The National Association of State Directors of Veterans Affairs

NATIONAL ASSOCIATION OF STATE DIRECTORS OF VETERANS AFFAIRS

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Presented by

Timothy (Tim) Sheppard

President, National Association of

State Directors of Veterans Affairs (NASDVA)

Executive Director, Wyoming Veterans Commission

INTRODUCTION

Chairman Moran and Chairman Bost, Ranking Member Blumenthal and Ranking Member Takano, 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 Director Tim Sheppard, NASDVA President and Executive Director, Wyoming Veterans Commission.

Our association was founded in 1946 following the end of WWII to bring together the Directors of the Veterans Affairs' Agencies from all 50 States, five U.S. Territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and the Virgin Islands), and the District of Columbia. In the aftermath of the war, Veterans earned Federal and State benefits, which required coordinated efforts to ensure they received their earned entitlements.

State Directors, as leaders of government agencies, are tasked and held accountable by their respective Governors, State Boards, or Commissions to address the multi-faceted needs of our Veterans irrespective of age, gender, era of service, military branch, or circumstance of service. Although each State or Territory is unique with its organizational structure, programs, and resources, we are well-positioned to deliver effective, Veteran-focused services, and importantly, partner with the U.S. Department of Veterans Affairs (VA) with the common goal to make a difference in the lives of our nation's Veterans.

State Departments of Veterans Affairs (SDVA) are comprehensive service providers, second only to the U.S. Department of Veterans Affairs in providing earned services and benefits. As such, we serve as the primary intersection for Veterans between Federal and State governments, as well as local communities, Veteran Service Organizations (VSO), community partners, and non-government entities. We encourage communication, facilitate discussion, and promote "best practices" to successfully advocate for the nation's 18 million Veterans, their families, caregivers, and survivors. It is honorable work, and we are committed with purpose and passion to address the important needs of Veterans.

USDVA – NASDVA PARTNERSHIP

The collaborative relationship between the U.S. Department of Veterans Affairs (VA) and NASDVA was originally formalized through a Memorandum of Agreement (MOA) in 2012. It will be updated in September 2025 with a Memorandum of Understanding (MOU) with SECVA Doug Collins and NASDVA President Tim Sheppard signing its renewal at the 2025 NASDVA Annual Training Conference in Cheyenne, WY. The formal partnership between the VA and NASDVA continues to yield positive results for our Veterans across the nation. Since

NASDVA's incorporation, there has been a long-standing "government-to-government" cooperative relationship that shares a common mission to facilitate accessible, timely, and quality care for our Veterans.

To highlight our partnership, the MOU also provides the VA Secretary a forum to highlight "best practices" among the States and Territories through the presentation of the much-coveted *"Abraham Lincoln Pillars of Excellence Award."* It recognizes innovative programs that are transferrable for other States to emulate. The 2024 award recipients will be recognized at the annual conference in September 2025.

VA FUNDING

NASDVA is committed to working with Congress and VA leaders to ensure scarce resources are allocated to priorities that will meet our Veterans' most pressing needs in a Veteran-focused manner. NASDVA applauds Congress' concerted efforts to improve VA funding accountability while providing adequate funds for health care, processing claims and appeals, and addressing homelessness and suicide prevention. Likewise, continued emphasis is warranted on preparing for the Veteran aging population, increase in the Veterans' cohort, and support for caregivers and survivors.

We support Congress' efforts to hold VA's *Electronic Health Record Modernization Integration Office (EHRM)* accountable for transitioning to a new electronic health record system that tracks all aspects of patient care. The evolutionary upgrades to the VA's millennium software system will allow clinicians to access a Veteran's medical history in one location easily. It needs to address the operational concerns of the medical providers and enhance healthcare delivery for Veterans. Likewise, it is essential to address system deployment challenges and be prepared for future development issues.

As the VA continues its transformational journey, NASDVA supports the continuation of new initiatives and collaborative outreach. It will require careful observation throughout VA to ensure effective and efficient execution and a continued focus to deploy resources where Veterans can best be served.

