconnected from VA and veteran service organization (VSO) communications at this time for any number of reasons. It is unrealistic that any amount of outreach from VA and VSOs would be enough to overcome these perceptions within a short 12-month period, especially for rural veterans. Consequently, many of them will remain unenrolled after October 1, 2023, leaving them once again ineligible for care and operating without a safety net should they become ill in the future.

Additionally, we are concerned whether veterans who become eligible for enrollment under the *Health Care for Burn Pit Veterans Act* would still be guaranteed access to care after the 10-year or 1-year windows close. VA's current policy assigns recently discharged combat veterans to the highest priority group they qualify for at the end of the five-year period. For those who are unable to establish a service-connected disability, qualify by virtue of a means test, or meet other eligibility criteria, this means a downgrade to Priority Group 8. Veterans in this priority group have been historically vulnerable to changes by VA in the level of services they are offered. According to the Congressional Budget Office, "[w]hen priority groups were established in 1996, the Secretary of the Department of Veterans Affairs was given the authority to decide which groups VA would serve each year. Because of budgetary constraints, VA ended enrollment of veterans in Priority Group 8 in 2003. Veterans who were enrolled at that time were allowed to remain in VA's health care system."[7] WWP is concerned that future budgetary constraints could prompt VA to end the provision of care for Priority Group 8 veterans altogether, leaving those who suffered toxic exposures and were downgraded to Priority Group 8 without access to care. Additionally, for a veteran who is unable to establish a toxic exposure service-connected condition, it is unclear what subgroup of Priority Group 8 they would be in or whether they would be eligible for health care benefits.

In sum, WWP will continue to champion the *COST of War Act* and the *Honoring Our PACT Act,* which would finally provide parity to current-era veterans and beyond who suffered

toxic exposure by guaranteeing them the same access to care as previous generations of exposed veterans. While we support the *Health Care for Burn Pit Veterans Act* as a first step towards achieving this goal, we oppose it a substitute for the *COST of War Act* and the *Honoring Our PACT Act.*

In closing, WWP thanks the committees for prioritizing this urgent issue and considering the *COST of War Act* and the *Honoring Our PACT Act.* We now urge Congress to work swiftly on a bicameral basis to resolve any differences in the legislation and send a comprehensive toxic exposure bill that accomplishes each of our stated goals to the president's desk without delay.

MENTAL HEALTH

With more than one million OEF, OIF, and OND veterans having some mental health need, and approximately 11 percent to 20 percent of post-9/11 veterans presenting with PTSD in a given year, WWP is committed to a public health approach that addresses suicide prevention and prioritizes providing high-quality mental health resources and treatment to veterans[8]. We offer a continuum of mental health programs to help warriors and their families build resilience and overcome mental health challenges, and support for public policies to support VA's ability to do the same has been a core tenet of our advocacy before Congress.

The Senate and House Committees on Veterans' Affairs delivered on the top priorities of WWP's 2020 legislative testimony by passing the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act.* Specifically, the new law provides authorization for VA to pursue a community grant program to connect more veterans with clinical and non-clinical services in their communities (§ 201) and enhanced research capabilities related to precision medicine for PTSD and TBI with a goal of developing diagnostic tests and personalized therapeutics for millions of veterans who suffer the devastating effects of trauma to the brain (§§ 305, 704, 705). WWP applauded the passage of this historic legislation, along with key supplemental improvements provided by the *Veterans COMPACT Act*, which will strengthen support during military transition, implement suicide prevention initiatives, and improve care and services for women veterans. Your committees have continued the positive momentum in the 117th Congress and delivered on many of the top priorities of WWP's 2021 legislative testimony by introducing the *Post-9/11 Veterans Mental Health Improvement Act* (S.3293) and the *Support The Resiliency of Our Nation's Great Veterans Act of 2022* (H.R. 6411), also known as the *STRONG Veterans Act of 2022.*

The *Post-9/11 Veterans Mental Health Improvement Act* and *STRONG Veterans Act* would collectively help make future improvements in several areas WWP has identified as top priorities, including: improving treatment for sleep disorders (S.3293 § 101; H.R. 6411 § 502); streamlining mental health consultations for veterans filing for disability compensation for mental health disorders (S.3293 § 102; H.R. 6411 § 404); and increasing access to treatment offered at Residential Rehabilitation Treatment Programs (RRTPs) (S.3293 § 103; H.R. 6411 § 503) and for co-occurring mental health and substance use disorders (SUDs) (S.3293 § 104; H.R. 6411 §504). WWP endorses both bills and believes they would make significant strides to

fills the gaps in care that have become pronounced within the community of post-9/11 wounded warriors that we serve.

Many of the provisions in the *Post-9/11 Veterans Mental Health Improvement Act* and the *STRONG Veterans Act of 2022* are particularly timely given the environment many veterans have been facing since the onset of the COVID-19 pandemic and the end of the war in Afghanistan. For example, eHome Counseling has been a partner of WWP since 2018 and currently serves warriors with nationwide, metrics based, video face-to-face mental health counseling services for general counseling along with PTSD- and addiction-specific programs. Over the past three years, eHome has served more than 1,600 warriors referred by WWP's mental health programs, including the Warrior Care Network. Data developed through this partnership has shown that the pandemic has significantly impacted veteran mental health. Pre-COVID (April to December 2019), 67% of warriors showed moderate or severe conditions compared to 77% post-COVID (April to December 2020). PTSD showed a particular rise from 54% to 64%. As the pandemic has progressed, scores have declined slightly (e.g., moderate/severe from 77% in 2020 to 75% in 2021), yet all are still significantly higher than pre-COVID. Co-occurring conditions increased significantly during the pandemic, making treatment more complex. Additionally, intake assessments showed a "September Anomaly" effect this year, with suicidality doubling month over month from 13% to 26%, and alcohol misuse from 20% to 31%. This is potentially related to the U.S. withdrawal from Afghanistan on August 31.

While connecting veterans to care through WWP programs and our programming partners, including VA, has certainly helped veterans manage or overcome their mental health symptoms, more work can be done to improve the mental health care landscape for wounded warriors. In addition to passage of the *Post-9/11 Veterans Mental Health Improvement Act* and *STRONG Veterans Act*, WWP also supports broader mental health reforms across American health systems which will provide a strong path forward to empower veterans facing mental health conditions and crises. The following recommendations represent what we believe to be the best path forward to improve access to care, provide greater quality of care, deliver needed services, and keep the mental health community accountable.

Community-based Suicide Prevention Services

Wounded Warrior Project has been a leading advocate for programs and policies that recognize the interconnectedness of factors such as social connection, financial security, physical health, and mental resilience on overall health and wellness. In 2022, VA is set to bring this approach to communities across the country when it launches the new Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (P.L. 116-171 § 201). A signature component of the *Commander John Scott Hannon Veterans Mental Health Improvement Act*, this program will further implement the agency's public health approach through new authority to combine community-based prevention with evidence-based clinical strategies through community efforts. Congress can play a pivotal role in ensuring its success.

In April 2021, WWP and many other organizations submitted public comments to VA advising the agency on what factors to consider when implementing this new grant program.[9] Generally speaking, we believe that protective factors like social connectedness, outreach, and

economic security – pursued by the WWP community in greater numbers during the spread of COVID-19 – underscore the importance of broadly defining "suicide prevention services." In addition to accommodating protective support services with inherent value, we believe many of these programs will drive referrals to the VA health system for clinical care. Accordingly, WWP stands by to assist the committees' efforts to oversee implementation of the SSG Parker Gordon Fox Suicide Prevention Grant Program, a critical new tool to prevent veteran suicide and a top mental health policy priority for WWP.

Additionally, we support Section 304 of the *STRONG Veterans Act* that seeks to implement more veteran suicide prevention proposals through the Governors Challenge Program, another avenue to develop and implement state-wide suicide prevention best practices using a public health approach. To date, 35 states take part in the challenge, and we believe the *STRONG Veterans Act* can help expand and bolster this program. WWP also endorses the peer support provisions included in Sections 302 and 401 of the *STRONG Veterans Act*. These provisions would make significant strides to engage more warriors through peer connection, including through the proposed designation of "Battle Buddy Check Week" to help increase outreach and education concerning peer wellness checks for veterans.

Substance-Use Disorder, Residential Care, and Challenges with Sleep

Wounded Warrior Project is working to address co-occurring mental health and substance use disorders by connecting veterans to the care they need, including investments in programs and studies. A 2020 report, *Improving Substance Use Care: Addressing Barriers to Expanding Integrated Treatment Options for Post-9/11 Veterans*[10], published by the RAND Corporation and commissioned by WWP, provided several key findings. This study reveals that co-occurring SUDs and mental health disorders are common among post-9/11 veterans. Substance use disorder is often present in veteran suicide, and screening positive for PTSD or depression has been associated with being almost 20 percent more likely to screen positive for hazardous alcohol use or a potential SUD. In our most recent *Annual Warrior Survey*, we note VA's estimate that two out of 20 veterans with PTSD also have SUD[11]. Monitoring substance use within the WWP warrior population is critical given the high prevalence of PTSD and other mental health problems that may put warriors at risk of self-medicating.

Despite this common co-occurrence, treatment facilities typically specialize in treating one type of disorder or the other. Mental health treatment facilities – particularly within VA's community care network – often require veterans to abstain from substance use; however, veterans may be using substances to manage their mental health symptoms. Veterans who receive substance use treatment alone may be at risk for failing to meet their treatment goals if their mental health symptoms are not addressed. Addressing both simultaneously and concurrently can be necessary for lasting improvement. It is critical that veterans can access programs and facilities that are equipped to treat the veteran population and that post-care plans are strong and coordinated with VA to help prevent relapse. Taken together, these findings underscore a recent $10 million investment from WWP in our Warrior Care Network partners – where each location also hosts a VA employee to help coordinate post-care referrals into VHA – of which $1.3 million will be utilized to offer treatment programs dedicated to treating SUD and co-occurring PTSD and SUD.

Wounded Warrior Project recently submitted further commentary on this topic in response to the November 4, 2021 Notice of Request for Information Regarding Health Care Access Standards[12]. WWP documented the challenges our organization has encountered while assisting veterans needing residential care, especially veterans presenting with co-occurring mental health and substance use disorders. We believe that the absence of an access standard specifically for Residential Rehabilitation Treatment Programs (RRTPs) has permitted inconsistent experiences for veterans seeking these placements. Without clearer regulations or policies to ensure consistent and predictable RRTP referral practices, we believe that veterans will continue to face unnecessary wait times for care that can jeopardize health and discourage health-seeking behavior.

In this context, WWP supports Section 104 of the *Post-9/11 Veterans Mental Health Improvement Act* and Section 504 of the *STRONG Veterans Act of 2022* which call on VA to conduct a study on treatment for co-occurring mental health and SUDs. We also support Section 103 of the *Post-9/11 Veterans Mental Health Improvement Act* and Section 503 of the *STRONG Veterans Act of 2022* that require a study on access to care through RRTPs and require consideration of whether new SUD tracks should be added.

Similarly, WWP supports Section 101 of the *Post-9/11 Veterans Mental Health Improvement Act* and Section 502 of the *STRONG Veterans Act of 2022*. These provisions focus on improving sleep disorder care furnished by VA, including requiring VA to conduct an analysis of the department's ability to treat sleep disorders. In WWP's *Annual Warrior Survey*, sleep problems (78 percent) are the most frequently self-reported injury or health problem, which can be a result of both physical and mental health injuries or problems. Sleep deficits can exacerbate or increase the risk for chronic conditions such as pain, anxiety, PTSD, depression, and unhealthy weight, which affect most veterans served by WWP. According to the National Veteran Sleep Disorder Study, veterans are six-times more likely to suffer from sleep disorder than the general population. Knowledge about the importance of sleep quality and awareness of sleep disorder treatment is the first step in impacting change for better health outcomes. Minor, incremental changes in behavior leveraging non-pharmacological treatment methods such as exercise and behavior-based sleep therapy to improve sleep quality and ultimately support improved health outcomes should also be promoted.

National Suicide Prevention Lifeline and Veterans Crisis Line

Wounded Warrior Project was pleased to witness passage of the *National Suicide Hotline Designation Act of 2020* (P.L. 116-172) to launch 9-8-8 as the new three-digit dial code for the National Suicide Prevention Hotline. WWP remains committed to helping more veterans learn about the new three-digit number following the July 2022 launch. We also recognize more work needs to be done to help the veteran community, and Americans more broadly, learn about this new number. To this end, we support the *Suicide Prevention Lifeline Improvement Act* (H.R. 4564) that would develop a plan to ensure the provision of high-quality service for the hotline, strengthen data-sharing agreements to transmit epidemiological data from the program to the Centers for Disease Control, and implement a pilot program focused on using other communications platforms for suicide prevention. WWP also applauds the provisions of Title II

of the *STRONG Veterans Act of 2022* which aims to strengthen training, quality, and oversight of the Veterans Crisis Line for veterans who dial "1" after calling 9-8-8.

Finally, WWP supports the *9-8-8 Implementation Act*. This comprehensive mental health legislation would provide sustained congressional support for state and local implementation of 9-8-8 and the continuum of crisis care services, including the hotline, mobile response, and dedicated crisis care. This legislation includes several key provisions that will bolster the effectiveness of 9-8-8, thereby helping ensure more Americans, including veterans, receive prompt and quality care when accessing this resource.

Telehealth

Based on figures from 2019, 11 out of 17 veterans who died by suicide were not connected to VA, and among those veterans who were connected, 40%[13] were not being treated for a mental health or substance use disorder. WWP's 2021 *Annual Warrior Survey* notes that a significant number of post-9/11 wounded warriors receive mental health care outside of a VA Medical Center, with only 56.6% of warriors receiving mental health care at a VA Medical Center despite the pervasiveness of PTSD (75%), anxiety (74%), and depression (72%). While many of these warriors rate VA as a top resource for mental health care and most (approximately 4 out 5) reported being able to receive the care they need, it follows that more can be done to increase accessibility to care for those not doing so at VA.

Wounded Warrior Project supports expanding access to telemental health by allowing practice over state lines – like VA's "Anywhere to Anywhere" initiative – by passing the *Creating Opportunities Now for Necessary and Effective Care Technologies (CONNECT) for Health Act of 2021* (S. 1512, H.R. 2903). VA has been able to deliver exceptional mobile care throughout COVID-19, due to the strength of its telehealth laws. This legislation would provide the Department of Health and Human Services (HHS) with the authority to waive telehealth restrictions, remove geographic restrictions for services like mental health and emergency medical care, and allow rural health clinics and other community-based health care centers to provide telehealth services. This, in turn, stands to benefit the many veterans who seek mental health care outside of VA, including in more rural parts of the country.

Wounded Warrior Project also supports H.R. 6202, the *Telehealth Extension Act of 2021*. This legislation ensures permanent access to telehealth for patients across the country by ending outdated geographic and site restrictions on where patients can receive approved telehealth services. The bill also temporarily extends emergency authorities established during the COVID-19 pandemic that authorize a wide range of providers and services via telehealth. The temporary extension of these authorities will prevent an abrupt cliff in services at the end of the Public Health Emergency (PHE) period and allow for further study of the utilization and impact of telehealth in different medical settings. This legislation also stands to benefit veterans seeking mental health care from community providers. Similarly, the *Stopping the Mental Health Pandemic Act* (S. 165, H.R. 588) directs HHS to award grants to upgrade technology to support effective delivery of telehealth services, promote collaboration between primary care and mental health providers, and support emergency crisis intervention.

Lastly, WWP supports interstate compacts that help increase access to mental health treatment. WWP supports the Psychological Interjurisdictional Compact (PSYPACT), an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries as this stands to help veterans have access to more mental health care providers. To date, 28 states have enacted PSYPACT legislation. We encourage the committees to consider ways of advocating for interstate compacts that can provide more flexibility for both mental health providers and patients/clients. For example, committee members may consider introducing legislation similar to 10 U.S.C. § 1784(h) that is designed to provide funding to support the development of interstate compacts.

WOMEN VETERANS

In the past several years, there have been important bipartisan legislative victories that have invested in our women veterans. However, as the fastest growing segment of the veteran population, WWP believes there are new opportunities for us to better understand, empower, and advocate for these women who have served our nation. With over 27,000 women warriors registered with WWP, our programs provide support and serve the unique and evolving needs of this population. We also are continuing to evaluate and develop new and innovative ways to serve women veterans.

Last year, WWP released the Women Warriors Initiative Report. This report was based on information collected from over 5,000 women veterans who gave us important insights into their lives, challenges, and experiences. In follow-up roundtables, we focused on five major issue areas these women identified: access to care, mental health, transition, isolation, and financial stress. Combined with our work collecting data through the *Annual Warrior Survey*, we set out to use the information we collected to determine how we and the veteran's affairs community at large, could assist women veterans. Our advocacy before your committees in the First Session of the 117th Congress was built upon the following foundations, and that advocacy will continue over the remainder of the Second Session.

Gender-Specific Care

Wounded Warrior Project continues to believe that increasing access to VA-facilitated care should be a top priority. While almost all our WWP-registered female veterans are enrolled in VA health care (95%), nearly two-thirds (64%) have had challenges accessing the care they need. Additionally, women veterans are more likely to report fair or poor health compared to women who are still serving and non-veteran women.[14,15] Simply put, more needs to be done to improve access and quality of health care for our women veterans. We also know that for post-9/11 women veterans, over 70% of all health care visits (both VA and non-VA) were to address women-specific health care needs.[16]

One important avenue for access to gender-specific care that continues to receive overwhelmingly favorable feedback on is women's health clinics. We have found that when available, women veterans prefer to use these specialty clinics and we believe VA should continue to invest additional resources to expand their sizes, staffs, and locations.

Another important avenue of care for women veterans is through telehealth. WWP women warriors were more likely to utilize telehealth than their male counterparts. We commend the tremendous efforts VA has made in leveraging telehealth throughout the COVID-19 pandemic and believe it is continued use will help to expand care to those that otherwise may not be able to access it, including rural women veterans and those that have difficulty finding childcare to attend appointments.

Unfortunately, according to the AWS, the type of care that women warriors are most likely to go outside of the VA for is infertility or reproductive services, further illustrates the need for greater access to gender-specific care. The reasons most often cited for going outside of VA for this type of care, include poor providers, inconsistent services, lack of available services, and difficulty accessing the type of contraception preferred or accessing the pharmacy at all. Because of these difficulties, WWP continues to support legislation that makes it easier for women veterans to access contraception and other reproductive services.

Wounded Warrior Project similarly supports the *Making Advances in Mammography and Medical Options for Veterans Act* (S. 2533, H.R. 4794). We believe this legislation will markedly improve access to potentially lifesaving care for the 1 in 8 women veterans in the VA health care system that develop breast cancer in their lifetimes. WWP is also proud to support the *Women Veterans TRUST Act* (H.R. 344), which would require VA to analyze the need for long-term, residential, women-specific drug and alcohol dependency treatment and rehabilitation programs, as well as a related pilot program. We thank the members that have sponsored these important pieces of legislation and urge quick action on them.

Military Sexual Trauma (MST)

Devastatingly, 44% of WWP women warriors report experiencing sexual assault, a rate which is 2.5 times higher than females in the general U.S. population. MST continues to be one of the most complex yet widespread challenges facing Servicewomen and women veterans. The prevalence of MST in the population of warriors we serve, and the severity of its impact make this issue a priority for WWP, both in the delivery of our programs and in our role as advocates for the veteran community. WWP has done extensive work to ensure our programming reflects the needs of sexual trauma survivors, including through clinical and non-clinical mental health programs or through social events designed to facilitate peer connection and healing.

While the effects of MST are wide-ranging, women warriors commonly described feeling a sense of isolation, experiencing a lack of support in the wake of traumatic events, and struggling to avoid further traumatization when seeking treatment or benefits. One of the top three challenges with transition WWP women warriors identified was coping with mental health issues related to MST. We believe that this point of transition is a critical junction for MST survivors. It is essential that we reach these survivors early and effectively in their transition to civilian life, not only to connect them with MST-specific resources, but to avoid some of the other challenges frequently cited during transition, including isolation, anxiety, or crises of identity.

We appreciate the efforts VA and Congress have made to begin to address and highlight this issue; however, more can be done to integrate MST-informed care across all disciplines, programs, and outreach efforts. One of the legislative efforts to do this that WWP has endorsed, is H.R. 2724, the *VA Peer Support Enhancement for MST Survivors Act*. This bipartisan bill establishes a peer support program at the Veterans Benefits Administration (VBA) for survivors of MST. We believe this bill will enhance support for MST survivors and better integrate peer support into the VA system. Similarly, the compensation and pension exam continues to be a point of frustration for survivors due to the risk of re-traumatization and the often intense nature of the exam. While we understand the need for these comprehensive exams, we continue to urge VA to ensure they are consistently compassionate and trauma-informed. We believe the *Servicemembers and Veterans Empowerment and Support Act* (S. 3025, H.R. 5666) would both improve the MST claims process and outcomes for survivors, and we urge Congress to pass this important legislation.

In 2020, WWP was pleased to see the passage of the *Deborah Sampson Act*. We believe this legislation has already resulted in positive changes for women veterans but want to highlight several provisions that we believe deserve especially close oversight and continue to ensure successful implementation. Sections 5501, 5502, and 5503 implement commonsense improvements in reporting requirements and benefits processing for MST-related claims that will enhance many veterans' disability, mental health, and physical health options.

Ongoing Connection and Support

Through our Women Warriors Initiative, WWP has found that women warriors often infrequently see themselves represented in the veteran community yet struggle to relate to civilian women who cannot relate to their military experiences. Many reported not having strong connections with other veterans but also describe a sense of relief in being with one another. In addition, over 80% of women warriors scored as lonely based on the UCLA Three-Item Loneliness Scale.

We believe that peer support programs are needed to fight against this isolation that many women warriors experience. Peer support groups facilitate the expression of their shared challenges and concerns while building support systems to fight against isolation. WWP has found that women-only virtual peer support groups can be especially useful. Over the course of the pandemic, WWP saw female representation rise dramatically through our virtual events. With barriers like physical distance and lack of access to childcare, virtual support groups have allowed many of our women warriors to connect in ways they could not before. As a response, WWP now has 12 Peer Support Groups meeting virtually across the country. We encourage VA to continue to capitalize on this time when many veterans are becoming more comfortable with virtual platforms and pilot online peer support for women veterans.

Given the importance of the transition process, WWP also recommends that DoD establish peer support groups for Service members going through the transition process. Many women warriors report that some of the best information they received during their transition was from other Service members who had previously transitioned or worked with those who had. These types of peer support groups will provide additional spaces for women veterans to receive

emotional support, share their challenges and concerns and fight against the isolation many describe during this period of transition.

In this context, WWP supports close oversight of Section 5206 of the *Deborah Sampson Act*, which requires VA to develop a staffing improvement plan for women peer specialists. As discussed, WWP understands the significant impact of peer support, especially for women veterans in underserved or hard-to-reach areas. This provision will ensure that women veterans across geographies are comfortable in engaging with qualified and resourceful peer specialists.

Safe and Welcoming VA Care Environments

One of the most common barriers for WWP women warriors to VA care was lack of sensitivity to women's needs. We know that the environments of care at VHA facilities can significantly impact women veteran's experiences and willingness to access care. Especially for the 1 in 4 women warriors that have experienced MST, entering a VA facility can be an overwhelming and scary experience. Many women have reported harassment, anxiety over being forced to walk through crowded spaces or their veteran status being questioned at VA facilities.

Because of these issues, we support VA's recent efforts to create a more inclusive and safe experience at VHA facilities, including initiatives like the White Ribbon VA and establishing designated points of contact for reporting harassment at each facility. However, we continue to believe more effort needs to be made to ensure safety, convenience, and overall ease of access by women veterans. WWP recommends that VHA facilities' physical layouts and utilization patterns are evaluated for potential issues that may arise for women veterans or trauma victims. This includes evaluating proximity to parking lots, lighting, distribution of functioning security cameras and private entrances. Facilities should, when necessary, adapt these layouts to improve privacy and safety for women veterans accessing care.

There are several additional provisions of the *Deborah Sampson Act* that reflect a number of the priorities we have mentioned, and we want to urge particularly careful oversight of a few specific provisions, including sections 5102 and 5103. These sections take steps to ensure that women veterans receive their health care in facilities that are well-equipped, functional, and comfortable by implementing the women veterans retrofit initiative – to address deficiencies in fixtures and other outfitting measures – and uniform standards and inspection requirements. Another section we are closely monitoring progress on is section 5107. This section establishes a permanent program to facilitate childcare for veterans utilizing regular or intensive health care services. This measure addresses a barrier that has long been identified by women veterans as burdensome, expensive, stressful, and an obstacle in their ability to access medical appointments and opportunities for peer support.

Wounded Warrior Project is excited to see the changes that have already been made because of the *Deborah Sampson Act* and we look forward to working with you to ensure these necessary updates and programs are carefully adapted to ensure the best outcomes for women veterans. Additionally, as VHA continues to modernize its facilities and operations to better serve women warriors, we are eager to see the nomination and confirmation of an Under

Secretary of Veterans Affairs for Health. This position – which has not been officially filled since January 2017 – will be key to guiding VHA's strategic efforts to improve the delivery of health care to all veterans, including more than 580,000 enrolled women and thousands more who will seek care at VA in the future.

LONG-TERM CARE AND SUPPORT

All veterans enrolled in VA's health care system are potentially eligible for long-term services and supports (LTSS), a suite of VHA programs that includes facility-based services, end-of-life services, and – most critically to the post-9/11 generation's severely wounded warriors – geriatric outpatient programs and home and community-based services. Providing necessary LTSS, to include enough of those services, to veterans who are relying on them earlier in life is a WWP priority. While WWP is meeting that priority through services like our Independence Program, the House and Senate Committees on Veterans' Affairs can drive critical improvements to VA LTSS by considering three key facts.

First, veterans under the age of 65 are using VHA's Geriatrics and Extended Care (GEC) programs at a high and increasing rate. In 2020, 27% of GEC program users were veterans under the age of 65.[17] That figure represents a 10% increase over 2019, when veterans under age 65 accounted for 16.7% of GEC program users.[18] Across all VA long term programs from fiscal year 2014 through 2018, the number of veterans who served on or after 9/11 and received long-term care has increased at a faster rate than the overall number of veterans who received this care.[19]

Second, veterans under the age of 65 are more likely to have been the beneficiaries of modern life-saving military medicine and technology during their time in service. Improvements in combat casualty care including better use of tourniquets, quicker blood transfusions, and faster prehospital transport times have saved the lives of many who would have been lost in previous wars, including those most critically injured, who experienced a three-fold increase in survival rates from 2001 to 2017.[20] Many of those who survived due to these advances in medical technology and battlefield care were very seriously wounded and will be challenged by lifelong physical disabilities or mental health conditions. Thus, this increased survival rate will continue to contribute to the need for LTSS services that are responsive to a community of younger veterans who will require more intensive care and case coordination over a longer period.[21]

Lastly, the current state of research in traumatic brain injury (TBI) indicates that there is still much to learn about the long-term care needs of those who incurred these invisible wounds in service. What is clear is that from 2000 to the third quarter of 2020, the Department of Defense (DoD) reports 430,720 TBIs among Active Duty Service members.[22] Research indicates that this figure could be even higher due to undocumented injuries in Iraq and Afghanistan before improvements in documentation implemented in November 2006.[23] Other research indicates that 1 in 4 veterans who have been hospitalized with TBI will develop long-term disability.[24]

Taken together, the factors above provide compelling evidence for the committees to consider the perspective of how younger veterans are relying on LTSS, how that reliance will grow and shift over time, and what can be done to ensure the best outcomes for veterans with a history of TBI.

Long Term Support Services

Our primary focus within LTSS is for Congress to explore whether the Geriatrics and Extended Care (GEC) services at VA are meeting the needs of a younger generation of veterans who are using these services earlier in life. The clinical diagnoses and symptomatology of veterans relying on VA LTSS is diverse, but for younger veterans with serious, persistent combat injuries, certain presentations may be more common and illustrative. For the post-9/11 generation, traumatic brain injury (TBI) provides a helpful benchmark of how VA programs are currently meeting the need of wounded warriors who are relying on LTSS.

In a recent study of the service needs and barriers faced by veterans years after sustaining moderate to severe TBI, the most frequently cited barrier to care was not knowing where to get help.[25] This finding underscores the fact that, while the number of Service members catastrophically injured in service has decreased in recent years, the needs of severely injured Service members and veterans with TBIs have not diminished over time and will, in many cases, grow. In the experience of WWP's Independence Program and Complex Case Coordination team, this lack of awareness is not limited to those with brain injury and is often an issue across the spectrum of injury and illness.

Wounded Warrior Project has found that establishing treatment and support programs may simply not be enough. Overlapping resources and nonuniform availability of federal, state, and local resources require a broad community effort to connect those in need with the services created for them. For this younger generation, VA's nomenclature has an impact. The word "Geriatric" – in reference to VA's Geriatric and Extended Care program office – can be a source of confusion or deterrence for both the veteran and their case manager or social worker to seek services. To overcome even this most basic barrier as well as others, a menu of available program options tailored to the veteran/family and based on his or her needs and eligibility would maximize the use and impact of those services. In addition, younger veterans with long term care needs and their caregivers are often overlooked for programs like Veteran Directed Care (VDC) and Home-Based Primary Care because they are a small – but vulnerable – portion of the eligible population. In many cases, they are in desperate need of these services but simply are not aware they exist. Because this population is relatively small and geographically diverse, increased training to identify younger veterans in need of LTSS may be needed.

Although contextually limited to the TBI landscape of care, the need for more coordinated care and outreach has been previously acknowledged. In a June 2013 report to Congress, the Centers for Disease Control and Prevention (CDC) and the National Institutes of Health (NIH) outlined three broad goals for TBI care in the military and veteran community: (1) increased awareness, (2) improved surveillance, and (3) stronger collaboration across the federal government.[26] Several recommendations – which were composed in collaboration with DoD

and VA – have been implemented, but guiding factors can still serve to improve the landscape of care today.

To improve continuity of quality care and service delivery along with inter-service, interagency, intergovernmental, and public and private collaboration for care, CDC and NIH called on VA to establish multiple reforms including implementing uniform training for recovery coordinators and medical and non-medical care/case managers, establishing a single tracking system, and providing a comprehensive plan for the seriously injured. The Federal Recovery Coordination Program was cited as a main driver of these reforms, but that office has since transformed into the Federal Recovery Consultant Office (FRCO) in February 2018 in response to the Presidential Executive Order, "Comprehensive Plan for Reorganizing the Executive Branch." While this shift may have created some efficiencies, WWP encourages a fresh assessment of whether the FRCO is sufficiently resourced to address the reforms that have not been fully realized. Additionally, we believe that similar efforts can be undertaken to support a broader population of veterans with complex needs and should include steps to ensure central oversight of policy implementation.

In consideration of the above, WWP supports draft legislation being developed by Rep. Julia Brownley (D-CA-26) that would commit VA to making improvements aligned with WWP's priorities for LTSS. We are pleased to see this legislation includes a section that would increase the amount VA can pay for non-institutional care provided to an individual veteran, making it more affordable for a veteran to choose care at home instead of in a nursing care facility. This will be particularly impactful for younger warriors who require a heightened level of care but for whom life in a nursing home is neither age nor culturally appropriate. Additional provisions to codify programs like VDC and Purchased Skilled Home Care will increase the likelihood that these programs become more accessible around the country. Lastly, we are encouraged by steps this legislation would take to make VA's non-institutional care programs more visible to veterans and caregivers who may no longer be eligible for the Program of Comprehensive Assistance for Family Caregivers (PCAFC). As new heighted eligibility standards have made PCAFC unattainable for many who nevertheless need or provide considerable support, improvements designed to help connect these veterans and caregivers to other programs that may provide needed assistance will be a critical backstop.

