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HEARING ON PENDING LEGISLATION

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED SEVENTEENTH CONGRESS

FIRST SESSION

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JUNE 23, 2021

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HEARING ON PENDING LEGISLATION

WEDNESDAY, JUNE 23, 2021

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 3:19 p.m., in Room SR-418, Russell Senate Office Building, Hon. Jon Tester, Chairman of the Committee, presiding.

Present: Tester, Murray, Brown, Blumenthal, Hassan, Moran, Tillis, Blackburn, and Tuberville.

Chairman TESTER. I want to call this meeting to order.

Before we get to my opening statement I just want to make one thing really abundantly clear. We have rules in this committee, when we want a testimony, we want it in before the deadline, not after the deadline. There is a reason for that. The reason for that is that both Jerry Moran and myself have some really amazing staff members that are able to scrutinize that testimony and get some questions driven by what that testimony says.

If the first time we see a testimony is a period not long enough for us to look at that testimony, that is a problem.

Next time, I will be much more pointed and a lot more mad if this happens. This is a professional outfit. You are a professional outfit. Rules are not made to be broken, in my opinion. They are made to be attended to. So I just want to say that to begin with. I hope I have made myself clear, thank you, and I hope that anybody from the VA that is listening to this, I hope I have made myself clear to them too. Okay?

We want to help you. We cannot help you if we do not know what the hell you are thinking. Okay? All right. Thank you very much.

Senator Moran will be here in a few minutes. I am going to start with my opening statement, and hopefully he will be here by the time I finish.

OPENING STATEMENT OF CHAIRMAN TESTER

Chairman TESTER. Good afternoon. I want to thank you all for joining us today to hear views from the Department of Veterans Affairs and veteran service organizations on 21 bills pending before this committee. Even before the pandemic, organizations working to support our nation's most vulnerable veterans told us they need bigger lifeboats as they could not fully support the existing population of veterans experiencing homelessness.

In April, we hosted a roundtable with VSOs on homeless veterans advocacy. We heard firsthand about the challenges they face

in facilitating a productive conversation with VA, HUD, Department of Labor about what needs to be done to address them. Included on today's agenda is my bill, the Building Solutions for Veterans Experiencing Homelessness Act. Every section of this legislation came out of a request made during that roundtable. This bill makes permanent COVID-related safety nets that have become essential to providing the most effective care and support to unhoused veterans and their families. These requests are not wish list items but concrete changes advocates have said are absolutely necessary in the fight to effectively end veteran homelessness. In fact, the Department is on record requesting some of the items in my bill from Congress.

Given this, it is disappointing that the VA has not provided views on my bill for this hearing, despite having had the text since May 24th. My expectation is VA will address this delay in views expeditiously.

Also on our agenda today is S. 1467, the VA Medicinal Cannabis Research Act, a bill that I worked on with Senator Sullivan that expands the research on alternative treatments for veterans who suffer from the seen and unseen wounds of war. A survey conducted by the American Legion tells us that 22 percent of veterans who responded already use cannabis to treat a medical condition. Our bill would help the VA get the necessary data to fully evaluate this treatment and educate veterans on the outcomes of using medicinal cannabis to treat certain conditions.

Once again, I want to thank our witnesses for being here today, and I mean that. Thank you. If we work together we can fulfill our promise to our veterans. We can reassure them that when they fight for us, we are going to fight for them, and guarantee they get the benefits that they deserve.

With that we are going to be in recess until Moran shows up.

[Recess.]

[The pending bills referred to by Chairman Tester appear on page 35 of the Appendix.]

Chairman TESTER. We will just go ahead. You guys start your testimony. The rules are that your full written statement will be put in the record, so if you can pare that written statement down to five minutes I would appreciate it.

PANEL I

STATEMENT OF MARK UPTON ACCOMPANIED BY GERARD COX; CLIFFORD SMITH; AND THERESA GLEASON

Dr. UPTON. Thank you, Chairman Tester and Ranking Member Moran and members of the committee. We appreciate you inviting us here today to present our views on bills covering many critical topics. Joining me today, I just would like to say thank you to Dr. Gerry Cox, Assistant Under Secretary for Health for Quality & Patient Safety; Dr. Clifford Smith, Director of Field Support and Analytics, Office of Mental Health and Suicide Prevention; and Dr. Theresa Gleason, Director of Clinical Science Research & Develop-

ment Service here in the Veterans Health Administration. I would also like to thank our VSO colleagues who will be part of the second panel. We truly appreciate what you do.

Mr. Chairman, I would like to start by just acknowledging your comments in the beginning. VA apologizes to the committee for our late submission of the testimony. We know that you depend on VA's views and pledge to work with you during and after this hearing to ensure you have the information that you need.

I will not be able to touch on all the bills in the agenda during these brief opening remarks, but our written testimony contains detailed comments on all but two of them, and I want to assure you that VA stands ready to engage with you on all of these bills.

VA has made mental health care and suicide prevention top clinical priorities, and we truly appreciate the committee's partnership on this important work. VA supports S. 544, that would establish an annual Buddy Check program. We appreciate the intent but cannot offer our support, however, for S. 613 and S. 951, both regarding therapeutic use of service dogs, due to different but overlapping concerns on both bills that we would be happy to discuss today.

Outreach during the transition to civilian life is critical, which is the subject of S. 1198, the Solid Start Act. This bill codifies vigorous outreach programs that we are doing now on a number of fronts. We do note some issues that are shared in our written testimony and certainly would be happy to discuss.

As the number of women veterans enrolling in VA health care increases, VA must be prepared to meet their needs. We appreciate the inclusion of reproductive health legislation on today's agenda. VA supports additional authorities to improve and expand these services, and a detailed analysis of S. 1280, the Veteran Families Health Services Act, is in our written testimony, including technical concerns and open questions, and we are eager to work with the committee to go through this in detail.

Let me assure this committee that nothing is as important to us as protecting the safety of the veterans who entrust us with their care. That must be paramount every hour of every day for VA. We support, with some suggestions, S. 539, the VCR Act, regarding the use of video cameras to monitor patient safety.

S. 372, the Ensuring Quality Care for Our Veterans Act, involves clinical reviews of the quality of hospital and medical services. We appreciate the committee's commitment to ensuring that veterans receive the safest and highest quality care possible, but do have concerns about the effectiveness of layering new requirements on top of existing review processes and mechanisms. We are eager to collaborate with the committee, however, as partners in patient safety.

VA remains committed to a strong, thriving, direct health care system, augmented by a robust and high-quality Community Care Networks. Veterans deserve and demand a strong VA health system tailored to their needs and a robust Community Care Network to supplement that system. The Guaranteeing Healthcare Access to All Personnel Who Served Act would make some fundamental changes to VA Community Care authorities, including codifying access standards now set by regulation.

We are concerned that it would eliminate VA's flexibility to react to changes in market conditions and other emerging issues, as well as preempt VA's ongoing intensive analysis of the access standards outlined in the MISSION Act. The bill would also directly mandate these access standards in our contracts with community providers, and we believe there could be disruptive, unintended consequences from that change and that network adequacy is an issue that requires the ability to adapt to changes in market conditions and emerging needs of our veteran population. There are other significant changes that would greatly affect VA's delivery of health care that we would be happy to discuss with the committee.

VA supports, with some technical changes, the Veterans' Emergency Care Claims Parity Act, and is glad to support S. 727, the CHAMPVA Children's Care Protection Act.

Our country's most sacred obligation is to prepare and equip the troops we send into harm's way, and to care for them and their families when they return home. The Building Solutions for Veterans Experiencing Homelessness Act is a package of provisions to buttress VA's efforts to support veterans in need of assistance. While VA has not been able to conclude views on this bill, there are many worthwhile concepts in this legislation, and we are eager to work with you, Mr. Chairman, and the committee on technical assistance in the meantime.

VA supports the Improving Housing Outcomes for Veterans Act, which would help coordinate best practices and other information on homelessness programs among homeless providers and VA medical center staff. We do note some duplications in the bill's provisions, however.

Finally, VA is glad to support S. 1040, which would expand eligibility to VA health care benefits to World War II veterans that are not otherwise eligible.

I want to re-emphasize that we greatly appreciate the partnership of this committee and the time to discuss these important bills with you today. This concludes my statement, and we look forward to your questions.

[The prepared statement of Dr. Upton appears on page 39 of the Appendix.]

Chairman TESTER. I appreciate that. I appreciate your comments on the testimony too. We will hold you to it.

As I pointed out in my testimony, there was no comments given on S. 2172, which is a bill that I am particularly fond of, but may not be perfect. When can I anticipate your comments on that bill?

Response: Comments were provided to SVAC Majority staff (Tess Wrzesinski) during a phone call with VA SMEs on June 30, 2021, and will continue with a follow-up call (and/or written TA) upon receipt of the revised version of the bill.

Dr. UPTON. Mr. Chairman, first off, as a frontline VA health care provider, the work that we do in VA to help homeless individuals is so important to me, so I truly appreciate that, just at the outset. I think one of the unique parts of being a VA provider is when I am taking care of a medical issue that is compounded by homelessness we are able to help both, which is very, very key.

In terms of the exact timeline, sir, I know we are actively working on that and will certainly be glad to take that for you after this hearing today. But you should receive that soon, and that is certainly our commitment.

Chairman TESTER. That would be good. Yes, I think it is really important.

Look, I do not want to bring up old issues, but we did a hearing on toxic exposure and the VA did not do any comments on any of those bills, for whatever reason. And quite frankly, we are paying for that right now. We are paying a price for that. And so just keep in mind that if there are bills out there, all you have got to do is say, "Yep, I like it," or "No, I don't, and here is why." That is it, and it is really important.

I have a question for you, Dr. Upton, and it has nothing to do with any of the bills. It has to do with the adequacy of our dental network in Montana, and I want to thank you for looking into that adequacy. My understanding of it is that of the 13 dental providers in the CCN serving Great Falls, just 7, a little over half of the dental providers are willing to make appointments for veterans, meaning roughly half of VA's directory of dental providers, developed by contractors, was unusable for the fourth-largest city in Montana, maybe the third.

Unfortunately, this is not an isolated issue, and one that should be reviewed nationwide, so the contractors are accountable for network adequacy and veterans are able to know what their actual options are for dental or medical care within the community.

What can the VA do to execute better the oversight of these networks?

Dr. UPTON. Thank you, Mr. Chairman, and just to echo both my role as a frontline doctor, as I mentioned before, as well as the head of Community Care in the Veterans Health Administration, ensuring that veterans have access to the care they need, it is critical. It is personal to me and it is our fundamental priority.

The CCN contracts that you reference are a substantial step forward in the care for our veterans and in the work that we do with Optum and TriWest, our focus is to get it right the first time. But there are certainly some things that we have learned, implementing large contracts in the midst of the pandemic, and my focus as well as our partners that we work with is when an issue gets identified, which I truly appreciate the VA Montana staff, your staff, relaying that to us, we take it seriously, we acknowledge it, we work to make it better, as well as work on large-scale initiatives.

So a lot of nuances to that, that I am happy to share with you, sir, and your committee, but the fundamental answer is I hold myself to a very high standard, our office as well as our contractors, and we are committed to ensuring that we get this right on all fronts, and I am happy to keep you and the committee updated on that.

Chairman TESTER. Okay. Thank you. Senator Tillis.

SENATOR THOM TILLIS

Senator TILLIS. Thank you, Chairman Tester. Thank you all for being here to testify. As you know, Senator Fischer and I have

been working on complementary legislation that seeks to provide veterans with access to proven alternative treatment models such as therapeutic training of service dogs, and in some instances, pairing veterans with such service dogs.

I am somewhat disappointed that the VA's testimony today raises a number of issues that have already been discussed and agreed-upon by the House's unanimous package of Representative Stivers' PAWS for Veterans Therapy Act. While I wish the VA would have accounted for these changes, which I believe resolved the majority of the outstanding concerns, I do want to raise a few specific questions that you outlined in your testimony. And, Chairman Tester, we got this information, or the feedback, just a couple of hours ago.

So when we have limited time I always hate it when members say, "Give me a yes or no answer," but to the extent you can give me a yes or no answer on some of these concise questions I would appreciate it.

Your testimony states, "Although possibly helpful to a limited number of veterans, the therapeutic medium of training service dogs does not have an adequate basis of evidence." Isn't it true that the VA has already conducted Train the Trainer Program at Palo Alto, VA?

Dr. SMITH. Correct. There is a program at Palo Alto.

Senator TILLIS. And isn't it the purpose of vital programs to test out these innovative approaches so we, as policymakers, can gather additional outcomes and data?

Dr. SMITH. Correct.

Senator TILLIS. And the VA's testimony also casts doubt on the efficacy of pairing service dogs with veterans experiencing posttraumatic stress, but isn't it true that the VA's own study recently found a reduction in severity of PTSD symptoms and suicidal ideation and behaviors in veterans paired with service dogs?

Dr. SMITH. There is not enough scientific evidence to support that broad conclusion.

Senator TILLIS. I will follow up on that with questions for the record.

Moving on to quality standards, which was outlined in the PAWS for Veterans Therapy Act that was unanimously passed by the House. You raised concerns that the standards and quality of partner service dog training organizations, yet isn't it true that the VA already has standards for seeing eye dogs?

Dr. SMITH. The VA uses the two accrediting organizations as their main bodies, correct.

Senator TILLIS. And isn't it true that those standards are defined in regulations and not in statute?

Dr. SMITH. I believe that is correct.

Senator TILLIS. You know, the PAWS for Veterans Therapy Act, which unanimously passed the House last month, in a cooperation on a bipartisan basis, requires any participating organization to be—these are the words—"accredited with demonstrated experience, national scope, and recognized experience in training of service dogs, as determined by the Secretary." Are you suggesting that the VA would set standards that are inadequate or lesser than those it currently uses?

Dr. SMITH. We would use the standards of the two accrediting bodies.

Senator TILLIS. Don't you agree that calling out specific accrediting bodies would hamstring the VA's ability to make future adjustments to maintain program integrity and quality? When I was a coder I called that hard coding. We wanted to give the VA flexibility. Would you agree that it would make more sense to give the VA flexibility?

Dr. SMITH. Well, we appreciate that intent at flexibility. We want to maintain the highest of gold standards, and those two organizations are the gold standard.

Senator TILLIS. Isn't it true that the VA worked directly with the House sponsors to arrive at a mutually agreeable standard in the PAWS for Veterans Act?

Dr. SMITH. Subject matter experts have been working with the House, correct.

Senator TILLIS. Now with VA authorities with regards to service dog pairing, VA's testimony states that Section 4 of my bill was duplicative because VA already has the authority to provide a service dog to a veteran, regardless of whether a veteran has mobility impairment. Has the VA ever used that authority?

Dr. SMITH. I am aware the Secretary has that authority. I believe it has been——

Senator TILLIS. They have not used it. I do not believe they have, and we can make sure you can submit those specifications for the record, at least based on our best research.

Isn't it true the VA's implementing regs are more limiting than the underlying statute?

Dr. SMITH. I would have to take that for the record.

Response: The Department does not ″place a service dog with a Veteran,″ although VHA Clinical Offices may provide recommendations for Veterans with various disabilities as to whether or not a service dog is appropriate for them as a Veteran seeks to obtain a service dog from a service dog provider.

VHA (Rehabilitation & Prosthetic Services) administers the veterinary health benefit for Veterans with approved service dogs that have been obtained from Assistance Dogs International or International Guide Dog Federation training organizations. Currently, this benefit extends to guide dogs (for visual impairment), hearing dogs (for deafness), and mobility dogs (for mobility disorders due to physical or mental health-related disorders).

Senator TILLIS. In our judgment it is. This section simply seeks to get VA to update its implementing regulations to reflect congressional intent. Unfortunately, the VA has ignored this spirit of the law, and instead applied its own narrow approach.

So in my remaining time, you know, here today are a series of concerns with respect to how the VA will execute the legislation. I firmly believe the VA has the tools and authorities necessary to make this program a success, and 435 of my House colleagues, and I will also say many of my colleagues in the Senate, agree. We have waited too long to provide the treatment, and I would like to move forward on it.

Thank you, Mr.—I almost called you Mr. President—thank you, Chairman.

Chairman TESTER. I would never forgive you if you did that. Thank you, Senator Tillis. Senator Hassan.

SENATOR MARGARET WOOD HASSAN

Senator HASSAN. Well, thank you, Chair Tester and Ranking Member Moran. Thank you to all of our witnesses for being here today and for your service. And I am going to direct these questions to you, Dr. Upton, and if you want to ask other panelists to chime in, please do.

Every year, 200,000 servicemembers transition from military to civilian life. The majority are in the 18- to 34-year-old age range, which also has the highest veteran suicide rate. That is why I introduced bipartisan legislation with Senators Cramer and Cassidy to strengthen and make permanent the Solid Start Program, which as you know, is the VA initiative that aims to contact every veteran multiple times by phone in the first year after they leave active duty, to check in and help connect them to VA programs and benefits.

So can you please speak to how Solid Start's early and consistent contact with new veterans is critical to their well-being?

Dr. UPTON. Absolutely, Senator, and we in VA completely agree that that transition from active duty service into our system is a very important transition period and one that should be taken with as much support as possible.

There are a lot of components to that, that relate to mental health, and so I am going to turn to Dr. Smith to touch on that quickly.

Senator HASSAN. Yes.

Dr. UPTON. I appreciate that.

Senator HASSAN. Thank you.

Dr. SMITH. Senator, we appreciate that bill and many of the aspects within that. I am aware of your commitment for those transitioning servicemembers. Broadly, our Solid Start Program is already incorporating many of the things you raise in the bill. There are some places we would appreciate further discussion for clarity. But overall, the current proposal is consistent with our implementation of the three phone calls within the first year. It is of critical importance to do all we can for that engagement of those servicemembers.

Senator HASSAN. Well, I think it will make a real difference, as you all have said, to mental health supports for our veterans, and that is why I think it should be made permanent, and I look forward to continuing to work with you on it.

Let's go on to the Buddy Check program, because veterans need outreach in a lot of different ways, and the American Legion's Buddy Check volunteer initiative is important because it connects veterans directly with other veterans. I introduced bipartisan legislation with Senator Ernst to build on the American Legion's efforts by directing the VA to designate 1 week per year as Buddy Check Week, to organize outreach events and educate veterans on how to conduct peer wellness checks.

So, Dr. Upton, and I think probably Dr. Smith too, can you please speak to how Buddy Checks, which are volunteer led, could complement the VA's efforts to support veterans' mental health?

Dr. UPTON. Yes. I will just say thank you for that, and we wholeheartedly agree. That bill, and because it is mental health specific, I will turn to Dr. Smith, but thank you.

Dr. SMITH. Thank you, Senator. We agree it is a great opportunity. We do many outreach activities now, Mental Health Month, for example, focusing on communications to not only VA enrollees but non-enrollee veterans. Buddy Check is another opportunity. I do think it is an opportunity to think broadly. It is not just a mental health issue. It is a community issue. We should be aware of our buddies. And so that is how we would approach it, moving forward, is it is not just a mental health focus. It is a veteran focus. It is about community.

Senator HASSAN. Yes, and it is also about different veterans with particular different needs or experiences being able to find each other——

Dr. SMITH. Absolutely.

Senator HASSAN [continuing]. And that is something I am hearing from women veterans, particularly in rural parts of my state. So I will look forward to working on that with all of you.

I want to follow up on the line of questioning that Doctor, Senator Tillis—I just made you a doctor, Senator—Tillis was talking about, because we need innovative solutions to address veteran suicide and post-traumatic stress disorder.

So as you may know, I support legislation like Senator Tillis' and like Senator Fischer's PAWS Act, which would establish a 3-year program at the VA where the Department would provide grants to eligible service dog organizations to pair more veterans with service dogs.

So what I think you are hearing from Senator Tillis, and what I would like some commitment on here, is we currently understand that the VA, just this morning, indicated it does not support these bills, but can we have your commitment that the VA will implement it as Congress intends by providing a legitimate avenue through the VA to provide service dogs to veterans with PTSD?

Dr. SMITH. Thank you, Senator. Absolutely. You know, we are aware, and we agree with the deep commitment to intervening in veteran suicide. We have to think big, think creatively. It is an opportunity to continue thinking big. I know, in addition to the two Senate versions there is a House version. We look forward to those continued conversations with our subject matter experts, staffers and yourself personally. We are committed to that.

Senator HASSAN. There are a lot of members of both sides of the aisle who are getting a lot of briefings and information that indicates that these would be really valuable pairings, efforts, and it really does support veterans with PTSD. So what you are hearing from us is a real desire, even if you have some differences, if it passes, that we get to work and do this in the way that Congress intends. Thank you.

Chairman TESTER. Thank you, Senator Hassan. Senator Moran for an opening statement.

OPENING STATEMENT OF SENATOR MORAN

Senator MORAN. Chairman, thanks for your accommodation. There are two hearings that I am the Ranking Member of going on at the same time, and a third one that I needed to attend, but I think I am with you for the rest of the afternoon, and I am not sure that you will find that pleasing but I am here for the duration.

Dr. Upton and our VSO witnesses that are here today, I say good afternoon to you and I am looking forward to hearing from each of you regarding the legislation before us. Today we have 22 bills for consideration, with most relating Veterans Health Administration. In recent years, Congress has passed significant reforms to modernize the system to be more effective, streamlined, and most importantly, veteran centered. These changes have yielded positive results with more veterans having a favorable opinion of VHA.

Integral to these reforms has been greater choice and flexibility among our veterans. Putting greater control into the hands of veterans through the VA MISSION Act has helped improve the VA and make certain that veterans have timely, reliable access to care.

In addition to the MISSION Act, the Commander John Scott Hannon Act, that Chairman Tester and I introduced, is enhancing veterans' care by building upon innovative suicide prevention services, expanding veterans' access to mental health care, bolstering VA's research efforts, and increasing VA accountability on all mental health and suicide prevention services.

Despite these recent achievements, gaps remain. My bill, Guaranteeing Healthcare Access to Personnel Who Served Act, or GHAPs Act, would work to close those gaps by ensuring certain and consistent coverage to veterans who get their care through the VA.

When introducing the GHAPs Act it was important to me to solicit support from all VSOs and veteran service organizations, large and small. Too often, in important legislation that impact veterans, only a few select groups are given the opportunity to discuss. With the GHAPs Act, my staff and I made it a priority to talk with numerous organizations which serve veterans across America. I am grateful to have the support of larger VSOs, such as the American Legion and Vietnam Veterans of America, and the smaller VSOs, such as the Alaska Native Veterans Association, the National Association of Black Veterans, and the American Ex-POWs, as well as the support of important stakeholders such as the American Red Cross and the National Association for Rural Mental Health.

In addition to GHAPs Act, I look forward to discussing my VA Supply Chain Resiliency Act, which would address VA's supply chain process, particularly during emergency periods. As we saw during COVID–19 pandemic, it is crucial that the VA have robust plans in place to take into account interdepartmental cooperation and to make certain the system has adequate and appropriate distributed resources in times of emergency.

On the remaining legislation on today's agenda there are a number of important bills from my colleagues that address critical topics such as patient safety at the VA medical centers, the VA Solid Start Program, alleviating veteran homelessness, and VA provider accountability. On this last subject, I am pleased to co-lead the bipartisan effort with Senator Manchin to ensure that only verified and credentialed providers are permitted to treat our nation's veterans.

Lastly, I would like to speak to our veterans directly. For your service you deserve a system that works for you. Whether you live in rural America or urban America, Indian country, or overseas,

your service to our country must be matched by this committee and the Department of Veterans Affairs.

I look forward to hearing testimony of each of the bills today, which I missed hearing it but I have it in writing, and I look forward to determining how we can work together to better serve our American veterans.

Mr. Chairman, I will ask my questions at a later time, and I yield back.

Chairman TESTER. Thank you, Senator Moran. Senator Murray.

SENATOR PATTY MURRAY

Senator MURRAY. Thank you very much, Mr. Chairman. I do want to talk a little bit about the two bills that I have on the agenda today, which would improve the lives of veterans in Washington State and across the country.

The first one is the Planning for Aging Veterans Act. It will require the VA to develop a strategy to address long-term care needs of veterans to guide our future investments. The bill would make improvements to VA's oversight of State Veterans Homes and provide geriatric psychiatric assistance to veterans in these facilities, which can improve the lives of veterans living with traumatic brain injuries or memory loss.

The second bill is the Veteran Families Health Services Act. It is critical for so many of our veterans with infertility, trying to realize their dream of having children. I have been fighting for the provisions in this bill to become law for almost a decade, because America's veterans deserve comprehensive health care benefits from the VA after their service to the country, and that includes fertility treatments. This legislation is needed because VA's current authority to provide fertility treatment, such as IVF, is limited. This bill would make VA's authority permanent and expand access to these services in a way that would meet the needs of veterans across my state and the entire country, and I really appreciate VA's technical assistance on this bill. I do have a few questions for the witnesses, and Dr. Upton, I want to start with you.

VA's existing authority to provide IVF is unnecessarily restrictive and means that many of our veterans do not have access to fertility programs they need to start a family. For example, VA's existing IVF policy prohibits the use of donated gametes. How common is it for private sector fertility providers to allow the use of donors?

Dr. UPTON. Thank you for the question, Senator, and as an internist myself and not a women's health expert I am happy to take that specific question for the record. But what I can say, as someone who executes the IVF contracts in the community as well as works closely with their women's health experts, they are very appreciative of many aspects of your bill and the need to create more of an equitable playing field and align more of our care with health care standards. And I think that will likely be aligned with that, but we are happy to confirm and report back.

Response: Allowing the use of donated gametes would be a standard of in-vitro fertilization practice for private sector fertility providers.

Senator MURRAY. Well, VA's existing authority to provide IVF comes from appropriations that have been enacted by Congress each year. How does not having permanent authority affect VA's

ability to plan ahead, to educate VA providers, and make sure there is continuity of care for our veterans?

Dr. UPTON. I will have to take that one for the record as well, Senator, but I will say that there are many pieces in the bill that we support and very much appreciate.

Response: Appropriation laws have expirations tied to the fiscal year cycle. VA has not been able to assure Veterans that the episodes of IVF care they are entering into will be authorized beyond a given fiscal cycle. The process of IVF treatments can easily require months of examinations, medication cycles to enhance ovulation, and specific scheduling of retrieval treatment attempts. In addition, Veterans may make decisions about pregnancy attempts based on the potential expiration of benefits rather than on what timing is best for their family.