VETERANS HEALTHCARE

NASDVA's priorities for the care of our nation's 18 million Veterans are consistent with those of VA. We fully support efforts to increase Veterans' access to VA Healthcare. This includes the continued collaboration of the State Department of Veterans Affairs (SDVA) with

Veterans Integrated Service Networks (VISN) and individual VA Medical Centers (VAMC) in enrolling Veterans and eligible family members in the VA healthcare system. This also includes expansion of Community Based Outpatient Clinics (CBOC) and Vet Centers, the deployment of mobile health clinics, and the expansion of the use of telehealth services. We applaud the VA's digital platform, which enhances a Veteran's access to their Health (appointments, messages, prescriptions, vaccine records, and COVID updates) and Benefits (disability rating and claims information).

NASDVA applauds recent VA initiatives involving mental health and Veteran suicide prevention. Veterans in acute suicidal crisis may now go to any VA or non-VA health care facility for emergency health care at no cost, including inpatient or crisis residential care for up to 30 days and outpatient care for up to 90 days. Veterans do not need to be enrolled in the Veterans Health Administration (VHA) to use this benefit. The expansion of care will help prevent Veteran suicide by guaranteeing no-cost care to Veterans in times of crisis. It will also increase access to acute suicide care for those 9 million Veterans not currently enrolled in VA.

The VHA must receive the funding required to care for the more than 9 million Veterans who are enrolled while the complexity of their care is increasing. They must have the resources necessary to recruit and retain doctors, nurses, and other professional staff. Under some circumstances, it is necessary and appropriate for Veterans to receive care at facilities and providers outside VA with community care, which currently accounts for 40% of the VA's total health care delivery. Lack of adherence to community care timeliness standards has been a source of contention by some Veterans. Referrals and appointments should be timely.

Reimbursements for community care services should also be prompt and meet industry standards. Slow reimbursements for care will discourage some healthcare providers from participating. The key is to focus on what is best for the Veteran and maintain a proper balance of in-house versus community care.

Telehealth services are mission critical to the service delivery of VA healthcare, and NASDVA applauds VA as a world leader in this practice. Telehealth is particularly critical to rural Veterans when timely access to mental health services is not available or when they must travel long distances to see a provider. SDVA can play an important role in connecting these Veterans to telehealth. Likewise, SDVA can provide outreach and connect our most vulnerable Veterans to life-saving programs. The collaborative 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.

NASDVA supports VA as they seek legislative authorities regarding telehealth prescribing of controlled substances to ensure that Veterans retain access to critical treatments and health

care professionals. Telehealth use dramatically expanded during the COVID-19 public health emergency in both Federal and private sector health care. During the pandemic, Federal and State flexibilities included authority for the prescribing of controlled substances as part of a telehealth encounter in the absence of a prior in-person medical evaluation. These flexibilities enabled many qualified health care professionals, delivering care through VA's telehealth programs, to initiate and maintain effective treatment plans for Veterans with chronic pain, substance use disorder, mental health conditions, or other conditions that required use of controlled substances for management.

Oral health is an important factor in physical, emotional, psychological, and socioeconomic well-being. VA offers comprehensive dental care benefits to only 600,000+ qualifying Veterans, and their dental issues must be directly related to their military service to be eligible. A veteran must typically have a service-connected dental disability, be rated at 100% disabled due to other service-related conditions, or be a former Prisoner of War. Veterans who do not meet eligibility criteria have to acquire oral health care outside of the VA. For many, this is difficult due to out-of-pocket expenses, distance to travel, lack of transportation, or lack of dentists in their communities. Oral health issues have a direct connection to overall physical health and mental health. Maintaining good oral health can lead to a reduction in heart disease. Presumptive conditions such as diabetes from Agent Orange exposure can also negatively impact oral health. Veterans struggling with mental health challenges may eat more sugary foods, drink, smoke, fail to perform daily tasks like brushing their teeth, and even have dry mouths from medications they are taking. These compounding issues may cost the VA healthcare system more money because they then become secondary ailments to the initial mental health disorder. NASDVA supports efforts to expand the eligible pool of Veterans entitled to dental care services through the VA, which in turn may reduce other health care challenges associated with poor oral care.