Traumatic Brain Injury

Wounded Warrior Project has previously advocated for new and continuing investment in research and programs to address near- and long-term needs, as well as the risk associated with brain injury. While Congress has extended support through several of these initiatives within the context of mental health, suicide prevention, and aging, WWP has called on Congress to concentrate efforts on TBI specifically. As the population of post-9/11 veterans living with the aftereffects of TBI during service continues to grow, little is known about the expected course of their condition or how to best meet their needs for long-term support service. To this end, two recent comprehensive reports offer constructive recommendations for improving TBI care and research: the DoD has released a report to Congress, *Eleven-Year Update: Longitudinal Study on Traumatic Brain Injury Incurred by Members of the Armed Forces in Operation Iraqi*

Freedom and Operation Enduring Freedom, and the National Academies of Sciences, Engineering, and Medicine released *Traumatic Brain Injury A Roadmap for Accelerating Progress*. These reports provide better understanding about which approaches may offer the best care for veterans with TBI, as well as help inform the policies and research needed to improve the care and support offered to veterans and their family members.

Wounded Warrior Project believes these reports highlight areas where oversight and new polices can play a role in ensuring the current and long-term care outlooks for post-9/11 veterans are a strong as possible. Some areas for potential oversight include (1) exploring how well VA is doing screening all veterans from OEF/OIF for possible TBI during their initial visit to VHA to enhance identification and treatment of TBI and any related physical, cognitive, and emotional problems; (2) reviewing the accessibility and capacity of polytrauma intensive TBI and PTSD programming across the Polytrauma System of Care; (3) assessing the adequacy and scope of current TBI research, including biomarker research authorized in *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* (P.L. 116-171 § 305); and (4) determining whether the current Federal Recovery Coordination Program is adequately resourced to meet current needs.

Another key area to explore is ensuring access to care. DoD's report makes many strong recommendations, finding Service members, veterans, and family members report barriers, such as distance to health care, time issues, and scheduling/availability of wanted services, as challenges to address ongoing needs[27]. The report also notes "[a]mong Service members and veterans with the most rehabilitation needs, over half report experiencing primary barriers, including community access to care limitations, availability of wanted or needed information, and attitudes of the family members or caregivers providing support."[28] Because veterans with cognitive problems have an impaired ability to engage in their care, efforts need to be made to find alternative and proactive ways to address these unique challenges[29]. Additionally, it is necessary to begin coordinating care soon after the onset of TBI and then continue the care as veterans age[30].

Warriors also indicate they face continued challenges navigating the system of care. Family education and support are critical components of acute inpatient rehabilitation. Additionally, needs are common in chronic stages of TBI, highlighting the importance of providing ongoing services through chronic stages of TBI and ensuring both veterans and their family members have the resources needed[31]. The access to support and educational services that are generally available to veterans during the acute stages of recovery wane across the patient's lifespan; therefore, it will be important to explore coordinated and enduring engagement for patients and families for those with severe and chronic functional impairment.[32] Service members and veterans experience physical, psychological, and cognitive problems that may impair their ability to recognize, participate in, or access care to address their needs; therefore, care programs should continue to adapt as needed to increase accessibility for disabled Service members and veterans who lack assistance or family support.[33]

As another compounding challenge, the National Academies of Sciences, Engineering, and Medicine TBI report, flags: "TBI care and recovery also involve multidisciplinary teams, diverse rehabilitation and community interactions during recovery, and needs that can evolve

over long time. Handoffs can easily turn into gaps, and coordination is challenging across the many phases of care, specialties, types of providers, and community environments. Patients and families often are left to navigate specialized services that are confusing and difficult to find and do not share data with other services. Many patients with TBI lack access to the types or amount of rehabilitation care and supportive services they may need over time. Furthermore, families and caregivers of people with TBI continue to report significant burdens and unmet needs."[34]

We also encourage more efforts to improve physical and mental health care rehabilitation needs. DoD's report notes, "Service members and veterans who received inpatient TBI rehabilitation continue to have rehabilitation needs for at least five years after TBI. On average, they report eight ongoing rehabilitation needs and three needs unmet by current care. Frequently cited areas of ongoing need include cognitive health (e.g., help with memory, problem solving), managing physical symptoms, and mental health (e.g., stress, emotional disturbances). Service coordination of physical and mental health needs is also critical."[35]

We also believe VA may need to revisit the current policy of not paying for room and board in assisted-living facilities as the current policy likely does not meet the long-term care needs of veterans with TBI. From 2009 to 2018, VA conducted a pilot program, Assisted Living for Veterans with TBI, in which veterans with moderate to severe TBI who needed long term neurobehavioral rehabilitation were placed in private-sector TBI rehabilitation facilities.[36] VA submitted an evaluation of the program to the House and Senate Committees on Veterans' Affairs finding the program experienced improvements in physical and emotional health, TBI symptoms, and other outcomes, and veterans and family members were highly satisfied with the care received.[37] Currently, VA facilitates such care through the Traumatic Brain Injury – Residential Rehabilitation program but does not pay the full cost. Veterans must pay for room and board, which can be a considerable out-of-pocket expense, often $800–$1,200 per month.[38] Long-term care for TBI can create significant financial barriers for many veterans, and VA may need more regulatory authority to pay for long-term rehabilitation; otherwise, a supplementary disability benefits may need to be considered for these veterans.

Wounded Warrior Project supports the recommendations found in DoD's *Eleven-Year Update: Longitudinal Study on Traumatic Brain Injury Incurred by Members of the Armed Forces in Operation Iraqi Freedom and Operation Enduring Freedom* and The National Academies of Sciences, Engineering, and Medicine released *Traumatic Brain Injury A Roadmap for Accelerating Progress*. These reports provide better understanding about the approaches that may offer the best care for veterans with TBI, as well as help inform the policies and research needed to inform the care, resources, and support offered to veterans and their caregivers. We encourage Congress to review these reports and take steps to begin implementing the recommendations intended to provide better long-term support and care to veterans with TBI.

CAREGIVERS

Supporting our nation's military and veteran caregivers is one of the most effective ways to improve the health and wellbeing of wounded, ill, and injured Service members and veterans. Without the support of 5.5 million military and veteran caregivers who provide billions in service value each year, VA would face insurmountable costs related to home-based care and supports. However, caregivers face a unique set of challenges in supporting their veterans. Caregivers suffer from high rates of depression, physical illness, and burnout. Critically, they are also on the frontlines of the veteran suicide crisis, watching for every emotional trigger, and monitoring every change in behavior.

As an early and enduring champion for caregivers and the warriors they care for, WWP has kept care for this community as a centerpiece of our advocacy and programming. Currently serving more than 700 warriors and nearly 500 caregivers, our Independence Program pairs seriously injured warriors who rely on their families and/or caregivers with a specialized case management team to develop a personalized plan to restore meaningful levels of activity, purpose, and independence into their daily lives. As PCAFC expansion drives forward, we a rapidly learning how new eligibility criteria are affecting post-9/11 veterans and caregivers who have had access to the program and using this perspective to guide our advocacy efforts.

Impact of PCAFC Expansion

Following passage of the *VA MISSION Act* (P-L 115-182 §§ 161-163), VA published a proposed rule to modify PCAFC eligibility criteria as part of the program's expansion to veterans and caregivers of all eras. In March 2020, WWP and more than 200 other commenters submitted public comments generally raising apprehension about the proposed eligibility standards' lack of clarity in key areas and their potential to exclude many caregivers to veterans with moderate and severe needs who would seemingly fit the program's intent of serving the most catastrophically wounded veterans.

Wounded Warrior Project is hopeful that PCAFC regulations will preserve (or help establish) eligibility for a meaningful number of veterans with moderate and severe needs, but the reassessment process for the program's legacy participants (those post-9/11 veterans and caregivers who were enrolled prior to the effective date of the new expansion-era regulations) are creating cause for concern that is consistent with forecasts WWP and others made in March 2020. Data from our 2019 *Annual Warrior Survey* data supported the proposition that several additions and modifications to PCAFC definitions may be too restrictive to accommodate formerly eligible and prospective PCAFC participants with moderate and severe needs. Extremely few warriors are completely dependent on caregivers to complete those activities of daily living (ADLs) that correspond with PCAFC ADLs. Less than two percent of responding warriors reported total dependence on another to complete an ADL – a statistic that spanned each of the seven PCAFC ADLs.

While this data is self-reported and not clinically verified, the number of warriors requiring assistance only some of the time to complete these ADLs was generally six to nine times higher than those requiring assistance each time. Of all warriors who completed the 2019

Annual Warrior Survey, only 1.7 percent reported complete dependence on assistance from another for 3 or more ADLs that align with VA ADLs (561 warriors). It is worth noting that this finding may not be consistent with clinical evaluations used by PCAFC for determining eligibility; however, it can reasonably be viewed alongside the 31.8 percent of all warriors who reported the need for aid and attendance of another person because of post-9/11 injuries or health problems.

Although these concerns were not addressed in VA's final rule that requires a caregiver to help a veteran with at least one of seven ADLs "each time" it is completed (or three of seven ADLs for the higher tier)[39], WWP has continued to work alongside warriors and VA to ensure that warriors and their caregivers are provided with the care, support, and acknowledgement that is consistent with the original intent of PCAFC. Unfortunately, anecdotal evidence being gathered from warriors and caregivers across the country suggests that clinical eligibility reviews are resulting in unexpectedly adverse decisions upon strict application of program rules by VA Clinical Eligibility and Appeals Teams and even examples of caregiving expectations that exceed the already high bar of entry for the program. Of note, WWP is concerned by the perceived differences in how PCAFC decision teams determine eligibility, how warriors with cognitive and/or behavioral health issues who do not meet the ADLs "each time" requirement – but require a full-time caregiver – are evaluated, and by the number of caregivers who have reached out to WWP and other veteran service organizations in anguish after being notified that they are no longer eligible to participate in the PCAFC.

As your committees oversee implementation of the long overdue and deserved expansion to veterans and caregivers of all ages, we encourage members to keep these concerns in mind. WWP will be continuing its work with warriors and caregivers to ensure the best outcomes for those who regularly provide for more assistance than the standards set forth by VA, often at great personal sacrifice.

FINANCIAL SECURITY & COMPENSATION REFORM

Along with physical and emotional health, financial security is an important factor in overall wellness and a key component to a veteran's success after service. Although our country has begun to recover from the economic impacts of the COVID-19 pandemic, many warriors and their families continue experience financial difficulties. With 42 percent of those who participated in our *Annual Warrior Survey* indicating that they experienced financial strain in the last year, WWP remains dedicated to promoting the economic empowerment of wounded warriors.

To that end, our Warriors to Work program provides a range of employment services to assist warriors and family support members with resumé building, job placement, interview skills, and skill translators. Through our Benefits Service, our network of accredited service officers located across the country stand ready to ensure that warriors are able to access the disability compensation and other financial benefits they have earned through their service. With a large population of our Alumni receiving benefits and services from VA, it is vital to ensure that the benefits approval process is friendly and places minimal stress on the veteran population.

Below are recommended legislative changes identified by our *Annual Warrior Survey* and through Warriors to Work and WWP national service officer analysis of VA programs and services that wounded warriors depend on.

Concurrent Receipt

When Service members retire from the military, they are entitled to retirement pay based on their years of honorable service. Most Service members become eligible for retirement after serving 20 or more years. Those who are forced to retire early due to medical conditions are known as Chapter 61 retirees. Like all veterans, military retirees who were injured while in service are also entitled to VA disability compensation. Unfortunately, many retirees are unable to collect both earned benefits due to a statutory dollar-for-dollar offset. WWP strongly believes that DoD retirement pay and VA disability compensation are two different benefits established by Congress for two different purposes, and no eligible veteran should have to forfeit a portion of their earned retirement income simply because they suffered a service-connected disability.

In 2004, Congress acknowledged this injustice by ending the offset for military retirees with at least 20 years of service and disability ratings of at least 50 percent. If enacted, the *Major Richard Star Act* would extend this policy to approximately 46,000 Chapter 61 retirees whose military careers were cut short due to combat-related injuries and illnesses, finally allowing them to collect the hundreds of dollars per month that they have been denied until now. [40] This would not only fully honor the extraordinary sacrifices they have made in service to our Nation but would also represent a meaningful step towards ending the offset for all.

This legislation was named in honor of Major Richard Star, an Army veteran who was diagnosed with stage 4 lung cancer after completing multiple deployments to the Middle East. Since his illness triggered a medical retirement before he could complete 20 years of active service, he was a Chapter 61 retiree, unable to collect the earned benefits that would have helped him and his family during this difficult time in their lives. Tragically, Major Star passed away of his illness in February of 2021 before the bill that was named for him could become law. WWP calls on Congress to honor his legacy by swiftly passing S. 344 and H.R. 1282, the *Major Richard Star Act*, finally eliminating the offset for all Chapter 61 retirees who were retired due to combat-related injuries and illnesses.

VA Clothing Allowance

One of the challenges faced by veterans whose injuries require the use of prosthetics, orthopedic appliances, and wheelchairs is that these devices often cause significant wear and tear to their clothing. This is also true of veterans who require medications and ointments for skin conditions such as severe burns. The need to frequently replace clothing that would have otherwise remained serviceable can create a significant financial burden for these veterans. For this reason, the VA provides an annual clothing allowance for eligible veterans to reimburse them for any clothing that may be damaged or require alterations throughout the year.

The VA clothing allowance is an important benefit to the population WWP represents. In our most recent *Annual Warrior Survey*, 15 percent of respondents reported service-connected

spinal cord injuries, 4 percent reported that they use a prosthesis. These responses represent warriors whose injuries may require them to use devices that cause damage to their clothing.

Under current law, veterans with a service-connected disability requiring the use of a prosthesis, orthopedic device, or skin medicine that causes damage or requires alterations to their clothes qualify for the VA clothing allowance. [41] This benefit is not, however, issued automatically to qualifying veterans. Even those with static disabilities such as amputations and permanent paralysis due to spinal cord injuries must reapply by submitting VA Form 10-8678, the Application for Annual Clothing Allowance, before August 1 of each year. This creates an overly burdensome process for veterans with disabilities that will not improve with time.

If enacted, the *Brian Neuman* and *Mark O'Brien VA Clothing Allowance Improvement Acts* (S. 2513, H.R. 4772) would solve this problem by directing VA to establish standards for determining whether a veteran's qualifying disability is static, meaning the veteran has an ongoing established need for a clothing allowance. If it is determined that the disability is static, clothing allowance payments would continue automatically on a recurring annual basis, finally removing the burden on these severely injured veterans to reapply each year. If the disability is non-static, VA will conduct periodic reviews to determine the veteran's continued eligibility. WWP believes this legislation will remove an unnecessary burden on severely injured veterans and urges Congress to pass it without delay.

Claims File Accessibility

When a veteran submits a claim for VA benefits, a claims file – commonly referred to as a "C-File" – is created. The C-File may contain the veteran's service records, VA exam results, additional information submitted by the veteran, and anything else VA deems necessary to decide a disability claim. A veteran may want to view their C-File to ensure all the information it contains is accurate and complete before the claim is decided or, once a case has been decided, to better understand how VA reached its decision.

Unfortunately, the process for a veteran to be able to view their C-File is antiquated and inconvenient. Currently, if a veteran wants to view their C-File, their options are: (1) making an appointment with their VA Regional Office (RO) to physically view the C-File in person. This option is often inconvenient to veterans who do not live within a reasonable proximity to the RO and to those who struggle to find time to visit during business hours; (2) submitting VA Form 3288, *Request for and Consent to Release of Information from Individual Records*, by mail or fax with no confirmation of receipt and a wait period that may last several months; or (3) submitting a *Freedom of Information Act* (FOIA) request, which is difficult for veterans who are not familiar with the procedure. Such requests often take substantial processing time.

It is also noteworthy that C-Files are delivered in paper form or as a compact disc (CD). As computer manufacturers are well along with a migration away from building internal CD drives, the CD format is quickly becoming old technology which many computers do not support. Accordingly, the time has come for VA to provide the option for electronic delivery of a C-File. VA has the technology to make information available online, and precedent has already been established by making medical records available through the My HealtheVet portal.

If enacted, the *Wounded Warrior Access Act* (H.R. 5916), would modernize this process by allowing veterans to electronically request and receive their C-Files easily and securely. It would also create reasonable timeliness standards for VA to confirm receipt of the request and provide the veteran with their records. This would make the process more convenient for veterans, increase veterans' faith in VA transparency, and decrease unnecessary appeals since more veterans will have access to all the information VA used to decide their claims. WWP urges Congress to pass this legislation.

Veteran Readiness and Employment (VR&E)

Under Chapter 31 of Title 38, the VR&E program provides employment opportunities through job training and other employment-related services, including education, job search services, and small business start-up funds. The program is designed to evaluate and improve a veteran's ability to achieve his or her vocational goal; provide services to qualify for suitable employment, enable a veteran to achieve maximum independence in daily living, and enable the veteran to become employed in a suitable occupation and to maintain suitable employment. WWP supports using the VR&E program as a pathway to long-term employment for disabled veterans.

The VR&E program offers five different support-and-services tracks to help veterans reach their individual employment goals. These tracks include Reemployment, Rapid Access to Employment, Self-Employment, Employment Through Long-Term Services, and Independent Living. Our Warriors to Work employees who help connect warriors to VR&E services report that the Self-Employment track, which is designed to help veterans start their own businesses, suffers from an unclear approval process and that VR&E counselors often lack expertise in key requirements such as building business plans and writing feasibility studies. These gaps in clarity and support lead to possible underutilization of the benefit. In our most recent survey, about 2 in 10 (20.2%) warriors indicated they have used the VR&E program but of those, only 8.4% took advantage of the Self-Employment track. WWP encourages Congress to conduct oversight to determine whether improvements to the VR&E Self-Employment track are needed.

ADDITIONAL AREAS OF FOCUS

Rural Veterans

One of the biggest ongoing challenges both VA and WWP continues to face is how to deliver care and services to veterans who live in rural and hard to reach areas. Our rural warriors report earning less on average than non-rural warriors, being less likely to be in the work force, being more likely to need aid or assistance than urban warriors and are more likely to report experiencing financial strain.

Travel is another issue faced by many of our rural warriors as they often must travel farther for care and with limited or no public transportation options. One study reported nearly 84% of urban veterans lived within a 30-minute drive of a VA primary care center, compared to

13% of rural veterans.[42] Another study found that rural veterans receiving care for PTSD from the VA had nearly 20% fewer visits to VA facilities over one year compared to urban veterans and 22% fewer visits to PTSD specialty clinics.[43] Many rural veterans also live in areas with outdated infrastructure, limited paved roads and roads with two lanes or fewer.[44] Given the importance of peer support for veterans, these physical barriers and geographic distance make it even more important for WWP and the veteran community to think more creatively about how we reach veterans in all parts of the country.

We also know that rural veterans are less likely to have high-speed internet or have access to a smartphone.[45] In fact, the VA reports that 26% of rural veterans enrolled in their healthcare do not have access to the internet at home.[46] Thankfully, VA has made great strides over recent years to lessen the digital divide experienced by many rural veterans and their embrace of telehealth has been largely effective and widely used by our warriors. Interestingly, our 2021 *Annual Warrior Survey* did not reveal any statistical differences on the use of telehealth between rural and urban warriors. However, WWP believes continued efforts need to be made to reach others through expansion of infrastructure and other IT resources.

Ensuring greater access to programs like telehealth by giving rural veterans access to broadband, is even more important given the limited access to healthcare providers in most rural areas. While many rural veterans qualify for community-based care under the *VA MISSION Act* due to their distance from VA facilities, they may still have difficulty finding providers in their area. The federal government now estimates that nearly 80% of rural U.S. is designated as medically underserved and this problem is only getting worse.[47] We are looking forward to reviewing the recommendations on how to "modernize and realign" the VA required under the *VA MISSION Act* soon and hope to work with you and the broader community in ensuring we are meeting the needs of our veterans in rural communities.

Airport Travel

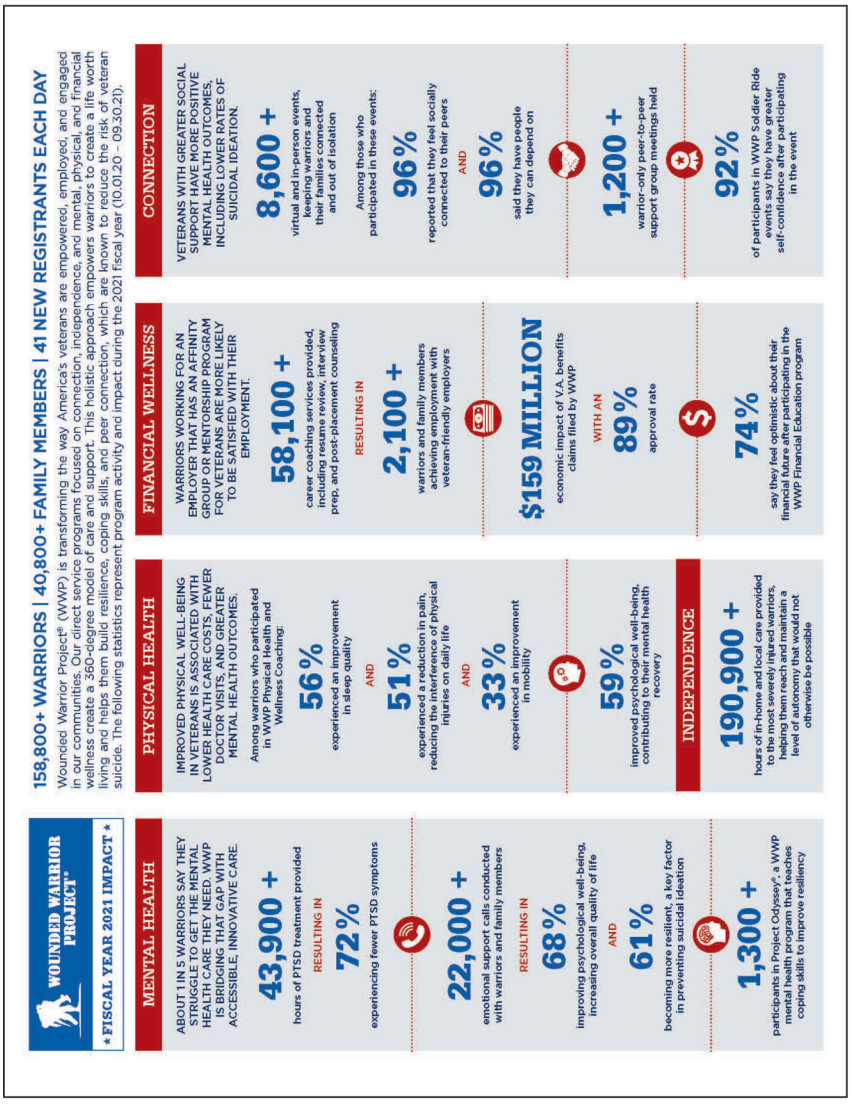
As we have seen in the last several years, air travel continues to be a stressful experience for everyone, but it is an especially serious challenge for severely disabled veterans. The process of having to remove prosthetics or other assistive devices, vacate wheelchairs, or make other accommodations to go through security can not only take quite a bit of a time but also leave a veteran stressed, frustrated, or embarrassed.

The *Veterans Expedited TSA Screening (VETS) Safe Travel Act* (S. 2280, H.R. 855) addresses this issue by offering TSA Pre-Check at no cost to severely disabled veterans who are amputees, paralyzed, blind, or require an assistive mobility device. This benefit is already offered to Active Duty, Reserve, and National Guard Service members. WWP believes this will allow veterans a more dignified travel experience and will also improve efficiency and safety. WWP thanks the sponsors and cosponsors and encourage Congress to take quick action to help our severely injured veterans.

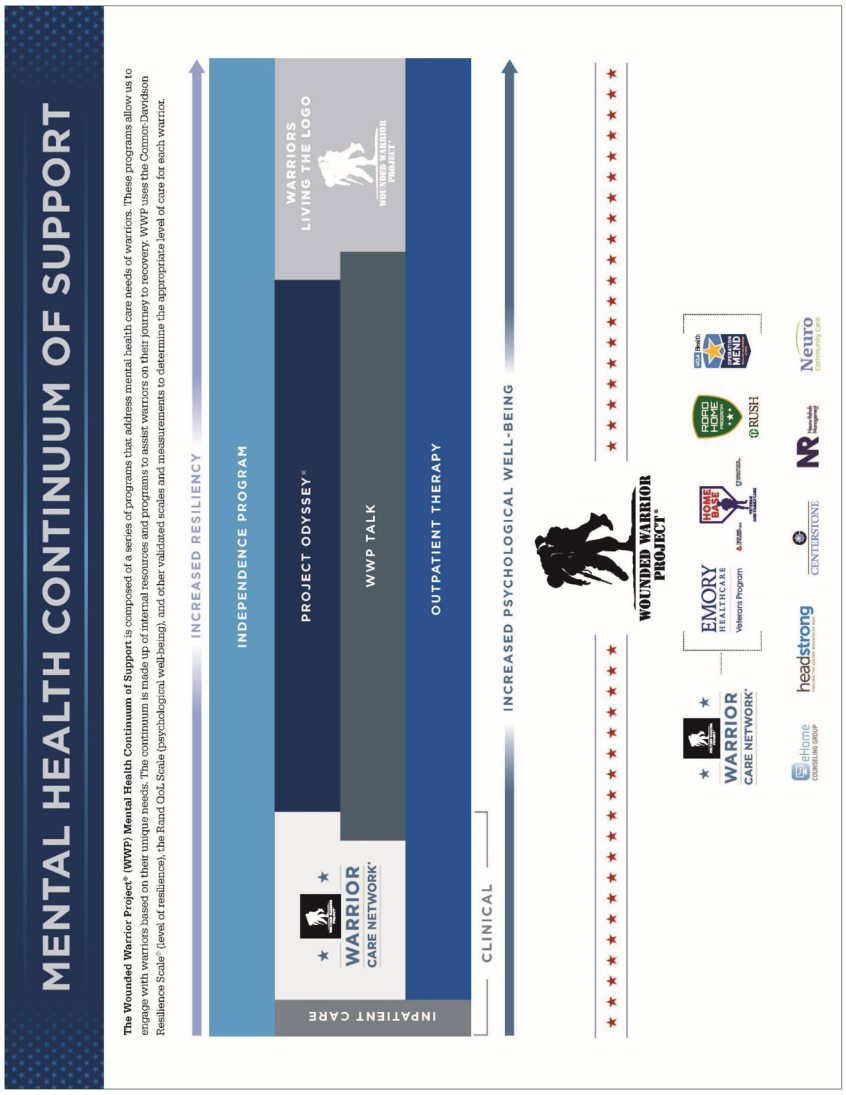
CONCLUSION

Wounded Warrior Project thanks the Senate and House Committees on Veterans' Affairs, their distinguished members, and all who have contributed to a robust discussion of the challenges – and the successes – experienced by veterans across our great nation. Your actions to address the impact of toxic exposure; to support quality mental health care and interventions; to meet the growing needs of women veterans; to consider the needs of veterans who are using long term care programs earlier in life; to recognize and support the indispensable contributions of caregiver; and to bolster the financial security of wounded warriors will have a particularly strong impact on the post-9/11 generation. WWP stands by as your partner in meeting the needs of all who served – and all who support them. We are thankful for the invitation to submit this statement for record and stand ready to assist when needed on these issues and any others that may arise.

APPENDIX 1


WOUNDED WARRIOR PROJECT®
* FISCAL YEAR 2021 IMPACT *
158,800+ WARRIORS | 40,800+ FAMILY MEMBERS | 41 NEW REGISTRANTS EACH DAY
Wounded Warrior Project® (WWP) is transforming the way America's veterans are empowered, employed, and engaged in our communities. Our direct service programs focused on connection, independence, and mental, physical, and financial wellness create a 360-degree model of care and support. This holistic approach empowers warriors to create a life worth living and helps them build resilience, coping skills, and peer connection, which are known to reduce the risk of veteran suicide. The following statistics represent program activity and impact during the 2021 fiscal year (10.01.20 – 09.30.20).
MENTAL HEALTH
ABOUT 1 IN 5 WARRIORS SAY THEY STRUGGLE TO GET THE MENTAL HEALTH CARE THEY NEED. WWP IS BRIDGING THAT GAP WITH ACCESSIBLE, INNOVATIVE CARE.
43,900 +
hours of PTSD treatment provided
RESULTING IN
72 %
experiencing fewer PTSD symptoms
22,000 +
emotional support calls conducted with warriors and family members
RESULTING IN
68 %
improving psychological well-being, increasing overall quality of life
AND
61 %
becoming more resilient, a key factor in preventing suicidal ideation
1,300 +
participants in Project Odyssey®, a WWP mental health program that teaches coping skills to improve resiliency
PHYSICAL HEALTH
IMPROVED PHYSICAL WELL-BEING IN VETERANS IS ASSOCIATED WITH LOWER HEALTH CARE COSTS, FEWER DOCTOR VISITS, AND GREATER MENTAL HEALTH OUTCOMES.
Among warriors who participated in WWP Physical Health and Wellness Coaching:
56%
experienced an improvement in sleep quality
AND
51%
experienced a reduction in pain, reducing the interference of physical injuries on daily life
AND
33%
experienced an improvement in mobility
59%
improved psychological well-being, contributing to their mental health recovery
INDEPENDENCE
190,900 +
hours of in-home and local care provided to the most severely injured warriors, helping them reach and maintain a level of autonomy that would not otherwise be possible
FINANCIAL WELLNESS
WARRIORS WORKING FOR AN EMPLOYER THAT HAS AN AFFINITY GROUP OR MENTORSHIP PROGRAM FOR VETERANS ARE MORE LIKELY TO BE SATISFIED WITH THEIR EMPLOYMENT.
58,100 +
career coaching services provided, including resume review, interview prep, and post-placement counseling
RESULTING IN
2,100 +
warriors and family members achieving employment with veteran-friendly employers
$159 MILLION
economic impact of V.A. benefits claims filed by WWP
WITH AN
89 %
approval rate
74%
say they feel optimistic about their financial future after participating in the WWP Financial Education program
CONNECTION
VETERANS WITH GREATER SOCIAL SUPPORT HAVE MORE POSITIVE MENTAL HEALTH OUTCOMES, INCLUDING LOWER RATES OF SUICIDAL IDEATION.
8,600 +
virtual and in-person events, keeping warriors and their families connected and out of isolation
Among those who participated in these events:
96%
reported that they feel socially connected to their peers
AND
96%
said they have people they can depend on
1,200 +
warrior-only peer-to-peer support group meetings held
92%
of participants in WWP Soldier Ride events say they have greater self-confidence after participating in the event

APPENDIX 2


MENTAL HEALTH CONTINUUM OF SUPPORT
The Wounded Warrior Project® (WWP) Mental Health Continuum of Support is composed of a series of programs that address mental health care needs of warriors. These programs allow us to engage with warriors based on their unique needs. The continuum is made up of internal resources and programs to assist warriors on their journey to recovery. WWP uses the Connor-Davidson Resilience Scale® (level of resilience), the Rand QoL Scale (psychological well-being), and other validated scales and measurements to determine the appropriate level of care for each warrior.
INCREASED RESILIENCY
INDEPENDENCE PROGRAM
PROJECT ODYSSEY®
WWP TALK
OUTPATIENT THERAPY
INPATIENT CARE
WARRIOR CARE NETWORK®
WARRIORS LIVING THE LOGO
WOUNDED WARRIOR PROJECT
CLINICAL
INCREASED PSYCHOLOGICAL WELL-BEING
WOUNDED WARRIOR PROJECT®
WARRIOR CARE NETWORK®
EMORY HEALTHCARE
Veterans Program
HOME BASE
CENTERSTONE
RUSH
ROAD HOME
MENTOR
NR
Neuro
eHome
COUNSELING GROUP
headstrong

The continuum of support doesn't define an exact, prescriptive path to recovery, rather the individual needs of each warrior to determine the order and frequency of appropriate program engagement. For example, a warrior in acute psychological distress may be referred to a number of clinical intervention programs. Another warrior with less severe mental health issues may participate in only one or two programs. Subsequently, any warrior who has a setback may be re-evaluated and referred back to one or more programs for additional care. The goal is to provide the appropriate amount of care a warrior may need to get to his or her highest possible level of resilience, psychological well-being, and healing.