Senator MURRAY. Well, I would say for my colleagues on the committee and in the Senate and everywhere else, that if they do not have permanent authority then it is very hard to help our veterans plan for the families that they deserve. They served our country. They were injured, which made limited opportunities for them to have children, a dream many people ought to have, including our veterans. And so we need to enact a full, comprehensive bill here that will allow them to get that, and for the people who are providing it to be able to give them the kind of education that they need to make sure that they can plan for their families.

Dr. Upton, I have spoken at previous hearings about the Planning for Aging Veterans Act and the importance of the VA preparing for the future long-term care needs of veterans. As the Department makes decisions about infrastructure and staffing, the VA has provided a lot of support to State Veterans Homes throughout the COVID–19 pandemic, and I hope the relationship between State Veterans Homes and the VA remains strong. However, the process of entering into sharing agreements between medical centers and individual State Veterans Homes can differ widely from state to state. Some VA medical centers are able to reach an agreement with a state home in a timely manner. Others, it takes years to get an agreement put together.

Can you describe for the committee how the lack of a standardized process to enter into these agreements can affect access for residents to State Veterans Homes?

Dr. UPTON. Thank you, Senator, and I just completely agree with the need for an important plan and partnerships as our veteran population ages. The partnership we have with our State Veterans Homes are critical, and we have certainly worked closely with them throughout the pandemic, as you know.

Our technical experts specifically related to those sharing agreements would be happy to comment on that, and I know they have in our testimony. But my assumption is they are very important and we appreciate your help improving that, and we will get you a formal answer as well.

Response: VA Medical Centers follow an internal VHA Directive 1660.01, Health Care Resources Sharing Authority—Selling, that has the defined process. A selling sharing agreement is used when a State Veterans Home (SVH) is required to provide a service under the federal regulation and they seek that service from the VA Medical Center.

An agreement does not have any impact on the SVH admission process.

Senator MURRAY. Thank you very much. I appreciate that. Thank you, Mr. Chairman.

Chairman TESTER. Senator Moran.

Senator MORAN. Chairman, thank you again. Dr. Upton, again thank you for being here. My staff and I have repeatedly shared our concerns with the Department regarding issues for veterans in rural and highly rural areas in obtaining high-quality virtual care from the VA during the pandemic. The primary answer we have received from the VA on that is their solution is that the Department is giving 5G-enabled iPads to veterans, though connectivity barriers continue to persist for veterans in VA care who reside in rural and highly rural areas.

Do you have anything more besides giving iPads to veterans and the ATLAS partnership that you can share with the committee on how the VA is trying to find innovative solutions for our rural and highly rural veterans?

Dr. UPTON. I appreciate that, Senator, and certainly we share the commitment to helping highly rural veterans, particularly in Kansas and across the country, who face those concerns. As you mentioned, our group who oversees telehealth and connected care have been very dedicated to doing that, offering 99,000 internet-enabled tablets, cellphones, as well as working with major telecommunication companies to help address what we call the digital divide, which is very critical.

I think there is still more work to do, both within VA and in the private sector, and we would look forward to partnering with you, Senator, on additional efforts to bridge that divide.

Senator MORAN. Dr. Upton, thank you. Let me ask about access standards. To paraphrase Dr. Matthews' testimony, on April 2019, at an SVAC hearing, the VA conducted a broad span market analysis of public and private sector plans as well as its own data to create access standards. She also testified the VA hoped to stick with an industry standard so that veterans might have a reasonable expectation of when they could actually receive care.

Do you agree with Dr. Matthews' sentiments, and do you still believe the VA did well when crafting access standards?

Dr. UPTON. I appreciate that, Senator, and I worked for Dr. Matthews during the time and I know there was a very thoughtful review that has been done. I would say that we are very committed to implementing the MISSION Act and providing the utmost best access to our veterans. We do feel that there needs to be a review at this point, as outlined in the MISSION Act, to truly understand those impacts. And the honest answer is, Senator, that those access standards went live and about 8 months into that the pandemic hit, and so there is still much more to be learned, and we are committed to working with you to do that and ensure that access is available to veterans.

Senator MORAN. Doctor, let me go back to what I think is the crux of my question. Dr. Matthews outlined the process that you went through, that she went through, the Department went through, to develop those access standards. The way she described it, in my view, was very positive. My question is, do you agree that the process that the VA went through was an appropriate process to determine the access standards?

Dr. UPTON. Having been a part of that process as well, Senator, I think it was very thorough, using the best industry information we had at the time. But as I believe Dr. Matthews said at the testimony, and elsewhere too, there was still a lot to be learned and a lot of parallels in industry for the similar standards that we were building. But we did a very thoughtful analysis at the time.

Senator MORAN. Thank you for that answer. Dr. Upton, in regards to Community Care and the access standards review next year, is it possible that a review could result in new access standards with longer wait times and drive times than what is currently in regulations?

Dr. UPTON. I will say that the Secretary is committed to making this the absolute best that it can be for veterans. I would not expect that to occur, but we are doing a very thoughtful analysis with veteran experience, outcomes, and wait times at the center of that, and we will be very transparent throughout that process.

Senator MORAN. If that was the outcome, would you consider that something that would be negatively affecting veterans?

Dr. UPTON. I would say that we absolutely do not want anything that would negatively affect veterans, Senator.

Senator MORAN. Is there anything preventing the VA from relaxing access standards as a result of the review?

Dr. UPTON. As I mentioned earlier, we are very committed to a transparent process, and in the current process that would involve regulation, which involves public comment, VSO comment, working with our congressional colleagues, and nothing will happen without a very transparent advanced notice, in collaboration with important committees like yours, Senator.

Senator MORAN. The possibility then exists for relaxing standards that would create longer wait times?

Dr. UPTON. I would say that that would certainly—anything that would negatively impact wait times for veterans would certainly not be our intent, Senator, and anything that we do will be very well thought out, based on evidence, and transparent throughout the whole process.

Senator MORAN. Dr. Upton, my staff has repeatedly shared our concerns about conflicting access standards and regulations and access standards in our CCN contracts. Has the VA modified Region 1 for contracts to incorporate MISSION Act access standards?

Dr. UPTON. Senator, as I have committed to your staff as well as to Senator Tester's staff, my initial focus has been to address the needs of highly rural veterans, similar to your State, in Kansas, and we are in advanced stages of modifying that highly rural drive time standard to substantially reduce that, and we would look forward to continue working with you and the committee on other potential avenues.

Senator MORAN. That would then be incorporated into the existing contracts?

Dr. UPTON. That is correct, sir.

Senator MORAN. Thank you, Dr. Upton. Thank you, Chairman.

Chairman TESTER. Senator Brown.

SENATOR SHERROD BROWN

Senator BROWN. Thank you, Mr. Chairman and Ranking Member Moran, for the good work you do together in running this committee. We have worked for years to strengthen veterans' health care, both in the VA and in the community. Young adults, as you know, age out of CHAMPVA coverage at 18, and if they are a student they age out at 23, understanding that ACA, people age out at 26 for private sector health care insurance plans.

We are recovering from the worst pandemic in 100 years. Now is the time to right the wrong and correct this oversight from 10 years ago. We made the change for TRICARE. We should do the same for CHAMPVA, which is what my CHAMPVA Children's Care Protection Act of 2021 would do. No parent or child should face the additional mental burden of worrying about their health care coverage.

Dr. Upton, from watching your head nod I assume you agree that CHAMPVA beneficiaries should have parity with TRICARE beneficiaries?

Dr. UPTON. Senator, I know we have many bills on the docket today. This is an area that I directly oversee and concur. And I will just say, very briefly, that the CHAMPVA program, the children that you are speaking of are children of servicemembers who either are severely disabled from war or who lost their parents, and they deserve to be treated equitably, similar to the other health plans that are out there. And so we are very supportive of this bill, in making that change, and I appreciate you raising that.

Senator BROWN. We will continue to work with you to make sure that it is enacted and carried out. Thank you.

I was glad to see that Senator Murray's bill, Veterans Family Health Services Act, that she was talking about when I entered the room, is on the agenda. I am a co-sponsor, as many are on this committee. It is beyond shameful we have not acted to make this change, this benefit permanent. I urge my committee colleagues to support this. This is a move forward, so that wounded veterans receive comprehensive health care benefits, including fertility treatments and counseling, to enable them to have families. I just wanted to concur with Senator Murray's very lucid comments.

I will end with one question for Dr. Smith, if I could. I have worked on a bill to improve mental health connections for transitioning servicemembers. It is not on today's agenda. My job is to convince the Chairman and the Ranking Member that it be. It is the Daniel Harvey and Adam Lambert Improving Servicemember Transition to Reduce Veteran Suicide Act. It would create a pilot program to counsel servicemembers about mental health, the challenges they might face during transition to civilian life and how that might affect their mental health, and the services available to them at their local VA medical facility, in the 90 days post transition.

A social worker or mental health professional from the local VA would call the servicemember to set up an appointment. We, I think, are increasingly conscious, as a society, as members of the Senate, reflecting much of the time that society we have simply not done what's needed to do for mental health services throughout our

government, throughout our society. No excuses for not doing it at the VA.

So Dr. Smith, talk to me, if you would, for a moment, about the value for veterans knowing that mental health programs are available to them at their local, very trustworthy in their minds, VA, and having that, shall we say, warm handoff back to civilian life.

Dr. SMITH. Thank you, Senator. We look forward to being able to review that and provide technical assistant as that is developed.

It is a critical time period. Transitions for any adult is critical. It is a critical time for an individual who is committed to serving in the military, and that may be the only job, profession, role that they are familiar with, coming right out of high school. So this is something new for them, and there are a lot of stresses during that time.

So you bring up excellent points. It has to be a seamless handoff, as much as we can be doing. The Hannon Act covers this, with Section 101, and what we can be doing for services in that first year. Solid Start is another addition to that. All of these should be working together, in union, to address the transition process, to make it as smooth as possible, as seamless as possible, and to encourage our servicemembers to make that transition.

Senator BROWN. Thanks. Mr. Chairman, thank you.

Chairman TESTER. Senator Tuberville.

SENATOR TOMMY TUBERVILLE

Senator TUBERVILLE. Thank you, Mr. Chairman. I feel like I am on the committee down here, on the end. You put me all of the way at the end of that. It is good.

Thank you all for being here. Like many Americans over the last year, Alabama's veterans took advantage of telehealth services to meet their doctors. The total number of telehealth visits for the VA-enrolled veterans in Alabama increased 886 percent in 2020, compared to 2019. I am an original co-sponsor of S. 1863, Guaranteeing Healthcare Access to Personnel Who Served Act, the GHAPs Act, which requires the Secretary of Veterans Affairs to develop a strategic plan to ensure the effectiveness of telehealth technologies.

Dr. Upton, given the astronomical increase in telehealth appointments, what changes do you believe need to be made to ensure quality of care for veterans who choose telehealth?

Dr. UPTON. I appreciate that question, Senator, and certainly telehealth has been one of the areas of the new normal in health care that we are all adapting to, both patients and providers, as a result of the pandemic, and VA has been a leader in telehealth. It is something we believe very strongly in.

And to address questioning that came up earlier about the digital divide, I think ensuring that veterans have the technology and the tools available to access telehealth is very critical, and VA, under the leadership of my colleague, Dr. Cox, does extensive work in quality monitoring and monitoring of patient safety, and certainly we would be happy to work together with you to share how we navigate that in the telehealth space as well.

Senator TUBERVILLE. Thank you. Anybody else want to comment on telehealth?

Dr. SMITH. I will just comment briefly, Senator, because I was the one that helped pull some of that data for you. Just looking at mental health, in 2019 there was about 2,000 encounters for a veteran having an appointment where they choose, be it their home, a parking lot, the VFW, wherever. In fiscal year 2020, the next year, there were over 11,000, a substantial increase.

We need, in mental health, it is highly efficacious. We know research supports it. But we have to do all we can to make that process smooth. It is not always smooth, right. There are IT difficulties. There are button difficulties. There are connectivity challenges. Dr. Upton spoke to some of that. We are committed to continuing to improve that process, because it is a critical avenue within mental health to provide access to care.

Senator TUBERVILLE. Thank you. Does the VA intend to include all the criteria listed in Section 201 of the GHAPs Act as part of the strategic review?

Dr. UPTON. Senator, our subject matter experts have reviewed that, in the telehealth world, and they have some technical comments that are outlined in our response to the legislation, and we would be happy to work with you and your staff to address that. I know you received it earlier today, so you have our commitment to be a partner to address that as we go forward.

Senator TUBERVILLE. Thank you. Thank you, Mr. Chairman.

Chairman TESTER. Thanks for being so efficient, Senator Tuberville. I appreciate that. We are going to go to the next panel. Doctor, Doctor, Doctor, Doctor, thank you all for being here today, and we will move on to the second panel, which will consist of veterans' advocates, and I will introduce them as they are getting sat down.

First we have Ms. Joy Ilem, National Legislative Director for Disabled American Veterans. Next we have Ms. Kathryn Monet, Chief Executive Officer of the National Coalition for Homeless Veterans. And last but not least we have Mr. Mario Marquez, Director of the Veterans Affairs and Rehabilitation Division, The American Legion.

Thank you all for being here. We appreciate your advocacy and we appreciate your testimony. As with the previous panel, know that your full written testimony will be a part of the record. If you can keep your verbal comments to five minutes it would be very appreciated. We still start with you, Joy.

PANEL II

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Mr. Chairman. DAV appreciates being invited to provide our views on the bills that are under consideration by the committee today. My written statement details our position on all of the legislation on the agenda. However, I will focus on my oral remarks on only eight of the bills.

Reducing veteran suicide and ensuring access to quality mental health care are key priorities for DAV. We know that peer-to-peer programs are effective in getting at-risk veterans the mental health

services they need. Therefore, we support S. 544, which calls for an outreach and training initiative for peer-supported wellness checks, to increase the number of trained peers available to assist veterans in crisis.

DAV is also pleased to support S. 796, the Protecting Moms Who Served Act, legislation that would increase support for VA's maternity care coordination activities and improve services for women veterans who are often at higher risk of adverse birth and health outcomes.

Likewise, we offer support for S. 2102, the SERVICE Act. This bill would revise the VA standards for mammography screening for women veterans who served near burn pits and ensure early access to these critical services that can save veterans' lives.

DAV is also pleased to support S. 1280, the Veteran Families Health Services Act. This legislation would improve reproductive services and facilitate research for veterans with genitourinary disabilities. It also adds access to fertility services for enrolled veterans who are unable to conceive or safely carry a pregnancy to term. Importantly, the bill would correct existing inequities by allowing veterans access to this benefit regardless of their marital status, gender identity, or sexual orientation.

DAV also offers our support for S. 1467, the Cannabis Research Act, which requires comprehensive research by VA into the therapeutic benefits and risks of cannabis as a possible treatment option for common conditions affecting service-disabled veterans with chronic pain and PTSD.

DAV also supports S. 1319, which would require VA facilities to disclose wait times, staffing levels, and information about safety, quality of care, and health outcome measures on the Department's Access to Care website. Public availability of this data will enhance veterans' ability to make more fully informed decisions about their care.

Mr. Chairman, a constant concern for seriously disabled veterans as they age is what will happen when their spouse or family caregiver is no longer able to provide a level of support needed for them to remain in their home. With more than half of the veteran population age 65 or older, a range of effective, long-term care options is required. We are therefore pleased to support S. 1965, the Planning for Aging Veterans Act, which would require VA to develop a strategic, long-term care plan for providing both institutional and non-institutional care through home and community-based services.

DAV supports a number of provisions in S. 1863, the GHAPs Act, including Sections 201 and 203, that would require VA to study the efficacy of, and develop a strategic plan for the use of telehealth services. Section 202 of the bill would require GAO to assess VA's third-party transportation program for rural veterans. As you know, DAV operates a large transportation network program, providing hundreds of thousands of veterans free rides to VA medical appointments each year. We recognize, though, that there are still parts of the country that are difficult to reach, and we agree that exploring additional modes of transportation could improve veterans' access to care.

DAV is unable to support Section 101 of the bill, to codify health care access standards promulgated by regulation in 2019. Last November, VA reported to Congress that neither VA nor the Community Care Networks were able to fully meet these access standards. Since the MISSION Act already requires VA to provide a report with recommendations for changes by next June, we believe it would be premature to make these access standards permanent now without sufficient evidence that doing so would improve access and quality of care to enrolled veterans.

[The prepared statement of Ms. Ilem appears on page 80 of the Appendix.]

Mr. Chairman, that completes my statement, and I am pleased to answer any questions you or members may have. Thank you.

Chairman TESTER. Thank you, Ms. Ilem. Kathryn, you may proceed.

STATEMENT OF KATHRYN MONET

Ms. MONET. Chairman Tester, Ranking Member Moran, and distinguished members of the committee, thank you for the opportunity to join you today. Last week, NCHV presented testimony before the HVAC Economic Opportunity Subcommittee on veteran homelessness in the wake of COVID–19, and our testimony touched on many things, most important among them that the need for sufficient funding must be incorporated into non-emergency appropriations and authorizations as we move away from COVID-specific emergency funding for homeless veterans.

It is my pleasure to let you know, Chairman Tester, that you will be awarded, NCHV's 2021 Policy Award in conjunction with our annual conference that is currently ongoing this week. We really appreciate everything that you did in terms of introducing the GRACE Act, and your team has been wonderful to work with, truly wonderful.

Chairman TESTER. Kathryn, thank you but I have just got to tell you, this is a joint effort, both sides of the aisle, everybody on this committee, so thank you.

Ms. MONET. I hear you. Well, I will share comments on a couple of bills. We do not oppose legislation that is not included in our views, but we have abstained from offering comments on legislation that is outside the scope of our expertise.

We appreciate, Chairman Tester, your legislation, Building Solutions for Veterans Experiencing homelessness. We appreciate everything that Congress did to make it easier for current grantees to take advantage of GPD capital grants to decongregate their facilities, and we have requested future rounds of capital grants in regular, non-emergency funding to allow time for appropriate planning and construction. This will allow our remaining congregate shelter providers opportunity to reconfigure their facilities, and they all will benefit from continued waivers of real property disposition and matching requirements.

Certain restrictions in the most recent capital grant NFO prevented certain grantees from making full use of this opportunity, including the availability of sufficient per diem funding to support 24/7 staffing operations and multiple sites, particularly for pro-

viders who were not able to decongregate their facility without adding to their physical footprint, meaning that they would need an extra building and a whole other set of staff. Grantees have found that current rates have been insufficient to run these programs well before COVID-related restrictions and the push to decongregate made that even more complicated. We do request that the per diem rate be maintained at 300 percent post-emergency, and we also ask that you require VA to identify a way to decouple payments to GPD operators from the state home per diem rate.

A key item to note here is that while the CDC has relaxed masking guidelines for many activities and types of locations, its guidelines for congregate shelter remain unchanged. They continue to recommend decongregating, keeping isolation and quarantine beds available, and continued social distancing, even as much of the country goes back to normal operations. So while certain bed models will continue to run deficits on a regional basis, the bill's proposed 200 percent rate of per diem is a first step toward funding providers for the level of care that is expected and the level of care that veterans deserve.

We support language in the bill that offers additional technical assistance and training, as the amount provided for those types of activities has not changed since programs have started, and we also support the additional flexibilities for transportation assistance.

We do anticipate that economic recovery will take time and that payments made for rent in arrears could potentially move veterans off of assistance before they have truly stabilized. So to that end, reemployment and reintegration efforts will be really critical through an expanded homelessness veteran reintegration program.

While we support your expansion of the program, because there are still a handful of states, including Kansas, who do not have any HVRP grantees, the program has really outstanding outcomes. Fifty-three percent of HVRP participants were placed in a job paying more than $15 per hour, and the economic crisis will continue to deepen when unemployment benefits sunset. We hope that adequate funding for programs that prevent homelessness and lift up veterans through quality employment are a direct result of this legislation.

We do support the intent of S. 612, and we recommend some technical changes to this legislation. We ask that you require HUD and VA to jointly develop a mechanism for effectively sharing and reporting data between HUD's HMIS systems and VA's HOMES system. We further recommend that additional funding be appropriated to VA's Health Care for Homeless Veterans Program to enhance coordinated entry specialist support at each medical center. Medical center catchment areas often overlay multiple HUD continuums of care, meaning that some VA coordinator entry specialists are responsible for maintaining partnerships with multiple, multiple—many—COCs, and that is a challenge with the staffing that they have got right now.

In closing, I do appreciate the opportunity to share views with you today, and it is a privilege to work with all of you to ensure that every veteran facing a housing crisis has access to safe, de-

cent, and affordable housing, paired with the supportive services they need to remain stably housed. Thank you.

[The prepared statement of Ms. Monet appears on page 101 of the Appendix.]

Chairman TESTER. Thanks, Ms. Monet. Mario, you are up.

STATEMENT OF MARIO A. MARQUEZ

Mr. MARQUEZ. Thank you, Mr. Chairman. Good afternoon. Robin Olson, a retired Navy chief petty officer, honorably served our nation for 20 years. He has been diagnosed with the mental health conditions of anxiety and depression. He is 100 permanent and totally disabled and does not qualify for VA's service dog veterinary health benefit. After taking three years of finding a nonprofit organization who was willing to take his case, a subsequent 14-month application and interview process, involving psychiatrists and psychologists, multiple meetings with dogs, home visits and training for him and his dog, Robin was finally paired with his service dog, Doc. This grueling effort was accomplished at Robin's own personal expense.

Chairman Tester, Ranking Member Moran, and distinguished members of the committee, on behalf of National Commander James "Bill" Oxford, representing almost 2 million dues-paying members, it is my duty and honor to present the American Legion's position on pending legislation being discussed here today.

Currently, Robin's service dog, Doc, knows more than 100 purpose-driven commands. He helps Robin adjust to the real world, in situations where Robin may otherwise be in danger to himself or others. The value that Doc has provided Robin's quality of life is immeasurable, a monetary price that Robin, and his family, are willing to pay out of pocket again. But they should not have to. No veteran should.

Robin's story is one example of the difficulties veterans face while transitioning from service in the military, difficulties that often lead to a feeling of helplessness or incapacitation, and can result in suicidal behavior. The pandemic exacerbated veteran suicide, and CDC statistics show that reports of anxiety and depression have tripled, and in some cases quadrupled, since 2019.

To combat this, the American Legion implemented Buddy Check Weeks, where veterans call veterans to create a space, and open and candid dialog with a veteran peer who has had similar experiences, and potentially make them aware of resources at VA or in the community.

S. 544 makes such suicide prevention efforts permanent by directing VA to designate one week annually as Buddy Check Week, for the purposes of encouraging outreach and peer wellness checks by veterans to other veterans. This week will be a VA-led but not VA-coordinated event. The success of Buddy Check Week will be reliant on grassroots efforts by veterans reaching out to veterans they served with, and letting them know they are part of a community that cares about them. A VA-led national Buddy Check Week will reach, support, and aid significantly more veterans. Getting this bill signed into law remains one of our top legislative priorities.

Shifting topics, and of urgent significance, is duly honoring our Greatest Generation by awarding them VA health care benefits while a fraction of the 16 million who fought and served are still alive. VA regulations determine a veteran's eligibility for health care benefits on factors related to income, disability rating, and military service history. As a result, World War II veterans are not exempted from means tests required to enter VA health care system.

S. 1040 would fix this problem by extending automatic eligibility to World War II veterans so those who currently do not qualify for health care will have access to VA hospital care, medical services, and nursing home care. We have done this in the past for veterans of the Spanish-American War and World War I, and it is time to do this for our Greatest Generation. World War II veterans are dying by the day, and there is no more time to wait. It is unacceptable that some of our veterans from the Greatest Generation do not have access to benefits they earned due to restrictions in eligibility for VA health care. This legislation is vital for the welfare of our World War II veterans, and we stand ready to assist Secretary McDonough in doing what is best for America's veterans.

We thank Chairman Tester and Ranking Member Moran for their incredible leadership and for always keeping veterans at the core of their mission. It is my privilege to represent the American Legion before this committee. I look forward to answering any questions you may have. Thank you.

[The prepared statement of Mr. Marquez appears on page 107 of the Appendix.]

Chairman TESTER. Thank you, Mr. Marquez. I appreciate your testimony. I appreciate the testimony of all three of you.

Just for a real quick update, and I do not know if you are going to be sticking around or not, Senator Tillis, but Senator Moran and I myself have a conversation with the CBO at 4:30. If you would be willing to chair the committee in our absence, I would appreciate that.

Senator TILLIS. Does that allow me to do a UC in the absence of any other members?

Chairman TESTER. You can do—well, Tuberville is here. He will object to everything you do. And Maggie is here, but Maggie is going to leave. Sorry.

I have a couple of questions, and I want to thank you all for your testimony, and as I said in the opening, your advocacy. This is for you, Ms. Monet.

After the pandemic-related flexibility ceases, the current maximum grant per diem rate will drop from 300 percent to 115 percent. This is less than one-fifth of the current guarantee, our operating within the 115 percent maximum. The bill that I have is going to permanently that maximum of 200 percent. Ms. Monet, what will be the impact on GPD recipients and the veterans that they serve when the emergency declaration is over and the maximum rate drops to 115 percent?

Ms. MONET. Well, I think the impacts will be dire on veterans. I think one of the challenges that providers often have is that the rate historically has not been enough to provide the level of serv-

ices that they need, so many of the grantees spend a good chunk of time private fundraising, finding other options to fill gaps, and that is time that could be spent actually caring for veterans.

I do also think, to some degree, that we have been pushing, and VA has also been pushing, facilities to decongregate, so to space people out better, to improve facilities for veterans, to give them the dignity that they need. Because I think one of the things that is often unnoticed is that the homelessness population is aging, so these are veterans who are in their 60s, 70s, in some places sleeping on cots or in bunk beds, and that is certainly not something that I would want for my 70-year-old grandfather, right?

And so we have been pushing for them to improve facilities and offer higher quality care, but they cannot do that at 115 percent. It is impossible. So if they go to decongregate now and they have got to have 24/7 staffing in two or three buildings, you are now doubling your staff costs with less funding. It just makes it very hard to provide that level of care.