STATE VETERANS HOMES

The State Veterans Home (SVH) Program is the largest and most cost-efficient partnership between Federal and State governments. SVHs provide more than 50% of total VA long-term care in the 50 States and the Commonwealth of Puerto Rico through **171 operational SVHs**. These homes provide a vital service to elderly and severely disabled Veterans with over 30,000 authorized beds of skilled nursing care, domiciliary care, and adult day health care.

NASDVA and the **NASVH** (National Association of State Veterans Homes) have a strong and collaborative working relationship. Both NASDVA and NASVH support a continued commitment to the significant funding of the VA's ***State Veterans Home Construction Grant***

Program. It is the largest grant program between Federal and State VAs. VA provides up to 65% of the cost of construction, rehabilitation, and repair, with States required to provide at least 35% in matching funds. The FY2024 Priority List includes 81 Priority Group 1 projects where States have already secured matching funds, which requires a federal share of ~ $1.3B. This is an increase of roughly 30% over the prior fiscal year. FY2024 at $171M appropriation was only enough for nine projects. VA's FY 2025 appropriation for State Veterans Home Grants is projected to be **only $147 million**. Veterans' needs for long-term care services are increasing. An estimated 8.4 million living Veterans are aged 65 or older, including approximately 2.6 million who are 80 or older and 1.3 million who are 85 or older. Thus, it is vitally important to our nation's senior Veterans to keep the existing backlog of projects in the Grant Program at a manageable level to assure life safety upgrades and new construction. To address the rising need and backlog and fund at least half of pending Priority Group 1 grant requests, Congress should appropriate **at least $650 million**.

NASDVA also has concerns about behavioral health and future incidences of PTSD, 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. VA is responsible for specialty care for Veterans in SVHs, particularly when the care is in response to a service-connected condition. Often, when the coverage requires specialized healthcare services such as psychiatric care, VA does not cover the cost. Psychiatric services are outside the scope of primary care provided to SVH residents; however, it should be treated as allowed specialty care similar to cardiology and urology.

The nationwide shortage of direct-care providers, including doctors, RNs, LPNs, and Certified Nursing Assistants, is well documented. COVID-19 exacerbated the decades-long decline while fewer health care professionals are recruited and providers are leaving the workforce or retiring in large numbers. The national competition for providers is also presenting an untenable situation, which is made worse by both burnout among nursing professionals from the rigors of care and the salaries offered by large, well-financed hospital

groups. SVH resident census is hard to maintain because of chronic staff shortages, resulting in fewer Veterans being served and providers unable to cope with financial losses due to lower reimbursement rates tied to a lower resident census. Vulnerable Veterans in need of care are being denied access because of insufficient staff to meet the demand. Meanwhile, CMS (Center for Medicare and Medicaid Services) is in the process of implementing staffing mandates at a time when many providers can't even fill staff vacancies to meet the needs of current operations. These shortages are projected to continue.

SVHs appreciate VA's ***Nurse Recruitment and Retention Grant Program*** that promotes the hiring and retention of nurses. However, this applies only for the positions of RNs, LPNs, Licensed Vocational Nurses, and Certified Nursing Assistants. An expansion of the grant program should include other critical staffing for Physicians, Physical Therapists, Dieticians, and Social Workers. This would help SVHs compete with private sector facilities that provide sign-on bonuses, higher salaries, and benefits. SDVA and VA must continue recruitment and retention efforts to have the quality and quantity of providers to care for eligible Veterans.

VA is authorized to cover up to 50% of the cost of care through per diem for residents receiving care in a SVH. However, the current basic rates cover less than a third of the costs. Many factors, such as labor costs in a competitive environment, higher cost for pharmaceuticals, increase in food costs, unfunded mandates, and overall medical inflation, have all diminished the value of per diem. Honorably discharged Veterans are eligible for a daily VA per diem payment. The FY2024 rates are as follows: Nursing Care $144.10 per veteran, per day; Adult Day Healthcare $114.81 per veteran, per visit; and Domiciliary Care $62.20 per veteran, per day. Both NASDVA and NASVH recommend a new Grant Per Diem scale; the rates need to be increased. Veterans who are 70% or higher service-connected disability are eligible for no-cost nursing care at the SVH; however, VA does not pay for high-cost medications for this cohort. Certain medications, such as chemotherapy, can cost thousands per month. Community contract nursing homes with VA are reimbursed when these costs exceed a certain percentage (typically 8.5%) of the per diem. Congress needs to legislate that SVHs receive the same reimbursement.