INPATIENT CARE
Clinical Intervention

Inpatient care is reserved for warriors in severe psychological distress who have exhausted all other resources. WWP may be able to fund inpatient services in order to stabilize warriors so that they can be engaged with other mental health programs in the continuum. The goal is to sustain and facilitate movement in the continuum through other programs.

WARRIOR CARE NETWORK
Clinical Intervention

To accelerate the development of advanced models of mental health care, WWP partners with four world-renowned academic medical centers to form Warrior Care Network®, leveraging our collective commitment and expertise. The Warrior Care Network treatment model delivers a year's worth of mental health care during a two- to three-week intensive outpatient program (IOP). This unique veteran-centric approach increases access to treatment and improves outcomes. Warrior Care Network provides a path to long-term wellness, improving the way warriors are treated today and for generations to come.

PROJECT ODYSSEY
Engagement Intervention

Project Odyssey is a 12-week mental health program that uses adventure-based learning to help warriors manage and overcome their invisible wounds, enhance their resiliency skills, and empower them to live productive and fulfilling lives. Based on their unique needs, warriors can participate in an all-male, all-female, or couples Project Odyssey. The program starts with a five-day mental health workshop, where warriors are challenged to step outside the comfort of their everyday routines. This opens them up to new experiences that help develop their coping and communication skills. After the workshop, participants work together with WWP to stay engaged, achieve their personal goals, and make lifelong positive changes.

★ PROGRAMS WITH MULTIPLE STAGES OF ENGAGEMENT ★

Within the continuum of support there are additional programs/resources that can be engaged at nearly any point in the continuum. These are WWP Talk and outpatient therapy. The Independence Program, which also encompasses multiple stages of engagement, is a unique component of the continuum. The resources provided by the Independence Program allow the most severely wounded warriors the ability to lead a full life at home instead of a long-term facility.

OUTPATIENT THERAPY • *Engagement and Clinical Intervention*

An additional clinical resource available to warriors across the stages of the continuum is outpatient therapy. Here WWP funds external partners to provide individual, family, or couples therapy delivered by a culturally competent therapist in the closest geographic location to the warriors as possible. With multiple funded clinical partners, warriors are able to engage in traditional outpatient sessions or, if in a remote location, engage in virtual therapy.

WWP TALK • *Engagement and Coordination Intervention*

WWP Talk is a telephonic emotional support program that breaks down the barriers of isolation and helps both warriors and family members plan an individualized path toward their personal growth. Participants work one-on-one with a dedicated team member during weekly emotional-support calls. Together, they set tangible goals and develop skills that lead to positive changes, like increased resilience and improved psychological well-being.

INDEPENDENCE PROGRAM
Engagement, Coordination, and Clinical Intervention

The Independence Program provides long-term support to catastrophically wounded warriors living with injuries such as: a moderate to severe brain injury, spinal cord injury, or neurological condition that impacts independence. The program is designed to support warriors who, without high-touch services, would struggle to live day to day due to the severity of their injuries. The Independence Program increases access to community services, provides rehabilitation through alternative therapies, and empowers warriors to achieve goals leading to a more independent life. Because every journey is different, we work as a team with warriors, their family members, and their caregivers to set goals to live a fulfilling life, at home, with their loved ones.

★ LIVING THE LOGO ★

The WWP logo is much more than a trademark—it is what we see as the ultimate goal for all warriors engaged with the continuum of support to achieve. It is the collective goal of the continuum of support (through resources and teammates) to empower warriors to make it to this final phase and live our logo. The logo, one warrior carrying another warrior, represents a peer assisting a fellow veteran—in essence, carrying him through the recovery process until he can walk of his own accord (through heightened resiliency and psychological well-being). Eventually, as resiliency reaches the highest levels in the continuum, warriors are empowered to help carry fellow veterans, essentially becoming force multipliers as they are engaged as peer mentors.

APPENDIX 3

WOUNDED WARRIOR PROJECT®

COMMUNITY PARTNERSHIPS

Wounded Warrior Project (WWP) believes that no one organization can meet the needs of all wounded, injured, or ill veterans alone. Our Community Partnerships team reinforces our programmatic efforts and expands our impact by investing in like-minded military and veteran support organizations.

★ CURRENT PARTNERS

The organizations listed below are WWP's current partner organizations. They exist as a network of support for the warriors and families we serve. Please refer to this list as you seek out resources beyond WWP.

Wondering which of our partners might best suit your current needs?

The WWP Resource Center can help! Call 888.WWP.ALUM (997.2586)

Current List Of Partner Organizations (11.1.21)

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Testimony *of*

Legislative Priorities
&
Policy Initiatives *for the*
117th Congress Second Session

Presented by

Jack McManus
National President

Before the
House and Senate
Veterans Affairs Committees

March 2, 2022

Attachments 1/2

Good afternoon Chairmen Tester and Takano, Ranking Members Bost and Moran, and distinguished members of your respective committees. On behalf of our members and their families, I want to thank each member of both committees for all that you do to transform support for veterans to real programs, initiatives, and benefits. I am pleased to appear before you today to present highlights of the legislative agenda and policy initiatives of Vietnam Veterans of America for the second session of the 117th Congress.

Vietnam Veterans of America is a national Vietnam Veterans organization chartered by the U.S. Congress and approved by President Reagan on May 23, 1986, as a nonprofit organization to: promote the well-being of American Vietnam Veterans; foster the improvement of the condition of Vietnam veterans; promote the social welfare (including educational, economic, social, physical, and cultural improvement) in the United States by encouraging the growth and development, readjustment, self-respect, self-confidence and usefulness of Vietnam veterans and other veterans.

The themes of our advocacy reinforce what we have always stood for as an organization: First, that we tell the truth to power as best we can determine the truth, and that we as individuals and as an organization act openly and honestly in all of our affairs. Second, we demand that our government *always* tell us the truth and that veterans be treated justly and with respect. Third, VVA demands accountability for the *effectiveness* as well as the efficiency of each government program charged with helping veterans and their families.

VVA believes that the key test of the effectiveness of a program is that each program designed to help meet the vital needs of veterans should have as its goal-helping veteran's return to the greatest degree possible of self-sufficiency or wellness of the whole person. Each program should be making progress toward that goal, using the principles of the Government Performance and Accountability Act as the guide, and should be doing so in the most cost-efficient and cost-effective manner possible.

We stand by our motto; Never Again will one Generation of Veterans Abandon Another.

THE FULLEST POSSIBLE ACCOUNTING of America's POW/MIAs has long been our solemn priority. VVA continues to press for answers regarding those Americans still listed as killed in action, body not recovered, in the Southeast Asia theatre of operations. We must insist that Congress fund the Defense POW/MIA Accounting Agency (DPAA) with

what is required to investigate potential crash and burial sites, and to recover and identify remains. This is the 29th year of our Veterans Initiative Program. We continue to assist our former enemy in locating their unrecovered loved ones by providing fate-clarifying information such as maps of mass burial sites, ID cards, photos, and more. As we continue to work veteran-to-veteran with our former enemy, we have strengthened the trust between American and Vietnamese veterans, and have encouraged the continued cooperation by Vietnamese authorities with DOD search teams.

VETERANS AND TOXIC EXPOSURES

From Vietnam to the present-day, members of the U.S. military have been exposed to numerous toxic elements, both at home and abroad, that have killed more people than our enemies. What has made the situation more disgraceful is the fact that our government hid the negative aspects of these toxic substances from everyone serving in these areas, and fought their resulting claims with VA for many years.

VVA appreciates the HVAC/SVAC Committee Chairmen's commitment to introducing comprehensive legislation to remove the many hurdles that veterans are facing in submitting and claiming justifiable benefits for health conditions they face related to their service in the military, whether it was in the jungles of Vietnam, the sands of the Persian Gulf, or the burn pits of Afghanistan. Too many veterans wait years to see those claims successfully processed and dispersed, and some even die awaiting the adjudication of their claims.

Two current bills -- H.R 3967, *Honor our PACT Act* introduced by Mark Takano (D-CA-41) and S. 3003, *Cost of War Act*, introduced by Jon Tester (D-MT), Chairman, Senate Veterans Affairs Committee -- focus on enacting bipartisan legislation that would streamline access to healthcare benefits for veterans who served, regardless of disability status. VVA fully supports the framework for both bills; however, we do have some concerns regarding the legislation, which are related to veterans presumed to have been exposed to herbicide (e.g., Agent Orange).

VVA agrees that the standard in the new presumptive determination "framework" should be "positive association," but with the caveat that the following provision from 38 U.S.C 1116, related to herbicide/Agent Orange, should be applied to all toxic wound cohorts under The *Honoring Our PACT Act/Cost of War Act*: "An association … shall be

considered to be positive for the purposes of this section if the credible evidence for the association is equal to or outweighs the credible evidence against the association."

As it currently stands, about future determinations of potential new presumptive conditions, the highly complex *Honoring Our PACT Act/Cost of War Act* leaves veterans with qualifying service in the Republic of Vietnam or Korea significantly worse off than under the "framework" specified in current law. The bill's repeal-and-replace of the existing herbicide (Agent Orange) presumptive determination "framework" would instead use a "framework" that is much more restrictive than current law. Thus, the *Honoring Our PACT Act /Cost of War* "framework" is much less likely than the current law "framework" to result in VA adding additional presumptive conditions. Therefore, this repeal-and-replace of the current law "framework" – with its clear adverse impact on Vietnam War and other herbicide-exposed veterans – is a non-starter that VVA strongly opposes.

Moreover, the *Honoring Our PACT Act/Cost of War* expansions relative to Gulf War presumptive claims have value, some more than others. In particular, the provision that would extend geographic service eligibility to qualifying veterans with service in Afghanistan, Israel, Egypt, Turkey, Syria, or Jordan is much needed and long overdue. VVA supports Gulf War provisions of the legislation; however, it is important to note that VA's exceedingly high denial rates of Gulf War presumptive claims perpetuate the misery being experienced by countless tens of thousands of Gulf War veterans.

Therefore, unless and until VA's presumptive Gulf War claims adjudication policies, procedures, training, and unacceptably high denial of approval rates are remedied, then expansions of eligibility for these presumptive conditions will be nearly meaningless. We would also like to remind the Committee that the pre-pandemic pledge to hold a roundtable aimed at developing solutions for these longstanding Gulf War issues has yet to be fulfilled.

Lastly, the *Honoring Our PACT Act/Cost of War Act* would favorably expand the list of named presumptive conditions for herbicide exposure (Agent Orange) to covered veterans. The expansion would add two additional presumptive conditions: hypertension and MGUS. VVA strongly supports the addition of presumptive conditions. We note, however, that for at least 15 years, VA's own research has shown significantly increased hypertension among herbicide-exposed veterans. Even given the existing "framework" for adding new herbicide presumptive conditions, VA failed to do so. This should serve as a powerful cautionary tale to the overly optimistic proponents for creating a new, one-size-fits-all (but does not) "framework" that leaves VA in the driver's seat. In this legislation, we most strongly support the provisions that add named presumptive conditions.

PUBLIC LAW 114-315 SUBTITLE C, THE TOXIC EXPOSURE RESEARCH ACT

The Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 in Subtitle C, Section 632, required the Secretary of Veterans Affairs to "seek to enter into an agreement with the National Academy of Medicine under which the National Academy of Medicine conducts an assessment on scientific research relating to the descendants of individuals with toxic exposure."[1] In other words, the National Academy of Medicine would be tasked with conducting the assessment, which would include a review of scientific literature on descendants of individuals exposed to toxins, an assessment of areas that require additional study, "an assessment of the scope and methodology required to conduct *adequate scientific research*" on the impact of this exposure, the establishment of categories to be used for evidentiary classification of exposure, and the "*identification of a research entity or entities*" that possess subject matter expertise and the ability to conduct research on toxic exposure issues. (Emphasis added).[2] Then, according to § 632(d)(1):

> Not later than 90 days after receiving the results of the assessment and determination under subsection (c), the Secretary shall submit to the Committee on Veterans Affairs of the House of Representatives a certification of the understanding of the Secretary, based on such results and determination, regarding the feasibility of conducting further research regarding health conditions of descendants of veterans with toxic exposure that is expressed by such results and determination.[3]

The VA Secretary certified that the establishment of a Health Monitoring Research Program (HMRP) to study the generational health effects of serving in the Gulf is not feasible.[4] In certifying infeasibility, Secretary McDonough cited a report from a VA Working Group tasked with assessing the viability of conducting the HMRP.[5] The Working Group first convened on January 31, 2020, and its report relied on a 2018 report from the National Academies of Science, Engineering and Medicine (NASEM).[6] The

[1] Pub. L. 114-315 § 632(a)(1).
[2] Id. at §632(b).
[3] Id. at § 632(d)(1).
[4] Letter to Senator Moran from VA Secretary McDonough, dated July 21, 2021 (hereinafter Letter to Sen. Moran)
[5] Id; *see Report of the Intergenerational Effects of Military Exposures Work Group to the Secretary of Veterans Affairs In response to Public Law 114-315, sec. 632 (d)* (May 2021) (hereinafter Working Group report).
[6] NASEM, Gulf War and Health, Vol. 11: Generational Health Effects of Serving in the Gulf War (Nov. 2018) (hereinafter "NASEM report)

Working Group only met on 13 occasions, adjourning for the last time on October 14, 2020 – seven months prior to finally publishing its report.[7] It is important to note that the assessment conducted by VA Working Group could not be sanctioned under §§632(a)(1) or (a)(2), as only the National Academy of Medicine or an organization that is not part of the Federal Government were authorized to conduct the assessment; i.e. the Working Group report cannot be used to supplant the conclusions and recommendations of the NASEM report. Irrespective of this fact, the VA Secretary was delinquent in submitting his certification following the publication of the 2018 NASEM Report.[8] Instead, he chose to paraphrase conclusions from the Working Group's report, and in his certification, Secretary McDonough stated that barriers to successful operation of an HMRP:

> [i]include lack of a national health record and a national birth defects database from which to draw data, inability to meet administrative, infrastructure requirements, and scientific evidence that does not support a link between in-service toxic exposures and adverse intergenerational health outcomes.[9]

It is evident that the VA Secretary did not follow Section 632 of the *Toxic Exposure Research Act* as identified in Public Law 114-315, and we are asking Ranking Member Jerry Moran (R-KS), the champion of this law, to hold an oversight committee hearing, with the VA Secretary as the star witness, to investigate what metrics he used that empowered him to not follow the law.

Mr. Chairman, during the January 2022 roundtable discussion, VSOs unanimously agreed that VA should conduct a multigenerational study on the effects of toxic exposure on the children of servicemembers. We do not need another study, but we would appreciate your support in ensuring that the already agreed-upon study is conducted, and that VA reconsider their denial of further study in the much-needed intergenerational research, in compliance with the law in section 632 of P.L. 114-315.

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[7] Supra, footnote 5.
[8] Supra, footnote 3.
[9] Letter to Sen. Moran

TOXIC WOUNDS REGISTRIES ACT OF 2021

This leads us to argue for legislation that will establish real registries to cover deployments during which troops were likely to have been exposed to airborne toxic hazards. Sadly, VA's Agent Orange Registry is little more than a mailing list. VA's Hepatitis C Registry, on the other hand, could serve as a template for subsequent and future registries. Toxic Wounds Registries would enable epidemiological research by linking a veteran's medical records, in Electronic Health Records, to their military history, encoded with their location and time of service.

Thus, if a veteran in Plano, Texas, comes down with a malady they feel evolved from a particular exposure, and their battle buddy living in Topeka, Kansas, is afflicted with the very same condition, VA techs would be able to access the appropriate registry to locate others with whom they served, no matter where they might be living.

With the proper database, VA techs could easily isolate trends in medical conditions related to certain geographic sites and times of service. This relatively simple tool would enhance both treatment of identified conditions, and potentially even prevention, or at least early identification and intervention of possible life-threatening maladies. For the record, we must insist that you in Congress ensure that this capability be incorporated into VA modernizations plans for the Information Technology system.

We are now seeking "champions" from both sides of the aisle and in both houses of Congress to introduce and enact *The Toxic Wounds Registries Act of 2022*. This legislation would direct the Secretary of Veterans Affairs to establish a master registry that would incorporate registries that have built-in linkages between medical records and date/place of service for:

- Exposure to Agent Orange during and in the aftermath of the Vietnam War;
- Exposure to toxicants relating to deployment during the 1991 Persian Gulf War;
- Exposure to toxicants from a deployment during Operations Enduring Freedom, Iraqi Freedom and New Dawn, and the Global War on Terror;
- Exposure to toxicants during a deployment to Bosnia, Somalia, or the Philippines; and

- Exposure to toxicants while stationed at a military installation contaminated by toxic substances overseas and/or here in CONUS.

This legislation would authorize the VA Secretary to enter into an agreement with the National Academy of Medicine to review published, peer-reviewed scientific research, and suggest future research on the health effects of the toxic exposures identified in those registries; and it would require those conclusions to inform the Secretary's selection of future research to be conducted and/or funded by VA.

It also would establish a presumption of service connection for the purpose of veterans' disability and survivor benefits, for any illness, that the VA Secretary determines warrants such presumption because of a positive association with exposure to a toxicant noted in the master registry. With a final caveat that the illness became manifest, within a time period determined by actual scientific evidence, conferred by act of the Secretary of Veterans Affairs, in a veteran who experienced such exposure while serving on active duty in the Armed Forces.

AGENT ORANGE EXPOSURE FAIRNESS ACT S. 332 AND H.R. 566

Many of our members have health problems commonly associated with herbicide exposure and have endured lengthy legal struggles to prove that these problems are service-related. Those diseases include chloracne, porphyria cutanea tarda, and acute and subacute peripheral neuropathy, which currently must have been manifest within a period of one year following service in order to be considered service-connected, i.e., presumptive.

P.L. 116-315, the *Johnny Isakson and David P. Roe, Veterans Health Care and Benefits Improvements Act of 2020,* signed into law on January 5, 2021. The law included provision in S.332 introduced by Senator Richard Blumenthal (D-CT); and H.R. 566, introduced by Congressman Joe Courtney (D-CT-2nd); that GAO must submit a report in 240 days regarding removing the one-year cutoff date of chloracne, acute/subacute peripheral neuropathy, and cutanea trada after the bill became law to the House/Senate Veterans Affairs Committee, also the VA has 120 days to comply to the decision. Chairman Takano/Tester as of today nevertheless, the report to this committee is past due, and we do not want see this provision in the law get lost in the bureaucracy of the federal government. Our membership call upon the leaders of both committee to

inquire in writing to GAO leadership, on the status of the briefing and report as required by the law in Section 2011 supporting our disabled veterans and their families.

THAILAND VETERANS

Thousands of men and women served our country faithfully in Thailand in toxic environments. Surviving Thailand veterans, whose health is deteriorating due to toxic pollutants' exposures, are now having their claims denied because they need to document that they were near the perimeter of the base.

However, VA does not define a perimeter. Is it a two-foot diameter extending out from the toxic pollutants' central site? Alternatively, is it a fifty-foot diameter? VA also fails to take into consideration when adjudicating these claims any possibility that the toxic dioxin became airborne. Sadly, many Thailand veterans have died from toxic exposure, and their widows have been denied compensation. The country has failed not only the servicemember; it has failed the families of the fallen.

VVA supports the passage of S.657, introduced by Senator John Boozman (R-AR), and H.R. 2269, introduced by Congressman Bruce Westerman (R-AR-4th). These bills, when enacted into law, would require VA to ensure, if it creates a presumption of service-connection between the occurrence of a disease and exposure to an herbicide agent while serving in the Armed Forces between January 9, 1962, and June 30, 1976, at a military base in Thailand, such presumption must also apply to exposure at any military base in Thailand, regardless of where on the base the veteran was located or what military job specialty the veteran performed.

S.657 has been in SVAC since April 28, 2021, and H.R. 2269 has been in the HVAC subcommittee on DAMA committee since June 22, 2021, and have seen no movement.

VVA urges Congress take further action on these bills immediately.

HYPERTENSION: THE DATA IS THERE

In November 2016, Veterans Health Administration researchers, at the request of former VA Secretary Eric Shinseki, finalized their research on the association between herbicide exposure and high blood pressure among 4,000 U.S. Army Chemical Corps veterans. They found a detectable link between service-related occupational exposure to herbicides and high blood pressure (hypertension) risk among U.S. Army Chemical Corps (ACC) veterans, a group of Veterans assigned to do chemical operations during the Vietnam War.[10]

Dr. Karl Kelsey, Professor of Epidemiology, Pathology, and Laboratory Medicine at Brown University and a member of NASEM, testified before the Senate Veterans Affairs Committee on March 10, 2021, on the 2018 finding in the *Veterans and Agent Orange Update #11*, which also found sufficient evidence of an association between toxic exposure and both hypertension and monoclonal gammopathy of undetermined significance (MGUS).[11]

The Agent Orange Act of 1991 specifies the timeline the VA Secretary is to follow having received the latest findings of NASEM as delineated in *Veterans and Agent Orange Update*. This has patently not been followed after the National Academy of Medicine *2018 Agent Orange Update* found a positive association between exposure to dioxin and myriad health conditions related to hypertension. We are heartened that after years of hurdles and delays, Secretary McDonough has acknowledged these studies on the association between hypertension and military service.

Senator Tester, Chairman, Senate Veterans Affairs Committee, introduced S.810 the *Fair Care for Vietnam Veterans Act of 2021*, in the Senate, and Representatives Josh Harder (D-CA-10th) and Pete Stauber (R-MN-8th) introduced companion bill H.R. 1972 in the house. This bipartisan, bicameral legislation has the potential to restore equity to all Vietnam veterans who were exposed to Agent Orange. This bill would add hypertension and monoclonal gammopathy of unspecified significance (MGUS) as presumptive diseases of

[10] https://www.va.gov/HEALTH/NewsFeatures/2016/November/Research-on-Vietnam-Veterans-and-Blood-Pressure.asp
[11] https://www.nationalacademies.org/ocga/testimony-before-congress/the-national-academies-report-veterans-and-agent-orange-update-11

Agent Orange exposure, and would, in due course, provide access to VA benefits and healthcare for hundreds of thousands of Vietnam veterans.

Vietnam veterans have waited far too long for access to VA healthcare and other benefits earned through their service to our nation. We ask for immediate action by Congress and the President of the United States to direct the VA Secretary to focus on the facts and follow their own research data to add hypertension to the list of health conditions VA recognizes as service-connected for Vietnam veterans, based on exposure to Agent Orange or other herbicides.

H.R. 1972 has been in HVAC subcommittee on DAMA since June 16, 2021, and S.810 since April 28, 2021; both have seen no movement. VVA urges Congress take action on these bills immediately.

VETERANS BENEFITS

VA PRESUMPTIVE DECISION-MAKING PILOT MODEL

The Department of Veterans Affairs announced on November 11, 2021, that it was piloting a comprehensive military exposure model to consider possible relationships of in-service environmental hazards to medical conditions. The stated goal of this new model was to lower the burden of proof for veterans impacted by exposure and to speed up the delivery of needed healthcare and benefits. The lack of transparency regarding this pilot program by Veterans Benefits Administration and VA has been staggering. Why? Because Stakeholders and Veterans Services Organizations were never allowed to provide input into this proposed plot model prior to release to the veterans community.

The pilot model erodes rather than streamlines the benefits and services to which veterans are entitled. It proposes a "New Standard" that undermines the entire established and hard-won presumptive association's framework and moves it to causation – a much higher standard of proof. VVA is extremely concerned by the deliberate lack of mention of "association" between toxic exposure and medical maladies, and by the emphasis, instead, on causation. It appears that the VA is attempting to negate the VCCA and other advances. This crucial shift in the proposed change of presumptive standards to standards based on

causation will have highly detrimental effects on claims, especially on those for secondary conditions.

VVA is also concerned with the language on Page 3 of the report stating why the change is called for now—because of expired provisions in 38 U.S.C. § 1116 (Agent Orange) and 38 U.S.C. § 1118 (Gulf War), which govern the use of the National Academies of Sciences, Engineering and Medicine (NASEM) reports. We are certain, based on the research in those reports, that hypertension should be included in the presumption decision model. NASEM clearly provided VA with ample scientific data, as reported in the *Veterans Agent Orange Update 11*, which found sufficient evidence of association for hypertension and MGUS. The VHA's own research study conducted in 2016 at the request of former VA Secretary Shinseki, further verified the findings of the NASEM reports. The VA Secretary, however, failed to add these two conditions to the list of presumptive.

Chairman Takano, Chairman Tester, the VVA stands ready to work with HVAC/SVAC to ensure that this pilot project meets the greatest needs of our disabled veterans and their families.

REINSTATE 48-HOUR REVIEW PROCESS

For many years, prior to issuing a decision, VA regional offices would allow VSOs 48 hours to review any drafted decisions in order to identify errors. This was a critical program that VVA utilized to correct numerous mistakes, thereby improving the accuracy of VA decisions, lessening the burden on the appeal system, and preventing substantial heartache for the claimant. While the VBA is pursuing the establishment of a system for electronic notification and has launched a Claims Accuracy Review (CAR) program, we believe it falls short of our desire to see upfront correction of errors. The CAR program is a reactive remedy to replace what was a proactive system of accountability. VVA strongly advocates in favor of re-establishing this important proactive program.

OVERHAUL THE BVA QUALITY REVIEW PROGRAM

In a collaborative effort between legal scholars and the former Chief of the BVA's Office of Quality Assurance, the first comprehensive study was conducted to measure the

effectiveness of the BVA's Quality Review (QR) program.[12] The 2019 study concluded that the BVA's QR program "had no appreciable effect on reducing appeals or reversals." Furthermore, "for both original and CAVC-remanded appeals, the QR program did little to stem the backlog of appeals sent back to the BVA for multiple rounds of decisions." Most troubling, the study's authors were able to "demonstrate that this inefficacy is likely by design, as meeting the performance measure of 'accuracy' was at cross-purposes with error correction."

To VVA's knowledge, the BVA's Chairman of the Board has not proposed or implemented any changes to QR in response to these stark revelations. BVA issued 4,740 decisions in January and February 2020, combined, for cases in the *Veterans Appeals Modernization and Improvement Act* (abbreviated as "AMA" by VA) system.[13] According to information provided to VVA in a FOIA request, the BVA's QR program reviewed only 195 decisions in the same period, or 4.1 percent.

QR identified 54 errors and assigned an accuracy rate of 72.6 percent for January and 87.4 percent for February, well below BVA's stated goal of 95 percent, and all of this took place more than a year after AMA was implemented.[14] Notably, where a decision has multiple errors, "that case is only counted once in the number of cases with errors column," thus the true accuracy rate should be even lower. According to the Chairman's 2021 annual report, the Board's accuracy rate remains "approximately 92.06 percent for legacy decisions and approximately 87.48 percent for AMA decisions." This 2021 statement unequivocally contradicts the 2020 QR findings cited above.

Although VVA fully supports BVA's goal of issuing decisions in a timely manner, we feel it is critical that quality not fall by the wayside. Failure to improve quality causes significant waste of public funds in litigation expenses and, most importantly, impermissibly delays or denies justice to our nation's veterans and their families. Therefore, VVA urges VA first to commission a study that evaluates how best to overhaul BVA's QR system, and then to implement the proposed changes in a timely manner.

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[12] Daniel E. Ho, et. Al., "Quality Review of Mass Adjudication: A Randomized Natural Experiment at the Board of Veterans Appeals, 2003–16," *The Journal of Law, Economics, and Organization* 35, no. 2 (July 2019): 239–288, https://doi.org/10.1093/jleo/ewz001

[13] https://www.benefits.va.gov/REPORTS/ama/

[14] BVA provided data from August 2019 through March 30, 2020. The highest accuracy rate in this period was 87.4% (February 2020).

PROVIDE OVERSIGHT FOR COMPENSATION AND PENSION (C&P) CONTRACTORS

Although VA has been required by law, for decades, to provide veterans with free, competent medical examinations to support their claims for disability benefits, it has never succeeded in implementing a system to ensure compliance with CAVC standards.

Initially performed by the Veterans Health Administration (VHA), these exams have been outsourced to contractors such as QTC and LHI at progressively greater rates over time. VA has as a stated goal the full privatization of the C&P examination process within the next few years.

While these contractors have been adept at managing the scheduling aspect of the process, VVA has observed no meaningful efforts to ensure that medical professionals hired by them provide an "adequate" examination. This term has been clearly defined by the CAVC in a long series of precedential decisions, yet VVA advocates continue to see hundreds of verifiably inadequate exam reports produced each year.

Invariably, these inadequate examinations are relied upon by VA adjudicators (who are prohibited from making medical determinations), resulting in the improper denial of benefits. VVA exhorts VA to implement a robust accountability system that ensures public funds are only used to procure adequate examinations for our veterans and their survivors.

The BEST for Vets Act (S. 2329), sponsored by Senator Rubio, would work to provide more accountability by requiring that only healthcare professionals who are fully licensed and not barred from practice may furnish medical disability examinations under VA's pilot program. These professionals would include physicians, physician's assistants, nurse practitioners, audiologists, and psychologists.

S.89 ENSURING SURVIVOR BENEFITS DURING COVID-19 ACT OF 2021

The country mourns the loss of over 19,000+ men and women who served in combat due to the COVID-19 pandemic and the number may well have risen before my testimony. VVA has received numerous complaints that survivors are being denied DIC benefits because their loved one's death certificate does not indicate that the veteran died of a service-connected disability due to complications from COVID-19; or that the veteran's disability was a contributing factor. This highly unsatisfactory situation indicates a dire

and pressing need to educate all healthcare professionals who provide care to, or conduct autopsies on veterans, on the critical importance of registering service-connected factors in the medical records of all veterans. We should make the process easier, not more complicated for survivors and dependents.

Consequently, one particularly important bill that VVA supports is *S.89, Ensuring Survivor Benefits during COVID-19 Act of 2021*. Introduced by Kyrsten Sinema (D-AZ), this legislation requires the VA Secretary to secure medical opinions for veterans with service-connected disabilities who die from COVID-19, to determine whether those disabilities were the principal or contributory cause of death. Our Veterans Service Officers in the field had noticed a trend in benefits for spouses and/or dependents being denied for Dependency Indemnity Compensation (DIC) because VA was attributing the veteran's death strictly to the virus. This bill must include efforts to inform the public, as well as professionals in the medical examiner/coroners' offices, about the consequential necessity to fully complete a death certificate.

These earned benefits have been out-of-reach for too many families for too long. S.89 has been held at the house desk since July 24, 2021. VVA must insist that Congress take further action on this bill immediately.

DEPENDENT INDEMINITY COMPENSATION (DIC)

It is inherently unfair that a surviving spouse of a veteran, in the normal circumstance, to qualify for Dependent Indemnity Compensation (DIC) must have had the loved one receiving 100 percent total and permanent disability for ten or more years. More ever, the veteran death was validated as dying of an injury or disease related to military service, because such a circumstance frequently places this survivor in a disadvantageous financial position and an undeserved financial crisis.

Section 1318(b)(1) of Title 38 of the United States Code provides Dependency and Indemnity Compensation (DIC) benefits for survivors of deceased veterans who were rated totally disabled for ten or more years. However, the financial status of the surviving spouse is compromised due to the care often required for the very disabled veteran by the spouse. The veteran's spouse, acting as a caregiver, must in many instances limit, give up, or put a hold on a career and other activities. As a result, the family unit suffers an immediate income loss upon the death of the veteran, which can lead to an undeserved financial crisis

from which it may not recover, especially if the surviving spouse is no longer of working age.

VVA is willing to work with both committees to introduce legislation, which reduces the rule for the DIC qualification period to a more reasonable period. Ideally, the new legislation would call for a qualification period of five years, starting with payments at 50 percent of the maximum amount, to be increased by 10 percent per year until the maximum payment is achieved, for each year the veteran has been rated at 100 percent permanent disability.

HEALTHCARE

CAREGIVERS EXPANSION

The Program of Comprehensive Assistance for Family Caregivers (PCAFC) provides a wide range of benefits, including monthly stipends, reimbursement for travel costs, medical coverage, training, counseling, and respite-care caregivers for veterans who were severely injured during service to their country. Since implementation, the program has assisted thousands of disabled veterans and their families during their long road to recovery and independence.