Chairman TESTER. There are currently few, if any, options for veterans with significant medical needs, especially elderly veterans, to escape chronic homelessness. Traditional transitioning housing facilities do not have the staff or the authority to provide assistance with activities of daily living, medication management, or medical crisis care. As such, these veterans often find themselves bouncing between facilities, ER waiting rooms, and the street.

The bill that I am sponsoring would allow transitional housing facilities to hire the nursing staff necessary to attend to the needs of these veterans and house them while they wait for open spots in long-term care facilities. Ms. Monet, can you explain how this provision would help connect these veterans to options for permanent housing?

Ms. MONET. Well, I think one of the challenges that, you know, we do not talk about a lot is that some veterans have care needs that are too acute to remain in shelter but are not acute enough to enter into long-term care. And when that happens there is nowhere really for them to go. And so we do hear from certain communities and certain providers where, you know, they are struggling because their liaison will not let them admit someone because they cannot provide the level of care, but the local nursing home is not willing to take them, so the person just ends up outside, back at square one, while people try to find other solutions. And I do not think that is something that anybody here supports.

Chairman TESTER. Thank you. Senator Moran.

Senator MORAN. Chairman, thank you. Thank you all three for being with us this afternoon. In the past 15 months, in the pandemic, there is a lot of light that has been brought to some gaps in the American health care system, and VHA is no exception to that. Persistent gaps in the VA health care system continue to hamper our veterans in obtaining the care they deserve, particularly in rural, highly rural, and medically underserved parts of the country.

Mr. Marquez, we appreciated the strong support of The American Legion for the Commander John Hannon Act, which was signed into law last October. Building on that legislation, and understanding your organization knows first-hand the importance of peer

support, can you speak how increased peer support can help veterans find and stay on the road to recovery?

Mr. MARQUEZ. Thank you, Senator. First, before I begin, on behalf of The American Legion we would like to thank you for your support recently when one of our posts in your state was devastated by a flood, which caused the loss of over 300 flags that you were able to replace, and that was detrimental to the events that we had planned, and we were appreciative of your efforts in that. So thank you very much.

The American Legion believes that peer support approach to mental health and suicide prevention is instrumental to anything that we do when it comes to our efforts and getting after, hopefully one day, figuring out this devastating issue of suicide. As a result, as you know, The American Legion has led into our own efforts by conducting Buddy Check Week. We believe that Buddy Check Week is a grassroots, boots-on-the-ground, in-your-face, veterans getting after veterans.

Something I learned in the military, Senator, as a sergeant major, it was devastating every time that I lost a marine while I was on active duty, but it was even more difficult dealing with the veteran that had already gotten out, and I just felt helpless in trying to reach and assist them. And the efforts that I believe we can achieve with peer-to-peer efforts at getting after suicide prevention I believe will be instrumental with the Buddy Check bill, and I hope that we can continue to get this legislation through and passed and into action immediately.

Senator MORAN. Thank you for that answer. Mr. Marquez, what are you hearing from your veteran members concerning current access standards? What would be the advantage of codifying the current standards, and what impact would a negative change to the access standards have on veterans?

Mr. MARQUEZ. Thank you, Senator. The American Legion believes that access standards are crucial to the success of the MISSION Act. If applied uniformly by VA and TPA networks, which are currently not being done, we believe it would facilitate access across the board in a fair standard.

Region 5, as you know, has a set of standards that we believe our veterans, and our members believe are the standard, but we also believe that is the minimum standard that we should strive for and improve from that. Having said that, The American Legion also believes that patient-centered access standards should not be altered in any form that places any more burden or reduce access on any veteran.

And finally, I do not foresee any scenario where adjusting access standards to put a greater burden on the veteran, by either expanding wait times or longer driving distances, would be advisable. The access standards that I talk about now are the bare minimum standards, and they should be codified as such.

Senator MORAN. Ms. Ilem, I appreciate the service DAV provides, particularly to our rural and highly rural veterans in regard to third-party transportation. Can you share with us, the committee, how you feel Section 202 of the GHAPs Act would assist Congress in filling those remaining gaps in rural transportation services? You mentioned it in your testimony, and I am not sure what—I

want to just flesh out what you think is there that would be helpful.

Ms. ILEM. I think just having a report and looking at the full scope of what is available for veterans. I mean, we know DAV's transportation network, very busy, and, you know, being able to provide services across the country. But with the pandemic and everything that happened, there are a lot of changes that have occurred. We want to make sure that veterans have access to the transportation they need to get to their appointments. We do not want it to be a barrier to care. So looking at all options is, I think, going to be really critical. Where are those specific gaps and where are they in the country, and what can be done to make other plans in those areas?

Senator MORAN. Thank you. Ms. Monet, you caught my attention. Apparently the Chairman is not going to give me time to ask a question, but the lack of Kansas participating in a program regarding homelessness veterans has caught my attention, and we will figure out what is going on. Thank you.

Chairman TESTER. Thank you, Senator Moran. I will recognize Senator Hassan and I will turn the gavel over to Senator Tillis.

Senator HASSAN. Well, thank you very much, Mr. Chairman and Ranking Member Moran, again, for this hearing, and to the three panelists, thank you, not only for your service but what you do for our veterans.

I want to just ask two very brief questions, and then you will see me dart out, so I apologize. But Mr. Marquez, you have testified about the Buddy Check program and the bill, something that Senator Ernst and I have sponsored. And I just wanted to get you to elaborate a little bit more. Can you please speak to how this Buddy Check Week initiative, how having a specific week for this would help veterans and how we can support these efforts through the VA, how we could reach more veterans?

Mr. MARQUEZ. Yes, ma'am. First of all, I would like to thank you for sponsoring this bill. Although it has not passed yet, it is a great victory in our effort to get after suicide and suicide prevention.

VA has a lot of great programs that they work on continuously to get after suicide and suicide prevention, and we applaud every one of their efforts. We think they are vital and they are important. However, the Buddy Check bill is complementary to everything that VA already does, and as I alluded to earlier, and something that I would like to emphasize, we like to talk about, unfortunately, that we were able to count the number of suicides. But what we cannot count, and something that I would love to be challenged with to count, is the number of wins and lives we have saved. That is the measure we need to achieve. How do we get after suicide prevention is trying to measure the number of lives we saved by engaging veterans in peer-to-peer efforts.

Senator HASSAN. Right. And if we focus a week on it I think it adds particular outreach and focus at a critical time. Thank you to The Legion for leading on this.

Mr. MARQUEZ. Yes, ma'am. Thank you.

Senator HASSAN. And Ms. Ilem, I wanted to thank you for your written testimony supporting the bipartisan legislation that I am leading on the Solid Start Act. That would focus on strengthening

outreach to servicemembers in the first year after they separate from the military, and it makes permanent and bolsters Solid Start by prioritizing outreach to veterans who accessed mental health resources prior to transitioning to civilian life and ensuring that calls are tailored to the needs of each veteran.

I have heard from New Hampshire veterans about the importance of this type of outreach, including specifically from women veterans who can face additional barriers to service and to support. So how would servicemembers transitioning from military to civilian life benefit from this tailored approach, and specifically, how would women veterans benefit?

Ms. ILEM. Thank you for the question. I think it is a great program, we agree, and we are pleased to support the bill. And I think with regard to women veterans, again, you have put your finger right on it, that sometimes there are some really tailored needs for women veterans or women that are experiencing certain barriers. So having that personal contact, especially if there are mental health challenges, like you said, someone that you know you can assist and maybe answer some of their questions right up front for them, make sure they know somebody is knowledgeable about what is helpful to them and trying to really connect them with the programs and services they need.

Senator HASSAN. Thank you very much. Thank you, Senator Tillis.

Senator TILLIS. [Presiding.] Senator Hassan, before you go, Senator Tuberville, I am going to let you ask questions next, but I thank you for your comments on service dogs. One thing I am going to ask the first panel to do is get back, and maybe as a starting point, since we have done a lot of work here, is to take a look at the bill that passed on the suspension calendar. I am convinced we can make progress. Senator Tuberville?

Senator TUBERVILLE. Thank you very much. Thanks for being here today. Mr. Marquez and Ms. Ilem, in both The American Legion and DAV testimony you note that your organizations support legislation such as PAWS for Veterans Therapy Act, because it allows for an alternative form of treatment for veterans suffering from TBI and PTSD. I agree with allowing alternative forms for treatment and I believe it is incumbent upon us to make available every treatment option for veterans available, suffering from any condition.

Today I introduced a bill that gives veterans suffering from TBI and PTSD the right to hyperbaric oxygen therapy. Just a question. Given your commitment to alternative, non-invasive treatment options for TBI and PTSD, would you commit to reviewing my legislation, which was out today, and work with my staff on a way forward where you can support this bill? I would appreciate that.

Mr. MARQUEZ. Yes, sir, we can.

Senator TUBERVILLE. Does anybody have any experience with hyperbaric treatment, with any veterans?

Mr. MARQUEZ. The American Legion does, Senator, but I would have to go back and do a little bit of research, and we can follow up with you and your staff as we do have some resolutions that address this matter.

Senator TUBERVILLE. Okay. Thank you.

Ms. ILEM. We are happy to work and review the legislation and provide any feedback. You know, we have been hearing about this for some time now, and again, I know some veterans have indicated they benefit from it, and we want to make sure that veterans have access to any treatments and services that may be helpful to them.

Senator TUBERVILLE. Anything we can do to help? You know, we are having way too many suicides, and I have some experience with some veterans that say it helps. And being a former football coach, we had a lot of head injuries, and we used that, and we made progress. It is something you cannot see, you know, PTSD, you can't look at it, but we have got to find some way to treat it. We just been through two wars and millions of veterans coming back, and they all have problems, to some form.

Mr. MARQUEZ. Senator, if I may, The American Legion, as you may be aware, has a TBI, PTSD, and Suicide Prevention committee. I can get this in front of my leadership and in front of the committee and the commission, and we can do a little bit more research and get you some information that I think we will find to be valuable.

Senator TUBERVILLE. Thank you.

Mr. MARQUEZ. Yes sir.

Senator TUBERVILLE. You probably heard my question earlier. Any experience, any feedback on telehealth during the pandemic?

Ms. ILEM. We have heard from some DAV members that, you know, they really liked it, I mean, for certain things. They felt that they were being cared for throughout the pandemic. They got their needs met, basic medications, that type of thing. And we know that VA was open and available for seeing veterans that needed to be seen in the facility. So I think people appreciated it. It was new. It is a little bit different. But I think for elderly veterans we need to make sure, and that is why studying it would be important, about, you know, if there is technology or a barrier for somebody who is not used to doing something remotely, on their own, and do they just forego care if they didn't know how to use the computer or be able to do that. So that will be important to look at and help outcomes.

Senator TUBERVILLE. We had huge benefits in rural areas from veterans. Ms. Monet, do you want to chime in on that?

Ms. MONET. Actually, I think telehealth was a really good-news story for veterans experiencing homelessness. Some of the provisions that you all enacted enabled VA to purchase telehealth equipment for veterans experiencing homelessness, and I believe that what we saw was that telehealth visits really increased and really helped. HUD-VASH case managers could case manage veterans remotely. And it was not a perfect system but it really helped veterans get through the pandemic. And so I do think we support further expansion of telehealth and some of the authorities that are in Chairman Tester's bill, to make permanent some of the things.

Senator TUBERVILLE. Thank you. Through The American Legion did you have any feedback on telehealth?

Mr. MARQUEZ. We did. Recently I spoke to my commission chairman and one of the things he reminded me of is although telehealth has been a great convenience in many ways, as I said in my

opening remarks there is a little bit of a limitation there. Some of it is connectivity, but also there is a matter and a concern of privacy. Not all veterans have the privacy, even if they have access to telehealth, whether it is at home or in the office, or sexual assault we mentioned earlier, a parking lot. A lot of times that may not be the right situation for a veteran to then drive themselves if they are not in the right mental state to properly finish whatever they just went through.

And so the concerns with privacy, we are looking at it. It is something we are researching in The American Legion, and we would like to look into it further.

Senator TUBERVILLE. Real quick, vaccines. How are we doing with veterans, in your eyes?

Ms. ILEM. I think VA has done a great job in terms of outreach and trying to make sure that all veterans know they have access. At first there was a big clamoring and lots of people coming in to get them, and I know VA is wanting to make sure that every veteran who wants to get a vaccine is able to get one.

Senator TUBERVILLE. Ms. Monet?

Ms. MONET. I would agree. I think they are doing a lot better at connecting with homeless shelters and permanent supportive housing providers to do more mass vaccination efforts, where that was really spotty and challenging at the start of the pandemic.

Mr. MARQUEZ. Senator, VA has done a great job in really getting after vaccine hesitancy. Our organization, The American Legion, does the same. We have published, on our websites, every possible manner, down through the chain of command, through the different posts. And as you may be aware, we also recently had the Secretary down in Alabama, and our Executive Director for Government Affairs was down with our National Commander as well.

So we are putting it down at the grassroots level, originating at the posts, and host any shot access that we can get done, vaccine opportunities, and just offering it up. Even if we do not get large numbers we are still continuing to see people slowly getting back into a little bit of trust and confidence with the vaccine. Because people want to get back to normal life, and they know that they are probably hampering that from happening in its totality.

Senator TUBERVILLE. Thank you. Thanks for being here today. Thank you.

Senator TILLIS. Well, thank you all. Mr. Marquez, thank you for your past and continued service to our nation and our veterans.

Mr. MARQUEZ. Thank you, Senator.

Senator TILLIS. You did a great job in your opening statement about Buddy Check Week. I am a co-sponsor. I think it is very important. I was just at an event that was hosted by the Independence Fund, called Operation Resiliency, where they are bringing units back. This unit had served in Iraq in 2011, bringing them together. And that connection, is something that is very important, so thank you for your support of that bill.

You also mentioned, in your opening, before you started the formal opening statement, the story of the journey of a veteran at his own expense for getting a service dog. How is that veteran doing now?

Mr. MARQUEZ. He is doing great, Senator. The only thing is that he is fighting for advocacy, so that other veterans do not have to pay. And I realize there is a very strict and regimented qualification process for that, and so in speaking to him he asked me that we do what we can to pass legislation to offer as many veterans. He is more concerned about other veterans than he is himself, because his exact words, "I could afford this. My family could afford this. We would do this again. But there are many veterans out there that they cannot afford this."

Senator TILLIS. Well, it just so happens I have a personal interest in this, and that is why my questions—I want to really get to a good place. I think most people know, in my six and a half years on the committee, I have maintained a very positive relationship with the VA. I know they have a complex task and I want to get through it.

Ms. Ilem, I know that the DAV expressed some concerns, I think, with the Senate version of the bill. I have been tracking very closely the compromise bill that passed on the suspension calendar in the House. Have you had an opportunity to take a look at that and take a position or express any concerns on it?

Ms. ILEM. I have not seen specifically that, but in comparing that to the Senate version, I mean, I think there were some changes to the bill when I did compare what I had availability to see, and I think, you know, there was certainly an effort to try to address some of those things that originally came up.

Our point is, I think, just as Mario has said, we want to make sure that this is an equitable benefit that veterans are going to have, that there is some standardized way to make sure service dogs are available. And as you heard from the VA, it is very limited ability to get a service dog. And while we are appreciative of these types of initiatives, we just want to see some standardized way, make sure there is an equity in this benefit, and the veterans that really need it can get access to a service dog.

Senator TILLIS. Could I get your commitment to take a look at—you know, in Washington, on our best day, it is hard to get 435 people to agree to something. And the fact that it passed out of suspension calendar I think is an indication that members who had similar but different bills were not out a compromise, that in many respects, I believe, represent a bridging of the gap between a couple of the bills that are in the Senate.

So I would like for you to take a look at that, because in good faith I would like to get with the VA and see if we can get to a good place on the legislation, ideally what passed out of the House. And I would appreciate the VA also providing us feedback on where they think that bill may still fall short, and work in good faith to resolve our difference. I would appreciate that.

Ms. Monet, I appreciate your commitment to the homeless vets. It is something else I have worked quite a bit on in North Carolina. We just stood up a new Veterans Life Center, which was, I think, going to be something that can be scaled across the country. It is extraordinary.

You mentioned that the VA should maintain 300 percent GDP rate post pandemic, and I know you probably understand the VA has still not spent much of the supplemental funding, and will not

award GPD this year. So what should the VA be doing to serve as many homeless vets as possible? New GDP awards? Other ideas?

Ms. MONET. So in regards to what they have spent, I think 75 percent of what has been allocated to HPO has already been spent. GDP is a little bit different because providers have to spend the money and then go back and seek reimbursement. So I do not know that I have any doubts that they will not spend their money by the end of the fiscal year. I mean, I think VA is probably in a better position to answer that question, but I think what I heard from the program office last week is that they will, in fact, spend all those funds.

I think that there are a lot of things that they can do in other programs to enhance the way that they serve veterans, so thinking about ways that they can increase HUD-VASH case management staffing, thinking about ways that they can coordinate better between programs, or that they can tie HVRP programs more closely to SSVF and the shallow subsidies. There is a lot that can be done, and that, I think, is in the works.

Senator TILLIS. Thank you. I know a lot of my members, we have several committees or subcommittees going on, so a lot of my members were not able to make it. But this is one of the great committees where we work together and try to produce a good bipartisan outcome, under Chairman Tester's leadership.

I want to thank you all for participating today, both the VA and the veteran service organizations. You have shared valuable insight, but you know that a lot of the good stuff happens when you come to our office and we work out differences and get to a good place. I welcome you all to continue to come to my office, and I am sure I speak for all my members, on bills that you are not there yet, that we would like to get to.

So we will keep the record open for a week, and thank you all for participating. The hearing is adjourned.

[Whereupon, at 4:47 p.m., the Committee was adjourned.]

A P P E N D I X

Hearing Agenda

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

Hearing: Pending Legislation

June 23, 2021, 3:00 p.m.
Russell Senate Office Building, Room 418

S.372	Ensuring Quality Care for Our Veterans Act
S.539	A bill to direct the Secretary of Veterans Affairs to submit to Congress a report on the use of video cameras for patient safety and law enforcement at medical centers of the Department of Veterans Affairs.
S.544	A bill to direct the Secretary of Veterans Affairs to designate one week each year as "Buddy Check Week" for the purpose of outreach and education concerning peer wellness checks for veterans, and for other purposes.
S.612	Improving Housing Outcomes for Veterans Act of 2021
S.613	PAWS for Veterans Therapy Act
S.727	CHAMPVA Children's Care Protection Act of 2021
S.796	Protecting Moms Who Served Act of 2021
S.887	VA Supply Chain Resiliency Act
S.951	PAWS Act of 2021
S.1040	A bill to amend title 38, United States Code, to expand eligibility for hospital care, medical services, and nursing home care from the Department of Veterans Affairs to include veterans of World War II.
S.1198	Solid Start Act of 2021
S.1220	United States Cadet Nurse Corps Service Recognition Act of 2021
S.1280	Veteran Families Health Services Act of 2021
S.1319	VA Quality Health Care Accountability and Transparency Act
S.1467	VA Medicinal Cannabis Research Act of 2021
S.1863	Guaranteeing Healthcare Access to Personnel Who Served Act
S.1875	Veterans' Emergency Care Claims Parity Act
S.1965	Planning for Aging Veterans Act
S.2041	Department of Veterans Affairs Provider Accountability Act
S.2102	Supporting Expanded Review for Veterans in Combat Environments (SERVICE) Act
S.2172	Building Solutions for Veterans Experiencing Homelessness Act of 2021

Prepared Statements

STATEMENT OF
DR. MARK UPTON
ACTING DEPUTY UNDER SECRETARY OF HEALTH FOR COMMUNITY CARE
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS

JUNE 23, 2021

Chairman Tester, Ranking Member Moran and Members of the Committee. Thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today are Dr. Gerard Cox, Assistant Under Secretary for Health for Quality & Patient Safety, VHA; Dr. Clifford Smith, Deputy Director, Office of Mental Health Operations, VHA; and Dr. Theresa Gleason, Director, Clinical Science Research & Development Service, VHA.

We are unable to provide testimony on the Unnumbered Senate Bill Building Solutions for Veterans Experiencing Homelessness Act of 2021 or the Unnumbered Senate Bill regarding mammography screening for Veterans who served in locations associated with toxic exposure (now S.2102, the Supporting Expanded Review for Veterans in Combat Environments (SERVICE) Act. We will provide views on these bills as soon as they are available.

S.372 Ensuring Quality Care for Our Veterans Act

S.372 would require VA to enter into a contract or other agreement with a non-Federal organization to conduct retrospective clinical reviews. The clinical reviews would be for licensed providers who were hired by VA while not meeting the licensure requirements outlined in 38 United States Code (U.S.C.) 7402 and VA Handbook 5005, specifically those who have had their license terminated (revoked) and not fully reinstated prior to their VA appointment. The requirement would apply to those license revocations that were "for cause" which would be defined as resulting from substandard care provided at a non-VA facility prior to coming to VA. Additionally, the proposed legislation would require the Secretary to notify patients if substandard care is identified through the retrospective clinical review.

VA does not support this bill because procedures and resources are already in place to accomplish outlined goals. VA understands, from previous communication with the Committee, that the proposed review would only apply to those hired in violation of existing licensure qualification requirements. A contract for this purpose is unnecessary because VHA has heightened processes to ensure that providers are not hired if they do not meet licensure requirements outlined in 38 U.S.C. 7402 and VA Handbook 5005. If an unexpected oversight is made, it is unnecessary to require a contract to perform a retrospective review because VHA has internal resources and mechanisms available for objective and thorough reviews to be conducted. VHA has over 70,000 licensed

independent practitioners working throughout the Agency who represent every specialty. A vast majority of these providers have academic appointments, are board certified, are active researchers, and experts in their field. Additionally, VHA currently has a contract in place which may be utilized for retrospective file reviews if VHA is unable to complete a review timely or if there is a perceived conflict of interest.

VHA has enhanced procedures to proactively identify and review providers who have had actions by a State licensing board prior to VHA appointment as well as during their VHA appointment:

(1) In January 2018, VHA implemented a robust review process of licensed health care providers who are being considered for final selection to determine if they have had a licensure action taken by a state licensing board. The licensure actions are identified through a query of the National Practitioners Data Bank (NPDB) during the credentialing process which reveals all actions reported by state licensing boards to the NPDB. If a reported licensure action is identified, a mandatory review process is in place requiring a written review by Human Resources leadership, with consultation with the Office of General Counsel, as necessary, to determine if the individual meets the appointment requirements outlined in 38 U.S.C. 7402 and VA Handbook 5005. The review of the licensure action is also entered into a database managed by Workforce, Management and Consulting for awareness and communication with the respective Veterans Integrated Service Network (VISN) Chief Human Resource Officer for additional review. This robust review process is in place to prevent the selection of licensed health care providers who are ineligible for appointment pursuant to 38 U.S.C. 7402(f).

(2) In December 2019, VHA proactively expanded the requirement of enrolling all licensed providers (versus only Licensed Independent Practitioners as previously required) in the NPDB Continuous Query program. VHA is unique in that its electronic credentialing system, VetPro, has an interface with the NPDB system. Through this interface, the systems are linked and monitor reports submitted to NPDB related to the enrolled providers 24 hours per day, 365 days per year. If a report is submitted to the NPDB related to enrolled providers, the full report is automatically populated into the provider's electronic credentialing file, the facility receives an automatically generated email alerting it of the report, and the Medical Staff Affairs VA Central Office (VACO) Program Office also receives an alert. If a state licensing board has taken a licensure action and reported the action to the NPDB, VHA will receive immediate notification through the NPDB Continuous Query process for immediate review and action as appropriate, including removal if a provider has a licensed revoked.

It should be noted that the text of S.372 is contradictory to VA's understanding of the intent of this bill. Under the definition of a "covered provider," it would include not

just a health care provider who was erroneously appointed in violation of 38 U.S.C. 7402(f), but also a health care provider who, subsequent to his/her appointment, had a license terminated for cause by a State licensing board (i.e., a part-time health care provider had an adverse State licensing board action taken against them outside of their VA duties). Thus, if the intention is for S. 372 to apply only to providers who were improperly appointed by VA, VA respectfully recommends S.372 be amended to clarify it would only apply in that situation.

The notice requirement provided in section 2(b) is unnecessary as VHA has a policy on disclosure of adverse events to patients. VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, dated October 31, 2018, provides clearly defined guidance on the ethical and policy requirements associated with a clinical disclosure to a patient when the actions of a VA staff member causes or contributes to potential or actual harm. VA facilities are already required to provide a quarterly report to VACO staff on activities that necessitate an institutional disclosure associated with death or serious injury to a patient.

S.539 Veterans' Camera Reporting Act (VCR Act)

The Veterans' Camera Reporting Act, or VCR Act, requires VA to complete a comprehensive review of policies and procedures and submit to Congress a report on its findings regarding the use and maintenance of cameras deployed by VA for patient safety and law enforcement at VA medical centers (VAMC). The VCR Act will also require VA to make recommendations to improve patient safety and law enforcement.

VA supports this bill.

S.544 To direct VA to designate one week each year as "Buddy Check Week" for the purpose of outreach and education concerning peer wellness checks for veterans, and for other purposes.

This proposed legislation would require VA to designate one week each year as "Buddy Check Week" for the purpose of outreach and educating Veterans on how to conduct peer wellness checks for Veterans. Additionally, other purposes of "Buddy Check Week" would include the following: 1) providing training on transferring Veteran's phone call to the Veterans Crisis Line (VCL); 2) providing resiliency training for Veterans on handling a Veteran in crisis; 3) making publicly available educational materials; and 4) requiring the head of the VCL to submit a plan to the Secretary for how to handle the potential increase in calls to the VCL during Buddy Check Week.

VA does not object to this legislation, as it could complement VA's robust ongoing initiatives to reach out to Veterans and encourage participation in treatment, when appropriate. VA is dedicated to ensuring all Veterans are aware of and have access to available mental health program and services when needed. VA's current outreach efforts to increase awareness and support among Veterans, with Veterans, and for Veterans is an integral part of VA's suicide prevention efforts.

Initial review indicates that media efforts dedicated to supporting implementation and engagement of S.544 may require an additional approximate $500,000 per year. Initial review indicates that indirect costs associated with this effort will likely be incurred at the local level to include and impact Suicide Prevention Coordinators, Public Affairs Officers and Peer Support Specialists.