VA's ***Geriatrics and Gerontology Advisory Committee*** is established to provide advice to the Secretery of VA on all matters pertaining to geriatrics and gerontology. This committee is in a position to provide recommendations on procedures and policies that govern SVH. It would be beneficial to the committee to have a *"voting"* member who is a licensed nursing home administrator and is currently serving as a SVH Administrator or in a supervisory role over SVH.

SVHs are subject to duplicate inspections. VA performs an annual survey that reviews clinical practices and life safety protocols and conducts a financial audit. Likewise, many SVH

are certified by CMS to qualify for CMS reimbursements, which requires them to undergo a separate CMS inspection. The VA and CMS surveys are identical in addressing the clinical and life safety sections. NASDVA and NASVH recommend that the SVHs have a single annual survey conducted by VA that is acceptable to CMS.

NASDVA is seeking support from VA to take administrative action to provide waivers for the SVH construction projects submitted before the ***BABAA (Build America, Buy America* Act)** effective date. BABAA was enacted with an enforcement date of May 14, 2022, and requires federal grantees to use Buy America preferences on all iron and steel, manufactured products, and construction materials incorporated into an infrastructure project, including the SVH construction grant projects. The law included certain waiver provisions: *when applying the domestic content procurement preference would be inconsistent with the "public interest;" when there are "nonavailability" issues where products or construction materials are not produced in the United States in sufficient and reasonably available quantities; and when the inclusion of products or materials produced in the United States creates an "unreasonable cost" condition, increasing the cost of the overall project by more than 25 percent.*

NASDVA agrees that the intent of BABAA is good for our Nation and that it was intended to strengthen Made-in-America Laws and bolster America's industrial base. Unfortunately, American manufacturing has not caught up to the requirements of the law. It has also negatively impacted the SVH construction grant projects found on the VA's FY24 Priority List. SVH construction projects listed on VA's FY 2024 Priority List initiated design planning and grant budget submittal before BABAA's effective date. Therefore, States did not have the opportunity to properly plan for the requirements associated with this Act, resulting in approved grant project scopes, schematic designs, and budgets that do not consider any of the BABAA impacts or cost increases.

Additionally, it has been confirmed by the VA that the availability of domestic products is a significant issue, and a vast number of the SVH construction grant projects will be unable to meet BABAA compliance due to industry constraints. More specifically, it was verified by the VA that SVH will be unable to purchase BABAA compliant electrical gear and mechanical equipment since these components are not domestically manufactured, e.g., this includes, but is not limited to, HVAC systems, switch gear, generators, step down transformers, and light fixtures. Simply put, these types of industrial constraints will also result in many of the SVH construction projects not being completed without a BABAA waiver, which would deprive many aging and ill veterans from receiving care in these long-term care facilities. Without resolution to properly address this matter, the quantity, quality, and continuum of long-term care and services we provide to our Veterans and their families is diminished, and the overall cost of these projects will continue to increase.

BURIAL AND MEMORIAL BENEFITS

NASDVA appreciates the National Cemetery Administration's (NCA) collaborative partnership with States, Territories, and Tribal governments through the ***Veterans Cemetery Grant Program (VCGP)*** and is the second largest VA grant program with States. VCGP-funded cemeteries complement NCA's 158 national VA-managed cemeteries for Veterans and their families and expand access to exceptional memorial benefits that meet "shrine" standards. Importantly, the program supports the NCA goal of increasing access to a burial option to more than 95% of all Veterans within a 75-mile radius of their home county. In FY2024, grant-funded cemeteries provided more **42,720** interments, which is **24%** of the total NCA and VCGP burials.

Since the establishment of the program in 1978, VA has awarded more than $1 billion grants to establish, expand, improve, operate, and maintain 122 Veterans cemeteries in 46 States, 14 Tribal trust lands Veterans cemeteries, and 3 Territorial cemeteries in Puerto Rico, Guam, and Saipan. Two (2) new cemeteries are currently under construction in Lubbock, TX, and Grand Island, NE, and a new grant is pending for Salcha, Alaska.