The Caregivers and Veterans Omnibus Health Services Act of 2010, P.L. 111-163, only provided these services to post-9/11 veterans, but with the passage of the *VA MISSION Act* in 2018, P.L. 115-182, and the new law allowed changes to the already established PCAFC. On October 1, 2020, family caregivers of veterans who were seriously injured in the line of duty on or before May 7, 1975, and who have a single or combined service-connected disability rating by VA of 70 percent or higher, regardless of whether it resulted from an injury, illness, or disease, became eligible for this program.

VVA applauded the expansion of this long-overdue caregiver benefit, which will enhance the quality of life for Vietnam veterans and their families. However, Veterans Health Administration has reported that most of these older and sicker veterans are being denied access to the PCAFC program because they do not meet the new eligibility requirements of the program.

VVA was hopeful that this new program would not repeat the mistakes that were made in 2018 and 2019, as foreseen by Senator Patty Murray (D-WA), and that are now being

repeated again in 2022. Unfortunately, reports indicate that access to the program has been denied to bilateral and triple Post-911 amputees with the only explanation being, "You don't qualify." This situation is both shameful and shocking; how can you deny a veteran, gravely injured in service to this country, who will need care and treatment for the rest of his or her life, the benefits he or she has earned? Is funding the only reason for the harsh treatment of our severely disabled veterans?

VVA has heard from frustrated members across the United States, and when we ask them to please contact their member of Congress to assist them, their response is that nobody in Congress is listening. If Congress was listening, our vets say, they could have stopped the bleeding months ago, when VA's September 30, 2021, press release was issued, indicating a reassessment of VA PCAFC requirements for legacy participants.

Perhaps Congress believed it would only affect aging veterans, but post-9/11 vets are being denied access as well. When the veteran then turns to VA for assistance, they are told to file an appeal. As Ron Nessler, a three-tour, severely disabled Vietnam vet, testifies, "You can't file an appeal without complete paperwork." Therefore, Ron attempted to submit everything he had, but was eventually denied access to the benefits. When he asked why, he was verbally told that he did not meet the new regulatory requirements, but he did not receive any written explanation of exactly how he fell short of those requirements. Ron's story has been repeated over and over again by our membership, and when VVA asked the VA Secretary why veterans were not receiving adequate notification of why their claims were being denied, he had no response.

Over 19,500 veterans and families are enrolled in the PCAFC legacy program, said VA Caregiver Support Program Executive Director Colleen M. Richardson, Psy.D, in a September 30, 2021, VA press release. It further stated that one-third, or 6,700, of those veterans and families would be denied benefits because they did not meet the statutory 70 percent service-connected disability requirement, or the statutory ADL requirement of the new rule. This is, simply put, a travesty, because there is a third stage of the program waiting to begin this year, and what will happen to those aging veterans if Congress sits back and does nothing? May I remind you, these are your constituents, the ones you praise and take pictures of every Veterans' Day or at candidate's forums when you promise to take care of them, as long as you can count on their vote? Representatives and Senators, our Veterans need you now to honor that promise; use your legislative power and bring a

halt to reassessment. This was never the intent of the PCAFC program, and is certainly no way to honor our veterans. Deny, deny until they die.

AGING VETERANS POPULATION IN RURAL AMERICA

A disproportionate share of veterans lives in rural America. According to the National Center for Veterans Analysis and Statistics and the U.S. Department of Veterans Affairs, Office of Rural Health (VA-ORH), of the nearly 20 million veterans in the U.S., 4.7 million live in rural America. Fifty-eight percent, or 2.7 million of these rural vets are enrolled in the Veterans Affairs (VA) healthcare system; of those rural, VA-enrolled veterans, 55 percent are 65 years, and older, and 56 percent are affected by a service-related condition.

These statistics are particularly important because veterans living in rural areas may have difficulty accessing health services for reasons similar to other rural residents. Some rural veterans also face poverty, homelessness, and substance use disorder, which can exacerbate their health issues.

In most cases, majorities of veterans are unaware of the benefits, services, and facilities available to them through VA, and it may be even more difficult for rural veterans and their caregivers to access healthcare and other services due to rural delivery challenges. These include, but are not limited to hospital closures due to financial instability; less available housing; fewer education, employment, and transportation options; greater geographic and distance barriers in terms of regular access to VA facilities; and lack of access to broadband services.

According to the official journal of the Catholic Health Association of the United States, *Health Progress,* May 2013 issue:

> "It is no long[er] possible to view rural veterans as a homogenous group. Changes in enlistment patterns are creating a more diverse population of rural veterans that includes a growing number of women, an aging cohort of veterans and a younger cohort of Gulf War and Iraq War veterans with potentially longer-term consequences from their combat service. These changes are challenging traditional veteran services systems to revise their programs and community providers to broaden their capacity to address the evolving needs of rural veterans.
>
> To best meet our obligations to those who have served our country, it is critical to focus on opportunities to expand access to accessible, culturally sensitive primary care, behavioral health, specialty care and other support services; improve

> coordination and co-management of veterans between community and VA-based service systems; increase the availability of community-based services; explore the use of technology and transportation programs to expand access to care; expand veteran outreach programs; improve the cultural competence of community providers; and enhance our understanding of the needs of the most vulnerable rural veterans."[15]

We at VVA fully concur with this assessment. Consequently, we must remind you to consider that aging Vietnam veterans and their families are registered voters who reside in each of your committee member's districts or states, whether urban or rural, and as your constituents must become a priority as both committees promote policy and issues according to the U.S. Census bureau. We have attached maps (Attachment 1) to our testimony identifying how many Vietnam veterans over the age of 65 are your constituents, and contribute to the economic stabilization of the communities they live in.

VHA VETERAN-DIRECTED CARE PROGRAM – GERIATRICS AND EXTENDED CARE

The Veteran-Directed Care Program (VDC) is operated by the Veterans Health Administration (VHA), in collaboration with the Administration for Community Living (ACL), and as a part of Health and Human Services (HHS). VDC is a self-directed program to which primary care providers or VA social workers refer veterans. The individual veteran who qualifies and has access to the program manages a VA-funded service budget, which they use to: hire their own employees including family, friends, and other individuals; and purchase other goods and services to support living safely and independently in their own homes and communities. VDC is modeled after self-directed services available in all fifty states via Medicaid State Plans and Waivers, and heavily supported by the Centers for Medicare and Medicaid Services (CMS). VA purchases VDC from Aging & Disability Network Agencies (ADNAs), which are part of ACL's no-wrong-door initiative. The VDC provider supports the qualifying veteran with managing their budget and all employer responsibilities, and provides case management to ensure their goals for community living are being met.

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[15] John A. Gale, M.S. and Hilda R. Heady, MSW, ACSW, "Rural Vets: Their Barriers, Problems, Needs," *Health Progress* (May-June 2013):
https://www.chausa.org/publications/health-progress/archives/issues/may-june-2013/rural-vets-their-barriers-problems-needs

As of November 2021, 70 VAMCs operate VDC programs, in partnership with 150 VDC providers who serve 3,750 enrolled veterans. The average veteran in VDC manages a monthly budget of approximately $2,408, 97% of which is typically spent on personal care services provided by the veteran's direct employees. Veterans in this program typically hire 1.5 workers, approximately half of whom are family members. In addition to personal care services provided by employees, veterans frequently use their VDC budget to pay for transportation to and from medical appointments, as well as for home modifications or the purchase or rental of medical equipment that supports the Veteran's personal care needs, and is not already provided by VA or another source, such as Medicare.

Several studies conducted by VHA, VAMCs, and non-VA researchers have demonstrated the value of VDC and other self-directed services. A recent national evaluation of VDC conducted by VA HS&RD found that veterans enrolled in VDC had fewer incidents of potentially avoidable healthcare facility use, compared to similar patients receiving other purchased care services. These benefits were more pronounced among rural VDC recipients than urban VDC recipients were. This finding supports similar reports from VAMCs who have found VDC substantially affects their ability to delay and even avoid nursing home placement for veterans with significant functional needs.

Because of the positive impact, VDC can have for veterans, their families, their caregivers and VA, VHA has announced funding to expand VDC to all VAMCs over the next five years. Beginning in early 2022, VHA will provide two years of funding for VAMCs without a VDC program to include staffing to hire a VDC Program Manager. Funding will also be provided to support the cost of 20 veterans per VAMC. VHA has identified and will support 14 new VAMCs in 2022, as they develop and implement new VDC Programs.

VVA fully supports the expansion of VDC, administered by the VHA Geriatrics and Extended-Care program, which will be evidently beneficial to many veterans, especially those who may be turned down due to ineligibility for the PCAFC. If qualified for VDC, all veterans will be allowed to manage their own healthcare needs, regardless of age or disability.

SERVING VETERANS WITH LONG-TERM PTSD

It should come as a surprise to no one that VA employs far too few mental health clinicians. This is true for myriad reasons, not the least of which are the hiring hoops clinicians must negotiate, which can take six, eight, ten months, or even longer before they can be officially employed by VA. As a result, in a shortsighted attempt to satisfy the needs of the moment, VA is leaving in the lurch too many vets afflicted with chronic, long-term PTSD. Indeed, VA is not addressing, let alone fixing, a situation its own bureaucrats have created. The question is: Will you in Congress use your standing to support these veterans? VA is currently still operating with critical shortages of staff that have, unfortunately, been exacerbated by a chronic and acute shortage of vitally needed mental health clinicians across the United States. If we are going to make progress on reducing the number of suicides among veterans of every age, the first step is to fill long vacant positions and to return to full staffing as quickly as possible.

VVA is also advocating for continuing care groups led by a clinician to be reinstated by VA to support either those veterans who are considering treatment for PTSD or related mental health issues, or those who need some help in maintaining the gains made after having gone through evidenced-based treatment. We are also asking the Department of Veterans Affairs to help those veterans who may have received a less than honorable discharge due to symptoms of PTSD, to begin the process of having their discharge considered for upgrade.

VVA would like to thank Representative Cindy Axne (D-IA-3rd) and Senator Tester for successfully advancing the *Sergeant Ketchum Rural Veterans Mental Health Act,* which became Public Law 117-21 last June. This bill requires VA to establish and maintain three new centers of the Rural Access Network for Growth Enhancement (RANGE) Program, which serves veterans in rural areas who are experiencing mental illness. While this change does not necessarily increase the overall number of clinicians, it does increase access for vulnerable veterans.

VETERAN SUICIDE

According to VA's *National Veteran Suicide Prevention Annual Report* of September 2021, the number and rate of suicide deaths rose from 2001 to 2018 across the U.S.

population. Yet the U.S. population, as well as the veteran population, experienced a decrease in the suicide count and rate from 2018 to 2019. Furthermore, in retrospect and with updated data, the veteran suicide count was noted to have decreased in 2018 — one year ahead of the U.S. population suicide decrease.[16]

Two out of three veteran suicides are over 55 years of age. Fourteen of 20 do not get care at a VA healthcare facility. Former Ranking Member of HVAC, Dr. Phil Roe (R-TN) was quoted as saying that more and more millions of dollars are being expended in an attempt to make an impact on the number of veterans who die by their own hand, yet the numbers do not seem to lessen. Mountains of studies, funded by millions of VA and DOD dollars, seemed only to develop recommendations revolving around the need to learn why veterans commit suicide . . . by funding yet more studies.

The whys may be unique for each individual who attempts to take their life, but they are no mystery: demons borne of the horrors of war, horrors they have experienced. Return from a war zone to a society that does not know, or understand, what they went through too often leads to drinking and/or drugging to ease the pain. In addition to these self-medicating behaviors, too many returned veterans experience fiscal uncertainties, failed relationships, and the loss of hope.

Permitting vets to seek help from non-VA practitioners may help some. This will be costly, and the overall effectiveness difficult to gauge. The answers may lie in community. Increased reliance on "battle buddies" may be viable for recent veterans, but not necessarily for those who served in Vietnam a half-century ago. We want to help VA create a culture that proactively seeks out lonely, homeless, family-less, disenfranchised veterans and brings them in from the cold.

In addition, let the experts at VA, clinicians who have been dealing with veterans every day, do what they do best. According to the testimony of Dr. C. Edward Coffey, Affiliate Professor of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, a leading expert on achieving system-wide culture change within a health system in order to reduce suicide deaths, given before the House Veterans Affairs Committee regarding a promising initiative to disrupt suicide attempts:

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[16] https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf

In conjunction with our National Center for Patient Safety, we developed the "Mental Health Environment of Care Checklist." Interdisciplinary inspection teams to assess the environment for hazards and determine actions that need to be taken to protect our veterans use this tool. The rate of suicide prior to the implementation of the checklist was 4.2 deaths per 100,000 admissions. It is now less than one per 100,000 admissions.

What Congress might do is enact a law that will make mandatory the insertion of this single question on every death certificate: *Did the decedent ever serve in the Armed Forces of the United States?* This simple step will enable researchers to do a more thorough medical postmortem of anyone determined to have committed suicide. This change, in turn, would add to our understanding of the whys and wherefores of a real American tragedy and allow us to get off the very expensive hamster-wheel of inconclusive research.

OTHER KEY LEGISLATIVE ISSUES

THE VETERANS ECONOMIC OPPORTUNITIES ADMINISTRATION

The most recent bill to establish the Veterans Economic Opportunity and Transition Administration is H.R. 2494/S. 1093, sponsored by Rep. Winstrup and Sen. Rubio. This bill is critical to easing transition for veterans, as this new organization would administer:

- Vocational rehabilitation and employment programs
- Educational assistance programs
- Veterans' housing loan and related programs;
- The Transition Assistance Program; and
- The database of small business concerns owned and controlled by veterans

This bill has been in committee since May 19, 2021 and has seen no movement. VVA must insist that Congress take further action.

HOMELESS VETERANS

VVA urges the Presidential Interagency Council on Homeless to recognize homeless veterans as a Special Needs Population. Further, we appeal to Congress to require all entities and agencies, including nonprofit and governmental, that receive and utilize federal program funding dollars, to report statistics on the number of veterans they serve, their

residential status, and the services needed by those veterans. VVA strongly urges its own membership, at the chapter and state council level, to work with their state and federal legislators to enhance services to homeless veterans in their home regions, and further encourages them to recognize these veterans as a Special Needs Population. Additionally, VVA supports legislation that would incorporate a "Fair Share Dollar approach" for the federal funding of all homeless programs. Furthermore, VVA presses VA Homeless Grant and Per Diem Program (HGDP) to provide payment directly for services, rather than continuing the method of reimbursement for services that it presently provides for transitional housing. Finally, VVA staunchly supports and seeks legislation to establish Supportive Services Staffing Grants for VA-HGDP Service Center Grant awardees.

Because a long-held and oft-stated key goal of VA has been to end veteran homelessness (a promise that, realistically, never could be kept), one attempt to meet that goal that has arisen is the placement of as many homeless vets as possible in apartments, if only for the short-term. As long as VA is able to provide a continuum of care, the key to which is a plenitude of well-staffed and well-funded transitional services, this policy is sensible. The initial statistics look good; VA can rightly claim its policies are helping. The reality that must be acknowledged, however, is that there are some homeless vets who will not come in from the cold. Despite their circumstances, they still are deserving of our respect and gratitude, twin attributes that VA might better promote through a sensitive outreach campaign.

VVA was pleased to read in the *2021 Annual Homeless Assessment Report* (AHAR) to Congress that the number of veterans experiencing homelessness on a single night in January 2021 had dropped to 19,750, very different from the 49,000 reported in January 2009. Our memories of advocating for homeless veterans in earlier years was that VA had no authority to seek housing for veterans, and HUD had no authority to provide medical care for veterans. It was former VA Secretary Shinseki who saw the need and stepped in to introduce a comprehensive plan to end veteran homelessness, which included discharge planning for incarcerated veterans re-entering society, supportive services for low-income veterans and their families, and a national referral center to link veterans to local service providers. Additionally, the plan calls for expanded efforts for education, jobs, healthcare, and housing to be pursued for the re-housed veterans.

VVA believes that we were on the right track with the passage of P.L. 107-95, the *Homeless Veterans Comprehensive Assistance Act of 2001*, for which, the VVA National Homeless Committee advocated for over 10 years before passage. However, it took the on-going help of VA former and present Secretaries, as well as a COVID-19 pandemic, before we saw a significant change in the number of our most vulnerable veterans finally being settled in a place to call home. The Homeless Committee is grateful for the decrease in the number of homeless veterans; however, we will not take a victory lap until we end homelessness among all veterans. See our executive summary of the 2021 Annual Homeless Assessment Report (AHAR) in Attachment 2.

In addition to the West Los Angeles VA Campus Improvement Act of 2021, which became Public Law 117-18, in June of last year, legislative initiatives that would benefit our homeless veterans and their families include the:

- *Reaching Every Homeless Veteran Act* (H.R. 5783/S. 3094, sponsored by Rep. Mann and Sen. Moran), which would require the organization and execution of an education and outreach program to ensure housing-insecure communities are aware of available benefits;
- *Building Solutions for Veterans Experiencing Homelessness Act* (S. 2172, sponsored by Sen. Tester), which creates a grant program for substance abuse and alcohol use disorder recovery for homeless veterans, a pilot program for elderly homeless veterans, and increases funding for homeless veterans reintegration programs; and
- *Improving Housing Outcomes for Veterans Act* (H.R. 876, sponsored by Rep. Gonzalez), which informs VA medical staff regarding best practices on collaborating with HUD to combat homelessness.

MINORITY VETERANS

Over 2800 South Korean military servicemembers who fought with American troops during the Vietnam War later relocated to the U.S., and are now American citizens. These men and women served on the sea, ground, and air of the Vietnam War Theater from 1964 to 1973, alongside their American allies. Consequently, they were exposed to many perils, including Agent Orange-related illnesses and disease. Today many of these veterans are falling ill due to their Agent Orange exposure, but medical care is not currently available to them through VA healthcare system. The conventional medical community, the only option for treatment and care for these Korean-American vets, still has very little

knowledge of the effects or treatment of Agent Orange-related illnesses given the concentration of these cases in the limited population of veterans, most of whom do not use conventional medical care.
The U.S. government has been supporting the reclamation of toxic exposed land in South Vietnam. The war is long over and we have restored the economy of the new, unified Vietnam. We have embraced our former enemy, supplying technical and material aid, as well as free medical assistance to their population. Our government has abandoned our South Korean allies and fellow veterans, but has embraced and supported a former enemy, North Vietnam. Rather than abandoning them, our government should instead be supporting our fellow Korean-American combatants in a way equal to our native-born American veterans' benefits and of course, equal to or exceeding the embrace and support it provides to our former enemy, Vietnam.

Congressman Mark Takano (D-CA-41st), Chairman of the House Veteran Affairs Committee has introduced *H.R. 234, Korean American VALOR Act;* this bill would amend U.S. Code: Title 38, in order to treat certain individuals who served in Vietnam as a member of the armed forces of the Republic of Korea, as veterans of the Armed Forces of the United States for the purpose of the provision of healthcare by the Department of Veterans Affairs. To qualify, the veteran must have been granted U.S. citizenship either on or after the date on which such services in the armed forces of the Republic of Korea ended. VVA fully supports this important bill and looks forward to working with the members of both committees to secure its passage into law.

THE NEEDS of WOMEN VETERANS

As VA continues to adapt to the reality of the increasing number of women in military service, they must continue to expand their healthcare delivery to meet their needs, e.g., providing (or contracting out) prenatal care, counseling victims of military sexual trauma, and understanding the unique problems faced after facial disfigurement or loss of a limb. To meet these relatively new challenges, VA must first call for and fund research that will illuminate treatment options; VA must also seek out and hire enough female OB-GYN specialists, whom many women veterans prefer. Finally, and perhaps most importantly, VA must be a safe place where women veterans can enter without fear of being victimized by sexual harassment.

With the enactment of P.L. 116-315 *The Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvements Act of 2020*, women veterans' issues are finally

being recognized. The law's provisions include the long-fought *Deborah Sampson Act*, named in honor of a colonial American, woman veteran who disguised herself as a man in order to join the Patriot Forces in the American Revolution, and subsequently became a champion for all women who served. We specifically thank Congresswoman Julia Brownley (D-CA) Chair of the Subcommittee on Health/Women Veterans Task Force and members of her staff, for a job well done, and VVA looks forward to working with Congresswoman Brownley to ensure that VA is adhering to the provisions in the law providing adequate services to women veterans.

VVA would like to acknowledge Senator Tammy Duckworth (D-IL) for championing the Protecting Moms Who Served Act P.L. 117-69 (passed November 30, 2021), which compels VA to provide community maternity care providers with training and support specific to the unique needs of pregnant and postpartum veterans, particularly regarding mental and behavioral health. VVA also supports the following bills, which would contribute to improved safety and better health outcomes for our sisters-in-arms:

- *The Servicemembers and Veterans Empowerment and Support Act* (H.R. 5666/S.3025, sponsored by Rep. Pingree and Sen. Tester), which reduces barriers for veterans to obtain treatment for military sexual trauma.

- *The DOULA for VA Act* (H.R. 2521/S. 1937, sponsored by Rep. Lawrence and Sen. Booker), which would establish a five-year pilot program to furnish doula services to pregnant veterans; and

- *The Improving VA Accountability to Prevent Sexual Harassment & Discrimination Act* (H.R. 2704, sponsored by Rep. Pappas), which would enhance VA's ability to respond to sexual harassment complaints in a timely manner, increase training, and would require annual reporting to the House and Senate Veterans Affairs Committees.

GULF WAR VETERANS

Veterans deployed to Southwest Asia during the Gulf War in Operations Desert Shield and Desert Storm are still waiting for answers. The list of toxicants to which they were exposed include (but are not limited to):

- Oil Well fires;
- Chemical and Biological weapons, including Sarin, from the demolition of the ammunition storage depot at Khamisiyah;

- Depleted Uranium used in U.S. military tank armor and bullets;
- CARC – Chemical Agent Resistant Coating – paint on military vehicles to resist corrosion and chemical agents;
- Pesticides;
- PB – Pyridostigmine Bromide – a pre-treatment drug to protect against the nerve agent Soman; and
- Solvents, including Benzene, Cyclohexanol, Ethylene Glycol, Methylene Chloride, Methyl Ethyl Ketone, Methyl Isobutyl Ketone, Naphtha, Toluene, Tetrachloroethylene, Trichloroethylene, and Xylenes.

When those who served, who did our nation's bidding, came home and encountered illnesses they couldn't explain, and subsequently went to a VA medical center, treatments often could not mitigate their maladies or their pain.

When they sought hard-earned disability compensation, most were treated as if they were trying to get over on the government, and claims denied. It is important to note that VA's exceedingly high denial rates of Gulf War presumptive claims (78 percent for presumptive Chronic Multi-Symptom Illness CMI and 93 percent for the broken Undiagnosed Illness UDX presumptive conditions in 38 CFR §3.317) perpetuate the real and on-going misery being experienced by tens of thousands of Gulf War veterans. Therefore, until VA's presumptive Gulf War claims adjudication policies, procedures, and training all are remedied, Gulf War veterans suffering at the hands of the organization that is supposed to help them will continue.

The Agent Orange Act of 1991 mandated that VA engage the Institute of Medicine, now the National Academy of Medicine of the National Academies of Science, Engineering, and Medicine, to convene panels of experts every two years to audit the peer-reviewed scientific literature; hold public hearings; and produce their findings on levels of association, ranging from sufficient to none known at this time, on suspect health conditions related to exposure to dioxin. The Act further mandated that their findings be published in biennial updates of *Veterans and Agent Orange*.

There is a real need for Congress to reauthorize the funding for this endeavor for at least another decade and to expand its scope to embrace the potential effects of past, present, and future exposures to toxicants on veterans of all eras, specifically the 1991 Persian Gulf War and the recent conflicts in Afghanistan, Iraq, and Syria.

This congressionally mandated research, paired with publication of the panel's findings, should also include the investigation of sites in the Continental United States (CONUS) known for the presence of toxic substances. This publication would follow the format of the *Veterans and Agent Orange* updates. These sites include, but are hardly limited to: Fort McClellan in Alabama; Fort Chafee in Arkansas; Fort Detrick and Aberdeen Proving Ground in Maryland; Dugway Proving Ground in Utah; the Marine base at Camp Lejeune, North Carolina; the former Marine air base at El Toro, California; Fort Greely in Alaska; and Luke Air Force Base in Arizona.

At the very least, veterans deserve an acknowledgment that their health may have been compromised in the long term by service-related toxic exposure. These include the tens of thousands of servicemembers in the Gulf War exposed to the toxic plume from the demolitions of the Iraqi ammunition dump at Khamisiyah and the CIA's detonation of at least five other sites that remain classified; and the hundreds of thousands of veterans who have seen service in Iraq and Afghanistan, working and sometimes living for months or years next to those insidious burn pits that pockmarked their bases in the desert. Also included are those exposed to Per- and Poly-fluroalkyl Substances, the "forever chemicals" in fire-fighting foam that are pervasive at overseas sites and at virtually all Air Force bases in CONUS.

In closing, for as long as we can remember veterans with a DD 214 (Certificate of Release or Discharge from Active Duty) have been turned away from the Department of Veterans Affairs when seeking benefits, because they cannot document every place they served. This long-accepted practice has been impactful: treating each request for benefits as an attempt to get something for nothing. Appraising our returned warriors as fakers or frauds as a first-step reaction is simply unacceptable. These benefits are an integral part of the cost of war. For example, too often have Navy veterans who spent their service in the engine room of a battleship been told that their hearing loss was a function of something else; or members of a field artillery team been informed that their hearing loss was caused by something that happened before their enlistment in the military. Of course, we acknowledge there are people that want to defraud anyone, including the Department of Veterans Affairs. What we are asking is that VA start from the premise of believing the individual veteran's story about military experience, and give it some consideration in their assessment, rather than

looking for holes and contradictions as a first reaction. Managing for fraud first and the veteran second is an upside-down approach, particularly for an agency whose stated mission is "to care for [them] who shall have borne the battle."

Vietnam Veterans of America greatly appreciates the efforts of both committees for your bipartisan support in adding three presumptive for Gulf War veterans, and the many laws that you have enacted to improve the quality of life for our veterans and their families. We also appreciate the opportunity to testify today, and look forward to working in concert with Congress, as partners, to make inroads into many of the issues and problems you have heard about this afternoon and over the past several weeks. Moreover, we will do our best to reply to any questions or concerns you might care to put to us.

VIETNAM VETERANS OF AMERICA

Funding Statement

March 2, 2022

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Director for Policy and Government Affairs
Vietnam Veterans of America
(301) 585-4000 extension 111

Jack McManus

Jack McManus was elected to serve as VVA National President at VVA's 20th National convention, held in November 2021, in Greensboro, North Carolina. First elected VVA national treasurer in 1995, he was re-elected to the position in 1997, and again in 2019. He previously served as the VVA Michigan State Council President for six and one-half years from 1989 to 1996, overseeing the largest state program in VVA. In 1997, he was awarded VVA's highest honor, the VVA Commendation Medal, for his extraordinary service to the organization, to all veterans, and to the community at large. The VVA New York State Council has also recognized him with its own Commendation Medal.

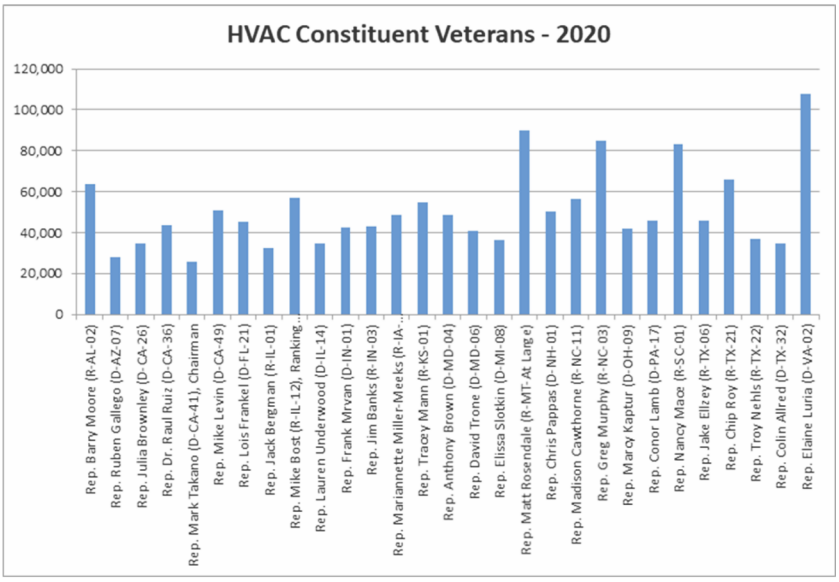
During his career as a private businessman, McManus's company employed approximately 3,500 in two service-sector businesses, with $150 million annually in sales. In 1978, his company was recognized as the first drug-free workplace in the building service contracting industry. The company also emphasizes special hiring programs for handicapped individuals, ex-offenders, and rehabilitated substance abusers for its internal rehabilitation programs. From 1978 to 1985, McManus was the program manager for his company's contract with the Kennedy Space Center space shuttle program in Florida.

Originally, from New York City, Jack McManus joined the Air Force in 1965, where he served until 1969. Between 1967 and 1968, he was assigned to Operation Ranch Hand in Vietnam.

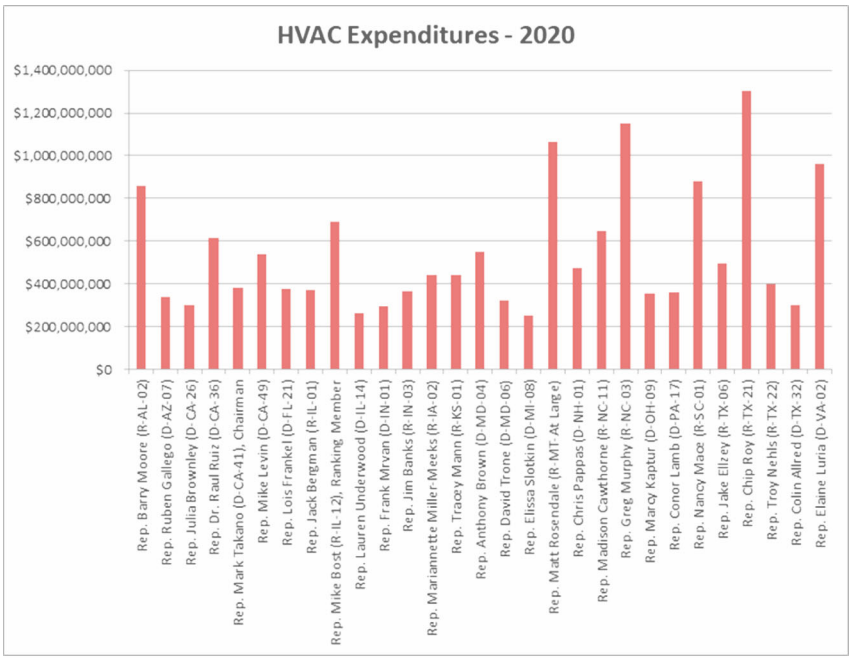
Jack received his B.A. in Business Management from New York University in 1973. He resides in North Carolina with his wife Jackie. He is a recipient of numerous business and community awards.