S.612 Improving Housing Outcomes for Veterans Act of 2021

The Improving Housing Outcomes for Veterans Act of 2021 requires VA to provide VA medical center staff and homeless providers information on the centralized or coordinated assessment systems established by Continuums of Care under 24 C.F.R. § 578.7(a)(8). The information should include best practices regarding the collaboration between VAMCs; VA homelessness service providers; local partners, including the Department of Housing and Urban Development (HUD) or public housing agencies and private and public local community organizations; making referrals; and sharing data. The VA Under Secretary for Health must also communicate with employees who work with homelessness assistance programs on how to measure performance of programs by the Homeless Programs Office (HPO) and how to obtain and provide feedback about performance measures.

VA supports the proposed legislation. However, VA believes the Health Care for Homeless Veterans (HCHV) program is already operating in a way that is consistent with the intent of proposed legislation. Given that HCHV's mission focuses on outreach and community partnerships within it's already established programs, HCHV has been designated as the lead program office within the national HPO to champion the efforts underway to integrate all VHA homeless services into local coordinated entry systems. This is accomplished primarily through the VA's Coordinated Entry Initiative which provides guidance to VAMCs regarding their roles and responsibilities in each of their local Continuums of Care (CoC) and CoC's coordinated entry systems. This guidance is also available to community homelessness service providers. All VAMCs are expected to fully engage with each of their local CoCs in several areas including case conferencing, maintenance of the By-Name-Lists, assessment, data sharing and prioritization and referrals of homeless Veterans.

HCHV holds a monthly "National Coordinated Entry Integration Call" for all VA homeless programs staff members who are involved in coordinated entry activities within their communities. Topics for these calls have included the role of coordinated entry in the local COVID-19 response efforts, best practices in integrating Grant and Per Diem (GPD) transitional housing into community coordinated entry systems (including referral process and sharing of data), integrating Veterans Justice Programs into local coordinated entry systems, case conferencing, and considerations and recommendations when building community relationships and leadership teams. VAMC homeless program staff present to their peers across the country on innovative practices involving coordinated entry collaborations within their communities. There is also an opportunity for resource and information sharing.

In addition, the HPO has established a workgroup to examine innovative and promising practices to help VA staff and partner organizations accelerate progress in reducing homelessness among Veterans. These practices cover a wide range of topics related to Veteran homelessness. White papers about these practices are published to inform VA staff, partners and others of innovative ways to improve outcomes for Veterans who lack stable housing. The white papers cover topics such as integrating GPD transitional housing into coordinated entry systems; effective team building models for effective service coordination; and engaging frontline staff in coordinated efforts to end Veteran homelessness. The white papers are available to the public and can be found at the following website: https://www.va.gov/homeless/promising-practices.asp.

In addition to providing teaching assistance to VAMCs, HCHV has developed detailed expectations and requirements for each area of the initiative, including case conferencing, maintenance of the By-Name-Lists, assessment, data sharing and prioritization and referrals of homeless Veterans. VAMCs are required to report on their progress in each of these areas for review by the HCHV National Office. Feedback on the VAMCs progress and, where needed, technical assistance on specific areas of coordinated entry integration are also provided by VACO and/or VISN-level homeless programs staff.

HCHV is estimating zero cost because current operations are already fully consistent with S. 612 and this would not require any additional staffing or resources.

S.613 Puppies Assisting Wounded Servicemembers (PAWS) for Veterans Therapy Act

This draft bill would require the Secretary to: (1) pilot a program to provide grants to non-governmental entities who will conduct dog training therapy for eligible Veterans; and (2) amend title 38 U.S.C. section 1714 to authorize the Secretary to provide service dogs to Veterans with mental illnesses who do not have mobility impairments.

With regards to piloting a grant program; the draft bill spells out what type of agencies should be eligible for these grants and requires VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants: (a) improve in psychosocial functioning; and (b) improve in their dependence on narcotics medication. The legislation also requires the Government Accountability Office (GAO) to evaluate the pilot program. The bill does not mention funding or the number of grants that would be required.

VA does not support S.613 as written because the program, described as a therapeutic medium of training service dogs, although possibly helpful to a limited number of Veterans, does not have an adequate basis of evidence. Sections 1-3 of the bill describe a pilot program under which the VA Secretary would award grants to eligible non-profit organizations for the purpose of assessing the effectiveness of addressing post-deployment mental health and the symptoms of posttraumatic stress

disorder (PTSD) through a therapeutic medium of training service dogs for Veterans with disabilities. The "train the trainer" program that has been in place for many years as part of the Palo Alto VAMC recreation therapy program is the prototype for the proposed pilot program.

Veterans diagnosed with PTSD participated in the Palo Alto recreation therapy program by helping to train dogs to become service dogs for persons with mobility impairments. The "dog training" consisted of Veterans working with the dogs on basic obedience commands and socialization, neither of which alone nor together is sufficient for certifying a dog as a service dog. Veterans eligible for the program only spent a few weeks helping with "dog training." These Veterans did not receive a service dog through the program in contrast to the bill which indicates that the Veteran who received the training as part of the pilot program will keep the dog unless the Veteran and the health care provider determine otherwise. Thus, while evaluation of the Palo Alto program, based solely on Veteran self-reports and informal observations by staff, may have been positive, it is not a model that results in Veterans being paired with service dogs.

VA does not support expansion of the scope of the program as the bill seeks to do by pairing the Veterans who received the training with the dogs because this method has an increased risk of Veteran/service dog team failure. This method does not ensure that the service dog is specifically trained to perform tasks that mitigate the Veteran's disability or that the dog is matched to the Veteran's personality, lifestyle and physical traits. Qualified service dog providers use an extensive matching process (based on the criteria referenced above) to ensure the Veteran/service dog team is compatible and is set up for success. This is especially true because of the additional challenges associated with identifying service dog organizations willing to commit their dogs to be trained by non-professionals, and the administrative infrastructure needed to ensure a safe and effective program for Veterans. The financial support of this type of effort would be considerable. For these reasons, VA does not support S.613.

Additionally, VA does not support providing grants to entities to provide Veterans with service dogs. VA currently does not provide dogs or grants in the administration of the Service Dog Veterinary Health Insurance Benefit; rather, VA provides Veterinary Health Insurance through a contractor to individual Veteran patients (not organizations). If VA were to provide grants, this legislation appears inconsistent with existing VA regulations that state that entities that provide service dogs must be accredited by Assistance Dogs International (ADI) or the International Guide Dog Federation (IGDF). This requirement allows VA to have reasonable confidence that dogs are well trained, healthy, and not likely to pose a threat of harm to Veterans or their families. Veterans who received dogs from non-ADI or IGDF organizations would not be eligible for the VA Service Dog Veterinary Insurance Benefit. We note that section 3(c)(12) affords VA discretion to require entities submitting applications to include certain information, certification and assurances; however, we are concerned such discretion will be limited by section 3(c)(1) which must be read in conjunction with section 3(c)(12).

S.613 does not give VA a role in determining when a service dog needs to be replaced for health or training problems and instead leaves that decision to the service dog organization and the Veteran. VA has serious concerns about this omission. A reputable service dog organization should not have concerns about a funding agency having a role in protecting Veterans. VA knows from experience, as do service dog training organizations, that once people bond to a dog, they are very reluctant to give it back even if its behavior or health are a serious problem. Unfortunately, VA has first-hand experience with this issue and has experience with service dog training organizations taking advantage of it to avoid having to replace a service dog with another dog at considerable expense.

Similarly, S.613 does not give VA the ability to evaluate and monitor the quality of the grant recipient organization's facilities, staffing, training and service dogs to ensure Veterans with PTSD receive a well-trained and high-quality service dog. VA has learned through the Phase I PTSD Service Dog study performed in Tampa that it was necessary to evaluate the performance of service dogs before they were paired with Veterans, because VA could not trust most organizations to disqualify poorly trained or poorly socialized dogs due to the cost to the organization of finding replacement dogs or the cost of committing additional training resources to the same dog.

Also problematic is the requirement that Veterans who participate in the pilot program receive training from a certified service dog training instructor. Unfortunately, there are no Federal standards for service dog training that VA can apply, and VA does not have the expertise to design its own accreditation program or standards.

Additionally, the legislation requires VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants improve in psychosocial functioning, and dependence on narcotics medication. VA does not believe that this data would be meaningful, as VA recently completed a study entitled "A Randomized Trial of Differential Effectiveness of Service Dog Pairing Versus Emotional Dog Pairing to Improve Quality of Life for Veterans with PTSD" (www.research.va.gov/ptsd-service-dogs.cfm) that found no differences on three primary outcome measures of quality of life, mental functioning, and physical functioning. However, among secondary outcome measures, Veterans paired with a service dog experienced a reduction in severity of PTSD symptoms (PCL-5) compared to Veterans paired with an emotional support dog, and had fewer suicidal ideations and behaviors, particularly at 18 months post-pairing. Also, narcotic medications are not typically prescribed for PTSD; rather, they may be prescribed for co-morbid conditions (such as chronic pain).

VA does not support amending title 38 U.S.C. section 1714 as proposed in section 4 of the Act. Section 4 of the Act authorizes the Secretary to provide a service dog to a Veteran pursuant to 38 U.S.C. 1714(c)(3) regardless of whether the Veteran has a mobility impairment. The Secretary's authority to provide a Veteran diagnosed with a mental illness, including PTSD, with a service dog already exists in 38 U.S.C. 1714(c)(3) and is not conditioned upon the Veteran having a diagnosis of a mobility

impairment. Separate authority exists in 38 U.S.C. 1714(c)(2) for the Secretary to provide a Veteran diagnosed with a mobility impairment with a service dog. Thus, section 4 of the Act neither provides the Secretary with any additional authority nor does it confer upon the Veteran an additional benefit.

S.727 CHAMPVA Children's Care Protection Act of 2021

If enacted, S.727 would allow a child to be eligible to receive medical care benefits under VA's Civilian Health and Medical Program (CHAMPVA) up until the age of 26. VA's CHAMPVA program is primarily for dependent spouses and children of certain Veterans, provided they do not qualify for the Department of Defense's TRICARE program for dependents. In the absence of a CHAMPVA-specific definition, CHAMPVA relies on the definition of "child" that is codified in section 101 of title 38, U.S.C., and applicable to other VA benefits available to a child. Generally speaking, a child reaches the age of majority when the child attains 18 years of age. Some exceptions exist, namely for a child who, before attaining the age of majority, became permanently incapable of self-support, or who after reaching the age of majority is pursuing a course of instruction at an approved education institution up until the age of 23 years.

In 2010, the Patient Protection and Affordable Care Act, as amended (the "Act"), required individual health insurance coverage plans that provide dependent coverage of children to make such coverage available for an adult child who is not married until the child turns 26 years of age. To clarify, it did not require health insurance plans to provide dependent child coverage, but for those that do, it required them to continue this coverage until a child reached the age of 26. This requirement addressed policy concerns that young adults were, in general, uninsured, had the least access to employer-sponsored health insurance, and lacked the financial resources needed to purchase health care insurance. For instance, prior coverage under their parents' plans typically ended after they graduated from college, or for others, it ended once they reached certain age thresholds. The Act remedied this problem.

VA is not subject to the Act, as CHAMPVA is not a health insurance plan; rather, it is a medical care benefit grounded in statute. No provision in the Act amended the title 38 definition of "child." Yet, because CHAMPVA operates in effect like a health insurance plan, this has resulted in confusion and disputes.

Senate bill 727 would extend a child's eligibility for CHAMPVA up until the age of 26, thereby aligning the age criterion for CHAMPVA eligibility with that applicable to health insurance dependent care coverage. It would, however, be a greater benefit than found in plans covered by the Act because this extended eligibility would be *regardless of a child's marital status*.

CHAMPVA is required by law to provide medical care to CHAMPVA beneficiaries in the same or similar manner as that which is provided to TRICARE dependents, and subject to the same or similar limitations as TRICARE. TRICARE provides extended

medical coverage for a young adult up until the age of 26 (provided the child is unmarried and meets certain other requirements such as ineligibility for employer-sponsored health insurance based on the young adult's own employment). Nonetheless, an unmarried child between the ages of 18 and 23 who is pursuing a course of instruction at an approved educational institution is eligible for CHAMPVA medical benefits only up until the child's 23rd birthday because, absent an amendment to section 1781, VA is still obligated to rely on the title 38 definition of a child.

For all these reasons, VA supports enactment of S. 727, noting that it would align eligibility for CHAMPVA with TRICARE and private insurance plans and go even further by extending the age limitation regardless of marital status, student status, or the child's eligibility for employer-sponsored health insurance. To be eligible for CHAMPVA medical care, the child is not eligible for TRICARE and the child's sponsoring Veteran-parent must have a total disability permanent in nature, resulting from a service-connected disability, or must have died as a result of a service-connected disability; or at the time of death had a total disability permanent in nature; or must have died in active service in the line of duty not due to personal misconduct. This patient cohort unquestionably merits the bill's generous extension of eligibility.

The estimated cost for medical benefits and additional full-time employees to provide this expanded CHAMPVA eligibility up to age 26 in FY 2022 is estimated at $82.4 million. The 5-year estimate from FY 2022 through FY 2026 is estimated at $459 million while the 10-year estimate from FY 2022 through FY 2031 is $1.1 billion.

S. 796 Protecting Moms Who Served Act of 2021

Senate bill 796 is the companion bill to H.R. 958 on which VA testified before the Subcommittee on Health, House Committee on Veterans' Affairs on April 15, 2021. If enacted, section 3(a)(1) of the bill would require the Secretary to carry out the maternity care coordination program currently established in VHA Directive 1330.03, *Women Veterans Maternity Health Care and Coordination*, and any successor policy. Section 3(a)(2) would require the Secretary to provide community maternity care providers who are furnishing authorized maternity care (under VA's Veterans Community Care Program or other contract authority) with training and support with respect to the unique needs of pregnant and post-partum Veterans, particularly regarding mental and behavioral health conditions. Section 3(b) would authorize to be appropriated $15 million for FY 2022, which would be intended to supplement, not supplant, other amounts authorized for VA's maternity care program.

VA supports the intent of section 3(a)(1) but believes it is duplicative of ongoing efforts. VA welcomes further discussion and would be happy to work with staff on issues related to maternity care. Currently, VA has 134 Maternity Care Coordinators (covering 140 health care systems) who support pregnant Veterans throughout pregnancy and the post-partum period. Coordinators screen pregnant Veterans for conditions such as post-partum depression and intimate partner violence. In addition, coordinators help patients access the following: VA-authorized maternity care services in the community;

VA care or VA-authorized care in the community for other physical and mental health conditions (needed during pregnancy and after delivery); and other private sector community resources from which they may benefit. Coordinators also connect patients to services after miscarriage and answer non-care questions such as those related to VA's maternity care authorization process and copayment obligations that may apply in connection with the receipt of maternity care through VA.

As to section 3(a)(2), VA already has training modules that are available to community maternity providers, and these meet the educational goals described in the bill. For instance, VA has developed web-based training titled "Caring for Women Veterans in the Community," which is housed on VHA's TrainingFinder Real-time Affiliate-Integrated Network, the most comprehensive national catalog of public health training opportunities. This training addresses the unique health care needs of women Veterans, the potential to employ different assessments, care, and resources, and the array of reproductive services available to this cohort. This training underscores the importance of screening for sexual trauma and how a woman Veteran's service might affect her post-deployment health. VA also shares this same information with maternity care providers in the community through myriad professional avenues. For instance, VA educates community providers on the needs of women Veterans as part of our participation as a member of the American College of Obstetrics and Gynecology (ACOG) and the Armed Forces Section of ACOG.

VA's Maternity Care Coordination Program is efficient and successful in meeting the needs of pregnant enrolled Veterans and in sharing medical information with community providers. Indeed, the drafters tacitly acknowledge this, as section 3, if enacted, would not remedy any identified current gap in policy or clinical practice (to include our manner of sharing medical information with community providers). It would merely mandate and codify in law what we do now in policy to ensure this program's continuity. Although we agree that policy can always be changed by an Under Secretary for Health, VA considers this program and the work of these coordinators to be key and more importantly, aligned with VA's standard of practice in delivering health care to women Veterans. VA cautions against mandating any program or practice currently established in policy, as VA requires flexibility in determining how best to deliver health care services, including coordination services, across the VA health care system. The Committee might consider an alternative approach to achieve its goal: VA could be required to give the Committee advance notice of any plan to rescind the subject policy (or successor thereto), the rationale for the decision, and a description of how VA will continue to deliver maternity care coordination services (or similar services) for pregnant women Veterans. The Committee can then pursue legislative action if it deems necessary.

Section 4 of the bill would require the Comptroller General of the United States to submit, not later than two years after the date of enactment of the bill, a detailed report to Congress on the mortality and severe maternal morbidity rates among pregnant and post-partum Veterans, with a particular focus on racial and ethnic disparities in maternal health outcomes for Veterans. (Section 2 of the bill would define the clinical and other

terminology relevant to the mandated report.). This report would need to include extensive data for the most recent 10 years of available data, draw research conclusions, and make a number of recommendations such as on how to improve coordination of care between VA and non-VA facilities for pregnant and post-partum Veterans and how to improve health record interoperability and training. The Comptroller General would need to obtain various and extensive data from VA and other Federal departments and agencies. As to this section, VA defers to the views of the Comptroller General.

If enacted, this bill would have no new costs.

S.887 VA Supply Chain Resiliency Act

The "VA Supply Chain Resiliency Act 2021" would direct the Secretaries of Defense and VA to enter into an agreement to allow for VA participation in the Defense Logistics Agency "Warstopper Program." The proposed legislation would establish reporting requirements for physical inventory and projected needs for critical items as well as implementation of VA integration into Warstopper.

As reported to the Committee in its March 24, 2021, hearing regarding VA's medical supply chain, VA has come a long way in strengthening its supply chain logistics. VA identified the immediate need for national personal protective equipment (PPE) asset visibility. VA's existing legacy system, a 50-year old inventory system, was unable to provide visibility into on-hand inventory and the usage or burn rate at each VAMC. VA defined standards for reporting PPE inventory levels and burn rates; developed the methodology, standard operating procedures, and SharePoint site for data collection; and within 30 days, deployed an electronic dashboard. This dashboard, still in use today, provides enterprise-wide visibility of PPE on-hand inventory, burn-rates, and projected demand, from the individual VAMC-level to enterprise-level.

To overcome the supply chain challenges, VA increased the amount of critical medical materiel held at each VAMC from 30 days to 60 days of supply. VA also established Regional Readiness Centers, geographically distributed to support the four VISN Consortiums. In doing so, we built resiliency into our internal supply chain to enable VHA to sustain continuous services to Veterans even when there are interruptions in support from the commercial supply chain. In the long term, the Regional Readiness Centers will support VHA preparedness for regional and national public health emergencies, including those secondary to national disasters (e.g., hurricane, flood).

VA is engaged with our interagency partners to ensure that the U.S. Government is prepared for future pandemics or other biological incidents by enabling a more integrated, responsive and aware system that can adapt to new conditions while maintaining the delivery of health care and other essential services. VA appreciates and supports the intent of S. 887, VA Supply Chain Resiliency Act, including providing durable guarantees that each department lives up to its commitments to the other. With

regard to the reporting requirements in the bill, Executive Order 14001, *A Sustainable Public Health Supply Chain* (Jan. 21, 2021), directed multiple agencies, including VA, to, among other things, determine the identification of emergency needs. VA requests time for the development and initiation of the *Pandemic Supply Chain Resilience Strategy* Implementation Plan required by Executive Order 14001 with the expectation that VA and DOD enter into an agreement described in section 2(b) of S. 887 not later than 365 days from enactment.

VA is unable to provide a cost estimate at this time. The plan required by Executive Order 14001 is not due until July 20, 2021 and this strategy will impact any potential costs. Costs will be determined by a number of factors to include approval/disapproval of the "strategy" and the number of agencies that participate.

S.951 PAWS Act of 2021

This bill would direct the Secretary to make grants to eligible organizations to provide service dogs to Veterans with severe PTSD and for other purposes.

VA does not support this bill. Among other concerns, as written, there is the potential to introduce a disparity in Veteran eligibility for the VA Service Dog Veterinary Insurance Benefit as well as concerns related to the health and training of service dogs provided. Although we understand the appeal of having VA provide service dogs for Veterans, the vast majority of reputable service dog organizations provide service dogs at no cost to Veterans (costs are covered by charitable contributions). Therefore, it is not necessary for VA to provide dogs or grants in the administration of the Service Dog Veterinary Health Insurance Benefit pursuant to title 38 C.F.R. section 17.148. Instead, VA provides veterinary health insurance through a contract to individual Veteran patients prescribed a service dog by a VA clinician and who obtain a service dog through an ADI or IGDF accredited organization, as opposed to unaccredited service dog organizations. For these reasons, VA does not support providing grants to organizations that provide service dogs and service dog training to Veterans with PTSD.

VA commends Congress for including in the bill the ADI and IGDF accreditation requirement which is critical in administering service dog benefits because VA must ensure that tested and proven criteria regarding service dog training and behavior are in place to allow VA to have reasonable confidence that dogs are well trained, healthy and not likely to pose a threat of harm to Veterans, their families and others who might come into contact with the dog. However, VA does not support that portion of section 3(c) that would make organizations eligible for grants that are not ADI or IGDF accredited because Veterans that receive service dogs from these unaccredited service dog organizations would not be eligible for the VA Service Dog Veterinary Insurance Benefit.

Pursuant to 38 C.F.R 17.148, VA requires Veterans to obtain service dogs from ADI or IGDF accredited provider organizations in order to receive the VA Service Dog Veterinary Insurance Benefit. VA's service dog veterinary insurance policy is not commercially available, is extensive in its coverage of wellness and medical/surgical

care and has no-out of pocket expenses to the Veteran. Thus, the commercial veterinary health insurance policy that eligible organizations would be required to provide in accordance with section 3(b) of the Act would be vastly inferior to the VA insurance benefit and any attempt to provide a policy comparable to that of VA would be a significant financial burden for these organizations. Even the largest and most financially solvent service dog provider organizations cannot provide a commercial insurance policy comparable to that of the VA service dog insurance policy. Thus, the inclusion of organizations other than ADI or IGDF accredited organizations would create a distinct and unfair inequity between Veterans in maintaining their service dog.

Section 3(c) would also allow organizations to meet the publicly available standards of the Association of Service Dog Providers for Military Veterans (ASDPMV) as an alternative to accreditation from ADI or IGDF. ADI and IGDF are national, industry-recognized organizations with established and proven health and training criteria. In addition, ADI has specific standards related to the training and placement of service dogs for Veterans with military-related PTSD. VA does not agree with allowing eligible organizations to meet the inferior standards and ethical principles of ASDPMV as opposed to the more rigorous standards and ethics that form the basis of the ADI and IGDF accreditation programs. For example, ASDPMV assesses the risk of hip dysplasia by the absence of clinical signs for this condition. Hip dysplasia cannot be diagnosed by physical examination and/or clinical signs alone; this condition dramatically shortens the working life of the service dog.

VA does not support the bill as written because it does not appear to afford VA oversight of the service dog training programs administered by the grant recipients after the grants are awarded. While, if enacted these grants would be subject to the Uniform Administrative Requirements for Federal Awards (2 CFR 200 et seq), VA would also need a mechanism to determine on an on-going basis if the dogs, trainers and facilities are of satisfactory quality. VA cannot support the award of grants to service dog organizations on behalf of Veterans without allowing sufficient oversight, including additional accountability mechanisms. VA understands the grant program is aimed at Veterans with PTSD whose VA clinical team determines based upon medical judgment that the Veteran may potentially benefit from a service dog. As such, the service dog would be adjunctive to other mental health treatment. Therefore, it is essential that the service dog pairing and training be administered appropriately and as part of a comprehensive mental health treatment program for Veteran participants.

Similarly, the bill does not give VA a role in determining when a service dog needs to be replaced for health or training problems and instead leaves that decision to the service dog organization and the Veteran. VA has serious concerns about this omission. A reputable service dog organization should not have concerns about a funding agency having a role in protecting Veterans. VA knows from experience, as do service dog training organizations, that once people bond to a dog, they are very reluctant to give it back even if its behavior or health are a serious problem. Unfortunately, VA has first-hand experience with this issue and has experience with

service dog training organizations taking advantage of it to avoid having to replace a service dog with another dog at considerable expense.

Furthermore, VA cannot support the bill because it requires VA to develop metrics to determine whether Veterans who are paired with a service dog through these grants improve in psychosocial functioning, and dependence on narcotics medication. VA does not believe that this data would be meaningful as VA recently completed a study entitled "A Randomized Trial of Differential Effectiveness of Service Dog Pairing Versus Emotional Support Dog Pairing to Improve Quality of Life for Veterans with PTSD" that found no differences on three primary outcome measures of quality of life, mental functioning, and physical functioning. Additionally, narcotic medications are not typically prescribed for PTSD; rather they may be prescribed for co-morbid conditions (such as chronic pain).

VA notes that the evidence on the benefits of service dogs for Veterans with PTSD is still at a preliminary stage and currently does not provide a confident basis for programmatic expansion. Specifically, the evidence does not support the statement in the legislation that "service dogs ameliorate the symptoms associated with PTSD."

Section 3(f) would allow a service dog, in addition to VA hospital care or medical services, to be provided to Veterans with PTSD, and any improvement in PTSD symptoms due to provision of a service dog would not affect eligibility to any VA benefits. VA cannot support the bill and section 3(f) as written. Generally, VA supports service dogs as an adjunct to evidence based mental health treatment, in addition to other options available such as yoga, art therapy, massage etc. VA encourages all Veterans to seek treatment for service-connected disabilities. However, under the Veterans Benefits Administration's (VBA) current process, if treatment results in a disability materially improving, VBA may reduce a disability rating percentage. Disability rating reductions may occur, to include ratings that have not been in effect for 5 years or are otherwise stable, if the evidence of record includes a thorough completed examination and the evidence reflects an improvement in the ability to function under the ordinary conditions of life, including employment.

As such, if the evidence of record shows material improvement in the Veteran's PTSD symptoms, VA may reduce a Veteran's disability rating percentage. Based on the current language in the bill, there would be an exception made to reducing disability rating percentages for service-connected Veterans with PTSD who use service dogs as part of the grant program. As a result, this would create an inequity between these Veterans and other Veterans who receive different types of treatment for PTSD, as well as other groups of Veterans who use service dogs for conditions other than PTSD.