The **FY2025** budget proposal for the VCGP is **only $60 million**. This is insufficient to allow NCA to address all of Priority Group 1 applications (projects needed to avoid disruption in burial services within 4 years of the date of the preapplication) and have any sufficient funds for Priority Goup 2 to establish new cemeteries. The recently published FY2025 Priority List reflects Priority Group 1 (expansion) projects that total more than $100 million, and likewise, the Priority Group 2 (establishment) projects also total more than $100 million. This hinders achieving NCA's 95% coverage goal, particularly for underserved rural areas. It is vitally important to keep the existing backlog of VCGP projects at a manageable level. It is difficult for States to get new projects codified in the State budgets plus acquire the land for a new cemetery. Likewise, it is difficult to justify continued support for a project while remaining on VA's Priority Group 2 list year after year, waiting to receive the federal grant, as other expansion projects are being funded. Also, there are more expansion and improvement requests from the existing aging cemeteries, making it even harder to have funds for new cemeteries. NASDVA strongly recommends increased funding support for the **VCGP to $120 million**.

NASDVA also recommends that the FY2025 budget authorize appropriate funds to provide an increase of the **plot allowance to $978** and provide **plot allowance for family members**. The President's budget submission proposes providing this benefit, *"Expand plot allowance for certain individuals eligible for interment in a national cemetery: The proposal would amend 38 U.S.C. § 2303 to provide plot or interment allowances to VA grant funded State and Tribal Veterans' cemeteries for interments of certain individuals eligible for interment in national cemeteries. This proposal aligns eligibility for the plot allowance in grant-funded*

cemeteries with eligibility criteria for interment in national cemeteries." This increase of plot allowance funds will help offset the higher operational costs being experienced across all VCGP cemeteries. Also, it would allow the States to avoid charging eligible family members and maintain parity with National Cemeteries, where family members are not charged. Currently, States are in a position where they have to charge the equivalent plot allowance or an established flat fee for the Veteran's spouse or eligible family member. This fixes the inequity between the federal and state systems.

The Burial Equity for Guards and Reserves Act was incorporated as Division CC of *Public Law 117-103 (The Consolidated Appropriations Act for FY2022)*. The VA Office of General Counsel determined that the law allows VCGP-funded cemeteries to inter certain "non-veteran" individuals; however, it does not compel such interments. The consequence for those who elect to do so is that they must bear the costs of the headstone and outer burial container or niche cover. Since there will be no plot allowance to help cover the cost of the interment, VCGP cemeteries will have to appropriate additional funds. Again, it creates an inequitable situation with the Veterans vs. Non-Veterans who receive full memorial benefits interred in the same cemetery. Even though the numbers are small for those without federal active duty and thus qualify as "Veterans," it is desirable for States and Tribal governments to provide the interment. The local appreciation and respect are strong for the Guard/Reserve members who respond to natural disasters in the community. The average citizen is unaware of differences in eligibility and simply views them as military members worthy of the same memorial honors.

In summary, NASDVA strongly recommends the following in the FY2025 budget for the VCGP: Increase the funding from **$60M to $120M**, authorize the **plot allowance to $978**, and importantly, authorize **Plot Allowance for eligible family members**.

VETERANS BENEFITS SERVICES

VA continues to provide more care, more benefits, and more services to more Veterans than ever before. In 2023 alone, the Veterans Benefits Administration (VBA) completed more than 1.9 million disability compensation and pension (C&P) claims for Veterans, an all-time VA record that broke the previous year's record by 15.9%. This resulted in Veterans and survivors receiving over **$150 billion** in disability C&P benefits. NASDVA applauds VBA's enhanced claims processing, expanded C&P examination capacity, digitization of federal records, and the increase in hiring and training of new employees. VBA is also transparent in its up-to-date reporting of claims inventory, claims backlog, claims accuracy, and fully developed claims.