Attachment 1

House Veterans Affairs Committee Data[17]



[17] National Center for Veterans Analysis and Statistics - 2020, VA (last visited Jan. 13, 2022), https://www.va.gov/vetdata/Expenditures.asp. All amounts are based on 2020 estimates and dollar amounts are actual.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$1,200,000,000
$1,000,000,000
$800,000,000
$600,000,000
$400,000,000
$200,000,000
$0
Rep. Barry Moore (R-AL-02)
Rep. Ruben Gallego (D-AZ-07)
Rep. Julia Brownley (D-CA-26)
Rep. Dr. Raul Ruiz (D-CA-36)
Rep. Mark Takano (D-CA-41), Chairman
Rep. Mike Levin (D-CA-49)
Rep. Lois Frankel (D-FL-21)
Rep. Jack Bergman (R-IL-01)
Rep. Mike Bost (R-IL-12), Ranking Member
Rep. Lauren Underwood (D-IL-14)
Rep. Frank Mrvan (D-IN-01)
Rep. Jim Banks (R-IN-03)
Rep. Mariannette Miller-Meeks (R-IA-02)
Rep. Tracey Mann (R-KS-01)
Rep. Anthony Brown (D-MD-04)
Rep. David Trone (D-MD-06)
Rep. Elissa Slotkin (D-MI-08)
Rep. Matt Rosendale (R-MT-At Large)
Rep. Chris Pappas (D-NH-01)
Rep. Madison Cawthorne (R-NC-11)
Rep. Greg Murphy (R-NC-03)
Rep. Marcy Kaptur (D-OH-09)
Rep. Conor Lamb (D-PA-17)
Rep. Nancy Mace (R-SC-01)
Rep. Jake Ellzey (R-TX-06)
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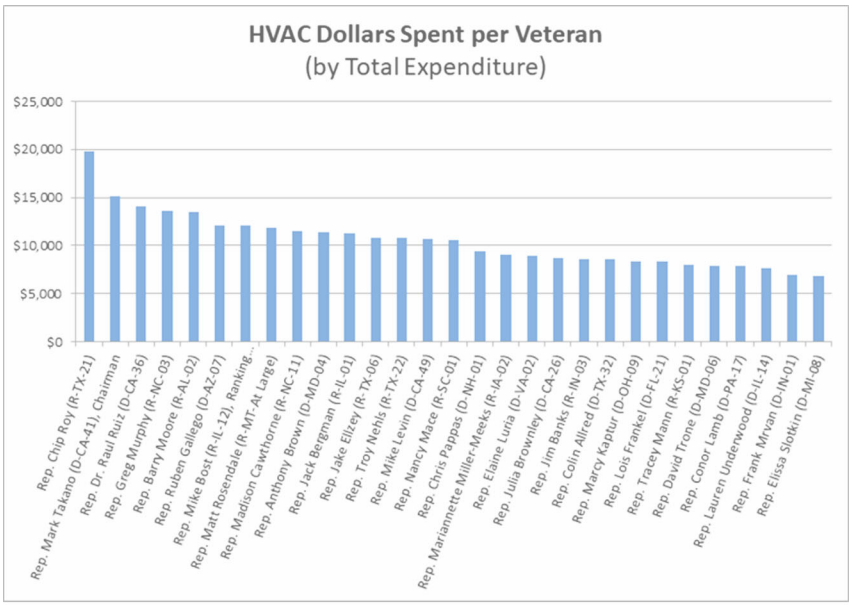
HVAC Dollars Spent per Veteran
(by Total Expenditure)
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$20,000
$15,000
$10,000
$5,000
$0
Rep. Chip Roy (R-TX-21)
Rep. Mark Takano (D-CA-41), Chairman
Rep. Dr. Raul Ruiz (D-CA-36)
Rep. Greg Murphy (R-NC-03)
Rep. Barry Moore (R-AL-02)
Rep. Ruben Gallego (D-AZ-07)
Rep. Mike Bost (R-IL-12), Ranking...
Rep. Matt Rosendale (R-MT-At Large)
Rep. Madison Cawthorne (R-NC-11)
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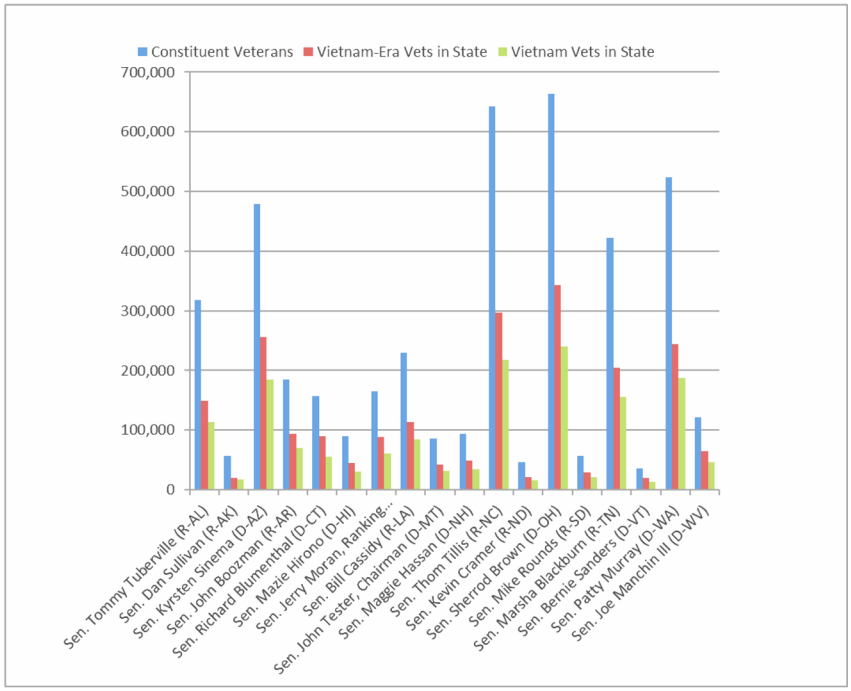
Rep. Lois Frankel (D-FL-21)
Rep. Tracey Mann (R-KS-01)
Rep. David Trone (D-MD-06)
Rep. Conor Lamb (D-PA-17)
Rep. Lauren Underwood (D-IL-14)
Rep. Frank Mrvan (D-IN-01)
Rep. Elissa Slotkin (D-MI-08)

Senate Veterans Affairs Committee Data[18]



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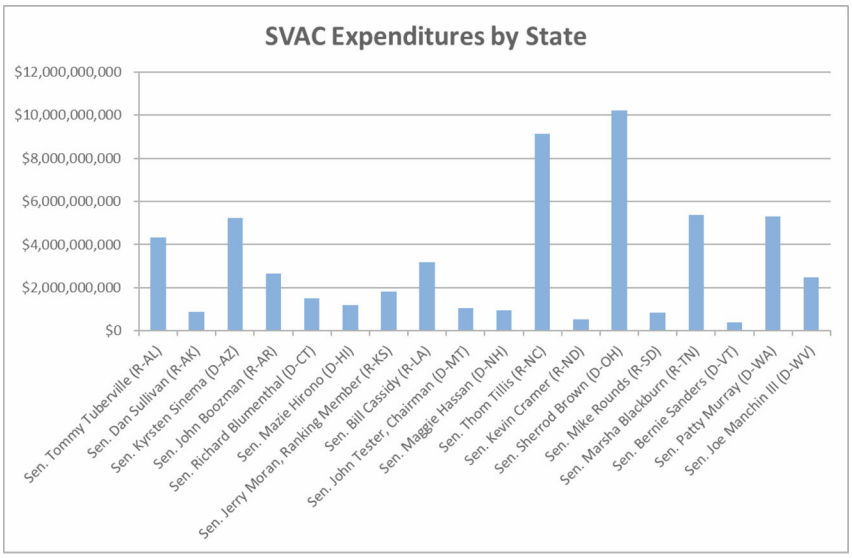
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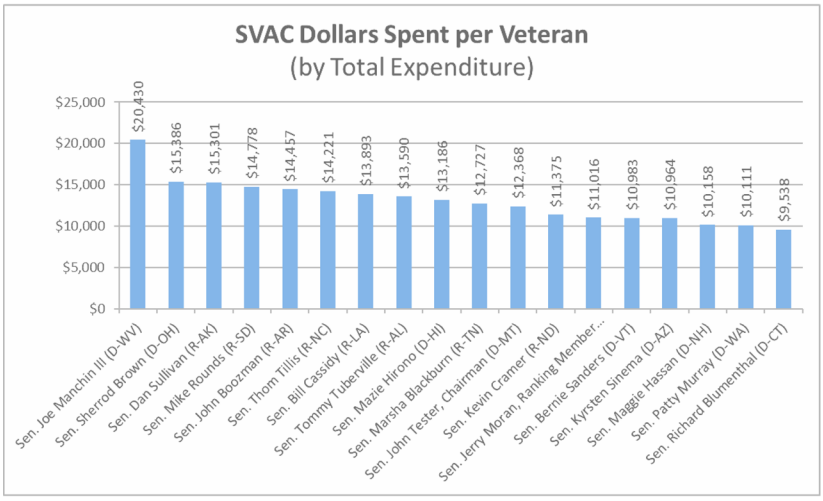
$8,000,000,000
$6,000,000,000
$4,000,000,000
$2,000,000,000
$0
Sen. Tommy Tuberville (R-AL)
Sen. Dan Sullivan (R-AK)
Sen. Kyrsten Sinema (D-AZ)
Sen. John Boozman (R-AR)
Sen. Richard Blumenthal (D-CT)
Sen. Mazie Hirono (D-HI)
Sen. Jerry Moran, Ranking Member (R-KS)
Sen. Bill Cassidy (R-LA)
Sen. John Tester, Chairman (D-MT)
Sen. Maggie Hassan (D-NH)
Sen. Thom Tillis (R-NC)
Sen. Kevin Cramer (R-ND)
Sen. Sherrod Brown (D-OH)
Sen. Mike Rounds (R-SD)
Sen. Marsha Blackburn (R-TN)
Sen. Bernie Sanders (D-VT)
Sen. Patty Murray (D-WA)
Sen. Joe Manchin III (D-WV)


SVAC Dollars Spent per Veteran
(by Total Expenditure)
$25,000
$20,000
$15,000
$10,000
$5,000
$0
$20,430
$15,386
$15,301
$14,778
$14,457
$14,221
$13,893
$13,590
$13,186
$12,727
$12,368
$11,375
$11,016
$10,983
$10,964
$10,158
$10,111
$9,538
Sen. Joe Manchin III (D-WV)
Sen. Sherrod Brown (D-OH)
Sen. Dan Sullivan (R-AK)
Sen. Mike Rounds (R-SD)
Sen. John Boozman (R-AR)
Sen. Thom Tillis (R-NC)
Sen. Bill Cassidy (R-LA)
Sen. Tommy Tuberville (R-AL)
Sen. Mazie Hirono (D-HI)
Sen. Marsha Blackburn (R-TN)
Sen. John Tester, Chairman (D-MT)
Sen. Kevin Cramer (R-ND)
Sen. Jerry Moran, Ranking Member...
Sen. Bernie Sanders (D-VT)
Sen. Kyrsten Sinema (D-AZ)
Sen. Maggie Hassan (D-NH)
Sen. Patty Murray (D-WA)
Sen. Richard Blumenthal (D-CT)

Attachment 2

Vietnam Veterans of America executive summary of the 2021 AHAR: Part 1 - PIT Estimates of Homelessness in the U.S

Question Asked: How did the count for ***sheltered*** homeless veterans came out to approximately 19,750 for 2021?

Answer: HUD relied on PIT and HIC reporting in a year where PIT participation was low and where HIC reporting requirements were reduced, resulting in an artificial decrease in the sheltered homeless veteran estimate.

Explanation

HUD's AHAR uses Point-In-Time (PIT) and Housing Inventory Counts (HIC) at the national, state, and Continuum-of-Care (CoC) level.[1] PIT counts are "estimates of both sheltered and unsheltered homeless populations."[2] HICs are a count of beds used for the homeless and are provided by each CoC.[3] In 2021, only 226 CoC communities conducted a PIT count "because their capacity to conduct counts was limited due to other pandemic-response efforts and the risk of transmitting COVID-19".[4] More specifically, only 150 communities (39% of all CoC communities) provided full unsheltered counts, while another 76 communities provided a partial count (and did not include household or demographic characteristics). Additionally, shelter providers reduced their bed counts where shelters were set up in a communal or barracks fashion, but not all CoCs reported the reductions in bed counts.

The AHAR itself says that "[e]stimates of the number of veterans experiencing sheltered homelessness at a point in time in 2021 should be viewed with caution, as the number could be artificially depressed compared with non-pandemic times".[5] Given the reduced participation in PIT by CoCs, in addition to reduced content

[1] https://www.hudexchange.info/homelessness-assistance/ahar/#2021-reports
[2] 2021 AHAR Report, p. 5.
[3] 2021 AHAR Report, p. 5.
[4] 2021 AHAR Report, p. 3.
[5] 2021 AHAR Report, p. 38.

reporting for HICs and a cut in the number of beds available due to social-distancing requirements, the numbers for homeless sheltered veterans are likely artificially low for 2021.

Note: The raw data for PIT and HIC are supposed to be available on the HUD website, but the data for 2021 is currently missing. Per the VA website, VA relies on HUD to conduct PIT counts, and explains that HUD only collects information on both *sheltered* and *unsheltered* homeless on odd-numbered years. The VA website also states that it combines the PIT count "with many other data points to make strategic decisions about programs" for homeless veterans. VVA believes that VA combines the PIT count numbers with self-reported data from veterans for an overall count of homeless veterans.

Joint Hearing to Receive the Legislative Presentation of the American Veterans

Greg Heun
National Commander
AMVETS

Before a Joint Hearing of the
House and Senate Committees on Veterans' Affairs
March 2, 2022

As the largest veterans service organization representing all of America's veterans, AMVETS is honored to provide our legislative priorities for the remainder of the 117th Congress.

Last Memorial Day weekend, AMVETS hosted our first "Rolling to Remember" pro-veterans demonstration ride here in Washington, D.C. This is the nation's largest veterans' event, which brings together tens of thousands of veterans and supporters from across the United States, riding their motorcycles to highlight critical issues. First, to demand continued and increased action for the 82,000 service members still missing in action, as well as raise awareness of the many veterans who die by suicide each day. This year's event will take place on May 29, 2022.

We will never forget our POWs and MIAs, and we won't stop fighting for real solutions to the suicide crisis. We will continue this incredible platform until they all come home and all who make it home are well.

2021 was tough on veterans, and we expect it to have lasting repercussions. First, the disastrous withdrawal from Afghanistan has caused significant increases in the number of veterans approaching our HEAL team for assistance. Second, COVID has continued to kill and sicken many in our population, isolate others, stress our VA medical care employees, and leave many unemployed or forced into stressful situations. And lastly, sexual assault survivors watched as senior senators on the Senate Armed Services Committee stripped language from the Military Justice Improvement Act that would have removed sexual assault from the oversight of their chain of command. A betrayal from the leaders who are in positions to protect our troops. Additionally, for the first time ever, the Pentagon denied veterans a permit for the annual Rolling to Remember Memorial Day ride.

In short, the 117th Congress has thus far been one of Congress and the Administration coming up significantly short for the military and veteran communities.

AMVETS will continue to highlight our number one priority for our fourth consecutive year: creating and funding effective programs and services that significantly reduce suicide.

For four years, AMVETS has made the painful, challenging, and unpopular assertion that we continue to trod down a path resulting in wasteful spending on poorly designed, old, and unproven methodologies intended to reduce suicide and negative symptomology amongst the veteran and military communities.

VA's mental health budget was more than 15 billion dollars this year. The highest revenue of any veteran non-profit in 2020 was the Wounded Warrior Project (WWP) at 280 million dollars. Disabled American Veterans (DAV) is not far behind at roughly 250 million. With the annual budget for mental health, we could fund nearly 60 DAV's or WWP's. Their yearly budget probably surpasses all of the countries major VSO's revenues combined, perhaps many times over.

As DAV and WWP know, expectations on those investments arise with this kind of funding. Annual reports, quarterly reports, and other documentation and outcomes are produced. Conventions are held, whereby these organizations answer to donors and members; and the organizations refine their products. Board members and appointed officials pour over data, examine outcomes, and ask tough questions. Longitudinal data is collected to show how their programs have had a lasting impact on their participants. Success stories are shared, and wasteful or inefficient programs and services are scrapped. Further, few CEOs in the country oversee annual revenue of 15 billion dollars, and those that do are expected to perform and are held to very high standards for outcomes. We believe few of the executives overseeing VA mental health would be considered qualified to run a 15 billion dollar organization.

Despite Congress having invested nearly $104.1 billion since 2006, you would be hard-pressed to find any meaningful data suggesting these investments have resulted in long-term impact on the veteran population; because those outcomes don't exist.

To offer another analogy, one of the worst kept secrets that Congress has failed to address is the extreme attrition rate from VA mental health programs. Depending on what data you look at, most research finds that between 50% to 90% of veterans drop out of VA programs and services before reaching the recommended number of visits. Again, as an analogy, let's open a fast-food burger chain making positive health claims, and in short order, we lose 50% to 90% of our customers. Would we scale that business? Would we argue that customers just need better "access" to our burgers? Would we blindly suggest that our burgers are "world-class" and no one can make a better burger? Would we blame the customer for our failure to retain them as customers? Do the burgers we sell result in just feeling better in the short-term, or do they result in positive lasting long-term outcomes?

We have scaled overpriced, underperforming models when tastier options with better long-term health outcomes exist. For the past four years, AMVETS has highlighted this. More than 18,000 veterans have died in that time, yet Congress continues to support scaling broken options blindly. Even worse, many members of Congress have continued to argue on behalf of this model while failing to: do due diligence on the available alternatives, failing to look into the extraordinary dropout rates of VA programs and services, failing to hold meaningful hearings that include researchers that have highlighted the poor outcomes occurring at VA, failing to hold hearings that include individuals who have presented robust longitudinal data on new and novel approaches that are resulting in veterans living meaningful, high-quality lives, failing to conduct

significant oversight travel to better understand the available options and the outcomes associated with those options.

All of this can change. Our suicide rate has nearly doubled since 9/11. The mental health budget has increased nearly fivefold in that same time frame. Generally, 4 Congressional Committee staff are left to tackle this issue along with 18 Senators and 30 Representatives.

You are the fiduciary members that make up the board that oversees what has been a notoriously underperforming mental health system with the budget of 60 Wounded Warrior Projects.

We need your help; our veterans' lives are counting on you to hold VA to act with a sense of urgency. We need a culture that demands better data-driven outcomes. We need a new model that immediately drives down suicide rates significantly and not marginally. We will not get there by dusting off the broken burger shop. We need significant game-changing ideas and action, which we will not get from the union or mental health industry, which is best served by continuing to scale the broken model that works for them. Despite growing its footprint five times, this model has not resulted in overall declines in the rate of suicide in the veteran population.

AMVETS primary legislative goals for the remainder of the 117th Congress:

- Encourage hearings, roundtables, and funding focused on new and novel programs to increase veterans' mental health as a form of suicide reduction
- Passage of the VA's current fiscal year budget as well as subsequent years to provide quality healthcare to our nation's veterans
- Create a safe, just, and welcoming VA/DoD for all veterans regardless of gender, race, or sexual orientation
- Pass legislation that addresses burn pit exposures and other toxic exposures that result in adverse health conditions
- Pass legislation allowing all congressionally chartered 501(c)(19) nonprofit organizations to receive tax-deductible donations

Mental Health & Suicide

The 117th Congress is falling victim to the same lackadaisical approach to the topic we have seen for two decades: simply pouring more funding into ineffective programs and services under the guise that "more" will lead to different outcomes. Each administration has conducted this poor approach to this massive policy issue since 9/11. As a result, the budget has grown from $3 billion a year at the start of the Global War on Terrorism to today's staggering $15 billion budget.

As such, Congress has and continues to fail to address the Suicide and Mental Health

epidemic collectively. First, there has been a failure to hold VA accountable for outcomes. VA has been unable to roll out the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program authorized over a year ago in S. 785, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019. Second, VA has failed to work with nonprofits to integrate best practices required by the Clay Hunt SAV Act of 2015. There have been zero hearings on the Clay Hunt SAV Act reports, which were created to measure the outcomes of VA mental health programs and services, and are alarming in many ways. Third, there has been a failure to insist on measurable and meaningful long-term outcomes for the dollars invested in programs to heal our veterans. No longitudinal studies suggest that any of the funded "Evidence-Based" programs provide positive long-term results.

Congress has ignored significant research highlighting program ineffectiveness and dropout rates. Few hearings are being held, no unique witnesses or witnesses critical of the status quo have been invited to testify, we have only seen more of the same with a general lack of urgency. The policies proposed and ultimately funded are primarily industry recommendations. These policies were rubber-stamped by veteran groups and lawmakers who trusted that more programs would lead to better outcomes.

Unfortunately, when we step back with two decades of data, we know that this reality has simply not occurred.

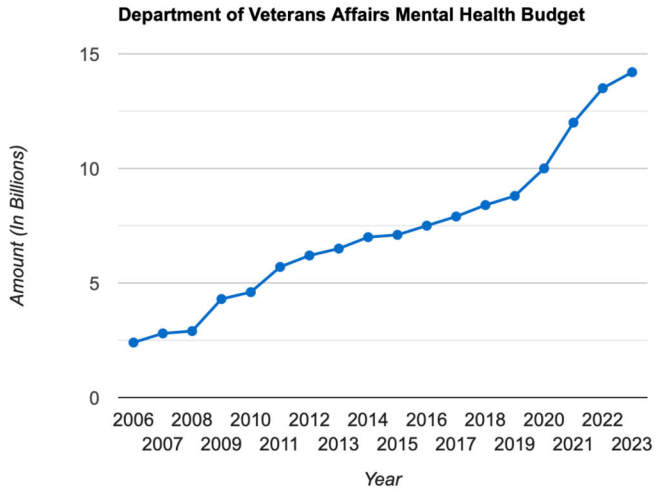
Congress has introduced 2,374 bills since 9/11 to address veterans' mental health and suicide. In this Congress alone, more than 221 bills have been introduced. Last Congress, 339 bills were introduced.

The most common policy ideas that have continued to pass into law and to be introduced have five similar general elements:

- Increase access to traditional mental healthcare (inclusive of telehealth proposals)
- Increase research funding (you name it, it's been thought of)
- Increase funding for mental health practitioners (inclusive of increased salaries for providers, increased space for practicing mental health, and scholarship dollars for those that provide it)
- Increased outreach and media to reach veterans in crisis
- Identifying at-risk veterans

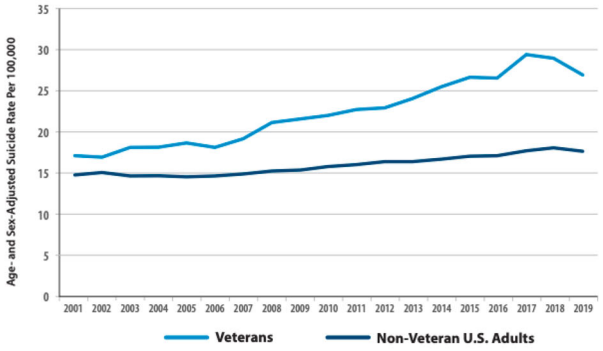
In general, these five bullets articulate the vast majority of legislative bills and laws that Congress has invested nearly $104.1 billion in since 2006.

Bill Number	Year of Passage	Title	Passed into law y/n?	Proposes to increase Access to Mental Health?	Proposes Research?	Proposes increase for mental health practitioners, space, or student loan programs for those practitioners?	Proposes outreach for suicide or mental health?	Proposes ways to identify and isolate at-risk veterans?
HR 327	2007	Joshua Omvig Veterans Suicide Prevention Act	Yes	Yes	Yes	Yes	Yes	Yes
HR 203	2015	Clay Hunt Suicide Prevention for American Veterans Act	Yes	Yes	Yes	Yes	Yes	
S 785	2019	Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019	Yes	Yes	Yes	Yes	Yes	Yes
HR 8247	2020	Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020	Yes	Yes	Yes	Yes	Yes	Yes



Despite a significant increase in funding, suicide numbers have only gotten significantly worse since 9/11. If the mental health industry had the answers, we would have had far better outcomes than what we have today, not just in the veteran population but also in the civilian population.

Figure 3: Age- and Sex-Adjusted Suicide Rates, Veterans and Non-Veteran U.S. Adults, 2001–2019



For these reasons, AMVETS has started opposing bills that fall into the cookie-cutter model that we have all collectively signed off on for two decades: Increase access to mental health models proven to be highly ineffective, increase funding for the practitioners that lead these highly ineffective programs (in jobs and scholarships), throw more dollars at ambiguous research (Despite billions spent, are there any tangible outcomes showing breakthroughs?), and others.

The Opportunity to Recreate the Future of VA

AMVETS is fully aware of the challenges of reorienting a VA system that so many veterans have come to rely on. Sadly had a better system existed veterans currently existing low-lows would have benefited from a more proactive approach had it existed previously. We have to start somewhere because our current policy is misaligned, provides negative incentives, and leads to poor outcomes.

As such, we recommend that Congress create a new office with significant funding, we recommend $1 billion dollars, to be achieved by not providing the casual annual increase to the mental health budget. The office should be given the mission of creating the future goals and vision of a VA that focuses on veterans maintaining their warrior wellness and providing proactive outreach, training, benefits, and services with the intent that they go on to live lives of purpose and meaning while maintaining a state of physical wellness, and understanding the components of living a mentally healthy lifestyle.

Let us imagine a VA that uses technology, such as a digital assistant that would help guide veterans through their transition from military service. Veterans can articulate their goals, learn about VA programs and resources, and receive payment for their gym memberships or active lifestyle choices. They can be notified that they have not conducted their annual physical examination, they can link their digital assistant with a Garmin or Apple watch to conduct a physical wellness assessment, or to monitor key health metrics. VA can check in with the

veterans at key touchpoints to see if they have interest in learning about VA home loans if they have not used them, provide them access to presentations on leadership from significant veterans in the community who can discuss well being, financial success, and their efforts to continue serving our nation. VA can lean more heavily on veterans who have overcome incredible odds and physical and mental barriers, to inspire and connect the veteran community. Let veterans know they are not alone, that to live is to struggle, and that VA is here to help them through tough times, and to help them get to their best days.

Oddly enough, VA is suddenly offering a 15 million dollar grant for a tech product that could theoretically reduce suicide by more than 10%. While the idea is laughable that VA would throw out a grant 1/1000 of its mental health budget and expect larger reductions in suicide than it has ever had with more than 100 billion in funding over two decades, it does mark the need for a significant course correction. If technology is connected with a better overall system focused on veterans becoming the best version of themselves and moving away from the antiquated broken veteran model, we would expect to see significant drops in the overall rate of suicide.

Some of our overarching community goals should be: reducing dependency on disability payments and the system that incentivizes veterans to achieve 100% disability (and incentivizes disability to gain access to other hand-up programs like VR&E), reducing healthcare costs related to poor lifestyle choices, reducing suicide, reducing the use of pharmaceuticals, reducing in-patient mental healthcare, and reducing traditional mental healthcare expenditures.

What can a 270-billion-dollar budget accomplish if its primary goal is to help veterans live high-quality, happy, healthy, financially-secure lives? How can we best spend $29,337 per veteran to assist them in living a great life, a life worth living? That is the answer to the suicide epidemic.

Our VA rewards disability, messages suicide, fails to provide tangible leadership and training for veterans upon their separation from service, fails to articulate and encourage meaningful positive goals, and provides no incentive for physical, mental, and financial readiness.

We need our President and we need congressional leadership and vision to start articulating a better VA; a VA focused on helping veterans reach their full potential and be the warrior-citizens our country deserves.

We have provided additional ideas for Congressional action in Appendix A and legislation that we have supported below in Appendix B.

The Senate Armed Services Committee (SASC) fails our troops via pressure from the Pentagon

AMVETS is extraordinarily displeased that SASC, under the leadership of Senators Jack Reed and James Inhofe, would coordinate with the Pentagon to utilize the conference process to gut meaningful legislation that would increase justice for sexual assault survivors. Perhaps more

consequential, the legislation would have resulted in a strong deterrent that would result in fewer sexual assaults in the future of our military. This is a problem that has plagued our community, and the actions of these few Senators are inexplicable. AMVETS will continue to support Senator Gillibrand's efforts to remove all felony charges from the chain of command's authority. We have included her statement on the situation below, which we fully support:

"As sexual assault survivor advocates warned would happen for months, House and Senate Armed Services leadership have gutted our bipartisan military justice reforms behind closed doors, doing a disservice to our service members and our democracy. Committee leadership has ignored the will of a filibuster-proof majority in the Senate and a majority of the House in order to do the bidding of the Pentagon. This disregards the calls of service members, veterans, and survivors who have fought for an impartial and independent military justice system. Worse yet, DoD successfully undercut Defense Secretary Austin's proclaimed commitment to removing sex crimes from the chain of command and ignored President Biden's public support for removing felonies from the chain of command.

"Despite claims otherwise, the NDAA does not remove the convening authority from military commanders. Removing that authority from commanders is critical. To quote Secretary Austin's own panel, "The DoD Office of the Special Victim Prosecutor structure must be, and must be seen as, independent of the chains of command of the victim and of the accused all the way through the Secretaries of the Military Departments. Anything less will likely be seen as compromising what is designed to be an independent part of the military justice process, thus significantly undermining this recommendation…Finally, because of the breadth and depth of the lack of trust by junior enlisted Service members in commanders, it was determined that the status quo or any variation on the status quo that retained commanders as disposition authorities in sexual harassment, sexual assault, and related cases would fail to offer the change required to restore confidence in the system."

"This bill represents a major setback on behalf of service members, women and survivors in particular. However, we will not stop seeking true military justice reforms for our brave service members and I will continue to call for an up or down floor vote."

-Senator Kirsten Gillibrand

The Charitable Equity for Veterans Act

AMVETS has asked Congress to support a legislative fix that would allow Congressionally-chartered 501(c)(19) non-profit Congressionally-chartered veterans service organizations to receive tax-deductible charitable donations.

The decades-old regulation in Internal Revenue Code section 501(c)(19) is harming our veterans' organizations. The 501(c)(19) non-profit designation is explicitly designated for veterans' service organizations. The key benefits of this designation are tax exemption and the ability to accept tax-deductible donations. However, the current regulation requires 501(c)(19) organizations to maintain a membership of at least 90% wartime veterans to accept tax-deductible contributions.

Forty-five years following the creation of this Vietnam-era regulation, there are 2.4 million veterans who honorably served in our armed forces while our nation was not at war. That

means more than 2.4 million veterans (13%) are not welcome in most veteran organizations, in part because of how they would impact the organization's tax status.

AMVETS is one of two of the "Big 6" Congressionally-chartered veterans service organizations open to all honorably discharged non-wartime veterans. About 38% of our members are not wartime veterans, leaving our 77-year-old organization unable to accept tax-deductible donations. This is especially harmful to our local posts located all over the country. AMVETS is active throughout thousands of communities in every Congressional district. But this antiquated tax code is hampering our efforts and limiting the good we can do in the community.

This year, our 250,000 members call on Congress to modernize the tax code by creating a statute that would allow any Congressionally-chartered 501(c)(19) veterans service organization to be eligible to receive tax-deductible charitable donations. This statutory change would positively affect several veterans' organizations and allow the 13% of veterans who served during peacetime to join those veteran non-profits that open their doors to peacetime veterans.

Supporting this fix would prove that you are committed to leaving no veteran behind - regardless of when or where they served.

VHA National Practice Standards

AMVETS is also closely watching the development of new health care national practice standards at VA. As outlined in a Rule published by the Department late last year, VA intends to establish national standards of practice which will standardize health care professionals' practice in all VA medical facilities. The national standards of practice will describe the tasks and duties that a VA health care professional may perform and may be permitted to undertake. VA believes that creating national practice standards is critical to the success of the new electronic health record (EHR) system being developed in conjunction with the Department of Defense (DoD). To be effective, VA believes it must standardize clinical processes with DoD and ensure that all who practice in a certain health care professions are able to carry out the same duties and tasks irrespective of state requirements. VA has made clear it also believes that agreement upon roles that are consistent with the most restrictive state scope of practice for its health care professionals is not an acceptable option because it will lead to delayed care and consequently decreased access and level of health care for VA beneficiaries.

AMVETS supports the creation of these new national practice standards to aid in the implementation of the new joint VA-DOD EHR system. AMVETS agrees with VA that basing these practice standards on the most restrictive state scope of practice for its health care professionals is not a viable option, as it would lead to decreased access to needed care and reduced health outcomes for our nation's Veterans. AMVETS urges VA to continue working toward utilizing its health care professionals to the full scope of their license, registration, or certification. As such, AMVETS believes these new national practice standards must be inclusive of all health care services that its health care professionals are authorized to provide in any state. Anything short of fully comprehensive practice standards will unnecessarily limit Veteran access to care and negatively impact Veteran access and health outcomes.