VA also notes that it would be unlikely that the evidence of record would be able to clearly indicate whether the improvement in symptoms was due to the provision of the service dog. Due to the above-stated concerns, VA recommends reconsidering the language in section 3(f) to allow VA to at least consider whether the effects of having a

service dog result in material improvement in a Veteran's PTSD condition and remain consistent with current practice.

S.1040 To expand eligibility for hospital care, medical services, and nursing home care from the Department of Veterans Affairs to include veterans of World War II

S.1040 would amend 38 U.S.C. § 1710(a)(2)(E) to expand hospital care, medical services, and nursing home care to Veterans of World War II. Currently, this provision provides VA hospital care, medical services, and nursing home care to Veterans of the Mexican border period and World War I.

VA supports this bill, assuming appropriations are provided for this purpose. The proposed legislation could potentially provide health care services to a Veteran population who may not otherwise be eligible for VA health care. While VA expects that the majority of the World War II (WWII) Veteran population is already eligible for Medicare and will rely on Medicare coverage for a significant portion of their health care needs, VA health care may be more appealing to Veterans who are unsatisfied with their current Medicare provider or who seek to reduce their copays. For example, VHA provides prescription drugs at copayment levels that tend to be significantly below the cost sharing requirements of Medicare beneficiaries.

If enacted, this legislation would grant priority group 6 eligibility to all WWII Veterans. Veterans that are currently enrolled in VA health care under priority groups 7 and 8 would be reclassified under priority group 6. Copayments for Veterans in priority group 6 are less than copayments for priority groups 7 and 8. The lower copayments could also induce higher reliance for those already enrolled and encourage new enrollment by currently eligible WWII Veterans that are not enrolled.

Reliable data is not available regarding the number of currently ineligible WWII Veterans who would enroll with VA; therefore, a total cost estimate has not been calculated. If passed, only a portion of WWII Veterans that become eligible are likely to enroll with VA health care. However, VA estimates that 14,000 ineligible WWII Veterans would be eligible to enroll in FY 2022 and 5,000 in FY 2025. The projected average annual expenditure per enrollee for FY 2022 would be $2,803 and $3,328 for FY 2025.

S.1198 Solid Start Act of 2021

This bill would codify VA's Solid Start Program (VASS) and would implement improved and expanded program initiatives. VA supports S.1198 but has some concerns regarding the requirements to implement certain program initiatives.

VA and the Departments of Defense (DoD) and Homeland Security (DHS) issued a joint action plan to provide seamless access to mental health care and suicide prevention resources in response to Executive Order 13822, *Supporting Our Veterans During Their Transition from Uniformed Service to Civilian Life.* On December 2, 2019,

VA, in coordination with DoD and DHS, launched VASS to implement Task 1.1 of that joint action plan to make early and consistent caring contact with recently separated Service members three times during their first year after separation (at around 90, 180 and 365 days following separation). The purpose of these calls is to help each Veteran establish a relationship with VA, increase their awareness of available VA benefits and services, lower their barrier to entry to VA mental health care services and support their successful transition to civilian life.

Since the launch of the VASS program on December 2, 2019, through May 31, 2021, VASS has successfully connected with over 127,000 VASS eligible individuals achieving a 59.2% successful contact rate. During this same period, VASS has successfully connected with over 21,000 Priority Veterans, achieving a 73.2% successful contact rate. For VASS, a Priority Veteran is defined as an individual who had a mental health care appointment during the last year of active duty. A successful contact is defined as speaking with the Veteran and completing at least one VASS conversation during the period of eligibility.

Assuming appropriations are provided for this purpose, VA supports the program initiatives set forth in proposed new section 6320(b)(1) in section 4(a) of the bill. Subsections (b)(1)(A)-(E) of section 6320 would require VA, in coordination with DoD, to: collect up-to-date contact information of transitioning Service members; call each recently separated Veteran, regardless of separation type or characterization of service, three times within the first year after separation; provide information about VASS on VA's website and in transition booklets and other resources; ensure calls are tailored to the needs of the Veteran; and prioritize outreach to Veterans who accessed mental health resources prior to separation from service. The remaining requirements for the proposed initiatives align with current VASS practices. Subsection (b)(1)(F) would require that women Veterans be provided with information tailored to their specific health care and benefits. Subsection (b)(1)(G) would require that VA, where feasible, provide information on access to state and local Veteran resources, to include Vet Centers and Veterans service organizations. Subsection (b)(1)(H) would require the collection and analysis of data to evaluate the effectiveness of the program. VA is also currently developing new VASS performance measures, which will include a means of assessing long-term outcomes to confirm that the VASS program is providing concrete improvement throughout a Veteran's post-separation life journey.

However, VA notes some concerns with the provisions of proposed new section 6320(b)(2) in section 4 of the bill, recognizing that these provisions are permissive and not mandatory. Subsection (b)(2)(A) would authorize VA, in coordination with DoD, to encourage transitioning Service members to authorize alternate points of contact whom VA may contact if the Veteran is unavailable at the time of VA contact attempts during the first year after their separation from service. VA believes this provision may be duplicative of current efforts under section 101 of the Veterans COMPACT Act of 2020, Pub. L. No. 116-214, which requires VA to develop a pilot program to allow transitioning Service members to designate up to 10 individuals to whom VA may send information regarding VA assistance and benefits for Veterans.

Subsection (b)(2)(B) would authorize VA to send tailored mailings to Veterans whom VASS is unable to contact by phone. VA is concerned that tailored mailings may be less effective than emails to recently separated Veterans and may be duplicative of emails.

Subsection (b)(2)(C) would authorize VA, where feasible, to reach out to Veterans who separated from service prior to the initiation of VASS to provide these individuals with similar services. VA is concerned that this provision may not align with VASS's specific mission to provide tailored support to Veterans during the critical first year after their separation from service as these individuals transition from military to civilian life. VA currently has comprehensive outreach programs and strategies in place to reach Veterans who are beyond the first year of their transition period from military to civilian life. VA also notes that more information would be needed to define the Veteran group Congress intends to include under this section for receipt of VASS services, and implementation of this provision may require additional appropriations.

While this bill would require appropriations to fund VASS, VA cannot provide cost estimates at this time.

S.1220 United States Cadet Nurse Corps Service Recognition Act of 2021

This bill would recognize and honor the service of individuals who served in the Cadet Nurse Corps during World War II.

Section 2 of the bill would amend 38 U.S.C. § 106 to deem as active duty for purposes of eligibility and entitlement to benefits under chapters 23 and 24 of title 38, U.S.C. the service of persons who served in the United States Cadet Nurse Corps during the period beginning on July 1, 1943, and ending on December 31, 1948. Within one year of the date of the bill's enactment, the Secretary of Defense would be required to issue to each member with qualifying Cadet Nurse service a discharge from service under honorable conditions.

VA has no authority to determine whether service provided to the U.S. Armed Forces by civilian or contract employees constitutes service for title 38 purposes. The authority to recognize civilian service as active duty has been specifically granted by Congress to DoD under Public Law 95-202. Should DoD characterize Cadet Nurse service as "active duty" in 38 U.S.C. 106, VA would support recognition of the service of the Cadet Nurse Corps as active duty for purposes of eligibility and entitlement to benefits under chapters 23 and 24 of title 38, U.S.C.

While VA recognizes the great contribution of the United States Cadet Nurse Corps, we cannot support the bill as drafted because of the potential for confusion in the application of benefits. If DoD characterized Cadet Nurse service as "active duty" in 38 U.S.C. 106, but only for certain but not all VA benefits as indicated in the bill, that would create a disconnect across VA benefit programs. The bill would provide that an

individual who receives a discharge for qualifying Cadet Nurse service would be honored as a Veteran with deemed active duty service. The bill would administratively establish active duty service, but not for purposes of all VA benefits. The bill would limit eligibility and entitlement to benefits under chapters 23 and 24 of title 38, U.S.C., but the bill text does not specify which benefits under those chapters are applicable. VA is concerned that the bill language may be confusing to beneficiaries and result in inconsistencies in the administration of benefits among VA benefit programs. Chapter 23 benefits include monetary allowances, burial flag and memorial products. These benefits are administered by the National Cemetery Administration (NCA) and VBA. Chapter 24 benefits would include burial in a national cemetery, which is managed by NCA.

Additionally, the lack of clarity in the bill text because of the inclusion of the parenthetical language (describing benefits "including with respect to headstones and markers") makes the scope of eligibility to other NCA-administered benefits unclear. For example, eligibility for burial in a national cemetery would ordinarily also entitle one to receive a Government-furnished headstone or marker under 38 U.S.C. § 2306 and a Presidential Memorial Certificate under 38 U.S.C. § 112, but the bill language makes this unclear. Further, section 2306 authorizes VA to furnish a medallion to signify a Veteran's grave in a private cemetery in lieu of a headstone or marker. It is unclear whether VA would be authorized to also furnish a medallion to a member of the Cadet Nurse Corps with qualifying service. VA welcomes the opportunity to discuss these concerns with the Committee and to offer technical assistance to address them.

S.1220 would authorize DoD to design and produce a service medal or other commendation or memorial plaque or grave marker to honor those who receive an honorable discharge for service in the Cadet Nurse Corps. The bill would also exclude eligibility for members of the Cadet Nurse Corps with qualifying service from interment in Arlington National Cemetery. VA defers to DoD concerning these provisions. However, VA does not support the provision of a separate DoD grave marker or memorial plaque to Cadet Nurse Corps members with qualifying service as it would directly conflict with VA's memorialization authorities governing the same benefits.

VA is unable to estimate the costs at this time for the additional funding and resources that would be needed if the bill were enacted.

S.1280 Veteran Families Health Services Act of 2021

Title I of the bill relates to DoD. Section 102 of the bill would require the Secretary of Defense to furnish fertility treatment and counseling, including through the use of assisted reproductive technology (ART), to a covered member of the Armed Forces, a spouse or partner to a covered member of the Armed Forces, or a spouse, partner or gestational surrogate of such member. Eligibility under this section would be without regard to the sex, gender identify, sexual orientation or marital status of the covered member. In in vitro fertilization (IVF) cases, the Secretary of Defense would be limited to furnishing no more than three completed cycles or six attempted cycles,

whichever occurs first. In cases where a covered member is unable to provide their own gametes, the Secretary of Defense is required upon the election of the member, to let the member use donated gametes and to pay or reimburse the member for the reasonable costs of procuring gametes from a donor. The Secretary of Defense would not, however, be required to find or certify a gestational surrogate for a covered member, or to find or certify gametes from a donor for a covered member or to connect a covered member with gametes from a donor. VA defers to the views of the Secretary of Defense.

Section 103 would require the Secretary of Defense, acting through the Assistant Secretary of Defense for Health Affairs, to establish procedures for the retrieval of gametes, as soon as medically appropriate, from a member of the Armed Forces in cases in which the fertility of the member is potentially jeopardized as a result of an injury or illness incurred or aggravated while serving on active duty. This would be done to preserve the member's (fertility) medical options. A retrieval of gametes procedure could occur only with the specific informed consent of the member, or if the member lacks the decision-making capacity to consent, if a medical professional determines the following:

- The future fertility of the member is potentially jeopardized as a result of an injury or illness as a result of an injury or illness incurred or aggravated while service on active duty or will be potentially jeopardized as a result of treating such injury or illness;
- The member lacks the capacity to consent to the retrieval of gametes and is likely to regain such capacity; and
- The retrieval of gametes under this section is in the medical interest of the member.

It would also provide that gametes retrieved from a member of the Armed Forces under this section could be used only with the specific consent of the member, or if the member has lost the ability to consent permanently (as determined by a medical professional) as specified in an advance directive or testamentary instrument executed by the member.

This section would require the Secretary of Defense, pursuant to regulations to be prescribed by the Secretary of Defense, to dispose of gametes retrieved from a member with the specific consent of the member, or if the member has lost the ability to consent permanently (as determined by a medical professional) and has not specified the use of gametes in an advance directive or testamentary instrument executed by the member. VA defers to the views of the Secretary of Defense.

Section 104 of the bill would require the Secretary of Defense to provide members of the Armed Forces with the opportunity to cryopreserve and store their gametes prior to deployment to a combat zone or to a duty assignment that includes hazardous assignment, as determined by the Secretary of Defense. It would provide these members with free cryopreservation and storage of gametes in a DoD facility or in

a private entity, including transportation of such gametes. These medical benefits would continue until the date that is one year after the member's retirement, separation or release from the Armed Forces. At the end of this one-year period, the Secretary of Defense would be required to permit an individual whose gametes are stored in a DoD facility to select, including pursuant to an advance medical directive or military testamentary instrument, one of the following options: to continue such cryopreservation and storage in the DoD facility at personal cost; to transfer the gametes to a private facility selected by the individual; or to transfer the gametes to a VA facility if cryopreservation and storage are available to the individual there. If the individual does not make any of these three selections, then the Secretary would be authorized to dispose of the gametes not earlier than the date that is 90 days after the end of the one-year period described above. While VA defers to the views of the Secretary of Defense, we note that with respect to the option to transfer gametes to a VA facility for cryopreservation and storage, this would not be practicable. VA has no in-house capacity to provide either of these services. Under VA's current IVF program, we contract for both of these services using specialists and facilities in the community.

This provision would also require a member of the Armed Forces who elects to cryopreserve and store their gametes under this section to complete a DoD advance medical directive and a military testamentary instrument that explicitly specifies the use of their cryopreserved and stored gametes if such member dies or otherwise loses the capacity to consent to the their use.

This section would authorize the Secretary of Defense to enter into agreements with private entities that provide cryopreservation, transportation, and storage for gametes. Again, VA defers to the Secretary of Defense.

Section 105 would require the Secretary of Defense to ensure DoD employees assist members of the Armed Forces in navigating fertility treatment (including those using ART) and counseling services, in finding a provider that meets their needs with respect to these services, and in continuing their receipt of such treatment and services without interruption during a permanent change of station. VA defers to the views Secretary of Defense.

Section 106 would require the Secretary of Defense and the Secretary of Veterans Affairs to share best practices and to facilitate referrals (related to fertility treatment and services), as they consider appropriate. Additionally, they would be required to enter into a memorandum of understanding (MoU) whereby the Secretary of Veterans Affairs would receive access to gametes stored by DoD, for purposes of furnishing VA fertility treatment under new section 1720K of title 38, as added by section 202(a) of this bill. The required MoU would also authorize VA to compensate DoD for its costs of cryopreservation, transportation and storage of gametes under section 104, discussed above. VA defers to the Secretary of Defense.

Title II of the bill relates to VA. We want to stress that VA believes strongly in fuller reproductive health options for Veterans and their families. However, as outlined

below, we believe more discussion on the details of this legislation is necessary for VA to support the bill. We are eager to work with the Committee to secure additional authorities that will improve these types of services for Veterans.

Section 201 of S.1280 would add new paragraph (I) to the definition of "medical services" codified in section 1701(6) of title 38, U.S.C., to include "fertility treatment and including treatment using assisted reproductive technology."

Section 202(a) would add new section 1720K to title 38, U.S.C., requiring the Secretary of Veterans Affairs to furnish fertility treatment and counseling, including through the use of ART, to a covered Veteran or a spouse, partner or gestational surrogate of a covered Veteran if the Veteran, and the spouse, partner or gestational surrogate of the Veteran, as applicable, apply jointly for such treatment and counseling through a process prescribed by the Secretary. A covered Veteran means a Veteran:

- Who has an infertility condition, unless the Secretary can show that the Veteran was completely infertile before service in the active military, naval or air service; and
- Who is enrolled in VA's health care system.

As to the first eligibility requirement, we note that the language "completely infertile" seems an impossible bar to meet because managing uncertainty is central to (and unavoidable in) the practice of medicine. The practice of medicine, including diagnosis, is based on informed and trained medical judgments. Knowledge of the absolute causation of any medical condition is not, in general, ascertainable.

Under this section, this treatment and counseling would have to be furnished without regard to the sex, gender identity, sexual orientation or marital status of the covered Veteran. In cases of in vitro fertilization, the Secretary could provide no more than three completed cycles or six attempted cycles of IVF, whichever occurs first. If the Veteran is unable to provide the Veteran's own gametes for purposes of fertility treatment under this section and the covered Veteran elects, the Secretary would be required to let the Veteran use donated gametes and to pay or reimburse the Veteran for the reasonable costs of procuring the donor gametes. We note that in contrast to section 102, above, this section is silent on whether VA would be required to find or certify gametes from a donor for a covered Veteran or to connect a covered Veteran with gametes from a donor. We further note that it does not include donation of embryos, despite the fact that many couples have donated their excess embryos to facilities/banks for use and adoption by others. Inclusion of donated embryos available for adoption might therefore be considered.

The bill would require ART to be provided to a covered Veteran ***or*** a spouse, partner or gestational surrogate of a covered Veteran if the Veteran, and the spouse, partner or gestational surrogate of the Veteran, as applicable, apply jointly for such treatment and counseling through a process prescribed by the Secretary. Although the provision of the benefit is contingent on a joint application process, it is unclear why the

care that is required to be delivered could be provided to one, the other, or both. The required use of a joint application does not avoid this ambiguity.

The use of the disjunctive here is problematic because at any point the personal circumstances or health of a Veteran might change such that the Veteran would not wish to pursue ART or continue ART, even if the spouse, partner or gestational surrogate does. A Veteran should be able to reject this treatment at any stage and for any reason. In some cases, as this is a lifetime benefit for an eligible Veteran up to its exhaustion, a Veteran may still want to bear a child or build a family but not with their current spouse, partner or surrogate. Due to the use of the disjunctive, VA could be required to provide the Veteran's spouse, partner or gestational surrogate with fertility treatment under this section, even without the consent (or even knowledge) of the Veteran. These non-Veterans could rely on the fact that a joint application was submitted originally. Is the use of the disjunctive deliberate to cover cases where a dying Veteran or one losing capacity permanently might agree that the spouse, partner or surrogate could alone use this benefit to use previously cryopreserved gametes with which to bear a child after the Veteran's death or after declaration of incompetency?

Under our current IVF authority, referenced above, the consent of each party is legally required to be obtained each cycle and third-party consent is prohibited. That would not apply to care and services provided under section 202(a), as added. Instead, VA's normal informal consent requirements and procedures would apply. ART does not require special or signature informed consent, and the joint application process that would be required to be established in regulation would not supersede applicable informed consent procedures and requirements, which allows for a surrogate decision maker to make treatment decisions for a Veteran who has lost decision-making capacity or who has been judicially declared to be incompetent.

Thus, unless amended, retrieval of a Veteran's gametes or use of the Veteran's gametes could occur if the Veteran's surrogate decision maker provides full and free informed consent. Yet, it would still be incumbent on the medical professional, as part of his or her clinical duties, to identify the range of medically acceptable procedures for the patient. That is, whether retrieval or use of a Veteran's gametes is medically appropriate in cases where the patient lacks decision-making capacity would remain a clinical analysis no different from what is done for those with decision-making capacity. For example, now when providing fertility treatment, including the use of ART under our current IVF authority, medical professionals address both the clinical (reproductive) needs of the Veteran as well as any psychological treatment needs (including those needed for quality of life). So, the responsible treating provider must exercise reasonable clinical judgment to determine if this treatment will produce the intended clinical benefits or quality of life goals. Despite the personal treatment preferences of the Veteran or surrogate, fertility treatment using ART may be determined to be medically inappropriate in a specific patient case. We therefore recommend, as discussed further below, that the bill be amended to ensure that this benefit is subject to the responsible treating provider's having determined that the fertility treatment and counseling, including the use of ART, is medically necessary and appropriate for the

Veteran. If not amended, VA would still impose this as an implicit requirement (to accord with generally accepted standards of medical practice and to protect our providers from licensure challenges by their state boards), but VA could be exposed to challenges for limiting the law beyond its terms.

For instance, there could be scenarios where gamete retrieval or gamete use is sought after a Veteran permanently lacks decision-making capacity, has been judicially declared to be incompetent, or is dying. In these cases, the Veteran's desire to have a child may be based on a past wish based on a prior clinical situation, which may no longer apply or may now, if provided, result in clinically inappropriate action or treatment inconsistent with the patient's prior stated preferences. Even if use of gametes were included in a Veteran's advance directive (and the Veteran currently lacks decision-making capacity), the purpose of this type of treatment would still require interpretation between the authorized surrogate decision-maker and the responsible practitioner as to whether its provision is clinically warranted and medically appropriate.

Apart from the noted clinical concerns, Veterans could also arguably experience potential domestic (interpersonal)-based abuses of this benefit if a surrogate decision maker could provide consent in his or her stead, particularly if there could be a conflict of interest, e.g. surrogate is the spouse or partner who would benefit financially from having a child with the Veteran. Another scenario: If the nexus is not required and the Veteran's spouse's, partner's or surrogate's eligibility for ART is not conditioned on the eligibility and consent of the Veteran, could a Veteran who later regains decision-making capacity later sue VA for wrongful birth? It is unclear that a mere joint application process, even if carefully crafted, could avoid some negative consequences or abuses if the law leaves in place unintentional ambiguity (i.e., not limiting this benefit to treatment that is medically necessary and appropriate as determined by VA).

In our view, VA should not be required to deliver this benefit against the current informed consent and will of the Veteran. It is a benefit targeted at Veterans and their reproductive health needs. Again, the eligibility of the Veteran's spouse, partner or gestational surrogate should clearly derive only from, and be contingent on, the Veteran's eligibility for this benefit and the Veteran's ability to provide informed consent per cycle. One must bear in mind that this is a treatment benefit required to help overcome the inability to procreate due to the infertility condition of the Veteran, or to restore the health of the Veteran, which includes, among other things, that which restores the quality of life that has been lost as a result of the Veteran's (infertility) condition.

If the drafters' use of the disjunctive is deliberate to ensure that a single Veteran would have access to ART, then be assured that we would not interpret the use of the conjunctive to require them to have a spouse, partner or surrogate or to exclude them. Veterans seeking to bear a child or build a family can only take advantage of ART if they have another individual or donor by which to complete the benefit. (This is precisely why our current general treatment authority, applicable only to Veterans, is inadequate to provide enrolled Veterans with a complete IVF benefit.) We recognize

that some single Veterans may only require donated gametes to have the opportunity to conceive or build a family, and, if eligible, we would ensure they have access to these services under new section 1720K, as added by section 202(a).

To address these various concerns, we recommend as a technical matter that the draft bill language be amended to establish eligibility for a covered Veteran "and, if applicable, the Veteran's spouse, partner, or gestational surrogate." This would cover both single Veterans and those with spouses, partners or gestational surrogates. Further, while VA supports expansion of fertility services and counseling, to include the use of ART, to enrolled Veterans and, if applicable, their spouses, partners or surrogates, we believe the language of new section 1720K(a)(1), as added by section 202(a), should be amended to ensure these are provided only in cases where VA has determined their provision or continuation is medically appropriate, *e.g.,* decisions such as whether the care would be consistent with the patient's preferences, in accord with accepted standards of medical practice, and based on existing standards of informed consent (*i.e.,* adequate practitioner disclosure, patient understanding and patient voluntariness). Otherwise, the bill, as drafted, could result in beneficiaries described in the draft bill assuming, in error, that they could receive these services on demand, as long as they meet the eligibility criteria stated in the bill. As discussed, requirements of this bill should not require VA to contravene applicable standards of medical practice or providers' professional ethical obligations. This could be accomplished by inserting in new section 1720K(a)(1) the words "medically necessary and appropriate, as determined by a VA provider employed by the Department" after "furnish" and before "fertility."

The bill should be amended to make clear that matters of ownership, future embryo or gamete donation, disposition or destruction would be matters governed solely by applicable state law and an agreement required to be entered into between the Veteran, the spouse, partner or gestational surrogate, and the facility storing the cryopreserved gametes or embryos to avoid potential ownership or custody issues. The Veteran and the spouse, partner, surrogate or donor should also be required to enter into a private agreement(s) governed by applicable state law that controls the use of donated gametes or embryos, including embryos donated for adoption, or, if applicable, the terms of gestational surrogacy arrangements to ensure understanding of ownership or custody issues. It should also be clarified that VA is not a party to any such private agreements and has no ownership or custody of cryopreserved gametes or embryos, and that VA is not to be involved in the disposition of excess gametes or embryos. The language of the bill should make clear that VA is solely a payer for the services covered by new section 1720K, as added by section 202(a).

The eligibility criteria raise other technical concerns. To be eligible under new section 1720K, as added, a Veteran would need to have an infertility condition, unless the Secretary can show that the Veteran was completely infertile before service in the active military, naval or air service. First, it is unclear if this is intended to include infertility resulting from the receipt of necessary VA-treatment, but VA would interpret it as including this cohort.

Additionally, while we welcome expanding coverage for ART to Veterans enrolled in VA's health care system without regard to their sex, gender identity, sexual orientation or marital status, Veterans in same-sex relationships, transgendered Veterans or those who are not in a relationship/single may need ART to conceive. If they lack access to ART, the clinical outcome is the same, even if the Veterans do not carry a diagnosis of infertility.

Some administrative eligibility procedures or contract or payment mechanisms will deny eligibility or payment if the ART is not for treatment of infertility based on a diagnostic code(s) for infertility. These Veteran-cohorts may have healthy physiological reproductive function from the strict view of infertility experts yet require ART on the basis of another clinical diagnoses such as gender dysphoria or another medical condition (or have diminished but not diagnosable fertility due to hormonal or other treatment required to treat gender dysphoria) or they may simply lack a partner at the stage in time when they are ready to start a family, as many have postponed childbearing or building a family until after they completed their military careers. This draft bill would still not cover these Veterans unless they have a diagnosis of infertility, which some will not. Inclusion of donor and surrogate benefits under this section would not remedy this gap. It would need to be amended to ensure that their reasons for needing ART are covered.

The new section 1720K, as added by section 202(a) of the draft bill, would also require the Secretary to carry out an outreach and training program to ensure Veterans and VA health care providers are aware of these benefits and any changes thereto. The Secretary would not be required to find or certify a gestational surrogate for a covered Veteran or connect the gestational surrogate with a covered Veteran. Neither would the Secretary be required to furnish maternity care to a covered Veteran, spouse, partner or gestational surrogate in addition to what is otherwise required by law.