SDVAs continue to take on a greater role in the effort to manage and administer claims processing. Regardless of whether the State or Territory uses accredited employees or nationally chartered VSO (Veterans Service Officer)/CVSO (County Veterans Service Officers), collectively, we have the capacity and capability to assist the VBA. NASDVA maintains a close working relationship with **NACVSO** (National Association of County Service Officers). VA should offer expanded virtual and in-person training opportunities to accredited Service Officers, particularly those newly accredited Tribal Veteran 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 the Regional Office level. Additionally, as claims are processed through the National Work Que (NWQ) to better distribute caseloads, personnel staffing the Helpdesk Line need to have increased understanding of claims and access to the claim to better assist VSO/CVSO calling for assistance. Increased training opportunities and increased support from the Helpdesk Line will support a more efficient claims process.

The *PACT Act* was a monumental piece of legislation. It is the most significant step ever taken by Congress in addressing the ravages of toxic exposure. NASDVA supports continued emphasis on implementation. It requires expanding VA health care and benefits for Veterans exposed to burn pits, herbicides, and other toxic substances. Our Veterans and their families deserve no less. VAMC and VA clinics across the country continue to enroll Veterans every day for new toxic exposure screening as a result of the *PACT Act,* which has resulted in a marked increase in the number of disability compensation claims submitted as shown in the biweekly VA *PACT Act* Dashboard. Veterans do not need to join class action lawsuits to address potential disabilities from toxic exposures. We are concerned about consumer protection for those who do so. Alternatively, Veterans can file a claim for *free* using an accredited Service Officer. Submitting a claim through a VSO/CVSO will sharply increase the chances of an individual's claim being processed timely and adjudicated successfully. VA and NASDVA will continue their collaborative, in-person outreach efforts about the provisions of the *PACT Act* in 2025. SDVAs perform a vital role every day interfacing with Veterans where they live to inform and help them with their individual needs and prospective claims earned through their service.

NASDVA applauds VA's service-connection decisions that are a follow-on to the signing of the *PACT Act* of 2022. In June 2024, VA added male breast cancer, urethral cancer and cancer of the paraurethral glands to the list of illnesses presumed service-connected in conflicts since 1990. Additionally, VA recently determined to assume a service-connection for veterans facing leukemia, bladder cancer, and other cancers who served in Somalia or Southwest Asia during the Persian Gulf War (on or after Aug. 2, 1990), along with those who served in Afghanistan, Iraq, and seven other nations including at Karshi-Khanabad (K2) Air Base,

Uzbekistan during that war or after Sept. 11, 2001. Importantly, these Veterans will not need to prove their illness was related to service to receive disability benefits and are eligible for free VA health care for their conditions.

Over two-thirds of the 118th Congress supported the ***Major Richard Star Act***, but unfortunately, the bill was not considered for passage. It directly affects more than 52,300 combat-injured Veterans who were medically retired with less than 20 years of service. These Veterans are subject to an offset with their retirement pay being reduced for every dollar of VA disability received. Retired pay is for completed years of service paid by the DoD, while disability compensation is for lifelong injury paid by the VA. These are two different payments for two different purposes. Reducing retirement pay because of a disability is an injustice. NASDVA strongly recommends that the 119th Congress pass the *Major Richard Star Act*.

NASDVA appreciates Congress' support of an increased VA budget in expanding the number of VA health care personnel and staff members who adjudicate claims and supporting VA's efforts to recruit and train additional staff to handle the forecasted influx of additional claims. We acknowledge that the number of claims and appeals will increase until enough qualified VA staff are in place to handle the workload. It will take time to continue to reduce the expected backlog. NASDVA will work with VA to exhaust all efforts to lessen the time Veterans must wait to have their claim completed whether related or not to the *PACT Act* or the recently passed *Dole Act* as it is implemented.

WOMEN AND MINORITY VETERANS

There are more than 2.1 million (11.7%) women Veterans out of the 17.9 million total Veterans, according to the VA's VETPOP data. By 2030, VA projects that women Veterans will comprise 13.5% (16 million total), and by 2040, the percentage will increase to 16.3% (13.4 million total), making them the fastest growing group in the overall Veteran population. The numbers reflect the need for continued emphasis that they are eligible for the full range of Federal and State benefits, including special programs. NASDVA has made a concerted effort in outreach to inform women Veterans of their earned benefits and services. There are several areas NASDVA believes VA can close gaps in service, ensure continuity of care, and better address the needs of women Veterans.