Cannabis

The Department of Health of Human Services has positively affirmed the medicinal value of cannabis as antioxidants and neuroprotectants by patenting and licensing cannabinoids, the chemical compounds found in the cannabis plant. The Drug Enforcement Administration currently considers synthetically derived tetrahydrocannabinol (THC), the primary cannabinoid found in the cannabis plant, to be a Schedule III drug that is non-narcotic and has low risk of physical or mental dependence. The Food and Drug Administration has recently argued that cannabidiol (CBD), a non-euphoric cannabinoid, does not meet the requirements for scheduling because of its non-intoxicating and non-toxic nature.

Several studies suggest that where medical and adult-use cannabis is accessible, there is a reduction in opioid prescribing, opioid use, and opioid-related overdose. Cannabis is currently legal and regulated for adult and medicinal use in more than 35 states, representing more than half of the U.S. population, yet veterans have no way to access cannabis through the Department of Veterans Affairs and risk loss of employment or imprisonment for cannabis use in certain circumstances.

We call upon the White House and Congress to fulfill their responsibilities to the nation's veterans by recognizing the inappropriateness of cannabis' current scheduling and removing it from the Controlled Substance Act, by removing the roadblocks to expanding approved cultivation and research and committing all necessary resources to understand the therapeutic potential of cannabis and bringing those derived medications to veterans as quickly as possible.

Conclusion

AMVETS is honored to have this opportunity to present our views and opinions to Congress. We understand that we are proposing some significant changes in moving toward a VA of the future. Additionally, we owe an incredible debt of gratitude to the VA for their efforts as it relates to the pandemic. Our veterans are most grateful, and most have indicated what an incredible job the VA did in administering vaccines and treating the tens of thousands of veterans that were infected. Our thoughts are with those veterans who died as a result of the pandemic, and their families. We know that had it not been for the incredible actions of the VA, many more veterans would have lost their lives. We are grateful.

We look forward to continuing our work this Congress and stand at the ready to continue pressing on the many issues facing our veterans. We will always continue our work to create better policies for the veterans we serve.

National Commander, Greg Heun
Navy veteran Gregory Heun was elected national commander at AMVETS' 76th national convention, which took place in August 2021 in Greensboro, North Carolina.

Commander Heun's journey with AMVETS started in 2002, where he was widely accepted by fellow AMVETS in his community, as well as at the national level. He has risen through the national ranks over the years, serving as a Post Commander, Department Commander, 3rd, 2nd, and 1st National Vice Commander en route to leading our nation's most inclusive Congressionally-chartered veterans service organization.

Commander Heun served in the United States Navy from 1984 – 1991 as an Aviation Structural Mechanic Second Class, serving aboard multiple aircraft carriers and airfields. He has also received notable accommodations from multiple naval captains.

About AMVETS
Today, AMVETS is America's most inclusive congressionally-chartered veterans service organization. Our membership is open to all active-duty, reservists, guardsmen and honorably discharged veterans. Accordingly, members of AMVETS have contributed to the defense of our nation in every conflict since World War II.

Our commitment to these men and women can also be traced to the aftermath of the last World War, when waves of former service members began returning stateside in search of the health, education and employment benefits they earned. Because obtaining these benefits proved difficult for many, veterans savvy at navigating the government bureaucracy began forming local groups to help their peers. As the ranks of our nation's veterans swelled into the millions, it became clear a national organization would be needed. Groups established to serve the veterans of previous wars wouldn't do either; the leaders of this new generation wanted an organization of their own.

With that in mind, 18 delegates, representing nine veterans' clubs, gathered in Kansas City, Missouri and founded The American Veterans of World War II on Dec. 10, 1944. Less than three years later, on July 23, 1947, President Harry S. Truman signed Public Law 216, making AMVETS the first post-World War II organization to be chartered by Congress.

Since then, our congressional charter was amended to admit members from subsequent eras of service. Our organization has also changed over the years, evolving to better serve these more recent generations of veterans and their families. In furtherance of this goal, AMVETS maintains partnerships with other Congressionally chartered veterans' service organizations that round out what's called the "Big Six" coalition. We're also working with newer groups, including Iraq and Afghanistan Veterans of America and The Independence Fund. Moreover, AMVETS recently teamed up with the VA's Office of Suicide Prevention and Mental Health to help stem the epidemic of veterans' suicide. As our organization looks to the future, we do so hand in hand with those who share our commitment to serving the defenders of this nation. We hope the 116th Session of Congress will join in our conviction by casting votes and making policy decisions that protect our veterans.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding federal grants and contracts.
Fiscal Year 2021 - None
Fiscal Year 2020 - None
Fiscal Year 2019 - None
Disclosure of Foreign Payments – None

APPENDIX A

Uncommon policy ideas/approaches that have not been attempted, introduced, or passed into law over the past two decades:

- An impactful hearing that includes new voices tackling mental health who can help inform new possibilities in your draft legislation. The committee has been guided by the mental health and pharmaceutical industries for far too long, which have failed to provide meaningful outcomes via their policy recommendations. Instead, we recommend hearing the voices of those working on alternative approaches at the ground level, such as Boulder Crest Retreat, Sheep Dog Impact Assistance, Big Red Barn Retreat, Camp Southern Ground, and the Permission to Start Dreaming Foundation. Additionally, we recommend including the authors of the recent JAMA reports highlighting VA program ineffectiveness, the authors of the Clay Hunt SAV Act reports, and individuals who researched alternative models being influential in the non-profit space. If we don't fully embrace and understand what is working well, what is not working, and what is kind of working, we will be unable to start charting effective models moving forward. More voices are needed.
- There is no longitudinal data measuring outcomes related to veterans that partake in existing programs and services. I.E. Do these programs and services have any meaningful long-term impact on veterans' quality of life? For example, data from the Clay Hunt SAV act reports, and JAMA articles, are concerning in the short term, yet there is no longitudinal data despite all of the funding for research.
- There is no research on VA programs and services' extraordinarily high dropout rates. Why do most veterans simply drop out of VA programs and services? Where do they go? What happens to those veterans? No one knows…
- There are nearly no investments in proactive training for servicemembers and veterans to learn about the core concepts of what it takes to maintain a status of being mentally healthy. The antidote to suicide is not a public health model combatting suicide; it's helping veterans live lives worth living with purpose and meaning. Instead, we are spending the vast majority of our funds in a non-proactive manner.
- The total investment in new and novel approaches for mental health totals .25% of the overall budget; we simply need more invested in promising programs, policies, and services. As we did last year, AMVETS recommends spending the entirety of any proposed budget increase for VA Mental Health on a VA/DOD Mental Health Center for Innovation. Any mental health increase in the budget should not be used as additional funding for approaches that fail far too many veterans, far too often, or for increasing access to those treatments. Instead, we should use this funding as an investment to incubate, test, and scale approaches that are proving to be effective. The majority of this funding should be allocated to fund alternative, novel, and non-pharmacological methods such as Post Traumatic Growth, recreational therapy, yoga, and others that VA has not fully embraced, tried, or tested.
- Lastly, our messaging to veterans is poor. We are telling veterans they are suicidal and broken. We want VA to reconsider its messaging to reflect what we want veterans to feel and act like. There is significant room for improvement on this front.

APPENDIX B
Legislation that AMVETS has publicly supported in the 117th Congress:

House of Representatives:

HR 475 Health Care Fairness for Military Families Act of 2021

HR 617 No Coronavirus Copays for Veterans Act

HR 781 Veterans' Telecommunication Protection Act

HR 845 VA Billing Accountability Act

HR 958 Protecting Moms Who Served Act

HR 1022 PAWS Act

HR 1276 VA VACCINE Act

HR 1281 To name the Department of Veterans Affairs community-based outpatient clinic in Gaylord, Michigan, as the "Navy Corpsman Steve Andrews Department of Veterans Affairs Health Care Clinic".

HR 1476 PFC Joseph P. Dwyer Peer Support Program Act

HR 2326 Veterans Cyber Risk Awareness Act

HR 2591 DUMP Opioids Act

HR 2634 To designate the Mental Health Residential Rehabilitation Treatment Facility Expansion of the Department of Veterans Affairs Alvin C. York Medical Center in Murfreesboro, Tennessee, as the "Sergeant John Toombs Residential Rehabilitation Treatment Facility".

H.R. 2789 To direct the Secretary of Veterans Affairs to administer a pilot program to employ veterans in positions that relate to conservation and resource management activities.

HR 2800 The Wingman Act

HR 3512 Healthcare For Our Troops Act

HR 3888 CHIP IN for Veterans Act

HR 4471 Improving Veterans Access to Congressional Services Act

HR 4571 Supporting Expanded Review for Veterans in Combat Environments (SERVICE) Act

HR 4732 Protecting Benefits for Disabled Veterans Act of 2021

HR 4831 Charitable Equity for Veterans Act

HR 5483 The Inform VETS Act

HR 5509 Student Veteran COVID-19 Protections of 2021

HR 5776 Serving Our LGBTQ Veterans Act

HR 5819 Autonomy for Disabled Veterans Act

HR 5901 Veterans Education is Timeless Act

HR 6227 Military Dependents School Meal Eligibility Act

HR 6307 Tiny Homes for Homeless Veterans Act

HR 6464 Hear our Heroes Act of 2022

HR 6672 - VSO Support Act of 2022

United States Senate:

S 189 Veterans' Disability Compensation Automatic COLA Act

S 194 SERVE Act

S 344 Major Richard Star Act

S 458 Veterans Claim Transparency Act

S 1147 Retired Pay Restoration Act

S 1183 Veterans Medical Marijuana Safe Harbor Act

S 1467 VA Medicinal Cannabis Research Act

S 1520 Military Justice Improvement and Increasing Prevention Act

S 1607 Student Veterans Transparency and Protection Act of 2021

S 1875 Veterans Emergency Care Claims Parity Act

S 1915 ACE Veterans Act

S 1944 Vet Center Improvement Act of 2021

S 1972 Health Care Fairness for Military Families Act

S 2530 Charitable Equity for Veterans Act

S 3017 Veterans Dental Care Eligibility Expansion and Enhancement Act

S 3025 Servicemembers and Veterans Empowerment and Support Act of 2021

S 3047 Veterans Pro Bono Corps Act of 2021

S 3163 RURAL Exams Act

S 3388 Veterans Benefits Improvement Act of 2021

Testimony of the

NATIONAL COALITION
for **HOMELESS VETERANS**

United States Senate & House of Representatives
Committees on Veterans' Affairs

"Legislative Presentation of The National Coalition for Homeless Veterans"

March 2, 2022

Chairs Tester & Takano, Ranking Members Moran & Bost, and distinguished Members of the Committees on Veterans' Affairs:

On behalf of our Board of Directors and Members across the country, thank you for the opportunity to share the views of the National Coalition for Homeless Veterans (NCHV) with you. NCHV is the resource and technical assistance center for a national network of community-based service providers and local, state and federal agencies that provide emergency, transitional, and supportive housing, food, health services, job training and placement assistance, legal aid and case management support for thousands of homeless, at-risk, and formerly homeless veterans each year.

We are committed to working with our network and partners across the country to end homelessness among veterans. We thank you for your leadership and continuing efforts to focus on the needs of veterans experiencing or at-risk of homelessness, as Congress put forth COVID relief legislation in the *Coronavirus Aid, Relief, and Economic Security Act* or CARES Act, P.L. 116-136 and in Public Law 116-315, *the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020 (Isakson/Roe)*. The assistance Congress provided has resulted in over $1.456 billion in new resources being distributed to organizations across the country to keep veterans safe from COVID by decongesting shelter spaces, ramping up rapid rehousing capacity, and focusing on individualized housing options in hotels and motels.

While HUD has recently released 2021 Point-in-Time Count data that showed a drop of 10% in the sheltered veteran population, that data is not inclusive of the entire system of care for veterans. Despite these gaps, NCHV remains cautiously optimistic. We know preceding the pandemic veteran homelessness decreased by 50% between 2010 and 2019. Homelessness was once again prioritized last year at the Department of Veterans Affairs (VA). It has become clear that we are making progress again and that we must maintain and enhance efforts to end homelessness. We can do this while simultaneously recalibrating them to respond to the urgent economic crisis COVID has created and the inequities that certain veteran groups continue to face.

The COVID-19 pandemic has impacted veterans in unprecedented ways, including by increasing housing and financial instability. VA has notified grantees that the Department of Health and Human Services' public health emergency could be lifted as early as this upcoming April with numbers of veterans still on the verge of homelessness. With many provisions in the *Isakson/Roe* bill tied to a declared state of emergency, NCHV has identified some program adaptations that should be kept as best practices. Some enhancements can be retained at very minimal expense, for example, extending the *Section 4201* spending flexibility for Supportive Service for Veterans and Families (SSVF) grantees would be essential. The ability to rapidly rehouse veterans into active hotels and motels to enable VA time to place a veteran in more permanent housing has become a model to be continued. VA should also allow service providers to continue to decongregate essential transitional housing capacity via capital grants.

Congress and the Centers for Disease Control recognized that homelessness makes both veterans, and the general population at large, more vulnerable to exposure to and transmission of highly communicable conditions like COVID-19. And as the largest health care system in the country, VA has been in a unique position leading the way for the country in testing, treatment access, and outcomes. The impending end of the pandemic designation is causing uncertainty among organizations serving veterans. We must take that into consideration as we move forward to ensure veterans can access a system of care that adapts to their needs in a post-COVID world.

During the emergency, providers of transitional housing were finally able to request reimbursement from VA for closer to the actual cost of sheltering a veteran. At the sunset of the declared emergency, this rate will be cut by over 60 percent. Many entities that are currently providing services for veterans will be unable to continue doing so. Service providers for programs like VA's Grant and Per Diem Program must justify all expenses and submit them to VA for approval at the end of the program year to even receive program funds. This is not a request for an across-the-board rate increase, as VA only ever pays for veterans actively receiving services. Congress would be letting service providers have the option of trying to justify the full cost of sheltering a veteran. This issue is taken up as a provision in Chairman Tester's bill, S. 2172.

The National Coalition for Homeless Veterans (NCHV), and over 60 organizations urge you to support one bill in particular, S. 2172, the *Building Solutions for Veterans Experiencing Homelessness Act of 2021*. The bill would preserve and enhance direly needed COVID-19-related program improvements from both CARES and Isakson/Roe. Without a legislative fix, additional VA grantees will be forced to make the tough financial decision others have related to prioritizing COVID safety measures at a financial loss, returning to pre-COVID program occupancy levels, or discontinuing essential shelter and treatment program operations altogether. The bill would reduce the regulatory burden on funding for renovation of shelter for all veterans experiencing homelessness and provide organizations nationwide with the funding and flexibility to provide adequate services to unhoused veterans. Every veteran deserves access to safe shelter and housing, whether they are currently experiencing homelessness or are facing housing-cost burdens that put them at risk of homelessness.

We have a renewed opportunity to continue reducing veteran homelessness nationwide, even with the impacts of the COVID-19 pandemic. There are other provisions in S. 2172 that are critical to our ability to address veteran homelessness. The bill would allow the Department of Veterans Affairs (VA) to provide adequate training and technical assistance for its homeless programs and enhance veterans' access to case management services to connect them with the benefits and resources they earned. It would also recognize the impact of the Homeless Veterans' Reintegration Program (HVRP) in connecting veterans with long-term, meaningful jobs. Reporting has shown there is tangible value added by HVRP in increasing the effectiveness, efficiency, and veteran outcomes of partnered programs.

Aging and Rural Veterans

Aging veterans and rural veteran populations have become an important intersection in the discussion of improving services, access and information dissemination for some of the most remote and inaccessible veterans. We must look at how programs communicate and interact with each other. NCHV recommends authorizing HUD-VASH with a grant making capability, where homeless service providers can provide enhanced aftercare services where elderly individuals may be on a wait list between programs, or to waiting to utilize a voucher, and providers would be able to accommodate these higher acuity aging veterans with access to funds for the necessary medical staff. With the passage of P.L. 116-315, VA has new authority to improve services across the board by providing communication, transportation as well as safety and survival necessities.

COVID-19 Crisis & Recovery

Presented with a good number of issues at the pandemic's outset, VA and its grantees have risen to the challenges to date. VA must continue to address veteran homelessness within the greater scale of the COVID-19 response, timely disseminating funding to grantees. VA must also get out timely information to community partners, especially regarding expansions of eligibility with extremely hard to contact populations. Approximately 15 percent of the veterans experiencing homelessness have other-than-honorable discharges, and in some urban communities that percentage rises as high as 30 percent. We acknowledge the intricacies of the intertwined health care systems, yet a year has passed, and every month without official guidance is another month an eligible veteran is deprived the benefit of a roof over their head.

We encourage collaborative Federal efforts to identify ways to efficiently serve veterans experiencing homelessness. As our country moves out of a crisis response phase and into a COVID recovery phase, we have the opportunity to focus on permanent housing as communities wind down COVID hotel and motel operations. One way to do that would be to appropriate case management funding to VA to fully utilize HUD-VASH vouchers for which funds have already been appropriated to HUD. Some communities are purchasing hotels and motels for conversion. Funding to renovate them, paired with project-based vouchers for operating funds could be a mechanism to increase the availability of affordable housing more rapidly than traditional affordable housing development timelines allow. There is absolutely no reason any veterans in motel/hotel placements temporarily should be exited back into homelessness at the end of the pandemic.

NCHV anticipates the economic recovery will take time, and payments made for rent in arrears could move veterans off assistance before they have stabilized. Re-Employment and re-integration efforts will be crucial to stabilize an anticipated influx of unemployed veterans through an expanded Homeless Veteran Reintegration Program through 2023. There will be a deepening economic crisis when unemployment benefits sunset. Similarly, sunset of the eviction and moratoria leaves veterans without a critical layer of protection against housing instability. Nearly 15 million Americans have accrued over $50 billion in missed rental payments. They will immediately be added to the "at-risk" category of homelessness if unable to access emergency rent assistance or other homelessness prevention funding.

Funding Recommendations for Fiscal Year 23'

NCHV recommendations are for appropriations in addition to program authorizations necessary for homeless veteran programs to function for the remaining balance of FY'22 and for FY'23 and considering passed and proposed program needs. NCHV estimates a total need in excess of $884 million, including $50 million for DOL's HVRP program and $100 million for HUD to provide new HUD-VASH voucher utilization capabilities to expand access to permanent housing in a recovery.

Calculations are made based upon current VA program spending rates in the first two years of this concerted effort and the ability of departments to spend current funds through 2023. From the outset of the pandemic and initial shutdowns in March of 2020, over the course of two years Congress has appropriated an additional $1.456 billion for VA's Homeless Program's office. Considering that VA spent over a billion dollars over the past year on rapidly rehousing veterans alone, as a bipartisan effort of the Country, NCHV recommends continued support at current funding levels to ensure that sufficient support for housing unstable veterans is available, even as other Federal, State, and Local pandemic-related supports for the general population are expended.

VA

a. **Health Care for Homeless Veterans Program (HCHV) - $50 million increase and reauthorization for** temporary housing for homeless vets to reduce social distancing and to increase PPE availability for VA staff, outreach, and surveillance of homeless encampments during the crisis and recovery period. The program currently does not serve veterans with an "other than honorable" discharge status. Due to the importance of this program, we request that Congress expand its eligibility criteria to include veterans with OTH discharges, and Guard and Reserve members who may not have been federally-activated.

b. **Supportive Services for Veteran Families (SSVF) $400 million increase and reauthorization** to provide flexible assistance targeted at keeping vulnerable vets in safe situations, addressing rental and other eligible arrears, and implement the shallow subsidies expansion. The program spent over a billion dollars during the pandemic getting veterans off the street and into hotels and motels while they found more permanent housing. This temporary increase would cement gains made in veteran homelessness during the pandemic.

c. **$230 million increase for the Grant and Per Diem Program (GPD) & Special Needs Reauthorization** to maintain an increase to the daily rate since social distancing has affected maximum occupancies and operating costs during the crisis and recovery period. This funding would also allow for two additional rounds of larger scale capital grants that are needed to extend the capabilities of service providers beyond the duration of the crisis.

d. **$54 million increase for the Housing and Urban Development – Veterans Affairs Supportive Housing (HUD-VASH) Program** for VA to provide additional VA or community contracted case managers**.** To increase the quality of services and increase voucher utilization and decrease case manager loads, increasing retention and rapport building capabilities.

HUD

$100 million increase for HUD-VASH to increase the recovery capacity of communities to move veterans from motel/hotel placements into permanent housing rather than releasing them back to the streets.

i. $40M for HUD to provide 5,000 new Project Based Vouchers, that are not counted against PHA utilization rates and caps on project-basing of vouchers.
ii. $55M for HUD to provide for new Public Housing Authority incentives.
iii. 5M for Tribal HUD-VASH

DOL

$50 million increase for DOL's Homeless Veteran Reintegration Program (HVRP) and reauthorization through FY'24 aimed at helping at-risk veterans due to pandemic-related job loss. The program is looking to continue to expand access nationwide.

NCHV appreciates every dollar Congress has allocated to ending veteran homelessness and we also recognize the need to fund these obvious program improvements for the next year and beyond. Our collective mission is to not only reduce, but end veteran homelessness finally.

In Summation

Thank you for the opportunity to submit this testimony for the record and for your continued interest in ending veteran homelessness. It is a privilege to work with all of you to ensure that every veteran facing a housing crisis has access to safe, decent, and affordable housing paired with the support services needed to remain stably housed. We remain in a state of emergency and veterans experiencing and at-risk of homelessness need continued safe housing now more than ever. We thank you for your attention as we work collectively to lessen the impact that COVID-19 continues to have on veterans experiencing or at-risk of homelessness.

Appendix A

Active Legislation

S. 2172 - NCHV supports this critical legislation that makes necessary program adjustments to better accommodate homeless veterans with difficulties accessing services, as requested by *both* VA and service providers. It would expand public transportation for veterans to access care, provide stable housing, and deliver appropriate medical care for aging veterans while they await long-term care placement. Emphasizing continuous improvement, the bill includes an assessment of remaining barriers to securing permanent housing and longer-term program reporting to refine veteran housing outcomes.

S. 3094 - NCHV supports extending access to the HVRP program. NCHV recognizes this will increase the cost of the program, but these should be weighed against the cost benefits incurred by programs pairing HVRP employment services with their housing programs.

H.R. 5025 – NCHV supports this bill which would increase and extend the authorization of appropriations for homeless veterans' reintegration programs

H.R. 5301 – NCHV supports the provision of technical assistance to recipients of grants for supportive services for very low-income families in permanent housing and comprehensive service programs, and for other purposes.

H.R. 5470 – NCHV supports the *HOMES for our Veterans Act of 2021.* The bill would improve grants awarded by the Secretary of Veterans Affairs for comprehensive service programs to serve homeless veterans. It would remove barriers to continuing to provide veterans services, for service providers that have successfully serviced the veteran population originally requested in their contracts and whose community needs have changed.

H.R. 5606 – NCHV supports the *Return Home to Housing Act.* This bill is the stand-alone adjustment to the rate of per diem payments provided by the Secretary of Veterans Affairs to grantees that provide services to homeless veterans.

H.R. 5783 - NCHV supports extending access to the HVRP program. NCHV recognizes this will increase the cost of the program but these should be weighed against the cost benefits incurred by programs pairing HVRP employment services with their housing programs.

WRITTEN STATEMENT OF THE SERVICE WOMEN'S ACTION NETWORK (SWAN)

Before The Joint Senate and House Committees on Veterans Affairs

Hearing on Legislative Priorities

2nd Session 117th Congress

March 2, 2022

Presented By: Lory Manning, Director of Government Operations at Service Women's Action Network (SWAN)

Service Women's Action Network

Introduction

The Service Women's Action Network (SWAN) thanks the Senate and the House of Representatives Veterans Affairs Committees for the opportunity to present our legislative goals for the 2nd Session of the 117th Congress. We deeply appreciate your splendid, bipartisan work on behalf of veterans during the 1st Session of this Congress in what was a difficult year for so many. As we begin the 2nd Session of the 117th Congress, we look forward to continuing our work with the members of the Veterans Affairs Committees of both Houses.

SWAN, founded in 2008, is a national, nonpartisan, not-for-profit, member-driven community network advocating for the individual and collective needs of currently serving women and women veterans of all eras. Over the years, SWAN has played a major role in opening all military jobs to qualified women, holding military offenders accountable for sexual misconduct under the military justice system, supporting all survivors of military sexual trauma (MST), bringing about changes in the disability claims system to better help MST survivors, and expanding access to a broader range of primary, reproductive, and mental-wellness services for military women.

SWAN's Legislative Goals for Women Veterans in 2022

- **Eliminate sexual assault and harassment at VA facilitie**s. All women veterans must feel safe, welcome, and well-cared for when visiting Department of Veterans Affairs (DVA) facilities.
- **Fix the Veterans Benefits Administration's (VBA) broken system for processing disability compensation claims tied to MST**.
- **Reform DBA's Character of Discharge (COD) Determination Process** to include transparency and standardization across VBA Regional Offices.
- **Toxic exposures and Women Veterans**: Ensure upcoming burn pit and toxic exposure studies examine the effect of such exposures on the development of breast cancer and infertility in women and men. Make mammograms regularly, routinely, and easily available for veterans.
- **Reproductive Healthcare**: 1.) Eliminate copays for contraceptives. 2.) Widen access to service-connected IVF treatment.

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- **Arlington National Cemetery (NC) Internments**: Designate a second national cemetery for rendering full-military-honors interments.

Eliminate Sexual Assault and Harassment at VA Facilities: Ensure all women veterans feel safe, welcome, and well-cared for when visiting DVA facilities.

In the past years, DVA and Congress have made hard-won improvements in the quality and comprehensiveness of women's healthcare and their access to other VA programs, but all that improvement and investment is for naught if women encounter barriers when trying to use this healthcare or access other veterans' benefits, they have earned.

For too many years, too many women veterans have been left in the lurch when trying to report they were sexually harassed or assaulted at VA facilities. A study[1] released in 2019 sampled women veterans at 12 VA Medical Centers and found that one in four women veterans reported receiving catcalls, propositions, and derogatory comments about their military service from male veterans. A New York Times story, also from 2019, recounts how "an entrenched, sexist culture at many Veterans Hospitals is driving away female veterans".[2] In 2020, instead of dealing with a report of sexual misconduct at a VHA Medical Center, the then Secretary of Veterans Affairs attacked the reputation of the Navy veteran—who was a staff member of the House Veterans Affairs Committee—after she reported that she was sexually assaulted at a VA Medical Center.[3]

These reports shook women veterans and their advocates deeply. Both Congress and the DVA are engaged in efforts to bring about the needed culture changes. However, as the most recent report of the

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[1] Klap, R. Darling, J.E. Hamilton, et al. "*Prevalence of Stranger Harassment at VA Medical Centers and Impacts on Delayed and Missed Care,*" Women's Health Issues, Jacobs Institute of Women's Health, Apr 2019. (http://whijournal.com/article/S-1049-3867(18)30194-4/fulltext).

[2] Steinhauer, Jennifer. *"Treated Like a Piece of Meat: Female Veterans Endure Harassment at the VA"*, New York Times, March 12, 2019.

[3] Shane, Leo, "*House Chair Calls for VA Secretary to Resign Over Handling of Sexual Assault Case",* Military Times, Dec 10, 2020.

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Women Veterans Advisory Committee documents, the problems persist.[4] Among the latest Congressional and DVA initiatives are the implementation of the programs and reports required by *P.L. 116-315 the Johnny Isaksen and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act*—which incorporates the provisions of the *Deborah Sampson Act*—aimed at bettering women's experiences at DVA facilities. Additionally, DVA has initiated a number of in-house programs to bring about the needed cultural transformation such as the White Ribbon Pledge, the Secretary's Sexual Harassment Working Group, and VHA's Stand Up to Stop Harassment Now! Declaration. It should be noted that DVA also participated with the Department of Defense in the Individual Review

Commission on Military Sexual Misconduct[5] ordered by President Biden.

SWAN Recommendations: We deeply appreciate the emphasis and effort both Congress and DVA are making to transform VA's culture so that women, members of racial and ethnic minorities and LGBT+ veterans are welcome and respected at all DVA facilities. We recommend that Congress and DVA leadership follow-up on these efforts 1.) By holding a hearing later this year to assess progress to date; 2.) By requesting a GAO Report on the successes and failures of current efforts to eliminate sexual harassment and assault of veterans using DVA facilities; 3.) By establishing standardized procedures for submitting and responding to reports of sexual assault and harassment made by veterans using all DVA facilities; and 4.) By establishing a central database for the collecting and tracking all such reports.

Fix VBA's broken system for processing disability compensation claims tied to Military Sexual Trauma (MST)

Women veterans not only face continuing sexual assault and harassment while seeking care at Veterans Health Administration (VHA) facilities, they and male survivors of MST must also contend with the years-long failure of the VBA to follow Congressional law and DVA guidance when processing and

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[4] 2020 Report of the Department of the Department of Veterans Affairs Advisory Committee on Women Veterans, September 2020.

[5] Hard Truths and the Duty to Change: Recommendations from the Independent Review Commission on Sexual Assault in the Military, July 2021.

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adjudicating claims for compensation for service-connected disabilities arising from MST. A report released last August by the DVA Office of the Inspector General (OIG) states that 57% of rejected claims for MST were improperly denied.[6] This long-standing problem has been worsened by the outsourcing of more claims work to civilian contractors. Judging by the number of Congressional Hearings as well as GAO and DVA OIG reports on this matter, this process has been broken for at least a decade–see a selection of these reports below.[7]

SWAN's Recommendation: SWAN strongly supports the passage of the *Servicemembers and Veterans Empowerment and Support Act of 2021* (S.3025) (H.R. 5666) introduced into both the House of Representatives and the Senate in October 2021.

Reform DBA's Character of Discharge (COD) determination process to include transparency and standardization across VBA Regional Offices

Access to veteran's benefits is not automatic. Veterans must have an honorable discharge to use GI Bill benefits and a discharge "under honorable conditions" to access most other benefits. Over the years, many veterans suffering from PTSD and other mental health issues related to combat or MST—and also LGBT+ veterans— were discharged under "Other Than Honorable" conditions and were unfairly denied the benefits they earned.[8] Congress has changed the requirements for the composition and procedures of the Services' Discharge Boards, Discharge Review Boards and Boards for the Correction of Military

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[6] "VA OIG: "Improvement Still Needed in Processing MST Claims" Report #20-00041-163, August 5, 2021.

[7] GAO Report 14-477 "MST: Improvements Made, but VA Can Do More to Track and Improve Consistency of Disability Claims Decisions," June 2014. GAO Report-21-444T "VA Exams: Better Planning Needed as Use of Government Contractors Continues to Grow," March 2021. VA OIG:" VBA Denied Posttraumatic Stress Claims Related to MST" Report 17-05248-241, August 2018. Hearing before the Subcommittee on Disability Assistance and Memorial Affairs, HVAC, on "Ensuring Access to Disability Benefits for Veteran Survivors of MST", June 20, 2019. Hearing before the Subcommittee on Disability Assistance and Memorial Affairs, HVAC, "Supporting Survivors: Assessing VA's MST Programs," Nov 17, 2021.

[8] Human Rights Watch. "Booted: Lack of Recourse for Wrongfully Discharged US Military Rape Survivors," May 19, 2016. Ali R. Tayyeb and Jennifer Greenburg. "Bad Paper:" The Costs of War for Excluded Veterans," Watson Institutes Brown University, June 20, 2017. Maureen Siedor. Swords to Plowshares Testimony before the Subcommittee on Disability Assistance and Memorial Affairs, HVAC, July 8, 2020.