The new section 1720K(c), as added by section 202, would require VA to coordinate fertility treatment and counseling for Veterans seeking fertility treatment and counseling but not eligible under section 1720K(a). It is unclear which patient population this provision intends to cover. Unless they are eligible for these services under this or other VA authority, it would be inappropriate to furnish them with care coordination services, which should be the responsibility of their treating provider(s). The Committee may have intended to authorize VA to provide referral services to non-Department sources as done for those ineligible for readjustment counseling services under 38 U.S.C. § 1712A(c) or military sexual trauma counseling under 38 U.S.C. § 1720D(b)(2)(C).

Section 203 of the draft bill would add a new section 1789 to title 38, U.S.C., authorizing the Secretary to pay an amount, not to exceed a specified amount, to assist a covered Veteran (as defined in section 202) in the adoption of one or more children regardless of the Veteran's sex, gender identity, sexual orientation or marital status. The allowable amount would be the cost that the Department would incur by paying the

expense of three adoptions, as determined by the Secretary. It is unclear to us if the monetary adoption benefit would include authority to reimburse adoption costs already incurred. By authorizing VA to pay, not reimburse, these costs, is it intended that VA would pay the monetary benefit in advance of the costs actually being incurred by the Veteran, like a set allowance similar to an annual clothing allowance? How would VA confirm the adoption expenditures occurred? In addition, the requirement to set a limitation on the amount that can be paid under this section is unclear; the limit would be equal to the cost the Department would incur by paying the expenses of three adoptions (as determined by VA). Given the variances across the country in adoption costs and in the types of adoptions, it is unclear how the Committee intends for VA to determine this limit, yet alone use it for all claimants.

Section 204 of the draft bill would require the Secretary to ensure that VA employees assist Veterans in navigating fertility treatment (including that which uses ART) and counseling services; in finding a provider that meets the needs of these Veterans with respect to these services; and in continuing their receipt of such services without interruption if they move to a different geographic location. We note this section does not include, however, the authority to transfer or transport gametes. We recommend section 204 of the bill be amended to authorize VA to pay for the costs of transporting the Veteran's gametes and/or embryos to the new storage facility.

Section 205 would add new section 7330D to title 38, U.S.C., requiring the Secretary to facilitate research conducted collaboratively by the Secretary of Defense and the Secretary of Health and Human Services to improve VA's ability to meet the long-term reproductive health care needs of Veterans who have a genitourinary service-connected disability or a condition that was incurred or aggravated inline of duty in the active military, naval or air services, such as a spinal cord injury, military sexual trauma, or a mental health condition, that affects the ability of the Veteran to reproduce. It would require the Secretary of Veterans Affairs to ensure that information produced by this research is disseminated across VHA if it may be useful for other VHA activities. It would also require the Secretary, not later than three years after the date of enactment, to submit a detailed report to Congress on the research activities conducted under section 7330D, as added. The report would need to include data disaggregated by Veteran's age, race, ethnicity, sex, gender identity, sexual orientation, marital status, type of disability (if applicable) and geographic location. As section 205 would impose VA-collaborative research requirements on DoD and the U.S. Department of Health and Human Services, VA defers to the views of these Departments on the feasibility of this provision.

Section 206 of the draft bill would require the Secretary to submit, starting not later than one year after the date of the enactment of this Act and not less frequently than annually thereafter, a detailed report on the fertility treatment and counseling furnished by VA, including through non-VA providers during the year preceding the submittal of the report. The annual report required by this section would yield no meaningful information. Fertility and infertility evaluation and treatment, including that using ART, is a clinical process that typically takes longer than one calendar year to complete. Therefore, an annual report would have overlapping and incomplete data.

This would create the potential for misinterpretation of the results. In addition, some of the listed reporting requirements, including "the number of veterans who self-reported difficulty becoming pregnant or successfully carrying a pregnancy to term to a health care provider of the Department or a non-Department provider," would be impossible to gather without performing an individual record review, which is not feasible. Inclusion of self-reports by patients are also inherently subject to bias, lack of recall, unreliability, etc., and they do not necessarily correlate with or substantiate clinical findings or evidence.

Section 207 would require the Secretary to submit, not later than 180 days after the date of the enactment of this Act and not less frequently than every 180 days thereafter, a report to Congress containing data on the timeliness and adequacy of access by Veterans to fertility treatment and counseling services under this title (to include that delivered by non-VA providers). We believe this report would be of little utility for the same reasons provided in connection with section 206. Many valid reasons exist for variance in timelines for when the services covered by this bill would be requested, scheduled and delivered. In our current IVF program, VA aims to comply with its policies on outpatient scheduling, but we consider this in terms of a treatment episode. The use of ART, like IVF, is a complex clinical area dependent on availability of highly specialized medical professionals in the community willing to contract with VA, and requiring myriad clinical steps and stages, with up to three completed cycles allowed. Section 207 would appear to presume that services provided under section 1720K, if enacted, would not be a complex, time-intensive procedure. It fails to appreciate that this treatment area requires the psychological readiness of the Veteran and, if applicable, the Veteran's spouse, partner or surrogate. Failures to become pregnant may understandably delay a beneficiary's desire to start a new cycle. It also assumes VA is readily able to purchase the required professional medical services and the required cryopreservation and storage services wherever an eligible Veteran is located.

Section 208 of the draft bill would require the Secretary, not later than 18 months after the date of enactment of this Act, to prescribe regulations to carry out sections 202(a) and 203(a) in title II of the draft bill. To complete rulemaking, we believe this timeframe is not practicable.

We welcome the opportunity to discuss S. 1280 and these technical issues with you and fully share your goal of providing a complete reproductive health care benefit that includes the use of medically necessary and appropriate assisted reproductive technology to Veterans and, as applicable, their spouses, partners, or gestational surrogates. To this end, we are eager to work with the Committee on addressing the technical issues identified. Until we can work with the Committee to address these issues, VA recommends the Committee reserve consideration of S. 1280.

S.1307 Department of Veterans Affairs Provider Accountability Act

S.1307 would amend title 38, U.S.C., to enforce licensure and related requirements for VA health care professionals. Specifically, section 2 would add a new

section, section 7414, to subchapter I of chapter 74 of title 38, U.S.C. Section 7414 would require VHA to: (1) verify licensure, certification and registrations of health care professionals; (2) determine if the health care professional holds a Drug Enforcement Administration registration; (3) understand education, training, clinical experience and clinical competence; (4) be aware of malpractice history and occurrence; and (5) continuously monitors any changes to provider status.

VA supports the enactment of the bill. The amendments in section 7414(a) are consistent with VHA policy. VHA currently monitors any changes to the matters under paragraph (a)(2) through participation in the National Practitioner Data Bank Continuous Query Program (NPDB CQ). Licensed Independent Providers (LIP) have been required to be enrolled in the program for many years. In 2019, the monitoring was increased for ongoing monitoring through the NDPB CQ process for all licensed providers.

Section 7414(c)(1) would require the Secretary to ensure each Department medical center carries out ongoing, retrospective and comprehensive monitoring of the performance and quality of the health care delivered by each Department health care professional located at the medical center. Additionally, each Department medical center must timely carry out timely and documented reviews if an individual notifies the Secretary of any potential concerns related to a Department health care professional's failure to meet generally accepted standards of clinical practice. Section 7414(c)(2) would require the Secretary to establish a policy to carry out these monitoring and reviews. VHA already reviews concerns relating to quality of clinical care which is outlined in the guidance document titled "Privileged Competency – Reviews, FPPE for Cause, and Investigations" published in 2018. This document will be converted to formal VHA policy in the near future.

Section 7414(e) prohibits certain settlement agreement terms. Specifically, it would prohibit the Secretary from entering into a settlement agreement relating to an adverse action against a health care professional if such agreement includes terms that require the Secretary to conceal the employees serious medical error or lapse from the employees personnel file. This prohibition already exists in VHA regulation (see 38 C.F.R. 46.7) and VHA policy (see VHA Handbook 1100.19, *Credentialing and Privileging*).

Section 7414(f) would require "not less frequently than annually," the Secretary to provide mandatory training for the employees responsible for carrying out requirements in section 7414. Development of this training is already underway. VA's Employee Education System expects to have all modules completed and in the VA Talent Management System by FY 2022.

Since VHA has established policies and trainings in place for many of the requirements set forth in section 7414, if enacted, this bill would have no new costs.

S.1319 VA Quality Healthcare Accountability and Transparency Act

The "VA Quality Health Care Accountability and Transparency Act 2021" would direct the Secretary to make certain information publicly available on the Access to Care site or its successor. VA does not support this draft bill without amendment. We believe the bill is redundant with current VA efforts and requirements and are unclear about what problem the bill is trying to solve or the desired outcome of the legislation.

VA believes this bill duplicates existing efforts to enhance quality and transparency and harmonize measurement and reporting across U.S. payers and providers. The portions of the proposed legislation that are feasible and consistent with medical confidentiality requirements are already in place – i.e., aggregate reporting of quality, safety and access metrics. The website www.accesstocare.va.gov is publicly accessible and can be linked to from the VA homepage as well as the homepages of individual VA facilities.

We believe the quality monitoring provisions are redundant with requirements stated under the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act in section 104 as well as VA's existing platform for posting Waiting Time and Quality information at our Access to Care website. The legislation also requires posting of MISSION Act-related staffing and vacancy information, which is already available on VA's website at the following link: https://www.va.gov/employee/va-mission-act-section-505-data.

The bill also requires that the website should be easily understandable and usable by the general public. However, research, history and experience inform us that solutions intended to serve all possible audiences often do not serve any of them effectively. This is why VA believes any statutory mandate for website content needs to be very carefully considered.

VA believes the more sustainable approach is to harmonize the entire process of quality measurement and reporting across all payers and providers, and VA has recently worked with the Defense Health Agency (DHA) and the Department of Health and Human Services (HHS) toward this end. VA is also participating in the Core Quality Measure Collaborative (http://www.qualityforum.org/cqmc/), which has a similar focus – making measures more meaningful and less burdensome to providers and patients.

We would welcome the opportunity to follow up with the Committee to provide further technical assistance on this bill.

S.1467 VA Medical Cannabis Research Act of 2021

S.1467 would require VA to conduct a series of clinical trials of at least seven strains of cannabis, with varying ratios of tetrahydrocannabinol (THC) to cannabidiol (CBD), and to collect, analyze and report on the effect of these strains on multiple symptoms of chronic pain and PTSD.

VA has a history of scientifically driven research and high-quality clinical trials that have advanced Veterans' and the Nation's health care. VA's Office of Research and Development regularly funds clinical trials approved through its expert peer review system, which evaluates studies for scientific merit based upon the rationale, design and feasibility of the study proposal. Such trials already include medical uses of cannabis for conditions that impact Veterans.

The proposed legislation is not consistent with VA's practice of ensuring scientific merit as the basis for a randomized clinical trial. The requirement in the legislation to study at least seven types of cannabis and their effects on symptoms of PSTD and chronic pain is not consistent with the current state of scientific evidence, which suggests that smaller, early phase, controlled clinical trials with a focused set of specific aims are optimal to determine proof of concept for use of cannabis in treating specific conditions.

Human subjects research must include an evaluation of risks and benefits and should include the smallest number of participants needed in order to avoid unnecessarily putting subjects at risk. In any study, the size of the experimental population is determined statistically so that the power to detect differences between the control group and the experimental group is based on known effects, using a specific outcome measure. With cannabis, some of these effects are not known, thus a circumscribed approach to determine dose, administration modality, and best outcome measure must be shown in a proof of concept approach to ensure the validity of the research.

Further, the scientific peer review system would not favor simultaneously studying seven variants of cannabis and their effects on varying diagnoses without first demonstrating a specific rationale for each of the queries. Progress in cannabis research must start with a scientific query of what is already known for specific diagnostic categories of interest, then moving to next level clinical investigation.

To that end, VA has and continues to examine the current clinical evidence regarding use of marijuana for medical purposes and agrees that more research is needed. VA has utilized the scientific peer review system and is currently supporting a clinical trial of CBD to treat PTSD where CBD is used as an add-on treatment to standard of care psychotherapy. The results from this study should be available next year.

Additionally, VA recently convened a team of experts who worked together to design another interventional cannabis study, focused on chronic, diabetic neuropathic pain. The resulting study is a double-blind, randomized, placebo-controlled study with randomization to one of 4 treatment arms: placebo, THC, CBD or a combination of THC and CBD. The first subjects are scheduled to enroll in January 2022.

VA is already dedicating resources and research expertise to study the effects of cannabis on conditions affecting Veterans. VA's approved interventional studies were

subject to peer review and have been approved as scientifically valid and posing the least possible risk to our Veteran subjects. Further, the proposed legislation is redundant to the extent that VA is already examining risks and benefits of cannabis in treating PTSD and chronic pain. For these reasons, VA does not support this proposed legislation.

S.XXXX Draft Veterans' Emergency Care Claims Parity Act

Section 2 of the proposed legislation would amend 38 U.S.C. 1725, *Reimbursement for emergency treatment*, and 38 U.S.C. 1728, *Reimbursement of Certain Medical Expenses*. The amendments would limit the timeframe in which an individual or entity may file a claim seeking payment for treatment for non-contracted community emergency care to 180 days after the care is provided. Additionally, the proposed legislation would allow for a Veteran to be held harmless for the cost of care provided to the Veteran in the event an individual or entity submits claims for payment to the wrong Federal agency or in the event an administrative error is made by VA, such as misplacement of a paper claim.

VA supports section 2. As currently written, the language which requires heath care entities or providers to submit claims prior to 180 days after care is provided, duplicates language in the VA MISSION Act of 2018 under Chapter 2, Paying Providers and Improving Collections, section 111, Prompt Payment to Providers, which amended 38 U.S.C. 1703D(b). VA is currently working on regulations to implement this provision in section 111 and would have included this requirement for 38 U.S.C.1725 and 1728(b).

The additional language is related to removing a Veteran's financial liability and provides additional financial support for Veterans in the event an individual or provider fails to meet timely filing requirements, when certain administrative errors occur during claim submittal, or when the claim is processed by VA. Providing Veterans with protection from being billed for non-contracted community emergency treatment when claims for the care are not submitted in a timely manner removes the potential financial burden when a Veteran seeks emergency treatment. Additionally, providing the authority not to hold a Veteran responsible for when certain administrative errors are made decreases the potential for balance billing as well as limiting those situations where a Veteran could be submitted for debt collection.

On a technical level, we have some concerns regarding some of the terms used in this bill. The term 'individual' should be defined and the term 'entity' should be replaced with 'health care entity or provider' to be consistent with the definition in 38 U.S.C. 1703D(i)(5).

Section 3 of the proposed legislation would require VA to publish on one or more of VA's publicly available internet websites a summary list of all VA emergency care authorities to authorize community emergency care, along with corresponding deadlines for submission of claims; an illustrated summary of steps, such as a process map, with

a checklist of how to comply with VA's requirements for submission of clean community emergency claims that non-Department providers can follow to assure compliance with claim-filing procedures; and VA's contact information to address community provider process questions. Additionally, VA would be required to review the information published, as described in this bill, at least every 180 days.

VA supports section 3, as VA already publishes community emergency care fact sheets and can refine the information with additional detail to meet the specific requirements in this bill.

Currently, VA develops and publishes community emergency care fact sheets with information of program requirements for both Veterans and community providers on the VA public-facing website. VA can refine these fact sheets with additional detail to meet the specific requirements in this bill illustrating a summary of steps, such as a process map with a checklist for the submission of clean claims for community care providers to follow and assure compliance with the claim filing process. VA has established timelines for publication reviews on a reoccurring basis.

VA estimates that there is no new cost to VA as a result of this proposed legislation.

S.XXXX To direct the Secretary of Veterans Affairs to improve long- term care provided to veterans by the Department of Veterans Affairs, and for other purposes

Section 2 of this bill would require the Secretary of VA to develop a strategy for the long-term care of Veterans. The strategy must: (1) identify current and future needs for the long-term care of Veterans based on demographic data and availability of services from VA and non-VA providers; (2) identify the current and future needs of Veterans for both institutional and non-institutional long-term care taking into account the needs of growing Veteran population groups; and (3) address new and different care delivery models, including by assessing the implications of such models for the design of facilities and how those facilities may need to change, and examining the workforce needed to support aging populations of Veterans.

VA has no objection to section two of the draft bill. We would note that VHA is developing a Geriatrics and Extended Care strategic plan for services focused on keeping eligible Veterans safely at home and would be happy to provide this plan once completed.

Section 3(a) of the bill would require the Secretary to develop a standardized process throughout VA for entering into sharing agreements between State homes and medical centers of the Department. Section 3(b) would require the Secretary to ensure that all Veterans who are catastrophically disabled are not required to pay a copayment for medication received at a State home. Section 3(c) would require the Secretary to monitor any contractor used by VA to conduct inspection of State homes, require that

any deficiencies of a State home noted during the inspection be reported to the Secretary, and require the Secretary to publish the results of any inspection of a State home on a publicly available internet website.

VA does not support section 3(a) of the draft bill unless amended. On a technical level, clarification is needed regarding the definition of "sharing agreements" in the proposed bill. Because sharing agreements are made at the local facility level due to varying needs from market to market, we are unable to provide a cost estimate for this section.

VA does not support section 3(b), as VA does not have the authority to comply with this section. Veterans enrolled in the VA health care system are generally eligible for care set forth in VA's medical benefits package which includes drug coverage. However, certain care is excluded from the medical benefits package, including outpatient care for a Veteran who is a patient in an institution of another government agency, if that agency has a duty to provide the care or services. State Veterans Homes are owned and operated by States. Section 511 of the Caregivers and Veterans Omnibus Health Services Act of 2010 prohibits VA from requiring a catastrophically disabled Veteran from making any copayment for the receipt of VA hospital care or medical services, to include medications. This law, however, does not prohibit States from imposing charges on Veterans in their State homes. For catastrophically disabled Veterans using their private prescription plan coverage for medications received at the State Veterans Homes, the Veteran will be responsible for any copayments and/or coinsurance under their plan.

VA supports section 3(c) of this bill. We have a current process to review inspections, aggregate data, and report to leadership in place and can make changes to inform the Secretary of inspection data. Additionally, reporting inspection results to a public-facing website aligns with current industry standards.

There will be costs associated with placing inspection reports on a public-facing website and additional resources will be needed to manage the website. VA estimates that the costs for section 3(c) will be $300,000 in FY 2022 and $1.64 million over the 5-year period between FY 2022 and 2026.

Section 4 of the bill would require the Secretary to commence, not later than one year after the date of the enactment of this Act, a pilot program under which the Secretary shall provide geriatric psychiatry assistance to eligible Veterans at State homes. The pilot shall run for a two-year period. The assistance provided under the pilot program may include the following: (1) direct provision of geriatric psychiatry services, including health care if feasible; (2) payments to non-VA providers in the community to provide such services; (3) collaboration with other Federal agencies to provide such services; or (4) such other forms of assistance as the Secretary considers appropriate. In providing assistance under this pilot program, the Secretary shall consider the geriatric psychiatry needs of the local area including by considering State homes with a high proportion of residents with unmet mental health needs, State homes located in

mental health care health professional shortage areas, or State homes located in rural or highly rural areas.

VA supports section 4 of the draft bill. Exploring ways to provide mental health services is currently being explored within the Geriatrics and Extended Care strategic plan. We estimate that the pilot program will cost approximately $1.37 million in FY 2022 and $1.41 million in FY 2023.

Section 5 of the bill would require the Secretary to work with public housing authorities and local organizations to assist aging homeless Veterans in accessing existing housing and supportive services, including health services such as home-based and community-based services from VA or non-VA providers, even if the Veteran is not eligible for such services from VA. The Secretary may and is encouraged to pay for these services.

VA has no objection to section 5 of the draft bill, but we note that the discretion provided to VA is an important feature, especially as it concerns ensuring adequate services for Veterans who are eligible for VA services.

S.XXXX Draft Guaranteeing Healthcare Access to All Personnel Who Served

Subtitle A of title I this bill deals with access to community care.

Section 101 of this bill would amend section 1703B of title 38, U.S.C., Access Standards. The amended section would create access standards to be used in determining eligibility for the Veterans Community Care Program. There would be access standards based on average drive times and number of days a Veteran would need to wait to receive an appointment within VA. When VA cannot schedule a VA appointment for a covered Veteran for primary care, mental health and non-institutional extended care service within 30 minutes average driving time from the Veteran's residence, or within 20 days of the date of the Veteran's request, the Veteran would be eligible under these access standards for treatment through a community provider. For specialty care or services, the standard would be within 60 minutes average driving time from the Veteran's residence, or 28 days from the Veteran's request for such an appointment. These access standards would apply both to VA when determining eligibility, and to community providers providing care when the Veterans Community Care Program (VCCP) eligibility has been established. In determining eligibility under these standards VA is not to consider the availability of telehealth appointments within VA. Driving time calculations would require VA to use geographic information system software. These access standards along with wait times would be required to be published and be updated on at least a monthly basis.

VA does not support section 101. VA has already designated access standards as required by section 104, Access Standards and Standards for Quality, in the VA MISSION Act of 2018. These access standards were implemented in regulation at Part 38 of the CFR, section 17.4040, Designated Access Standards. Section 104 of the

MISSION Act also requires the Secretary to conduct a review of the Department's access standards no later than three years "after the date on which the Secretary establishes access standards" and to submit a report to Congress on "the findings and any modifications to the access standards with respect to the review." While it has only been 2 years since the MISSION Act access standards were established by regulation, Secretary McDonough has directed an internal review to assess the impact of the MISSION Act's access standards on Veteran access and outcomes, and VA's ability to continue to deliver high quality, evidence-based, integrated care. Placing these requirements in statute prior to the completion of the statutorily mandated review of VA's access standards will not only prevent the Department from incorporating any key takeaways from the access standards review required by the MISSION Act, but it will also eliminate VA's flexibility to react to changes in market conditions and other emerging issues. VA believes that mandating the current access standards would be premature until a full analysis of their impacts has been conducted.

Additionally, VA agrees with the critical importance of ensuring Veterans have access to high-quality health care in VA's direct care delivery system and in the community but does not believe that mandating these access standards in all of VA's Community Care Network (CCN) contracts would be appropriate. The three key reasons are supply of providers in the private sector, provider choice, and projecting community care demand. Throughout the U.S., there are geographic regions with gaps in access to care, due to shortage of health care providers. The supply of community providers in these areas cannot be influenced by VA. Additionally, community providers choose where to locate their practices. Even in areas with community providers, the providers may ultimately choose not to participate in VA contracts, VA's goal is to provide outstanding access to high-quality care for Veterans and is proud of the more than 1.1 million providers that are a part of VA's CCN. VA and our third-party administrators have worked extensively to build a network that meets the needs of Veterans and takes into account local and regional needs and both parties continue to work together to build and refine the network based on needs that are identified. While we recognize that this statute allows for waivers to the requirements, network adequacy is an issue that is best addressed in the contracts with the third party administrators so VA has the ability to change them as needed due to changes in market conditions, or when new contracts are awarded.

Section 102 requires VA to develop and periodically update a strategic plan that would ensure there is a continuity of care under the VCCP. Specifically, this would be in cases when Veterans are transitioning to receiving care under VCCP due to a realignment, move or closure of their VA medical facility.

The strategic plan shall include an assessment and identification of realignments of VA medical facilities and what impacts they may have with VCCP health care providers in the areas where the changes are occurring to include potential gaps. Additionally, the strategic plan would describe how VA can inform Third Party Administrators (TPA) in area of the realigning VA medical facility and develop a process with the TPAs to ensure provider coverage for Veterans during the realignment.

VA does not support this section. Section 102 legislates what should be internal VA business processes. Placing these types of business processes in statute not only imposes unnecessary restrictions on VA's resources, but also limits VA's ability to quickly and effectively adapt to changes in circumstances.

Subtitle B of title I of this bill deals with the creation of a "Community Care Self-Scheduling Pilot Program".

Sections 111, 112, 113 and 114 of the bill would require VA to create a pilot program which would allow Veterans to use an internet website or a mobile application to request, schedule and confirm appointments made with a participating Veteran Community Care (VCC) provider. The pilot program would need to be implemented in five or more VISNs for a minimum of 18-months.

In order to implement the pilot, VA would need to be able to modify existing self-scheduling tools or enter a contract using competitive practices with one or more contractors to provide the needed services. The required capabilities include the Veteran having the ability to request, schedule, modify, view and cancel appointments for primary, specialty and mental health care and to be able to search for participating providers and have all of the relevant provider's contact information available. VA would also need to be able to load relevant patient information, store, and print VCC authorization letters and to have it integrated with the Veterans Health Information Systems and Technology Architecture of the Department or any successor information technology system.

VA supports this subtitle in principle; however, it is unclear if or how VA could contract for these services. Moreover, while VA has had similar initiatives in the past and has built a basic system, this system does not have the extensive capabilities that would be required by these sections. Additional time is required to understand the feasibility of these approaches and to consider the potential costs. This section would also be subject to availability of appropriations.

Section 121 of this bill adds new 38 U.S.C § 1703G, Credentialing verification requirements for providers of non-Department health care services. This new section provides specific requirements for VA's TPAs and credential verification organizations to ensure certain health care providers are excluded from participating in the community care network. Among other things, TPAs and credential verification organizations would need to: hold and maintain an active credential verification accreditation from a national health care accreditation body; conduct initial verification of provider history and license sanctions for all States and U.S. territories for a period of time that includes the period before the provider began providing non-Department health care services; and dating back not less than 10 years; perform recredentialing, including verifying provider history and license sanctions for all States and U.S. territories not less frequently than once every three years; and implement continuous monitoring of each provider through the

National Practitioner Data Bank established pursuant to the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.).

VA does not support this section. This section imposes specific requirements for reviewing providers' credentials. These requirements would need to be cross-checked against existing CCN contracts and their requirements. It is unclear if these requirements go beyond the CCN contract requirements for credentialing. If they do go beyond the CCN contract requirements, this could disrupt the entirety of the CCN networks, as all of those networks would need to be re-credentialed. Additionally, codifying such requirements in statute is overly prescriptive and can cause VA to fall behind future industry standards. For example, VA currently utilizes the National Practitioner Databank (NPDB) for monitoring whenever applicable, but also utilizes additional sources such as state boards, the Federation of State Medical Boards (FSMB), and other sanction sites. Historically, the NPDB was a recommended source for sanction and adverse action monitoring. However, current industry standard practice now includes additional reviews for ongoing monitoring because NPDB is reliant upon organizations submitting a report which has the potential for gaps. VA believes it is more efficient to work with our TPAs and credentialing services to make necessary changes to keep up with industry standards without requirements mandated by Congress.