Women Veterans are impacted by the nationwide provider shortage for the delivery of gender-specific healthcare. We encourage the VA to continue its aggressive recruiting and retention efforts for qualified health care professionals. In addition, VA priorities should include addressing the needs of all victims of Military Sexual Trauma (MST), especially women

Veterans, including those who served in the National Guard and Reserves. 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. Reconciliation of MST claims for PTSD should continue as recommended by the VA Inspector General.

VHA should also ensure women Veterans have access to and receive timely high-quality, gender-specific, and individualized prosthetic care that will allow them to improve their quality of life. Their healthcare needs to include infertility care, and NASDVA advocates support for Veterans with infertility issues caused by illness or injury while serving in the military. The *PACT Act* ensures that those eligible women Veterans who are experiencing infertility due to issues caused by toxic substance exposure are identified and eligible for care. The decision-making and planning for new clinics or renovation of existing clinics should 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. 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 reimbursement for the costs of services for minor children of homeless women Veterans. The issue disproportionally impacts women Veterans as they often 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 women 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. In addition, women Veterans are more likely to die by 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 who could be at risk of death by suicide.

According to the U.S. Department of Veterans Affairs, minority Veterans is defined as those who are identified as African Americans, Asian American/Pacific Islander, Hispanic, Native American/Alaska Native, and Native Hawaiian. To serve this important cohort of Veterans, NASDVA applauds the U.S. Department of Veterans Affairs recent release of its 2024 Equity

Action Plan, which states, "to help ensure that VA delivers on its promise to provide world-class care and benefits to *all* Veterans, their families, caregivers, and survivors regardless of their age, race, ethnicity, sex, gender identity, religion, disability, sexual orientation, or geographic location."

Veterans in Island Territories have had significant issues with earned services and support due to their isolation. When there are natural disasters, such as hurricanes, VA can often be the only available provider. During catastrophic events, NASDVA recommends that all Veteran categories should be accepted for urgent medical care. Native American Veterans are chronically underserved on their reservations. NASDVA applauds the recent Memorandum of Understanding between the U.S. Department of Veterans Affairs and the U.S. Department of Health and Human Services' Indian Health Service, seeking to increase access and improve the quality of health care and services for eligible American Indians and Alaskan Natives.

NASDVA supports the successful implementation of the January 2023 rule by the VA, waiving copayments incurred for eligible American Indian and Alaska Native Veterans. Eligible American Indian and Alaska Native Veterans who have submitted appropriate documentation to VA will no longer be required to pay copays for health care services. Funding Veterans in local native clinics puts resources back into their networks to provide care to all. This worked across Alaska, where VA clinics were closed several days a week. The IHS network is working well and very robust when the VA pays for the care for our Veterans in the Alaska Native Healthcare system. The limited funds they receive from IHS tend to go much further.

Native Veterans would much rather be cared for by IHS and have VA reimburse IHS. This appears to be a working model and should be continued. This is especially true on the large reservations and in Alaska, where distances are vast. We are aware that there are Veterans who are dual users of IHS, VA tribal health, or both. This allows the Veteran to choose the most convenient for his or her care. NASDVA wants to make sure that our Veterans and the systems that they access have the resources available continually. Should there be a government shutdown, IHS should continue as the VA does with medical care for our Tribal Veterans.

VETERANS HOMELESSNESS AND SUICIDE PREVENTION

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, work history, and high-cost rent.

NASDVA recommends continued funding for specialized homeless programs such as *Homeless Providers Grant and Per Diem, Health Care for Homeless Veterans, Domiciliary Care for Homeless Veterans, Supportive Services for Veteran Families (SSVF) Shallow Subsidies, 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 should continue to 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. Case management is imperative in these instances. These collective programs must be adequately staffed and fully funded in the current and future budgets.

NASDVA commends VA and HUD for their collaboration in increasing the number of Veterans Affairs Supportive Housing (VASH) vouchers. Unfortunately, in 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 vouchers be tied to local markets to ensure they can support Veterans with secure permanent housing.