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Records to avoid unfair "OTH" discharges in the future. To remedy past mistakes, both DoD and VA have conducted outreach to veterans who may now be eligible for a discharge upgrade and the access to VA benefits that would accompany it. However, most Service Discharge Review Boards are experiencing backlogs of months to over a year in processing these discharge reviews delaying veterans access to their earned benefits. Most veterans are unaware that, in the meantime, they can apply directly to VA for those benefits which will trigger a COD determination by the VBA. If granted, the veteran will become eligible for earned benefits immediately. The scanty statistics I've come across on the COD determination process indicate VBA seldom decides in the veteran's favor. But I think that with help from Congress, CODs can become useful for veterans with erroneously awarded OTH and Bad Conduct Discharges (BCD). This would require Congress and the DVA to clarify the vague statutory and regulatory language underlying COD determinations, to standardize COD procedures and transparency across all VBA Regions, to train the COD adjudicators; and to conduct outreach to the public aimed at reaching veterans of all eras who are not users of DVA benefits.

SWAN's Recommendations: 1.) Mandate a GAO study on the current administration of COD determinations across the VBA. The study should examine COD procedures and training at all Regional Offices and gather available data on denial and approval rates across Regional Offices. 2.) SWAN supports passage of the *Unlawful Turn-Aways Act* (H.R. 5321) (S. 2786).

Toxic exposures and Women Veterans: As Congress, DoD, DVA and the American public turn their attention to the grievous damage toxic exposures from burn pits and other sources have caused to veterans of the Post 9/11 wars, SWAN strongly believes planned studies of these damages must include data collection on linkages between such exposures and the development of breast cancer and infertility in both women and men. Although women are the fastest growing portion of the veteran's population, they comprise less than 10% of current users of VA healthcare so there is a possibility of researchers overlooking cancers that mainly affect women for consideration as "presumptive for service-connection."

VHA follows the American Cancer Society's breast cancer screening guidelines which recommend beginning routine mammograms at age 45 or at 40 if family history warrants; but VA can also provide

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mammograms for younger veterans when appropriate. In light of research suggesting that there may be a higher rate of breast cancer among younger women veterans than among their civilian counterparts,[9] SWAN believes there is a need to communicate to younger veterans that they can request mammograms if they are concerned about service-connected toxic exposures or for other reasons.

SWAN Recommendations: 1.) Include breast cancer and infertility in studies of the effects of burn pits and other toxic exposures on service members. 2.) SWAN strongly supports the passage of the *Making Mammography and Medical Options for Veterans Act* (H.R. 4794) (S. 2533). We particularly applaud the provisions of this bill which making access to mammogram services for paralyzed, other disabled veterans and those who live in underserved areas easier.

Reproductive Healthcare: 1.) Eliminate copays for contraceptives; 2.) Widen access to service-connected IVF treatment.

1.) Eliminate Contraceptive Copays: The Affordable Care Act (ACA) requires most private health plans to cover all FDA-approved birth control methods for women without cost sharing. However, the provisions of the ACA do not extend to healthcare provided by the Department of Veterans Affairs. Thus, while contraception for most women in this country is fully covered by their health insurance, most women veterans are still required to make copays for contraceptives.[10] Even small copays can be prohibitive for those struggling to make ends meet. It is disgraceful that unlike most other women in this country, women veterans are subject to contraceptive copays. To remedy this, the House of Representatives passed the *Equal Access to Contraception for Veterans Act* in June (H.R. 239). The Senate has yet to pass it.

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[9] "Women with Breast Cancer in VHA: Demographics, Breast Cancer Characteristics and Trends," (pubmed.ncbi.nlm.nih.gov). Yuen-Hee Anna Park, MD, Allison Keller, MS, et.al."Screening High Risk Women Veterans for Breast Cancer" (pubmed.ncbi.nlm.nih.gov). Kate Hendricks Thomas. "The Enemy is Lurking in Our Bodies," Warhorse, Oct 14, 2021. Rajeev Samant, Proposal Submission to DVA Project Number 2I01BX003374-05 Public Health Relevance Statement. VA contract awarded Feb 05, 2021.

[10] Under the VHA formulary, drug copays currently range from $5 - $11 per month depending on which of three tiers the drug falls under.

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2.) **Widen access to service-connected IVF treatments**: In 2016, pursuant to a provision attached to the annual Appropriations bill—and included every year since then—the Veterans Health Administration (VHA) began funding IVF for a narrow segment of veterans with service-connected infertility. To be eligible, these veterans had to be legally married, the spouses had to produce the needed gametes and the female spouse had to receive the implanted embryo.[11] The VHA's eligibility requirements deliberately mirrored those used by the DoD when it began providing IVF for service-connected infertility under TRICARE in 2012.[12] These regulatory restrictions remain in effect today. Thus, IVF treatments for service-connected infertility for both active-duty members and veterans are limited to legally married, heterosexual couples able to produce their own gametes with a female spouse able to receive the implanted embryo. Candidates who are single, in same-sex marriages, or who require donor sperm and/or eggs or surrogacy services are not eligible. SWAN is grateful that IVF services are available to at least a segment of the veterans' population experiencing service-connected infertility; but, in fairness, these services should be available to all with service-connected infertility.

SWN Recommendation: SWAN strongly recommends that DoD eliminate the restrictions placed on IVF services in 2012 and that their linkage to IVF services provided by VHA be dissolved so that all active-duty members and veterans with service-connected infertility can receive IVF.

Arlington National Cemetery (ANC) Interments

P.L.115-232 *The John S. McCain National Defense Act of 2019 Sec. 598* directed the Secretary of the Army in consultation with the Secretary of Defense to revise the criteria for in-ground burial—interment—at ANC. Under current interment criteria, ANC is expected to reach full capacity in 30 years or so. The goal of revising interment criteria is to ensure space at ANC will be available into the far future defined as 150 years. Under current criteria those eligible for interment include retired members

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[11] 82 Fed Reg. 6273 (Jan 19, 2017).

[12] DoD Implementation Guidance Memorandum: Policy for Assisted Reproductive Services for the Benefit of Seriously Ill/Injured (Category II or III) Active-Duty Service Members (ADSMs) 3 (2012). https://www.sart.org/globalassets/asrm/asrm-content/news-and-publications/news-and-research/press-releases-and-bulletins.pdf/dod_policy_guidance.pdf

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of the military receiving retirement pay and those who die while on active duty other-than-for-training. A proposed rule setting forth changes to current ANC burial criteria has appeared in the Federal Register[13] and the final rule is expected to be published in the Federal Register shortly. Under the proposed rule, interment would be limited to POWs; recipients of awards for combat valor at the Silver Star and above level; recipients of the Purple Heart; those on active duty who died while preparing for operations related to combat; U.S. Presidents and Vice Presidents; and veterans with armed conflict service who later served in significant government positions.

Unlike interment at other national and state veterans' cemeteries, interment at ANC includes the rendering of full military honors. The prospective revocation of this long-promised benefit—a great comfort to family members—affects certain groups in particular: 1.) A great number of Cold War veterans—whose final directives express their desire to be buried at ANC; 2.) Most service women;[14] and 3.) Some high-achieving veterans such as astronauts and others who engaged in pioneering and dangerous non-combat operations.

SWAN Recommendation: SWAN recommends that interment at a National Cemetery with full military honors remain a benefit for all eligible under current criteria. This can be accomplished by designating an existing National Veterans Cemetery as a site for the rendering of full military honors for those eligible.

Conclusion: SWAN supports most of the legislative goals of the VSOs that have testified before the House and Senate Veterans Committees at this year's hearings. We also deeply appreciate the opportunity to present key legislative goals specific to women veterans—who comprise the fastest

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[13] Federal Register 09/15/2020 "Army Cemeteries" FR document 2020-17801 Citation 85 FR 57640.

[14] Women were excluded from all combat occupations and assignments until the early 90s when most combatant ships and aircraft were opened to them by Congress. In 2016, the Secretary of Defense opened all ground combat positions to qualified women. The combat requirements under the proposed rule eliminate most women from interment at ANC. Those who would remain eligible include four living POWs, two recipients of The Silver Star and recipients of The Purple Heart as a result of terrorist attacks, service in the Gulf War or the Post 9/11 wars.

growing demographic group within the veteran's community. We look forward to working with both Committees to further these goals throughout 2022.

Service Women's Action Network
441 4th St NW, Suite 707N
Washington, DC 2001
www.servicewomen.org

BLINDED VETERANS ASSOCIATION
SERVING BLINDED VETERANS SINCE WORLD WAR II

TESTIMONY
PRESENTED BY

Joseph D. McNeil, Sr.
BVA NATIONAL PRESIDENT

BEFORE A JOINT SESSION OF THE
HOUSE AND SENATE COMMITTEES
ON VETERANS AFFAIRS

MARCH 2, 2022

INTRODUCTION

Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and distinguished Members of the Committees on Veterans Affairs, on behalf of the Blinded Veterans Association (BVA) and its membership, we appreciate this opportunity to present our legislative priorities for 2022. As the only congressionally chartered Veterans Service Organization (VSO) exclusively dedicated to serving the needs of our nation's blinded veterans and their families, BVA first wishes to highlight "National Blinded Veterans Day," which occurs March 28. The day coincides with the 77th anniversary of the organization's founding by World War II blinded Army service members at Avon Old Farms Convalescent Hospital in Connecticut in 1945.

BVA hopes that this second session of the 117th Congress will proactively address the following legislative priorities:

I. Oversight of VA 508 Compliance
II. Caregiver Benefits for Catastrophically Disabled Blinded Veterans
III. Renewable VA Auto Grant for Service-Connected Blinded Veterans
IV. Support adequate funding of Veterans Health Administration Blind Rehabilitation Service
V. Defense Health Agency (DHA)-Blind Rehabilitation Service (BRS) Continuum of Care
VI. Support the continued improvement of programs and services for Women Veterans
VII. Request the enactment of adequate protections for guide dogs and service dogs on federal properties
VIII. Support the VA FY23 Budget request for Prosthetics and Sensory Aids

I. OVERSIGHT OF VA 508 COMPLIANCE

BVA thanks Congress for its continued support of our nation's blind and visually impaired veterans, demonstrated most by the passage of S. 3587, the *VA Website Accessibility Act of 2019*. This bipartisan legislation directed VA to report to Congress on the accessibility of VA websites (including attached files and web-based applications) to individuals with disabilities.

This report shows that only 7.7 percent of all 812 VA websites are fully 508 compliant, uncovering a significant barrier that blind and visually impaired persons--including veterans and VA employees--have known for over two decades, as they have been disenfranchised by not being able to access non-compliant VA websites. This barrier to the blind and visually impaired at VA is illegal and needs to come down.

The law requires that all VA websites, medical center check-in kiosks, and the new Cerner Electronic Health Record, be fully 508 compliant. BVA requests stronger Congressional oversight and agency transparency on VA's progress of updating websites, files, and applications that are still inaccessible to blinded individuals.

Platforms such as SharePoint, used throughout the VA enterprise, and other similar platforms are still not addressed by this review as VA does not consider these to be websites. It is noteworthy that Microsoft, the maker of SharePoint, posted on its website, "What is SharePoint? Organizations use Microsoft SharePoint to create websites. You can use it as a secure place to store, organize, share, and access information from any device. All you need is a web browser, such as Microsoft Edge, Internet Explorer, Chrome, or Firefox." To the blind or visually impaired user SharePoint looks just like a website. VA skirting 508 compliance is a departure from its goal as a world-class promoter of Inclusion, and specifically excludes blind and visually impaired persons.

Additionally, BVA is equally disheartened to learn that VA will take several years to address accessibility issues with respect to the check-in kiosks at VA facilities. BVA believes these challenges will continue until accessible communication becomes a top priority for VA's entire senior leadership.

BVA urges VA to create an Under Secretary of Accessibility to champion with the authority and subject matter expertise to lead VA's 508 compliance efforts and ensure that all VA websites (to include SharePoint) and facilities—including self-service kiosks at VA Medical Centers and Community Based Outpatient Clinics (CBOCs)—will be accessible for all blinded and visually impaired individuals.

II. CAREGIVER BENEFITS FOR CATASTROPHICALLY DISABLED BLINDED VETERANS

Last fall VA reported that **76 percent** of all PCAFC applications for FY21 were denied. BVA is concerned that blinded veterans are not only being discriminated against, but also are not being provided with an adequate "reasons and bases" in their PCAFC decision notification letters. Additionally, many blinded veterans are facing denials to their FOIA requests for their PCAFC files, which unfairly and unlawfully inhibit their ability to appeal. These are gross violations of due process.

Further, blinded veterans face an ambiguous eligibility standard based on VA's rulemaking, ***"...the need for supervision, protection, or instruction in order for the individual to maintain personal safety on a daily basis"*** **or the inability to perform Activities of Daily Living (ADLs).** Depending on how broadly or narrowly these standards are interpreted, there is much gray area here. The wide varying functional ability of blinded veterans with the same clinical diagnosis and severity of blindness—and subjectivity in the evaluation of their disabilities—further complicates the adjudication of blinded veteran PCAFC applications. BVA believes that too many blinded veterans are being unfairly denied due to these ambiguous standards.

Medication management is critically important to blinded veterans, but VA does not consider it an ADL. Instead, VA classifies medication management as an iADL, which it has yet to define. Caregivers play a critical role in helping blinded veterans take the correct medication in the right amount at the proper time, yet VA minimizes this important task when adjudicating PCAFC applications for blinded veterans.

BVA and other VSOs have noticed VA denying veterans' FOIA requests for copies of their PCAFC claims file, which is part of their VA medical record. How can the veteran and their advocate construct an effective appeal without the file? Veterans have a right to a complete copy of the file that was used in the adjudication of their PCAFC claim.

Caregivers are the most important component of rehabilitation and maintenance for veterans with catastrophic injuries, and the welfare of their caregiver has a direct impact on the quality of care a veteran receives and the quality of life they can sustain. One of the factors that most commonly leads people over age 65 to seek admission to nursing homes is blindness. Such admissions are sought based on a false assumption that nursing homes are the only place where blind individuals can obtain the support and assistance they need. However, there is ample evidence to indicate that paying for nursing home care is neither cost effective for VA nor in the best interest of most veterans over age 65. Rather, many such veterans can and should age in place, supported by one or more caregivers, and VA support for these caregivers would require a fraction of the cost of nursing home care. The PCAFC allows blinded veterans to age at home with a greater degree of independence—and at significantly less cost to VA—than they would be in a VA-funded nursing home.

BVA urges that Congress provide further clarification on eligibility standards, such as a clear definition of, ***"...the need for supervision, protection, or instruction in order for the individual to maintain personal safety on a daily basis"*** and a definition of iADLs, which the VA has failed to provide in its rulemaking process. BVA strongly supports modification of PCAFC eligibility criteria regarding "activities of daily living" to include catastrophically disabled blinded veterans.

BVA supports the Independent Budget Veteran Service Organization (IBVSO) recommendation of 100 new Full-Time Employees (FTE) dedicated to appeals work in the Caregiver Support Program's central office, which requires approximately $10 million be added to the program's budget. BVA further supports the IBVSO recommendation of an additional $480 million in FY2023 to cover the cost of caregiver benefits and increased staffing.

Blinded veterans want a fair opportunity to be considered for the PCAFC program and are disproportionately affected by the uneven management of this program. Congressional intervention is necessary to ensure clear eligibility standards for blinded veterans, along with full due process.

III. RENEWABLE VA AUTO GRANT FOR SERVICE-CONNECTED BLINDED VETERANS

Why does a blinded veteran need an automobile? Accessible transportation options remain a persistent problem for blinded veterans, especially for those who live in rural areas and have either no options or very limited ones for getting to and from medical appointments and places of employment. Public transportation is often unavailable or too unreliable, and ride share services can be prohibitively expensive. The VA Automobile Allowance makes health care and employment more accessible to blinded veterans who have a spouse or other person who can drive for them.

The VA Automobile Allowance has helped thousands of blinded veterans overcome these access barriers. Unfortunately, the cost of replacing vehicles presents a financial hardship for many blinded veterans. Currently, after the use of this one-time grant, the veteran must then bear the full replacement cost once the adapted vehicle has exceeded its useful life. The divergence of a vehicle's depreciating value and the increasing replacement cost compounds this hardship.

To mitigate this hardship, BVA supports the IBVSO recommendation of a renewable automobile grant for eligible veterans equal to 100 percent of the grant maximum amount at the time the grant is renewed. BVA strongly supports H.R. 1361 and S. 444, AUTO for Veterans Act.

IV. FUNDING BLIND REHABILITATION

BRC Staffing

VA currently operates 13 residential Blind Rehabilitation Centers (BRCs) across the country. These BRCs provide the ideal environment in which to maximize the rehabilitation of our nation's blinded veterans. Unfortunately, Veterans Integrated Service Network (VISN) and VA Medical Center (VAMC) Directors at some sites housing BRCs are failing to replace BRC staff who retire or transfer to other facilities, thus failing to support congressionally mandated maintenance of staffing at previous levels. During the COVID-19 surge, all 13 BRCs were closed as beds were reallocated for alternative needs. As a result, rehabilitation training for blinded veterans went entirely virtual, accompanied by telehealth care. Consequently, many BRCs lack the staffing needed to help blinded veterans obtain the essential adaptive skills they require to overcome the many social and physical challenges of blindness. Without intervention, BVA fears that the number of BRCs in this situation will grow.

Spinal Cord Rehabilitation has dedicated funding for this express purpose. Modeling BRS funding after this manner would ensure such excellence in care. VAMC Directors should not be allowed to divert BRC Full-Time Equivalents (FTEs) or funds designated by the Veterans Equitable Resource Allocation (VERA) System for these rehabilitation admissions from the blind centers to other general medical operations.

Clinical Resource Hub

Not every blinded veteran is able to attend a BRC. Therefore, BVA supports the $3.5 million appropriations request for a Clinical Resource Hub proposal by BRS that provides a framework for the development and deployment of a Blind and Visual Impairment Rehabilitation Clinical Resource Hub that focuses on the provision of care coordination, treatment, and rehabilitation using a virtual modality of service delivery.

The intent is to expand access to care for veterans with visual impairments by providing virtual treatment to any veteran or active-duty service member within the system, *regardless* of residential location. The model includes clinical and administrative support similar to a traditional Blind Rehabilitation Center. The BRS core programs are Low Vision Optometry, Low Vision Therapy, Vision Rehabilitation Therapy, Orientation and Mobility, Computer Assistive Technology, Admissions Coordination, Visual Impairment Service Team (VIST) Coordinators, Blind Rehabilitation Outpatient Specialists, Recreation Therapy, Audiology, Nursing, and administrative oversight provided by National Program Consultant and Advanced Practitioner.

VIST Caseload

In October 2020, VHA implemented a new Continuum of Care for visually impaired veterans resulting in 81,583 low-vision and legally blinded veterans comprising VIST Coordinator case management rosters. VHA research studies estimate that there are 131,580 legally blinded veterans living in the US. VHA

projections indicate that there are another 1.5 million low-vision veterans in the US with visual acuity of 20/70 or worse.

BVA is concerned about the caseload of VIST Coordinators and Blind Rehabilitation Outpatient Specialists (BROS). Now that the national caseload has increased from approximately 40,000 to more than 73,000 visually impaired veterans, their capacity to meet the needs of assigned caseloads is now in doubt.

BVA again requests that VHA conduct a resource/demand gap analysis to identify VIST Coordinators and BROS whose caseloads are now over capacity. The creation and staffing of additional VIST and BROS positions may be necessary to adequately address the needs of these additional 40,000 visually impaired veterans.

Contracted Care

BVA is further concerned that community care funding contracted under the auspices of the VA MISSION Act will take funds away from VA BRCs. BVA holds that VHA must maintain the current bed capacity and full staffing levels in the BRCs that existed at the time of passage of the "Veterans' Health Care Reform Act of 1996" (Public Law 104-262).

BVA calls on Congress to conduct oversight, ensuring that VHA is meeting capacity requirements within the recognized systems of specialized care in accordance with Public Law 104-262 and the "Continuing Appropriations and Military Construction, Veterans Affairs, and Related Agencies Appropriations Act of 2017," (Public Law 114-223). Despite repeated warnings about these capacity problems, Congress has conducted minimal oversight on VA's ability to deliver specialized health care services.

BVA requests that if VA does contract with private agencies to provide rehabilitation training to blinded veterans, VA should ensure that the private agencies with which it contracts have a demonstrated capacity to meet the peer-reviewed quality outcome measurements that are a standard part of VHA BRS. BVA further recommends that VA require private agencies with which it contracts to be accredited by either the National Accreditation Council for Agencies Serving the Blind and Visually Impaired (NAC) or the Commission on Accreditation of Rehabilitation Facilities (CARF). Additionally, VA should require those agencies to provide veterans with instructors certified by the Academy for Certification of Vision Rehabilitation and Education Professionals (ACVREP).

An agency should not be used to train newly blinded combat veterans unless it can provide clinical outcome studies, evidence-based practice guidelines, mental health care counseling, and joint peer-reviewed vision research. BVA also supports the FY19 IBVSO recommendation mandating that competency standards for non-VA community providers be equivalent to standards expected of VA providers, and that non-VA providers meet continuing education requirements to fill gaps in knowledge about veteran-specific conditions and military culture.

Private agencies for the blind lack the necessary specialized nursing, physical therapy, pain management, audiology, speech pathology, pharmacy, and radiology support services that are available at VA BRCs due to their location adjacent to VAMCs. In addition, most private agencies are outpatient centers located in major cities, making access difficult for blinded veterans from rural areas, if not impossible. In many rural states, there are no private inpatient blind training centers at all. Therefore, the availability of an adequately funded and staffed VA BRC is the only option. Veterans from rural areas should not be

compelled to utilize alternative facilities when VHA BRS has the capacity to ensure that they have access to a program at a facility that is adequately staffed and funded.

V. DHA-BRS CONTINUUM OF CARE

BVA appreciates the bipartisan support demonstrated with the *National Defense Authorization Act* (NDAA) of Fiscal Year 2022 (FY22), which included a mandate that the DoD Defense Health Agency (DHA) comply with Section 703 of the NDAA (Public Law 114-328) of FY17 requesting the designation of four ocular trauma specialty centers. We sincerely thank all members for their continued support of blinded and visually impaired veterans.

The designation of four ocular trauma centers has created an opportunity to strengthen clinical coordination between DoD and VHA. BVA urges DHA and BRS to work more closely together to ensure the continuum of care for wounded warfighters who transfer from these four ocular trauma centers to VA BRCs.

VI. SUPPORTING WOMEN VETERANS

BVA applauds the bipartisan support women veteran issues received in the 116th Congress and looks forward to that continued support in the 117th. The passage of the *Deborah Sampson Act* was a great victory for women veterans in the fight for equality of care at VA, but there are still many concerns that BVA urges Congress to address in the upcoming session. For example, many Military Sexual Trauma (MST) victims are uncomfortable with having medical providers of the opposite sex treat them and, consequently, they avoid care.

VA needs additional resources to meet the needs of women veterans. BVA fully supports the IBVSO FY23-24 recommended appropriations of $905 million for women veterans.

BVA recommends stronger support for MST survivors as well as greater oversight of VA's handling of MST claims to ensure that they are handled with sensitivity and fairness, as well as promptness. While MST is not exclusively a women's issue, it commonly affects women service members and veterans in greater numbers. It is also an issue that has been swept under the rug for too long. BVA urges members of Congress to continue working alongside VA to increase accountability regarding MST care needs and claims processes.

VII. PROTECTING GUIDE AND SERVICE DOGS

Guide and service dogs are critical to blind, visually impaired, and other disabled veterans working toward regaining lost independence. Guide and service dogs assist blind or disabled veterans with mobility, retrieving objects, balance, and several other vital tasks. Training guide and service dogs to perform their jobs costs upwards of $50,000 and can take up to two years to complete. Many prospective guide and service dogs do not complete the training, making successful guide and service dogs (approximately one in ten) incredibly valuable. BVA is concerned about the safety of these guide and service dogs while on federal properties. Uncertified and often untrained support animals pose a direct threat to guide and service dogs, as well as to disabled veterans who depend on their dog for assistance. Since 2016, there

has been an 84 percent spike in reported support animal incidents to include urination, defecation, and biting. This additional threat to both veteran and service animal poses health and financial risks as the costly, lengthy, and rigorous training that the animals undergo becomes less apparent to the uninformed public, which perceives as the same the rigorously trained service animal and the poorly trained support animal.

The Department of Transportation (DOT) issued a new rule last year regarding service animals on airplanes. According to the rule, emotional support animals are no longer considered to be a service animal. Airlines may require travelers with service animals to provide forms developed by DOT attesting to the dog's training, health, and behavior. Implementing policies such as DOT's at VA facilities would offer a greater level of protection for guide and service dogs, as well as for their handlers and other veterans.

BVA strongly urges VA to implement stricter guidelines for animals eligible for entrance onto VA properties and to ensure standardization across all facilities. BVA also suggests implementing training policies for VA employees on guide and service dog etiquette to increase the safety of the dogs and their handlers while also raising awareness. BVA also requests a dedicated guide dog champion at the Veterans Affairs Central Office (VACO) and at each VAMC. The addition of these champions can ensure proper training and understanding through Standard Operating Procedures as to the expectations, roles, and responsibilities of a service animal as well as to ensure uniformity and equal treatment across locations.

VIII. SUPPORT THE VA FY23 BUDGET REQUEST FOR PROSTHETICS AND SENSORY AIDS

BVA supports VA's FY23 request of approximately $4.8 Billion for the Office of Prosthetic and Sensory Aid Service (PSAS) to provide prosthetic and orthotic services, sensory aids, medical equipment, and support services to veterans. Approximately half of enrolled veterans in VHA utilize PSAS services. Blinded veterans rely on PSAS services for low vision and mobility devices, and this reliance increases as we age. VA expects the usage of PSAS services to increase as more veterans enroll in the VA healthcare system. BVA urges VA and Congress to monitor this amount closely to determine if supplemental appropriations may be required to meet demand.

CONCLUSION

Once again, Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and all Committee members, thank you for the opportunity to present to you today the legislative priorities of the Blinded Veterans Association. We look forward to furthering our relationships and working with you productively during these challenging times.

JOSEPH D. MCNEIL, SR. BIOGRAPHY

BVA National President

Joseph D. McNeil Sr., Georgia Regional Group, was born in 1958 in Philadelphia, PA -Westside. Joe was the oldest of seven brothers and sisters and the first in his family to graduate from college. He earned a Bachelor of Science in Business and a Master's Degree in Human Resources. After graduating from high school, Joe joined the Army National Guard and worked his way through college, joining the Army ROTC program. Upon graduation, he received his commission as a 2nd Lt U.S. Army, Field Artillery. His duty assignments included 2nd Infantry Division Korea, 42nd FA Brigade, V Corps G3 Operations Germany, 197th Infantry Brigade Fort Benning and 18th Airborne Corps Fort Bragg. He held numerous Staff jobs during his tenure. Upon his diagnosis in October 1989 of Retinitis Pigmentosa (RP), he was processed off active duty as a Captain, after which he re-enlisted in the Georgia Army National Guard and served 4 years before his vision prevented him from doing his assigned duties as Personnel Staff Noncommissioned Officer (PSNCO).

Joe is a multi-graduate of three different VA Blind Rehabilitation Centers. He joined BVA in 2005 and has held positions as Georgia Regional Group's Columbus Chapter Vice President from 2005–2007 while simultaneously serving as Georgia Regional Group's Secretary from 2005-2007. He was the Georgia Regional Group President from 2007-2015, BVA National Treasurer from 2015-2017, BVA National Secretary from 2017-2019, BVA National Vice President 2019-2021, and BVA National President from August 2021 to the present.

Since the time of his retirement, Joe has worked as an accomplished entrepreneur, in addition to being the father of six and grandfather of four. He serves his community by sitting on numerous boards representing the blind community as an ambassador to the capabilities of the blind and visually impaired. He holds membership in multiple service and civic organizations. He is a certified National Veterans Service Officer (NVSO) for BVA. Joe also speaks before civic groups and churches about blindness and the help that is available.

BLACK VETERANS EMPOWERMENT COUNCIL

Statement of
Victor LaGroon, Chairman
of
Black Veterans Empowerment Council
before a joint hearing of the
Senate And House Veterans' Affairs Committees
One Hundred Seventeenth Congress

Wednesday March 2, 2022

Introduction

Chairman Takano and Tester and Ranking Member Bost and Moran, I am pleased to speak before the Joint House and Senate Veterans Service Organization (VSO) hearing today on behalf of the Black Veterans Empowerment Council (BVEC).

BVEC is a non-partisan coalition of national, state and local veterans organizations seeking to shift long-standing racial inequities suffered by Black veterans in the United States. Since its inception, BVEC has grown to represent 15+ organizations, representing more than 20,000 members with the ability to reach hundreds of thousands more in communities across our nation.

BVEC has been greatly appreciative of the opportunity to collaborate robustly with HVAC and SVAC in advancing sensible and sustainable solutions to the issues affecting all veterans.

As the work of the 117th Congress progresses, we understand that that country is at the nexus of crises -- political discord and unrest, rising military conflicts, economic recession and the tail end of a two-year pandemic. We must all work to ensure no veteran is left behind during these difficult times.

Benefits Usage

Black veterans disproportionately hail from at-risk, low-income and underserved communities, joining the military in the hopes of serving our nation while seeking economic mobility and access to housing, education and healthcare benefits often lacking in their respective environments.

Though underserved communities are heavily recruited, many Black veterans return to resource-poor neighborhoods and withstand frequent denials, deterrence or misinformation on how to appropriately utilize the veterans benefits they've earned. To that end, BVEC is piloting an initiative to train 500 Black veterans service officers across the country to ensure veterans benefits are widely understood and adequately accessed.

To address historical disparities, VA must contend with the ways dishonorable discharges have adversely affected Black service members, impeding their ability to attain crucial veterans benefits and job placement post-service. A

legacy of stark disparities in punishment under the Uniform Code of Military Justice continues to fuel a pipeline of Black veterans who fall victim to homelessness, joblessness and mental health crises which place undue burden on under-resourced municipalities and nonprofits. BVEC calls for the convening of a Taskforce to formulate recommendations to confront the legacy of discriminatory Bad Paper Discharges with an emphasis on their disproportionate impact on Black and minoirty veterans to ascertain and codify VA's role in mitigating this harm moving forward.

To fulfill its commitment to diversity, equity and inclusion – VA must also improve micro-targeting outreach across the Black veterans community. BVEC and its affiliate organizations stand willing to assist VA leadership in this effort. The looming homelessness crisis coupled with persisting unemployment and underemployment reflects a bleak series of crises on the horizon. BVEC is pleased that there is a continued push to expand eligibility for VA homeless programs for those who hold other than honorable discharges. We firmly support expanding eligibility for benefits programs broadly, including education and VA home loans. BVEC applauds the implementation of a rapid retraining program for veterans who have exhausted their G.I. Bill benefits during the pandemic. We ask for the dissemination of demographic data of participants to-date to ensure Black veterans are being engaged at adequate rates.

As a host of factors complicate benefit utilization, BVEC supports the work of the Black Veterans Project (BVP) in advancing research on racial disparities in access to veterans benefits across the Department of Veterans Affairs. BVP's findings to date reveal statistically significant racial disparities in disability grant rates and denials suffered by Black veterans and highlights a need for redress and reform. BVEC commends the recent passage of S. 1031 – a bill requiring the Government Accountability Office to conduct its own independent study of racial disparities in the allocation of veterans benefits. To date, BVP's FOIA requests seeking historical data on racial disparities in VA disability benefits (from 1920 to 2000) remain unfulfilled. We thank Chairman Takano and his team for assisting BVP in attaining these critical data sets and for the willingness of committee members to engage in formulating recommendations and solutions once full findings become public later this year.

Black Women Veterans

BVEC commends the passage of the Deborah Sampson Act which provides much needed reforms to VA to accommodate the care of women veterans, we also applaud the implementation of a zero-tolernace policy around sexual harassment at VA facilities championed by Chairman Tester.

BVEC affiliates, Kappa Epsilon Psi Sorority Inc. and the National Association of Black Military Women have shared a number of concerns that directly affect Black women service members and veterans. We urge this committee and the VA to develop a plan of action to address these issues.

Women of color continue to be the fastest growing segment of our homeless veteran community. We ask that the VA prioritize a plan centered on preventing and aiding our women members with stable housing suitable for them and when applicable, their children.