Section 122 of this bill amends section 108 of the VA MISSION Act of 2018 to deny or revoke the eligibility of a community health care provider to provide care to Veterans when, on or after of the date five years before the date of the enactment: 1) a provider was removed from employment with VA for violating policy regarding safe and appropriate health care; or 2) violated the requirements of a medical license of the health care provider that resulted in the loss of such medical license that occurred.

VA does not support this section. This section is unnecessary as VA already reviews whether a provider was terminated for violating policy regarding safe and appropriate health care or violated the requirements of a medical license of the health care provider that resulted in the loss of such medical license. In fact, VA does not restrict how far back this review goes. Section 122 potentially limits VA's ability to properly vet a community provider on past employment.

Section 201 of this bill would require VA, not later than one year after enactment of this bill, to develop a strategic plan to ensure the effectiveness of the telehealth technologies and modalities delivered by the Department. The strategic plan would be required to be updated not less frequently than once every three years. The strategic plan must include a list of all services provided through telehealth, an assessment of the effectiveness and patient outcomes for each specialty for which telehealth is provided, an assessment of Veteran satisfaction with telehealth services, an assessment of the modalities used to provide telehealth services, an outline of all partnerships related to telehealth, an assessment of barriers faced by VA in delivering telehealth, a detailed plan showing how VA is working with other Federal agencies to enhance the availability of telehealth to rural, highly rural and medically underserved areas, the feasibility of partnering with certain other entities to provide telehealth services in these underserved

areas, and an evaluation of the number of enrolled Veterans who have previously received care through the VCCP. The section would also require VA to periodically submit the strategic plan to Congress along with an identification of areas of needed improvement by VA.

While VA understands and supports the intent of section 201 of the proposed legislation, it does not support the bill as written. VA has significant reservations about the specific language and timelines. As one example, the bill requires VA to complete "An assessment of the effectiveness and patient outcomes for each type of health care specialty delivered by telehealth or virtual care by the Department." This requirement would require tremendous organizational coordination and resources. Telehealth is essentially delivered by every specialty, meaning this bill would require a complete assessment of every service delivered in VA. This is not a feasible requirement within the allotted timelines.

VA welcomes the opportunity to work with Congress to provide technical assistance to help resolve concerns about specific language and timelines in the bill.

VA defers to the Comptroller General on the requirements of sections 202 and 203 of this bill.

Section 301 requires VA to undertake an analysis of the feasibility and advisability of expanding assistance and support to caregivers to include caregivers of Veterans in the Republic of the Philippines.

VA does not support section 301 of the draft bill without amendment. While we appreciate the intent of the bill to determine the feasibility and advisability of expanding assistance and support to caregivers to include caregivers of Veterans in the Republic of the Philippines, we are unable to comply with the reporting requirements of section 301(c)(3) as written. Of the Veterans who are enrolled in the patient enrollment system and reside in the Republic of the Philippines VA would be unable to identify those who also have a caregiver and who also would be determined eligible to receive support and assistance under 1720G.

VA defers to the Comptroller General on the requirements of section 302 of this bill.

Section 401 of this bill would require VA to complete an analysis of the feasibility and advisability of making repetitive transcranial magnetic stimulation (rTMS) available at all medical facilities and electroconvulsive therapy (ECT) available at one medical center located within each VISN. Included within the report shall be an assessment of the final report of the COVER Commission, the number of Veterans with treatment resistant depression (TRD), the number of Veterans with TRD who received rTMS or ECT, and the number of facilities offering rTMS and ECT.

VA supports this section. VA recognizes the importance of providing evidence-based treatment for Veterans with TRD. In addition to evidence-based pharmacotherapy and psychotherapy, VHA currently provides the following evidence-based somatic treatments for Veterans with TRD: ECT, rTMS, ketamine infusions, and esketamine (Spravato®). Given the nature of the severity of TRD and its associated risk of suicide, these somatic treatments are considered essential services and as such ensuring access to Veterans who need these treatments is of upmost importance.

VA has been monitoring the utilization of ECT, rTMS, as well as the safety and effectiveness of ketamine infusions since FY 2015. Annual monitoring of these treatments and the newer esketamine (Spravato®) treatment will continue going forward, with assessments of the number of patients treated with one of these treatments and the locations where these treatments are provided. The most recent data available is for FY 2020.

VA suggests the final report not be limited to analysis of rTMS and ECT alone, but rather all four of the essential somatic treatments as listed above. VA recommends the analysis be based on requiring ketamine infusions and esketamine (Spravato®) treatments be available at one medical center located within each VISN.

VA estimates a cost of $38,600 associated with the requirements of this section.

Section 402 states that within a year of the enactment of the Act, VHA shall modify the Veterans Equitable Resource Allocation (VERA) system, or successor system, to ensure that resource allocations under the system include peer specialists.

VA supports this section. VHA peer specialists document all their work with Veterans in the Veterans' medical records. In 2014, clinic stop codes and a Current Procedural Terminology (CPT) code for peer specialists were established in the documentation system to accurately identify the individual and group encounters that peer specialists have with Veterans. Although the designated peer specialist H0038 CPT code does not have an associated work relative value unit (wRVU) value for reimbursement of services, the H0038 CPT code is used to document peer specialists' workload and is already considered in the VERA patient classification process that ultimately determines resources are allocated. Peer specialists and their supervisors have received guidance about how to appropriately document encounters using the H0038 CPT code so that peer specialists' workload can be counted toward their facilities' VERA. VHA's Office of Mental Health and Suicide Prevention continues to provide training and guidance for staff to ensure that appropriate coding of peer specialists' documentation occurs so that their workload can be accurately captured for inclusion in the VERA patient classification process.

Section 403 of this bill would require VA, not later than 270 days after enactment, to perform a gap analysis throughout the VHA on the use and availability of psychotherapeutic interventions recommended in widely used clinical practice guidelines as recommended in the final report of the COVER Commission. The gap

analysis must include an assessment of psychotherapeutic interventions that are available and routinely delivered at VAMCs, and an assessment of the barriers faced by medical centers in performing such interventions.

VA supports this section if amended to allow for sufficient time to perform the analysis. While VA supports the intent of this bill to identify gaps in VA's ability to provide psychotherapeutic interventions, the requirement to complete this analysis within 270 days is not realistic. Time is needed to define the parameters and to develop the mechanisms to collect and validate the information needed to provide a meaningful analysis. VA believes it would take 24 months to perform the analysis and provide a report.

VA has some concern about the scope of the term "psychotherapeutic interventions." Additionally, VA thinks it could be beneficial to include psychotherapeutic interventions performed via telehealth in the analysis. VA welcomes the opportunity to discuss these matters with the committee and to offer technical assistance if it is requested.

VA estimates a $750,000 cost associated with performing this analysis, if the section is amended to allow for a 24-month timeline.

Section 501 of this bill would require VA, not later than 180 days after enactment, to establish an online health care education portal to ensure Veterans are aware of health care services provided by VA. The portal must include modules on the Veterans Community Care Program, telehealth services, the VHA appeals process, patient aligned care teams, mental health services, suicide prevention services, specialty care services, dental health services, women's health services, navigating VHA websites and mobile applications, vaccines, toxic exposure, military sexual trauma, and the topics listed in section 121(b) of the VA MISSION Act of 2018. These modules must be updated not less frequently than once each year. The portal must be directly accessible from the main website of the Department, and the websites of each of the VAMCs. The portal must be easily understandable and usable by the general public.

VA must also ensure that all materials in the portal are available in print form at VAMCs. VA must consult with Veterans Service Organizations. VA may enter into a contract for the design of the portal and modules. Not later than one year after the establishment of the portal, VA must provide a report on the use of the portal, its effectiveness, and suggestions for improvement.

VA does not object to this section subject to the availability of appropriations as there would be some cost involved in creating the system.

Section 502 of this bill would exempt VHA's conduct of research from application of the Paperwork Reduction Act.

VA does not object to this section. VA does not believe there will be any cost impact to this provision.

Conclusion

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

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STATEMENT OF
JOY J. ILEM
DAV NATIONAL LEGISLATIVE DIRECTOR
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JUNE 23, 2021

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

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

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

S.372—Ensuring Quality Care for Our Veterans Act

S. 372 would require the VA Secretary to enter into a contract with a third party to review clinical providers (appointees) in the Veterans Health Administration (VHA) who had a health care license terminated for cause by a state licensing board for services rendered at a non-VHA care facility. The bill would also require the third party to review patients records for the purposes of quality of care management and, if it is determined that the standard of care was not met, VA would be responsible for notifying the patient of that finding.

States might terminate licenses for clinicians for a variety of reasons—for example, sexual misconduct, insurance fraud, running "pill mills," patient abuse, convictions, or substance abuse. When a medical license is revoked, the state bans the clinician from practicing within its boundaries and usually reports the clinician to the National Practitioner Data Bank—which VA may use as a credentialing resource.

Looking at trends in disciplinary actions taken against medical doctors, in 2019 the Federation of State Medical Boards reported that of the more than one-million licensed physicians in the U.S., 266 had their licenses revoked. This number does not include all medical professions and there are potentially more individuals who surrender

their license prior to revocation or who receive lighter penalties such as suspension or probation that the bill does not address.

Maintaining safety and ensuring quality care for all VA patients is critically important. VA is responsible for ensuring proper credentialing of clinical providers and oversight of disciplinary actions that occur while employed by VHA or while under contract for providing health services to VA patients. The Office of Inspector General (OIG) is also often called upon to investigate incidents of substandard care. While DAV does not object to a third party review as prescribed in the bill, we believe a more comprehensive approach to improve VA's credentialing, privileging and monitoring processes is necessary to ensure the quality of VA care. Therefore, we recommend the Committee work with VHA to determine a comprehensive plan and best practices for oversight of actions reported by relevant entities to monitor medical malpractice claims, medical license revocation, penalties, suspension and probationary actions.

S.539—Requires VA Secretary to submit a report to Congress on the use of video cameras for patient safety and law enforcement at VA medical centers

This bill would require the VA Secretary to submit a report to Congress on increasing the use of video cameras, along with recommendations on video monitoring to improve patient safety and law enforcement at VA medical centers.

The report must contain information about patient safety, to include how cameras are used to monitor staff and patients, areas in which cameras are used to protect patients, procedures used to position cameras and how to ensure that cameras used in drug storage areas are properly monitored. The report should also include recommendations that improve patient safety as well as law enforcement practices. Additionally, the bill requires information on data storage, the number of staff required to monitor video footage and funding necessary to establish routine use of interior and exterior video use to protect patient safety. We recommend that the report also include analysis and recommendations about best practices for ensuring that use of security cameras protects patient privacy to the greatest extent possible.

While DAV does not have a specific resolution calling for a report on video camera use at VA medical facilities, we do support a safe and welcoming environment for all veterans using VA health care services. This legislation would help VA determine best practices for ensuring patient safety and enforcement of policies to help promote a safe environment for both patients and staff at all VA health care facilities. For these reasons, we have no objection to the Committee's favorable consideration of the legislation.

S.544—Directs the VA Secretary to designate one week each year as "Buddy Check Week" and provide training for peer wellness checks for veterans

This bill would require that VA designate one week each year as "Buddy Check Week" and organize outreach events to educate veterans on how to conduct peer supported wellness checks for veterans. The bill would require VA to collaborate with people and organizations that work with or serve veterans and provide educational materials on conducting peer wellness checks and information on available resources veterans may need. All educational training materials must be made available on VA's website and include resiliency training and how to transfer calls to the Veterans Crisis Line. The proposal also includes provisions to ensure the VA Crisis Line can handle an increased number of calls during the designated "Buddy Check Week".

DAV is pleased to support S. 544, a bill aimed at assisting veterans with mental issues and reducing suicide in the veteran population through a targeted outreach initiative and training program for peer-supported wellness checks. This legislation is in line with DAV Resolution No. 307, which supports improvements in VA mental health programs and suicide prevention efforts.

S. 612—Improving Housing Outcomes for Veterans Act of 2021

This bill would require the VA Under Secretary for Health to ensure best practices information is shared between VA homelessness service providers, public and private community organizations and partners including the Department of Housing and Urban Development (HUD) through the coordinated assessment systems operated by the Continuum of Care Program. In addition, it would require the Under Secretary to communicate information about the performance measures of homelessness programs and how to obtain and provide feedback about such measures with VA employees whose responsibilities are related to homelessness assistance.

This legislation follows a 2020 Government Accountability Office report (GAO-20-428), which noted that despite significant gains in reducing homelessness among veterans over the past decade, improvements could be made in the administration of services by VHA's Homeless Program Office to better support collaboration with local partners and other federal agencies, including HUD. The report also found shortcomings in VHA's communication with VA medical centers, service providers, and local partners regarding the delivery of services for veterans experiencing homelessness, in collaboration with local "Coordinated Entry" systems.

DAV is pleased to support this legislation which seeks to improve collaboration between VA and its partners with a goal of more effective delivery of homelessness services to veterans. S. 612, is in accordance with DAV Resolution No. 369, which supports VA's initiative to eliminate homelessness among veterans and strengthen the capacity of its homeless program and services.

S. 613—PAWS for Veterans Therapy Act

S. 613, the Puppies Assisting Wounded Servicemembers (PAWS) for Veterans Therapy Act, would require the VA to carry out a five-year pilot program to award grants to one or more non-government agencies to assess the effectiveness of a service dog training program for veterans suffering from post-deployment mental health issues and post-traumatic stress disorder (PTSD). Veterans would need to be referred to the program by a qualified health care provider and may participate in the program in conjunction with VA's compensated work therapy program.

To remain eligible for the program, veterans must see a VA mental health care provider who is treating them for PTSD at least once every six months. VA would be required to develop metrics and measure effectiveness of the program on reducing veterans PTSD symptoms and their overall progress over a five-year period. The bill would require a GAO report to evaluate the methodology established for determining a veterans' overall improvement with respect to psychosocial function, therapeutic compliance, and reducing dependence on certain medications. Finally, the bill includes a provision to authorize VA to provide service dogs to veterans with mental illness regardless if they have a mobility impairment. We note that VA has the authority to prescribe a service dog to a veteran with mental illness including PTSD under title 38, United States Code (USC), section 1714.

DAV understands that many veterans would like the opportunity to try alternative mental health treatments to reduce symptoms associated with PTSD, an often severely debilitating condition, without taking medication. While we do not object to a pilot project looking at the therapeutic medium of training service dogs on reducing the severity of symptoms of veterans with PTSD, we want to ensure there is a consistent application of benefits provided to service-disabled veterans who are prescribed a service dog by a VA provider related to a service-connected condition.

Recently, VA completed a multi-site study of the differential effectiveness of service dogs and emotional support dogs on assisting veterans with PTSD. According to the study report released in January 2021, of the 227 study participants, 181 veterans were paired with either a service dog or emotional support dog and followed for a period of 18 months. Researchers evaluated outcome measures for overall disability and quality of life. Secondary outcomes included PTSD symptoms, suicidal ideation, depression, sleep and anger. The study concluded that both groups showed some improvements in outcomes but that there were no marked differences between having a service dog compared to an emotional support dog in terms of improvements in quality of life and in limiting the effects of their disabilities. Among veterans paired with a service dog there was a reduction in the severity of PTSD symptoms compared to

participants paired with an emotional support dog along with fewer suicidal behaviors and ideations, particularly at 18 months post-pairing.[1]

Currently, under title 38, USC, Section 1714 a service-disabled veteran diagnosed as having a visual, hearing, mental illness (including PTSD) or substantial mobility impairment may be prescribed a service dog if, in the clinical judgement of the veteran's VA provider, it is deemed a trained service dog could assist the veteran to manage his or her impairment and live independently. A service dog prescribed to a veteran with service-connected PTSD may be trained to perform specific tasks that enable the veteran to maintain their independence, the ability to function in the community and interact with other people. For example, such dogs may be trained to "sweep" a room for signs of danger, to recognize and deter veterans' destructive behaviors, such as self-mutilation, and to navigate veterans out of situations in which they have become anxious or confused—they may even be trained to remind veterans to take prescribed medication.

VA prescribes service dogs, which are then obtained by veterans through a non-profit agency. Veterinary health insurance benefits are provided for an accredited service dog under title 38, Code of Federal Regulations (CFR), Section 17.148(c) for veterans prescribed a service dog for a visual, hearing or substantial mobility impairment. The dog and veteran must successfully complete a training program offered by an organization accredited by Assistance Dogs International (ADI), the International Guide Dog Federation (IGDF), or both (for dogs that perform both service and guide dog assistance). We note that "mental illnesses including PTSD" (included in the statute) is not included in the regulation authorizing veterinary benefits to veterans with service dogs that have successfully completed training by an accredited organization described above. We urge VA to amend the regulations to match the statute and provide equity to veterans prescribed a service dog for mental illnesses or PTSD.

We also note that the FY 2021 National Defense Authorization Act passed in the 116th Congress (Public Law 116-283), included a provision (in Section 745 of Title VII Subtitle D) that requires the DOD Secretary to establish a Wounded Warrior Service Dog Program to provide service dogs to service members and veterans with certain disabilities, including: blindness or visual impairment; loss of use of a limb; paralysis or other significant mobility issues; loss of hearing; traumatic brain injury; PTSD; or any other disability that the Secretary considers appropriate. It appears that DOD has called for grant applications to implement this provision of the law, and we are eager to understand more about this important new benefit for service-disabled veterans.[2]

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[1] Department of Veterans Affairs A Randomized Trial of Differential Effectiveness of Service Dog Pairing Versus Emotional Support Dog Pairing to Improve Quality of Life for Veterans with PTSD Office of Research and Development Veterans Health Administration Department of Veterans Affairs Washington, DC January 5, 2021.

[2] Federal Grant Opportunity for Wounded Warrior Service Dog Program (WWSDP) FY2021 HU000121USU0001. Posted Dec 4, 2020. Due Feb 3, 2021. Department of Defense. CFDA 12.750 -

We urge the Committee to clarify how the Wounded Warrior Service Dog Project under Public Law 116-283 will affect disabled veterans' access to service dogs and ensure there is a standardized benefit package available to all veterans with a clinical need of a service dog regardless of the type of disability they have. As currently written, we believe S. 613 would contribute to the confusion and inequity in VA policy regarding service dogs. If one disability group receives a trained service dog at no out-of-pocket cost then other disability groups should also receive a trained service dog at no cost. We further believe that all service dogs should be trained by an accredited organization that is recognized by VA under title 38, CFR section 17.148(c) and receive the same veterinary benefit. For example, if a veteran participating in the pilot program benefits from training a service dog and elects to keep the service dog, that service animal should be eligible for the veterinary health insurance benefit available to other veterans to whom service dogs have been prescribed.

S. 727—CHAMPVA Children's Care Protection Act

This legislation would increase the maximum age for children eligible for medical care under the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) until the child's 26th birthday, regardless of the child's marital status.

We are pleased to support S. 727, the CHAMPVA Children's Care Protection Act, in accordance with DAV Resolution No. 081 which calls for legislation to allow dependent children eligible for CHAMPVA to remain covered until the child's 26th birthday regardless of their marital status.

S.796—Protecting Moms Who Served Act of 2021

The Protecting MOMs Who Served Act would require the VA to increase support for its maternity care coordination activities and requires GAO—the Government Accountability Office to report on maternal mortality and morbidity among veterans using VA health care services with a focus upon racial and ethnic disparities in these adverse outcomes.

Women using VA health care have a number of factors such as advanced age, mental health conditions, including post-traumatic stress disorder and substance abuse, and physical disabilities that may put them at higher risk of adverse birth and health outcomes. Maternity services for women veterans are provided through VA's Community Care Network. In order to ensure that women veterans are receiving high

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Uniformed Services University Medical Research Projects. Accessed on https://govtribe.com on 6/19/2021.

quality care, VA has instituted a Maternity Care Coordination policy. Unfortunately, this important care coordination position is often a collateral duty and coordinators prioritize direct care duties when they become overburdened.

This legislation would provide additional resources to VA to ensure training is available and that staff have adequate time to execute VA's maternity care coordination policy. This bill also require the Comptroller General to use existing data to assess maternal mortality and severe morbidity among veterans using VA.

DAV Resolution No. 020 calls upon DAV to support program enhancements and improvements including gender-specific services for women veterans. DAV Resolution No. 133 is supportive of VA's efforts to identify and research associations between military service and impact on health. In accordance with these resolutions, DAV strongly supports this bill.

S. 887—VA Supply Chain Resiliency Act

S. 877—the VA Supply Chain Resiliency Act, requires the Department to submit a report containing a description and quantities of items that are critical to the VA's ongoing response to the COVID-19 pandemic and any potential future epidemic, pandemic, emergency, national emergency, or natural disaster.

It also requires VA to enter into an agreement with the Department of Defense (DOD) for participation in the Warstopper Program of the Defense Logistics Agency (DLA)—a program established to satisfy requirements for sudden and sustained increases in production of critical industrial and medical items.

Under this agreement, the DLA must:

- Ensure the maintenance and stability of items the VA identifies as critical in its report,
- Establish guidance for VA's participation in the program, and
- Use existing and new contracts and agreements to reserve the supply of critical items.

Finally, the VA would be required to submit a report on the planned implementation of the program and ensure it does not exclusively rely on holding regional, physical inventories of critical items in order to respond to greater than expected needs during an epidemic, pandemic, emergency, national emergency, or natural disaster situations.

The VA carries the responsibility of serving as a backup for DOD, responding in concert with the Department of Homeland Security, and coordinating with the Department of Health and Human Services to fulfill its indispensable role in our nation's emergency preparedness strategy. Lessons learned from the pandemic illustrated the

serious consequences when normal supply chains for critical medical supplies and personal protective equipment are disrupted, and the need for alternative preparedness plans.

For these reasons, DAV supports S. 877, in accordance with DAV Resolution No. 96, which recognizes and supports VA's critical fourth mission of providing needed assistance during natural disasters and national emergencies.

S. 951—Puppies Assisting Wounded Servicemembers (PAWS) Act of 2021

The PAWS Act of 2021, would require the VA to establish a three-year program to authorize grants of up to $25,000 to eligible organizations to pair veterans suffering from severe post-traumatic stress disorder (PTSD) with service dogs. In addition to initial pairing costs, the grant funding to a non-profit organization would cover:

- The veterinary health insurance policy for the life of the dog;
- Service dog hardware if clinically determined to be needed to perform tasks; and
- Payment for travel expenses for the veteran to obtain the original service dog.

In order for an organization to be eligible for the VA grant, it must be (1) a non-profit organization that provides service dogs to veterans with PTSD; (2) accredited by Assistance Dogs International (ADI), the International Guide Dog Federation (IGDF) or other organization the VA secretary deems to meet its accreditation standards; (3) have expertise in the unique needs of veterans with PTSD.

To be and remain eligible to participate in the pilot program a veteran must: (1) be enrolled in the VA health care system; (2) have completed a course of evidence-based treatment for PTSD but remain significantly symptomatic; (3) continue to see their VA health care provider at least once every 6 months to determine if the veteran continues to benefit from the service dog.

The bill includes provisions to ensure a veteran furnished a service dog under the program may elect to keep the dog for the life of the service animal, regardless of the continued participation of the veteran in the program or return the dog to the grant organization if he or she is unable to safely care for the dog.

The Comptroller General would be required to submit a report on the program, which must contain an evaluation of the approach and methodology used to help veterans with severe PTSD return to civilian life, to include findings for participants related to psychosocial function and therapeutic compliance and reducing the dependence on prescription narcotics and psychotropic medications.

DAV does not have a specific resolution calling for a pilot grant program described in the legislation, but we are supportive of alternative, non-pharmacological,

mental health therapies and treatment options for veterans suffering from unrelenting PTSD symptoms and who are at high risk for suicide.

DAV recognizes that trained guide and service dogs can play a significant role in maintaining functionality and promoting maximal independence for individuals with disabilities. As noted above in relation to our testimony on S. 613, we do want to ensure there is a consistent application of benefits provided to service-disabled veterans who are prescribed a service dog by a VA provider for a service-connected condition. This bill does address a number of the concerns we commented on in S. 613, but it would still establish a precedent for a non-VA entity (non-profit organization) to provide lifetime veterinary insurance benefits for a service dog if the veteran elects to keep the service animal—specifically, putting veterans at risk for liability of covering veterinary insurance costs should the non-profit organization be dissolved. DAV also notes that only providing service dogs to veterans with PTSD, while excluding veterans with other severe mental health conditions, raises questions of equity to this benefit.

S.1040—Expansion of Eligibility for VA Medical Services to World War II Veterans

S. 1040 would require the VA to offer hospital care and medical services to veterans of World War II regardless of service-connected disabilities, income level or other eligibility criteria. It would also authorize the VA to provide nursing home care if it determines the need for such care. DAV does not have a resolution on this issue and takes no formal position on the bill.

S.1198—Solid Start Act of 2021

This bill would strengthen and codify the Solid Start program, created by the VA in 2019. The Solid Start program requires VA representatives to make calls to newly separated service members over the first year post-transition period to help them navigate the process for accessing their VA benefits or any other resources they may need for a successful transition from military service. During these calls, VA representatives check on the veteran's overall transition experience, answer questions and direct veterans to needed resources, supportive services and programs.

The "Solid Start Act of 2021" strengthens this program by including specific language to help connect women veterans to VA resources and a provision that recommends the VA provide information about state and local resources, as well as contact information to local chapters of VSOs. It also directs the VA to focus these efforts on separating service members who accessed mental health services prior to separation.

In accordance with DAV Resolution No.100 we are pleased to support S. 1198, and the efforts of Congress to monitor, improve, and report on this important program to

ensure that all transitioning service members have the tools and support they need to establish productive lives after military service.

S.1220—United States Cadet Nurse Corps Service Recognition Act of 2021

S. 1220, the United States Cadet Nurse Corps Service Recognition Act of 2021 would amend Title 38, United States Code, to recognize and honor the service of individuals who served in the United States Cadet Nurse Corps during World War II. This act would require Department of Defense (DOD) to discharge certain nurse corps cadets of service and allow them burial benefits (except at Arlington National Cemetery) and would create an award for their service to the nation. The bill does not include provisions that would make them eligible for VA disability compensation or health care benefits.