NASDVA recommends additional attention for older homeless veterans, particularly those Vietnam Veterans who are now experiencing issues with injury or disease and can no longer care for themselves. These Veterans are very vulnerable and require long-term care but may not have filed for service-connected disabilities nor can navigate the system, which also may include Medicare. NASDVA recommends Congress review changing policy to allow these veterans to use HUD/VASH vouchers for long-term care. We owe these senior veterans the care they deserve for serving our nation.

VA continues to place strong emphasis on Veteran suicide prevention, but it still lingers as a societal crisis. We recommend increased collaboration between the VAMC, VARO, and SDVA to impact all facets of prevention. Data indicates that 70% of Veterans who take their own lives do not engage with VA. Access to VA has improved, but outreach to inform Veterans about their health benefits needs continued emphasis.

The entire Veterans community must take on the critical task of suicide prevention. Engaging community coalitions through the Governor's Challenge and Mayor's Challenge on Veterans' Suicide Prevention can support the VA's effort. The Governor's Challenge advances a public health approach by bringing together key state leaders to develop strategic action plans focused on Veteran suicide prevention. Teams receive support from VA and SAMHSA that includes technical assistance, consultation with subject matter experts, and sharing of best practices and innovations with other teams across the nation. NASDVA applauds these VA community-based Interventions, which reach Veterans through multiple touchpoints, cross-agency collaborations, and community partnerships.

TRANSITION ASSISTANCE PROGRAM (TAP)

Department of Defense reports that approximately 200,000 Service Members (SM) leave the military each year and transition to civilian life. They face the challenges of employment and education, finances, housing, health and new relationships. NASDVA strongly encourages the most effective national and state-level transition programs possible to ensure success during this stressful time. It is important for their emotional well-being and getting a good start in establishing the next phase of living a productive life.

SM are required to participate in the multi-day Transition Assistance Program (TAP) at their military installation before separation or retirement. Spouses are also encouraged to attend as appropriate. TAP is a mandated, standardized workshop across all services and components and primarily delivered by the Department of Defense, Labor, and Veterans Affairs. It focuses on earned benefits, employment opportunities, and education. Depending on the service members' plans, the TAP process can be inadequate to meet individual needs and it can be a challenge to absorb the amount of information. As a result, many see TAP as something they need to get through to leave the service rather than a helpful resource. Regardless, NASDVA recommends increased emphasis on mandatory participation in TAP.

It is often challenging for Transitioning Service Members (TSM) to connect with available earned State services, benefits, and support. Likewise, it is difficult for SDVA to make service members aware of these benefits and services, especially in their new communities. This lack of connectivity between TSM and the States contributes to significant barriers to employment and increases the mental stress associated with their transition. NASDVA applauds the recent change allowing pre-discharge documents to provide for "opt-out" (instead of "opt-in") for the sharing of email addresses and contact information to the States. States are in a unique position to provide critical information to access earned Federal and State services, benefits, and support. As well, post-service contact information on the electronic DD Form 214

discharge remains important to engage and inform those retiring or separating service members with the States and community-based organizations.

Likewise, NASDVA applauds recent coordination and efforts by the Veterans Benefit Administration to allow for a 45-minute block of instruction in their 8-hour curriculum for representatives from the States and VSOs to participate. We believe this important initiative taken by the VBA Under Secretary allows SDVA and VSO to provide information on the types of additional services and benefits available for those staying in their current location or moving elsewhere, further allowing TSM to make the best decision on their post-service careers. In the end, an effective TAP, across all partners at the federal, state, and local levels, makes a significant difference for the Veteran and their family to experience a smooth transition.

CONCLUSION

NASDVA respects the important work Congress has done and continues to do to improve the well-being of our nation's Veterans. As stated, we are "government-to-government" partners (Federal-to-State) and are second only to federal VA in delivery of earned benefits and services to those who have served our great country, particularly State Veterans Nursing Homes and State Veterans Cemeteries. State VA agencies serve as a vital link to Veterans where they reside. We are an integral part of the "whole of government" in serving our nation's Veterans, their families, caregivers, and survivors. With your continued support, we can ensure that the needs of our Veterans remain a national priority. In doing so, we are fulfilling the promise to take care of those who "have borne the battle" and are demonstrating a commitment to the nation's future Veterans.