Black women face higher rates of breast and gynecological cancers. We implore VA to expand early screening options and the acquisition of the latest screening technologies to ensure robust care across VA facilities nationwide.

BVEC also supports the expansion of current gynecological and reproductive services to *all* women veterans to include coverage of in vitro fertilization, intrauterine insemination and oocyte cryopreservation. Women veterans continue to suffer long-wait periods and inadequate health coverage in spite of the recent reforms.

6888 Congressional Gold Medal

BVEC supports the immediate passage of bipartisan legislation to award the Congressional Gold Medal to the members of the Women's Army Corps, who were assigned to the 6888th Central Postal Directory Battalion – the "Six-Triple-Eight" – during World War II. Given the increasing age of surviving 6888 veterans, time is of the essence to provide these heroic and groundbreaking women this well-deserved, overdue recognition.

The women of the 6888th count among thousands of Black veterans denied military honors over the course of America's wars. BVEC requests the lifting of statutes of limitations and convening of a Taskforce to investigate and review of Black veterans from all wars whose military records and official descriptions of combat actions support consideration for the Medal of Honor and other military citations or medals.

GI Bill Repair Act

The introduction of the G.I. Bill Repair Act by U.S. House Majority Whip James E. Clyburn and Congressman Seth Moulton — which seeks to provide GI Bill benefits to the surviving spouse and descendants of Black World War II veterans alive at the time of the Bill's enactment — is profoundly necessary legislation that begins a process of amends for 900,0000 Black WWII veterans and their families. We implore the bill's passage into law.

NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

Joint Hearing of the House and Senate Veterans' Affairs Committees

March 2, 2022

Presented by

Thomas (Tom) Palladino

President, National Association State Directors of Veterans Affairs

Executive Director, Texas Veterans Commission

INTRODUCTION

Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost and distinguished members of the Committees on Veterans Affairs, this written testimony is submitted on behalf of the National Association of State Directors of Veterans Affairs (NASDVA). I am the NASDVA President and serve as the Executive Director for the Texas Veterans Commission.

NASDVA is comprised of the State Directors of Veterans Affairs for all fifty (50) States, the District of Columbia, and five (5) territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands). The appointed head of each State/Territory governmental Department/Agency of Veterans Affairs is by constitution a member of NASDVA (established 1946). We are neither a Veteran Service Organization (VSO) nor a Military Service Organization (MSO) membership-based organization.

State Departments of Veterans Affairs (SDVAs) are comprehensive service providers to the nation's 19 million Veterans and their family members. As such, SDVAs serve as the intersection for federal government and local communities and as a nexus for community partners, other State Agencies, local government, and non-profit organizations.

Our purposes are "to foster the effective representation of persons claiming entitlements on account of the honorable military service of any person defined in 38 U.S.C. 101; to provide a medium for the exchange of ideas and information; to facilitate reciprocal State Services; to ensure uniformity, equality, efficiency and effectiveness in providing services to Veterans and their family members in all States and Territories; and maintain an interest in all Veterans' legislation."

State Departments are second only to the U.S. Department of Veterans Affairs (USDVA or VA) in providing services. We perform as service providers, coordinators, connectors, and conveners; in essence, we act as a hub for the Veteran. Our mission includes advocating for all our nation's Veterans

and their family members and survivors to access earned federal and state benefits:

- SDVAs also advocate for Veterans' access to VA healthcare (including mental health),
- filing disability claims and appeals on behalf of Veterans,
- establishing and operating State Veterans Homes and States Veteran Cemeteries,
- connecting women, minority, LGBTQ and rural Veterans to needed services,
- acting as the State Approving Agency for GI Bill use,
- support for the establishment and operation of Veteran Treatment Courts,
- support for local community efforts to end and prevent Veteran Homelessness,
- the awarding of grants to local governments and non-profit organizations,
- help service-members with transition, employment services and economic empowerment.

Beyond these core missions, the role of SDVAs continue to grow and serve as "one-stop shops" to help Veterans in ways that may not fit into established programs. To this end, SDVAs are on the front line near the Veterans where they reside and have the capacity to assist VA in the development and deployment of new programs and initiatives. The combined services provide a much broader connection to all Veterans rather than just to those who are currently enrolled and are using VA services. Despite constrained State budgets in the face of the COVID pandemic, States collectively contribute greater than $10 billion each year in support of Veterans. NASDVA, through its member States and Territories, is the single organization outside of federal VA that serves all Veterans.

State Directors are tasked and held accountable by our respective Governors, State Boards or Commissions and are responsible for addressing the needs of our Veterans irrespective of age, gender, era of service, military branch, or circumstance of service. As such, State Directors and their staffs are confronted with unique situations daily.

USDVA – NASDVA PARTNERSHIP

This relationship between USDVA and NASDVA was formalized through a Memorandum of Agreement (MOA) originally signed in 2012 and updated with Secretary Denis McDonough at the NASDVA Mid-winter Training Conference on February 21, 2022. This formal partnership between USDVA and NASDVA continues to yield positive results for our Veterans across the nation. Since NASDVA's incorporation in 1946, there has been a long-standing government-to-government cooperative relationship. We share a common goal to facilitate accessible, timely, and quality care for America's Veterans. This MOA sets forth a framework of intent and cooperation between NASDVA and VA to achieve the following objectives:

1. Support VA priorities and integrate with State-wide programs.
2. Make customer experience a top priority with improved delivery of healthcare and other services provided by VA and the States.
3. Reduction of Veterans suicides and homelessness.
4. Increased direct involvement of State Directors with VA.
5. Increased communications between VA and NASDVA.

The MOA also establishes the "Abraham Lincoln Pillars of Excellence" award that evaluates best practices from NASDVA members that develop effective programs that are worthy of emulating. The Secretary of Veterans Affairs recognizes the recipients at the NASDVA Mid-winter Training Conference.

VA FUNDING

Full congressional support of the President's FY 2022 VA budget request is vital to meet the growing needs of Veterans to fulfill the VA's mission. NASDVA is committed to working with Congress and USDVA leaders to ensure scarce resources are allocated to priorities that will meet our Veterans' most pressing needs in an efficient, effective, and Veteran-focused manner. As the VA

continues its transformation journey particularly with modernization of the Electronic Health Record, NASDVA supports a continuation of new initiatives, careful observation in ensuring effective and efficient program execution, and a continued focus to deploy resources where Veterans can best be served. The House Committee on Veterans Affairs (HVAC) and Senate Committee on Veterans Affairs (SVAC) work is vital to improve overall funding for healthcare, claims and appeals processing, cemetery operations, and homeless Veterans' programs, and to meet the needs of the new generation of Veterans who require extensive medical and behavioral care and transition to our communities. While there is significant focus on our returning service members, we must continue this work of serving all Veterans, especially the large cohort of aging Veterans.

VETERANS HEALTHCARE BENEFITS AND SERVICES

The Veterans Health Administration (VHA) is a comprehensive healthcare system that provides the full spectrum of care for our Nation's Veterans; in many cases, care that is provided nowhere else. VA also conducts extensive research and training that benefits our entire country. Plans for realigning capital assets for healthcare delivery must allow VA management flexibility, perhaps at the regional Health Care System level, that emphasizes an integrated (VA and Non-VA) and flexible care model based on geographic population models. A proper mix of care delivery should be based on Veterans' needs, location, accessibility, and availability of services. Decisions for care within VA or in the community should be determined by the Veteran and his/her provider.

State Directors, represented by NASDVA, fully support efforts to increase Veterans' accessto VA Healthcare. This includes the continued involvement of SDVAs with VA Medical Centers (VAMCs) to collaborate in enrolling Veterans and eligible family members in the VA healthcare system. This collaboration also continues to address expansion of Community Based Outpatient Clinics (CBOC) and Vet Centers, the deployment of mobile health clinics, and maximizing the use of

tele-health services. We commend VA's efforts to address behavioral health, rural Veterans, Military Sexual Trauma, and women Veterans' health issues.

NASDVA's priorities for the care of our Veterans are consistent with those of VA. While the VA continues to place emphasis on suicide prevention, there is still much work to be done given that the rate of suicide is still too high. It is critical that SDVAs work with the VA healthcare system to address this high priority clinical and social issue. NASDVA proposes the creation of "outreach grants" from the VA to SDVAs. These grants could potentially address shortfalls and needed improvements in suicide prevention and awareness outreach. States are in a better position and closer to vulnerable Veterans that need help. The VA and other government health care networks must be the core for providing health care services. External networks and preferred providers should be expanded to provide care where VA services are not available. In short, NASDVA supports an "all of the above" strategy for health care delivery which recognizes the diversity, geography, and demographic makeup of today's Veterans.

It is imperative that VA, specifically VHA, receives the funding required to care for the over 9 million Veterans who are enrolled while the complexity of their care is increasing. VHA must have the resources necessary to recruit and retain doctors, nurses, and other professional staff. A policy of wholesale privatization or contracting outside a Veteran-centric environment, may diminish VA experience. Under some circumstances it is certainly necessary and appropriate for Veterans to receive care at facilities andproviders outside VA. Reimbursements for such service/care must be prompt and meet industry standards. Slow reimbursements for care will discourage providers to participate.

Telehealth services are mission critical to the service delivery of VA healthcare particularly during the pandemic. NASDVA applauds the VA as a world leader in this practice. Telehealth is

particularly critical to rural and highly rural Veterans when timely access to mental health services is not available or when they must travel long distances to see a provider. SDVAs can play an important role in connecting these Veterans to telehealth. With funding, SDVAs can provide outreach and connect our most vulnerable Veterans to life saving programs. This outreach effort will help close the gap in access to mental health care in rural areas, American Indian/Alaska Native lands, and other underserved minority communities.

To meet the demands of the 21st century Veteran, we are also prepared to assist VA as they develop, evaluate the performance, and deploy the Electronic Health Record (EHR). This complex, multibillion dollar modernization program is essential for the care of Veterans in the future. This time, failure is not an option, and the States are positioned to advocate, promote, and provide VA with timely feedback for the success of this large and comprehensive electronic modernization.

STATE VETERANS HOMES

The State Veterans Home (SVH) Program is the largest and one of the most important partnerships between SDVAs and VA. SVHs provide over 53% of total VA long-term care (one of the largest nursing home systems in the nation) and is a cost-efficient partnership between federal and state governments. SVHs are the largest provider of long-term care to America's Veterans through 160 operational SVHs (nursing homes), 51 Domiciliary Homes and 3 Adult Day Care Facilities in 50 States and the Commonwealth of Puerto Rico. These homes provide a vital service to elderly and severely disabledVeterans with over 25,000 skilled nursing beds, over 5,200 domiciliary beds, and 109 adult-day health care services.

SVHs, as well as VA, are experiencing serious healthcare provider shortages and it is becoming critical for homes to maintain capacity of care. Resident census cannot often be maintained because of staff shortages. Vulnerable Veterans in need of care are being denied access because of insufficient staff

to meet the required CMS/VA contact ratios. The national competition for providers is presenting an untenable situation, which is exacerbated by burnout among nursing professionals from the rigors of care during the COVID-19 pandemic. These shortages are projected to continue for the next decade. It is imperative that SDVAs and VA continue recruitment and retention efforts to have the quality and quantity of providers to care for eligible Veterans.

NASDVA and the National Association of State Veteran Homes (NASVH) have actively advocated for the principle that Veterans in our nursing homes are entitled to the same level of support from VA as Veterans placed in Community Living Centers and VA community contract nursing homes. Both national associations have been engaged with Congress to demonstrate program needs and required levels of funding support. We maintain that the benefit is to the Veteran, regardless of where he or she chooses to receive their care. To ensure SVHs can continue to operate and provide high quality care, the Provider Agreement provision to care for the most vulnerable and compromised Veterans (70% or above service-connected disabled) must be maintained and codified in future legislation. Furthermore, care must be taken to ensure Veterans are able to use VA for services and specialty care not traditionally part of nursing home operations.

NASDVA also has concerns about behavioral health and the future incidences of Post-Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI) and other conditions in the aging Veteran population. While there are war-related traumas that lead to PTSD in younger OEF/OIF Veterans, aging Veterans can be exposed to various catastrophic events and traumas of late-life that can lead to the onset of PTSD or may trigger reactivation of pre-existing PTSD. PTSD has been seen more frequently in recent years among World War II, Korean and Vietnam War Veterans and has been difficult to manage. VA has limited care for Veterans with a propensity for combative or violent behavior and the community expects VA or SVHs to serve this population. NASDVA and NASVH

recommend a new Grant Per Diem scale that would reflect the staffing intensity required for psychiatric beds and medication management. SVHs and VA Community Living Centers are unable to serve intensive care psychiatric patients; therefore, VA cannot turn over hospital psychiatric beds because of a lack of community psychiatric step-down capacity. This level of care is critically needed in our States.

NASDVA continues to recommend that VA, in consultation with NASVH, begins an evaluation process to implement an Assisted Living level of care or enhanced domiciliary grant program. Currently there are only three levels of care: Skilled Nursing Care, Domiciliary or Adult Day Health Care. The Domiciliary rate does not cover the cost of caring for this level of care. NASDVA and NASVH will be asking VA to collaborate on this critical effort and ensure that Veterans have options, especially when unable to age at home.

With implementation of the Electronic Health Record, our State Veterans Homes with over 30,000 beds across the nation, should have access to the system. In the past, select facilities have had read only access. Full access, as planned for community clinics and providers, will allow SVHs health care providers to seamlessly coordinate the care of our Veterans.

NASDVA and NASVH support a continued commitment to the significant funding of the State Veterans Home Construction Grant Program. It is important to the Veterans we serve to keep the existing backlog of projects in the Grant Program at a manageable level to assure life safety upgrades and new construction. In the budget proposal, VA is requesting $90 million for SVH grants. NASDVA and NASVH encourages full funding support for the priority one projects, which is estimated to be approximately $500 million.

VETERANS BENEFITS SERVICES

SDVAs continue to take on a greater role in the effort to manage and administer claims processing. Regardless of whether the State uses State employees, nationally chartered Veterans

Service Organizations (VSO) and/or County Veterans Service Officers (CVSO), collectively, we have the capacity and capability to assist the Veterans Benefits Administration (VBA).

NASDVA applauds VA's efforts to overhaul its disability claims process administered by VBA. NASDVA remains concerned that there is a backlog and focus must be kept on adjudicating claims in a timely manner and committing resources to reduce the backlog while working with SDVAs. Recognizing that there is a wide range in the resources available in individual States, NASDVA recommends serious consideration to making federal funding available to States for outreach and to assist with efforts "on the ground" to further reduce the backlog and maintain progress on expediting existing and new claims.

A success story of government-to-government collaboration between VA and NASDVA is the work that led to the modernization of the Claims Appeals Process. A multi-state team joined VA, Veterans Service Organizations (VSOs) and Congressional staffs to process that resulted in the Appeals Modernization Act (AMA). AMA allows for Veterans and their advocates to have more choice in their review and appeals process. An unexpected result has been an increase in Veterans choosing hearings at the Board of Veterans Appeals (BVA). Chairman Cheryl Mason has attacked the growing number of pending hearings by establishing a virtual option, which increased the overall number of hearings held. However, the BVA still uses manual processes to in take the appeal, schedule hearings, and the dispatch of a decision. BVA requires additional resources to improve their information technology systems. NASDVA supports BVA's request for increase funding to automate their processes, which will result in an increased number of timely board decisions.

Additionally, the VA should offer expanded virtual and in person training opportunities to accredited service officers to improve the "inputs" (e.g., changes to forms, updated processes, and/or new policies) to the benefits systems. These opportunities should be at the national level and at the

regional office level. Additionally, as claims are processed through the National Work Que (NWQ) to better distribute caseloads, personnel staffing the VSO/CVSO Helpdesk Line need to have increased understanding of claims and access to the claim to better assist VSO/CVSOs calling for assistance. Increased training opportunities and increased support from the Helpdesk Line will support a more efficient claims process.

Given the claims backlog and number of claims on appeal, NASDVA recommends serious consideration to making federal funding available to States to assist with efforts "on the ground" to further reduce the backlog and maintain progress on expediting existing and new claims. Beyond funding, the VA should offer more virtual training to accredited service officers to improve the "inputs" (changes to forms, processes, or policies) to the benefits systems.

STATE APPROVING AGENCIES

State Approving Agencies (SAA) operate in all states and are responsible for the approval and oversight of programs offered by Post-secondary Institutions that wish to provide for the use of GI Bill educational benefits. Twenty-six SAAs operate under their SDVAs, while the remainder operate within a State's Department of Education, or other State agency. NASDVA has entered a formal Memorandum of Understanding with the National Association of State Approving Agencies (NASAA) to support NASAA's efforts to promote and safeguard quality education and training programs for all Veterans.

Currently, all SAAs are funded through contract with the VA. Since the passage of the Post 9-11 GI Bill, the role of the SAAs and the associated contractual requirements have expanded significantly. The increase in their role comes with added responsibilities, making it increasingly difficult for SAAs to meet their contractual requirements as well as protect the Veteran educational benefits in their State

from waste, fraud, and abuse.

Through close collaboration with our NASAA partners, NASDVA has identified three priorities:

1. Cooperative Agreements, NASDVA requests that Congress initiate a formal review of the Allocation and Funding Model that directs the distribution of contract dollars to the SAAs. The VA review should be transparent and include both NASDVA and NASAA representatives. It should also provide the opportunity for information sharing and feedback to better understand the practical application of the model. The federal appropriation that supports the SAA's contracts has remained stagnant for several years although State costs to support the program have increased annually. NASDVA requests a fiscal analysis to ascertain the current state administrative cost requirements to effectively fulfill the contractual obligations.

2. Regulation Promulgation, several significant pieces of legislation have been enacted over the past few years that provide necessary protections for Veterans and their earned educational benefits, including the Colmery Act and the Isakson and Roe Act. NASDVA requests that Congress ensures the timely and effective implementation of these invaluable pieces of legislation through the promulgation of regulations by VA. It is imperative that Title 38 reflect these new laws, thereby providing the SAAs the necessary authorities to review institutional programs and conduct oversight procedures more effectively.

3. SAA Authority, NASDVA requests that language be added to U.S.C. 3696 that provides the SAAs the authority to restrict an institution that has had their approval revoked "for cause" from immediately re-applying or applying for approval in another State. For example, if an institution has engaged in deceptive advertising, or unlawful recruiting practices, the SAA may immediately revoke their approval. There is no statutory timeframe established that restricts an institution from immediately reapplying. The school will often reapply the next day, or in the case where a State has a law in place to address this

issue, the institution will shop other States for approval, effectively avoiding the intended protections of U.S.C. 3696.

BURIAL AND MEMORIAL BENEFITS

NASDVA appreciates the National Cemetery Administration's (NCA) collaborative partnership with States, Territories and Tribal governments. The Veterans Cemetery Grants Program (VCGP) complements NCA's 155 national cemeteries in 42 states and Puerto Rico and is an integral part of NCA's ability to provide burial services for Veterans and their eligible family members. State, Territory and Tribal cemeteries expand burial access and support the NCA number one goal of "increasing access to a burial option in a National or State Veterans cemetery" and provide burial services to over 95% of all Veterans within in a 75-mile radius of their home. There are currently 119 VCGP cemeteries located in 48 States, Guam, Saipan, the Commonwealth of Puerto Rico and 13 operational tribal cemeteries and 2 cemeteries under construction in Ardmore, Oklahoma, and a tribal cemetery in Metiakia, Alaska. In fact, these cemeteries provided over 45,500 interments in FY 2021, which is approximately one-fourth of the total interments by both NCA and VCGP cemeteries.

We recommend that the construction grant program budget be increased to $60M. This modest increase to the $45M budget proposal would allow funding of some new State cemeteries and upgrade projects that currently go unfunded while also allowing NCA to respond to emergent requirements.

NASDVA fully supports the NCA goal of ensuring that State and Tribal Veterans cemeteries are maintained through a Compliance Review Program to the same standard of excellence applied to the national cemeteries. This aligns a review process for VA grant-fundedState and Tribal Veterans' cemeteries to achieve National Shrine Standards. The operational cost for State Veterans Cemeteries depends on the plot allowance for Veterans but there is no plot allowance for the interment of family members. NASDVA recommends that Congress authorize and appropriate funds to provide a plot

allowance for family members or increase the level of plot allowance for Veterans. Either increase in funding would help to offset the operational cost in burials for family members and would allow the States to not charge family members and maintain parity with the National Cemeteries. Additionally, there is no plot allowance for Veterans buried in Tribal cemeteries, which adversely affects their ability to maintain their cemeteries and is an inherent inequity compared to the State cemeteries. This too needs funding authorization and appropriation to correct.

WOMEN VETERANS

Women now comprise nearly 20% of the Armed Forces and assume roles in nearly all military occupational specialties and is the fastest growing Veteran cohort. Elimination of the Department of Defense (DoD) combat exclusion rule means more women will fill the full array of military occupational specialties. There are several areas NASDVA believes VA can work on to close gaps in service, ensure continuity of care, and better address the needs of Women Veterans.

Women Veterans are impacted by the provider shortage for the delivery of gender specific healthcare. In addition, we understand the VA priorities include addressing needs of victims of Military Sexual Trauma (MST) to include those who served in the National Guard and Reserve. Due to an increasing volume of Veterans with MST, compatible care and provider alternatives need to be deliberately extended to all those Veterans who might otherwise be dissuaded from seeking treatment at the VA. Work must continue the reconciliation of MST claims for PTSD recommended by the VA Inspector General. Of note, one of the "factors leading to the improper processing and denial of MST-related claims" was the implementation of the National Work Queue resulting in a "lack of specialization" for claims requiring special handling.

Additional gender specific healthcare includes infertility care. NASDVA advocates progressive support for Veterans with infertility issues caused by illness or injury while serving in the

military. VHA must also ensure that Women Veterans have access to and receive in a timely manner high-quality, gender specific, and individualized prosthetic care that will allow them to improve their quality of life.

With the relatively recent VA investment of state-of-the art women's clinics across the country, there still exists a disproportionate and non-standard availability to access gender- specific healthcare relative to the population of Women Veterans. The decision-making and planning for new clinics or renovation of existing clinics must be data driven to ensure Veterans receive care commensurate with the population.

The largest emerging population of Homeless Veterans is women. Recent efforts across the country to end and prevent veteran homelessness are commendable and deserve recognition. We know the true numbers of this emerging population are underrepresented due to prescribed models of addressing homelessness. For example, a victim of domestic violence fleeing an abuser and living with a friend is not considered homeless. NASDVA will work with VA and HUD to allow flexibility in their definition of homelessness and revitalize transitional housing models to better serve Women Veterans especially those with children.

Currently, the VA does not have the authority to provide the reimbursement for the costs of services for minor children of homeless Veterans. This issue disproportionally impacts women Veterans as women bear the primary responsibility of child raising. A GAO report found that this inequity led to financial disincentive for housing providers and in turn limits housing for Veterans with young children.

Homeless Veterans consistently identify childcare as a top unmet need. The cost is a common barrier for many as they try to seek employment and healthcare. As noted earlier, WomenVeterans are more likely to commit suicide than non-Veterans. NASDVA recommends that VA develop a

mechanism between VHA and VBA to identify at risk Veterans at the time a claim is initiated or when a service is requested through the VBA. In short, any coordination gaps between VBA and VHA need to be mitigated to identify veterans at risk of committing suicide. NASDVA recommends that more efforts through the VA Experience Office be made to support the community efforts to prevent suicide. Data indicates that 70% of the Veterans who take their ownlives do not engage with VA. This access issue can be improved. The entire Veterans community must take on the critical task of suicide prevention.

MINORITY VETERANS

NASDAVA fully supports VA's Diversity, Equity, and Inclusion (DE&I) efforts in ensuring all Veterans receive their earned benefits and services. Likewise, NASDVA applauds VA for elevating the DE&I issues in VA staffing and care to all Veterans. This emphasis will make a difference throughout both VA and SDVAs. Even though intuitional changes will be hard to measure they will occur and for the better. Since Veterans have served in integrated and cohesive units, they also need to receive benefits and serves in an all-inclusive manner from VA and SDVAs. Any attitudes against this effort regardless of how minor must be stamped out.

NASDVA also supports VA to consider identifying and resolving overlooked Veteran challenges and issues for other unique groups. Veterans in Island Territories have had significant issues with services due to their isolation. For example, during hurricane catastrophes in Puerto Rico and the Virgin Islands, theVA was one of the only available providers, yet category 7 and category 8 Veterans were not accepted and thus did not have any viable options for their urgent medical needs. NASDVA recommends provisions in VA healthcare to allow care to all Veterans in VA facilities during catastrophic events.

Native American Veterans are underserved on their reservations. Veteran Service

Organizations (VSO) and SDVAs do not have the capacity to provide services consistently. We commend VA for the recent rule changes that allow SDVAs to accredit Tribal Veterans Representatives (TVR) and/or allow for Tribes to seek their own accreditation. This will ensure TVRs serve their nations within their cultural beliefs and sovereignty and promote self-sufficiency.

HOMELESSNESS AMONG VETERANS

NASDVA commends VA's effort and continued emphasis on ending homelessness among Veterans. States will continue to develop and support outreach programs that assist VA in this high priority effort, particularly in further identifying those Veterans that are homeless and programs to prevent homelessness. As partners with VA at the nexus of local communities, we are focusing on addressing the multiple causes of Veterans' homelessness e.g., medical issues both physical and mental, legal issues, limited job skills, and work history. We appreciate the continued funding for specialized homeless programs such as Homeless Providers Grant and Per Diem, Health Care for Homeless Veterans, Domiciliary Care for Homeless Veterans, and Compensated Work Therapy. It is vital to continue VA's partnership with community organizations to provide transitional housing and the VA/HUD partnership with public housing authorities to provide permanent housing for Veterans and their families.

We know that many stages of homelessness exist and likewise we know that many factors contribute to homelessness among Veterans. Contributing factors are alcohol and drug abuse, mental health issues, PTSD, lack of employment, and involvement with the justice system. To eliminate chronic homelessness, we must address the root causes. They need to receive attention and action by providing the necessary mental health and drug treatment programs in conjunction with job skills training and employment. These collective programs must be adequately staffed and fully funded in the current and future budgets. Another revolving door that appears to increase the rolls of

homelessness among Veterans is the overburdened courts and corrections system.

NASDVA commends VA and HUD for their collaboration in increasing the number of Veterans Affairs Supportive Housing (VASH) vouchers. Unfortunately, in large cities with high costs of living, the voucher value is insufficient to allow the Veteran to secure adequate housing. Some cities need cost of living adjustments to ensure the VASH voucher will cover most of the cost of affordable housing. NASDVA recommends that vouchers be tied to local markets to ensure they can support Veterans with secure permanent housing.

The VA Veterans Justice Outreach (VJO) Program is a prevention-focused component of VA's Homeless Programs Office (HPO), whose mission is to end homelessness among Veterans.VJO Specialists at every VA medical center have provided outreach and linkage to VA and/or community services for justice-involved Veterans in various settings, including jails and courts. VJO Specialists are essential team members in Veterans Treatment Courts (VTC) and other Veteran-focused courts, as they connect Veteran defendants with needed VA services and provide valuable information on their progress in treatment. NASDVA supports increased VA funding for more Veteran Justice Outreach Coordinators to increase this valuable service.

VETERANS TREATMENT COURTS

States continue to recognize the increase in justice-involved Veterans, especially in the time shortly after discharge, and continue to work with leaders at the State level to create and support Veterans Treatment Courts (VTC). After discharge, some Veterans suffer from mental conditions and emotional problems that result in behaviors that are disruptive and often criminal in nature.

It is important that we all remain committed to seeking innovative ways to help justice-involved Veterans become productive citizens. Support for Bureau of Justice Assistance (BJA) and

National Drug Court Institute (NDCI) orientation and training programs for jurisdictions interested in establishing VTCs is important to that effort. The States respectfully request support for increased funding to the BJA, so more jurisdictions can participate. Additionally, increased funding for multi-year grants to aid jurisdictions in the establishment and sustainment of VTCs is needed. VTCs are problem solving courts that through direct supervision can help make life altering and positive societal transitions for Veterans.

TRANSITION ASSISTANCE PROGRAM (TAP)

Our organization strongly encourages the most effective transition program possible, to ensure success when a military member leaves military service and returns to civilian life. This is a tremendously important and sometimes stressful time for service members and their families. Service-members are required to attend the Transition Assistance Program (TAP) at their military installation prior to separation or retirement. TAP is a mandated workshop across all services and all components and primarily delivered by the Department of Defense, Department of Labor and Veterans Affairs, and focuses on benefits, employment, and education.

NASDVA supports the changes to the program over the last few years and especially with initiatives to address transition-related issues, such as including contact information on the electronic DD Form 214. The creation of a standard record of service for members of the reserve components; the creation of an online application for the TAP; and the provision for the DoD to connect retiring or separating members from the Armed Forces with community-based organizations and SDVAs. NASDVA has long advocated for this connection since States are in a unique position to provide separating members with critical information to access the benefits and services to meet their needs. However, we need a closer partnership with all the federal agencies who are part of the TAP.

TAP is a cooperative effort among DoD, DoL, VA, Education, Homeland Security, SBA,

and OPM. However, there is no mandate to include the SDVAs in the TAP curriculum. It is a significant challenge for Transitioning Service Members (TSM) to connect with the State benefits and services available to them. Likewise, it is extremely difficult for SDVAs to make them aware of these benefits and services. This lack of connectivity between TSMs and SDVAs contributes to their significant barriers to employment and increases their mental stress associated with their transition. NASDVA recommends that all SDVAs be included in the TAP at military installations in their State and be allowed to connect with TSMs who are moving to their State prior to separation. Additionally, NASDVA recommends that TSM contact data in the Defense Manpower Data Center (DMDC) be available to SDVAs longer than the current 45-day time limit.

JOBS FOR VETERANS STATE GRANT (JVSG) MANAGEMENT BY DOL-VETS

SDVAs have clearly witnessed how viable employment is essential to a successful transition from uniformed military service to civilian life. To assist in this transition, the U.S. Department of Labor-Veterans Employment and Training Services (DOL-VETS) manages the Jobsfor Veterans State Grant Program. However, the flexibility of the States to serve the employment needs of Veterans is greatly restricted in many cases by DOL-VETS. States should determine the agency that can best administer, control, and fund this critical program. In some states it could be the employment agency, in other states it could be the SDVA or other entity. Ultimately, individual States' Chief Executives (Governors) should have authority to determine what organizational structure may best serve the employment needs of that State's Veterans and the work force needs of the State. NASDVA commends the continued emphasis on hiring Veterans for federal employment and the awareness of the provisions and benefits under the Uniformed Services Employment and Re- Employment Rights Act (USERRA), the Transition Assistance Program, and the efforts to connect members retiring or

separating from the military with SDVAs and community-based organizations.

SUPPORTING VETERAN FAMILIES

Veteran families are an important part of the Veteran's transition and continued experience. NASDVArecognizes the important role of families in the Veteran life cycle. VA, States and Congress, must recognize that the family unit serves, and all programs and legislation must consider these unsung heroes. While the VA's Congressional authorization is to serve Veterans, more must be done to include their families and ensure their emotional and physical wellness. VA spends billions of dollars to provide care to the Veteran but if the family is not well, the probability for the Veteran to reach his/her highest level of functioning will be compromised resulting in the waste of precious resources.

CONCLUSION

Chairman Tester, Chairman Takano, Ranking Member Moran, Ranking Member Bost, and distinguished members of the Committees on Veterans Affairs, we respect the important work that you have done and continue to do to improve the well-being of all Veterans. I emphasize again, that we are "government-to-government" partners and are second only to VA in delivery of benefits and services to those who have served our great country. SDVAs serve as an expanding hub and link to local communities where the Veteran resides. This opportunity for submitting a written testimony illustrates your recognition of NASDVA's contribution and value in serving our nation's Veterans and their families. With your help and continued support, we can ensure our Veterans and their needs are adequately resourced and remain a priority. The challenges we overcome today become the foundation of our promise to serve those who have borne the battle and for their families and survivors, and our commitment to the nation's future Veterans.

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