DAV recognizes the great service and sacrifice made by the uniformed women who stepped in to save the U.S. medical system from collapse during World War II so professional nurses could attend to the needs of the military and our injured service members. We take this opportunity to thank the surviving members of the U.S. Cadet Nurse Corps for their support and service to our nation however, we have no resolution on this matter and therefore take no formal position on the bill.

S.1280—Veteran Families Health Services Act of 2021

S. 1280, the Veteran Families Health Services Act would support the needs of veterans with a diagnosis of infertility or the inability to conceive or safely carry a pregnancy to term. The bill would make assisted reproductive technology (ART), including in-vitro fertilization, available to all enrolled veterans unless the conditions rendering them infertile were acknowledged before military service.

VA and DOD currently offer this benefit to a limited group of service disabled veterans who are legally married and can produce their own genetic material. Single veterans, with or without partners, and veterans with same-sex partners, even those who are legally married, are prohibited from accessing these services due to existing provisions that do not allow the use of surrogates. The Veteran Families Health Services Act would correct existing inequities by allowing all enrolled veterans access to this benefit regardless of the cause of their infertility, marital status, gender identity or sexual orientation. Partners would be required to agree to clinical participation in the process but would not be eligible for maternity care benefits unless they were eligible as a veteran.

Currently, this benefit is limited to veterans with grave disabilities generally involving biomechanical impediments, such as spinal cord or genitourinary injuries. Yet, there is a growing body of evidence that commonly-experienced conditions often related

to military service, such as post-traumatic stress disorder, depression, anxiety and exposure to toxic or hazardous materials, can be associated with infertility.

DAV Resolution No. 381 calls for VA to improve the care provided to veterans with service-connected disabilities affecting the ability to procreate and allows DAV to support S.1280—Veteran Families Health Services Act of 2021.

S. 1319—VA Quality Health Care Accountability and Transparency Act

S. 1319, the VA Quality Health Care Accountability and Transparency Act would require VA to improve the way it discloses health care measures and staffing levels at its facilities to help ensure veterans have access to information they need to make informed decisions.

This bill calls for VA to streamline its disclosure of wait times; safety, quality of care and outcome measures; staffing and vacancy information; and other indicators related to veteran-centered care via the department's Access to Care website. The bill authorizes VA to work with outside entities to contract website redesign to enhance the usability and presentation of information for patients and consumers. Additionally, this legislation would require an annual audit of information published on this site to ensure accuracy and completeness, and to identify any deficiencies.

We believe publishing this information in a user-friendly, accessible format can not only aid veterans in making educated health care decisions, but it would also help identify facility locations that require more attention and resources. One suggested area for long-term improvement would be to publish better, more comparable data between VA facilities and specific non-VA community care providers in lieu of community averages or benchmarks.

DAV supports S. 1319 in accordance with DAV Resolution No. 368, which calls for the strengthening and reform of the VA health care system, to include measures that enhance transparency, efficiency and accountability.

S. 1467—Cannabis Research Act

S. 1467, the Cannabis Research Act would require the VA to conduct clinical trials on the effects of medical-grade cannabis on the health outcomes of veterans with chronic pain and PTSD.

The study is required to evaluate if medicinal cannabis has an effect on osteopathic pain, inflammation, sleep quality, as well as increase or reduction in certain medications and alcohol use. The study is also required to evaluate the effects of cannabis use on PTSD symptoms to include changes in mood, anxiety, social functioning, and frequency of night terrors or nightmares. The clinical trials may include

an evaluation of the effects of cannabis use on several health systems such as pulmonary function, cardiovascular events, head, neck and oral cancer and certain mental health conditions. In conducting the study, VA is required to use various forms of cannabis to include whole plant raw materials and extracts and no less than 7 unique plant cultivars with specific tetrahydrocannabinol/cannabidiol ratios.

Finally, a provision is included in the legislation to ensure veterans participating in the clinical study will not be affected or denied eligibility or entitlement to other VA benefits, as a result of such participation.

In accordance with DAV Resolution No. 076, we support more comprehensive and scientifically rigorous research by the VA into the therapeutic benefits and risks of cannabis and cannabis-derived products as a possible treatment for service-connected disabled veterans.

S.1863 - Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act

S. 1863, the Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act, would make a number of changes to current laws and regulations intended to improve veterans' access to health care, including to VA's new Community Care Networks (CCNs).

Section 101 of the bill would codify VA health care access standards adopted by regulation in June 2019 as required by the VA MISSION Act. Specifically, the bill would make permanent the current access standards for primary care, mental health care and non-institutional extended care services which are 20 days waiting time for an appointment or 30 minutes average driving time from the veteran's residence. For specialty care and services, the current access standards are 28 days waiting time or 60 minutes average driving time. The bill would apply these same access standards to CCN providers and would also codify a waiver process for the Third Party Administrators (TPAs) of CCNs for geographic areas that have a scarcity of medical providers. This section would also require VA to review these access standards at least once every three years.

DAV does not support Section 101 of the bill. We believe it is premature to codify access standards that have already been adopted by regulation without sufficient evidence that doing so would improve the access to or quality of health care provided to enrolled veterans.

Last November, in its Report to Congress on Access Standards, VA found that neither VA nor the TPAs were able to fully meet the current access standards. The report, which only reported data on new patients, found that VA was unable to meet the 20-day standard for primary care more than a third of the time. For specialty care, VA could not meet the 28-day standard for new patients between 22% and 44% of the time, depending on the specialty.

The TPAs had to meet different access standards based on their contracts with VA. For wait times, the TPA contract standard was 30 days for both primary and specialty care, rather than the VA standards of 20 and 28 days, respectively. VA indicated that the TPAs were meeting or close to meeting the 30-day CCN timeliness standard, but that for specialty care referrals, the TPAs were unable to meet the wait time standard between 10% to 30% of the time, depending on the type of service. For drive times, the TPA contract standards ranged from 30 minutes in urban areas up to 180 minutes in highly rural areas, significantly different than the VA standards.

VA's November 2020 report did not include any findings or recommendations about whether the current access standards were appropriate or effective, or whether they should be modified in any manner. The report included only wait time data on new patients, leaving out critical information on existing patients. The VA report also noted that the ongoing COVID-19 pandemic significantly impacted veterans normal health care usage and utilization patterns, with many veterans deferring care over the past 15 months. Furthermore, the new CCNs were not fully implemented and functioning until last year, making it difficult to make firm judgements about their performance.

Under the VA MISSION Act, VA is required to undertake a review of the access standards by June 6, 2022, and submit its findings to Congress with recommendations for modifications (Title 38, USC, Section 1703B(e)). We believe it would be premature to codify access standards before VA completes this review next year.

We note that in Section 101 there is a provision mandating that in determining a veteran's eligibility to receive community care, VA "…shall not take into consideration the availability of telehealth…" which would seemingly diminish VA's provision of telehealth services, even if proven to be as effective as in-person care. Over the past year, VA significantly increased its provision of telehealth and other virtual care modalities in response to the pandemic. While we supported this expansion, we also have concerns about whether all medical services can be provided through telehealth as effectively as in-person care. As such, DAV does support section 201 to have VA develop a strategic plan for telehealth and section 203 to have GAO conduct a study on the efficacy and effectiveness of telehealth. However, we believe it would be shortsighted to completely eliminate consideration of telehealth when making judgements about veterans' access to quality care. For many patients who are homebound or remote it may be a preferable option to difficult and long travel. Even as the pandemic winds down, VA and the private sector are likely to continue to use telehealth as an alternative for in-person care and many veterans will continue to choose it.

Section 101 also includes a waiver provision for TPAs based on the unavailability of health care providers in a geographic area. Currently, the TPAs have provisions in their contracts allowing VA to waive network adequacy requirements when there is a scarcity of providers in a geographic region. As with codifying access standards, DAV believes it is premature to codify TPA waivers until access and quality standards for

CCNs are equivalent to VA's standards. Veterans should have assurance that they will receive the same quality of care and health outcomes when they elect to go to CCN providers.

Section 102 would require VA to develop a strategic plan to ensure continuity of care under the Community Care Program in the event of the closure of a VA health care facility. When the upcoming Asset and Infrastructure Review (AIR) process concludes in a couple years, it is likely that some VA facilities, or parts of facilities, may be closed or realigned, and affected veterans will instead be furnished care from community partners. We believe that the intent of this provision is to ensure that in every instance VA is prepared to ensure a seamless transition. DAV agrees with the intent of this provision, but recommends that it be modified to ensure that VA has operational plans, not just strategic plans, to ensure continuity of care. Furthermore, we recommend that language be included to mandate that VA may not close a VA health care facility unless it has an up-to-date operational plan that will ensure a seamless transition of veterans to alternate care providers, without any reduction in the timeliness or quality of care.

Sections 111 thru 114 would require VA to establish a pilot program to allow veterans to self-schedule community care appointments through the Internet. The pilot program would begin within 120 days at 5 locations, and run for 18 months, at which time VA would determine whether to roll out the self-scheduling system to other VISNs.

For years, veterans have called for, and VA has worked towards, allowing the ability to self-schedule medical appointments. As part of its work on the electronic health record modernization (EHRM), Cerner is working on developing a Centralized Scheduling Solution that would help to establish a common platform for VA and community care appointment scheduling, a critical step towards universal self-scheduling. At present, however, VA is only capable of offering limited self-scheduling opportunities for just a few services in some locations. During recent VSO stakeholder briefings, VA's Office of Community Care indicated that a comprehensive Internet-based self-scheduling solution for VA appointments was likely years away, and one that incorporated community care networks was not yet on the horizon. Both TPAs also confirmed this assessment during separate briefings with VSO stakeholders.

While DAV agrees with the basic intent of this provision—to allow veterans greater control over scheduling their medical appointments—we believe this provision would only address one part of veterans' medical care scheduling needs. A foundational principle of VA's community care program is that veterans must be fully informed about both their VA and CCN options. Currently, veterans are referred to TPAs when VA cannot meet an access standard, without knowing whether a CCN provider can offer quicker, more conveniently-located and at least equal quality care. A true self-scheduling system must provide direct comparisons among all VA and VCN options about the wait times, driving times, locations, quality metrics, patient satisfaction and other critical information to allow veterans to make informed decisions about what is in their best medical interest. As such, we believe that it makes little sense to rush out a

limited self-scheduling system only for community providers. Instead, VA must work with the TPAs to develop a single comprehensive scheduling solution for both, one that includes the most robust and informative self-scheduling system practicable.

DAV supports sections 121 and 122 of the legislation which aims to strengthen credentialing verification for VCN providers to better ensure that veterans receive care from fully qualified clinicians.

As noted above, DAV supports sections 201 and 203 which would require VA to develop a strategic plan for telehealth and have GAO conduct a study on the efficacy and effectiveness of telehealth. Over the past 15 months, the provision and use of telehealth, not just in VA, grew dramatically across the country in response to the emergency need to provide medical care that was socially distanced. While we support the expanded use of telehealth, we also agree there needs to be a strategic review and plan developed to ensure that telehealth is used only when it is proven to be at least as effective as in-person care.

Sec. 202 requires a GAO study of third-party transportation services to rural veterans to determine if there are gaps that could and should be covered through additional programs and services, including potentially contracting with taxis, Uber and Lyft.

As you may know, DAV operates a national transportation program that provides free rides for veterans to their VA health care appointments. Since 1987, we have deployed DAV vehicles in every state and nearly every congressional district serving our nation's ill and injured veterans. The DAV Transportation Network is the largest program of its kind for veterans, staffed by 155 hospital service coordinators and more than 7,600 volunteer drivers at VA medical centers across the country. During FY 2020, our volunteer drivers spent over 675,000 hours transporting veterans to their VA medical appointments. Despite challenges due to the COVID-19 pandemic, these volunteers logged almost 10 million miles and provided more than 243,000 rides to VA health care facilities, saving taxpayers more than $18.4 million. Since our national transportation program began in 1987, more than 19.6 million veterans have been transported over 760 million miles.

Last year, DAV donated 111 new vehicles to VA facilities to use for transporting veterans, at a cost of more than $3.6 million. To date, DAV departments and chapters have donated 3,558 vehicles to the VA for transporting veterans to their medical appointments, at a cost of more than $83 million. This year, we plan to donate an additional 73 vehicles to the VA, at a cost of over $2.3 million. We also want to recognize the contributions of Ford Motor Company, which has supported this effort by purchasing 239 vehicles, including eight more this year, to donate to VA at a cost of more than $5.6 million.

However, despite the success of our program, we recognize that there are still parts of the country, particularly in rural and highly rural areas—where neither the DAV nor any other third-party transportation program is available for some veterans. As such,

we agree that having additional modes of transportation to supplement what already exists could help to improve veterans access to care, and we have no objection to the study.

Section 301 would require VA to study the feasibility and advisability of expanding its comprehensive caregiver assistance program to eligible veterans in the Republic of the Philippines. Section 302 would require a GAO study of the foreign medical program for veterans living overseas. DAV has no resolutions regarding care for veterans living overseas, but has no objections to these studies that may benefit service-disabled veterans.

Section 401 requires VA to assess the feasibility and advisability of expanding mental health interventions for treatment-resistant major depressive disorders, such as electro-convulsive therapy and repetitive transcranial magnetic stimulation. DAV supports expansion of innovative evidence-based practices in mental health treatment, and thus supports further studies about their efficacy and effectiveness.

Section 402 would modify VA's resource allocation system (VERA) to include peer specialists. DAV strongly supports this provision as a means of expanding the use of peer support throughout VA.

Section 403 would require VA to undertake a gap analysis of its use of psychotherapeutic interventions that are recommended in widely used clinical practice guidelines. DAV supports this provision to help determine whether there should be greater use in VA of evidence-based psychotherapeutic interventions, and what barriers may exist to their usage. DAV supports this study to ensure veterans continue receiving the highest quality mental health care.

Section 501 would require VA to develop an online health education portal that contains interactive modules for veteran patients on such matters as eligibility for community care, telehealth, the VHA appeals process, navigating VHA resources and a variety of services lines such as primary care, mental health and women's health care. DAV supports this section, which includes a requirement to consult with VSO stakeholders, in order to ensure veterans have access to information about their VA medical benefits and rights.

Section 502 would exclude VHA's research activities from the requirements of the Paperwork Reduction Act, the same as the National Institutes for Health receives for sponsored research. DAV supports this provision to help remove unnecessary delays and obstacles to critical biomedical research.

S.1875 Veterans' Emergency Care Claims Parity Act

S. 1875 would establish a deadline of 180 days for the submission of claims for payment for veterans' emergency care treatment in non-VA facilities. The bill would ensure that veterans are not held liable for claims submitted after the 180-day deadline

due to administrative errors made by the provider or VA. It would also ensure that VA makes information available to non-VA providers to improve claim submissions including a summary of VA authorities for reimbursing costs for emergency care with corresponding deadlines for submission of claims; an illustrated summary of steps to ensure "clean" claim submission; and contact information for questions related to the claims process.

A 2019, VA OIG report found a significant number of veterans' emergency care claims were inappropriately denied and many rejected claims were inappropriately processed, with some leading to wrongful denials and rejection of claims. DAV is aware of veterans who have been held liable for health care costs billed to them long after services were rendered when they had assumed that VA had handled any financial obligations for such care. These unfortunate billing surprises often wreak havoc on their personal finances, can damage a veterans' credit and often cause confusion and unnecessary anxiety.

DAV is pleased to support S.1875, the Veterans' Emergency Care Claims Parity Act, which is in accord with DAV Resolution No. 79 supporting legislation to address barriers to emergency care and payment or reimbursement for such care for disabled veterans.

S. 1965—Planning for Aging Veterans Act of 2021

This bill intends to strengthen long-term care (LTC) for veterans by requiring VA to develop a strategic long-term care plan for providing both institutional LTC through VA's Community Living Centers (CLCs), State Veterans Homes (SVHs) and community nursing homes, as well as non-institutional care through home and community-based services. The bill would also make a number of modifications to improve the oversight and operation of SVHs.

With more than half of the veteran population aged 65 or older, the need for a broad and effective range of long-term care options will continue to increase in the years ahead. In accordance with DAV Resolutions 072 and 372, DAV supports this legislation.

Earlier this year, DAV and our Independent Budget partners (Paralyzed Veterans of America, Veterans of Foreign Wars) called for VA to "develop a new strategic plan that estimates the number of veterans who will require institutional LTC and the number of veterans that VA will support in LTC facilities. Additionally, [VA] should develop a plan to build, maintain, and subsidize sufficient LTC facilities within the VA's nursing homes (CLCs), and SVHs."[3] Section 2 of this legislation would accomplish that goal and we strongly support this provision.

To improve oversight of State Veterans Homes, the bill would require VA to conduct quarterly reviews of the quality of inspections conducted on SVHs by VA

[3] http://www.independentbudget.org/117-congress/healthcare

contractors. The bill would also require that all deficiencies found during an inspection be reported to VA, and that VA publish such inspection reports on its website. DAV supports increased transparency and public information about the quality of SVHs and all long-term care options to better inform veterans.

Section 4 of the bill would authorize VA to establish a geriatric psychiatry pilot program at SVHs to provide care for aging veterans with severe mental health and behavioral issues. Today, neither VA's CLCs, SVHs nor community nursing homes are well situated to handle the intensive and expensive needs of such veterans. DAV supports this provision to conduct pilot programs at SVHs to help develop models for providing such care.

The bill would also call on VA to work with public housing authorities and local organizations to expand supportive services for aging veterans at risk of homeless. DAV supports this provision to help prevent homelessness among older veterans.

S. 2102—SERVICE Act of 2021

S. 2102, the Supporting Expanded Review for Veterans in Combat Environments Act—or SERVICE Act of 2021, would revise the VA's standards for mammography screenings to include those veterans who have served in locations known to have been associated with toxic exposures.

The bill would expand eligibility for these life-saving screenings beyond the commonly-advised age and risk scope to encompass those who have served in specific locations and timeframes, including Iraq, Afghanistan, and areas of Southwest Asia, as well as other areas where U.S. military forces utilized burn pits. Finally, the bill requires a report to Congress comparing the rates of breast cancer among troops deployed to areas with known exposures with service members not deployed to those locations and to the civilian population.

VA historically outperforms the private sector in providing breast health screenings for women, and this bill will bolster those efforts ever further. Better screening and early detection, especially among those with known risk factors, can help save lives.

A 2014, DOD Defense Health Agency research report to Congress mandated by Public Law 112-239 (FY 2013 NDAA Sec. 737) indicates that women who have served in the military have an elevated risk for breast cancer compared to their non-veteran peers. Nearly half of the growing demographic of women veterans is under age 45, and after nearly two decades of war many will have had exposure to various toxins during service including milieu of toxins associated with exposure to burn pits. It is imperative these veterans have access to early breast cancer detection services that align with their history of toxic exposures during military service.

DAV strongly supports the SERVICE Act of 2021, in accordance with DAV Resolution No. 20, which calls for enhanced medical services for women veterans.

Draft: Building Solutions for Veterans Experiencing Homelessness Act of 2021

This bill proposes to strengthen and expand services to veterans who are experiencing homelessness or are at risk of becoming homeless. Specifically, the Building Solutions for Veterans Experiencing Homelessness Act of 2021, would:

- Adjust the grants awarded by the VA for comprehensive homeless service programs;
- Increase the maximum rates of per diem payments provided by the VA;
- Provide technical assistance to low income families receiving grants;
- Establish a report on the rental assistance program to include information on serving special populations, i.e., elderly veterans, women and minority veterans and disabled veterans
- Create a program to provide services to assist veterans with navigating housing and health care resources;
- Create a grant program for homeless veterans that coordinates alcohol and substance use disorder recovery services;
- Increase and extend the appropriations for homeless veterans re-integration programs;
- Require the Comptroller General of the United States to provide a report on the availability of affordable housing for veterans who have participated in any program administered by the Homeless Programs Office of the VA; and
- Create two pilot grant programs to care for elderly homeless veterans and to improve public transportation services to veterans.

We supports this bill in accordance with DAV Resolution No. 369 which supports legislation to maintain and improve VA's programs and services to eliminate veteran homelessness. While DAV supports this legislation, we would like to point out two sections in the bill we recommend be amended to more accurately reflect the economic needs of homeless veterans.

First, related to section 3 of the bill, we appreciate the increase of the per diem rates to eligible entities in the Grant and Per Diem (GPD) program from 115% to 200% of the authorized State Home per diem rate for domiciliary care and from 150% to 200% for a homeless veteran in housing that will become permanent. However, we recommend that the maximum allowable rate be maintained at the 300% level that was authorized in Veterans Health Care and Benefits Act of 2020 (P.L. 116-315). The higher amount would cover continued rising costs, higher cost-of-living areas, and costs for additional staff.

Second, DAV supports the Homeless Veterans Reintegration Program (HVRP) reauthorization of $75 million through 2025 as outlined in Section 8 of the bill, but we believe that additional funding may be needed. HVRP is an employment focused competitive grant program of the Department of Labor, Veterans' Employment and Training Service (DOL-VETS)—the only federal grant to focus exclusively on competitive employment for homeless veterans. However, we believe that an effective program such as this will likely need to expand to encompass the overflow from the Veteran Rapid Retraining Assistance Program—or VRRAP that is on pace to max out its funding before it achieves its 17,250 participant mark. The popularity of the VRRAP program shows that programs such as HVRP are still in high demand among unemployed veterans and we recommend it be expanded to address the growing demand.

Again, DAV is pleased to support this bill and look forward to working with Committee to pass this important legislation for our nation's homeless veterans.

S. 2041—Department of Veterans Affairs Provider Accountability Act

This draft bill, the Department of Veterans Affairs Provider Accountability Act would require the Secretary of Veterans Affairs to enforce compliance with all credentialing requirements for VA medical providers by:

- Ensuring VA medical centers compile, verify, and review documentation for each health care professional;
- Continuously monitoring changes to licensure, certification or registration, including registration with Drug Enforcement Administration (DEA) to prescribe controlled substances;
- Requiring a consistent quality review process for each VA medical center in monitoring performance and quality of health care professionals and completing timely reviews when substandard care is alleged;
- Requiring notification of state licensing, certification and registration entities; DEA and the National Provider Data Bank if substandard care is substantiated;
- Requiring training for employees involved in credentialing and quality care reviews; and
- Requiring audits by an independent agency and reports to Congress to ensure VA compliance with these measures.

DAV supports S. 2041, in accordance with DAV Res. No's. 82 and 89, which call for assurances of quality of VA care through appropriate funding, various management initiatives and effective recruitment and retention practices. DAV is supportive of the checks and balances required in this draft bill, but does note that adding layers of review and oversight to the existing credentialing and privileging process could impede timeliness required for VA to recruit scarce medical professionals and cautions the Committee to consider ways to expedite this already lengthy process when it deliberates this bill. In recent years, VA has been able to improve its hiring and

onboarding activities to more quickly hire clinicians who have recently completed their medical education. That said, DAV recognizes the importance of ensuring patient safety and appreciates the gravity and potential consequences of not applying enough rigor to these processes.

Unfortunately, too often, Human Capital Management seems to receive limited attention from VA leadership and other Federal Government leaders. A 2017 GAO report (GAO-17-627T) found that throughout the federal government, human resources specialists often lack the skills to lead strategic Human Capital Management activities. Earlier that year, a GAO report (GAO-17-30) had determined that VHA had limited human resources capacity to monitor its training activities and align its performance management system with leading human resources practices. VHA may be long overdue for a comprehensive third-party review of its human resource policies and practices and a strategic plan for VA to develop internal expertise which would better ensure some of the provisions in this draft bill could be adequately addressed.

Annual training, quality review and assurance audits and potentially adding new databases and resources for VA Human Resources Management personnel to complete these activities with integrity is likely to require additional employees and funding to fully implement all the provisions of this comprehensive bill.

Mr. Chairman, this concludes my testimony. I will be pleased to answer any questions you or members of the Committee may have.

Testimony of the

NATIONAL COALITION
***for* HOMELESS VETERANS**

United States Senate
Committee on Veterans' Affairs

Hearing on Pending Legislation

June 23, 2021

Chairman Tester, Ranking Member Moran, and distinguished Members of the Senate Committee 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.

I thank you for your leadership and continuing efforts to focus on the needs of veterans experiencing or at-risk of homelessness, as Congress has enacted several pieces of COVID relief legislation in the form of the Families First Coronavirus Response Act, the Coronavirus Aid, relief, and Economic Security or CARES Act, the past year's National Defense Authorization Act or NDAA, the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, and most recently the American Rescue Plan. The assistance Congress provided has resulted in over $971 million in supplemental resources, 75 percent of which had been obligated as of May, being distributed to organizations across the country to keep veterans safe from COVID by decongregating shelter spaces, ramping up rapid rehousing capacity, and focusing on individualized housing options in hotels and motels.

Last week NCHV was afforded the opportunity to present testimony before the House Committee on Veterans Affairs Economic Opportunity Subcommittee on veteran homelessness in the wake of COVID-19. Our testimony touched on many items, most important among them the need for sufficient funding must be incorporated into non-emergency appropriations and authorizations as we move away from COVID-specific emergency funding, if we are to move out of this emergency and continue to decrease veteran homelessness, implement program expansions enacted earlier this year, and incorporate program changes included in current legislative proposals.

While veteran homelessness decreased by 50 percent between 2010 and 2020, HUD's 2020 Point-in-Time Count data revealed a slight uptick in veteran homelessness to 37,252 individuals on any given night. While 37, 252 veterans homeless is far more than there should be, this count is a snapshot of the population on one given night. Given the way the homeless population ebbs and flows, the population of veterans served in a year is much higher.

Decreases in veteran homelessness were made possible over the last decade due in large part to Congressional investment in key Federal Programs, adherence to evidence-based solutions, and

dedicated coordination at the national and local level. As we progress into 2021, veteran homelessness is once again a priority at the Department of Veterans Affairs (VA,) and it is unavoidably clear that we must double down on ongoing efforts to end veteran homelessness, while simultaneously recalibrating to respond to the urgent economic crisis COVID has created and the inequities that certain veteran groups face.

Today's Senate hearing is a testament to the ability of the Veterans' Affairs Committees to continuously work towards bettering the lives of veterans through your bipartisan legislative efforts. NCHV would like to note the importance of all the pending legislation today covering a wide number of subjects. However, a few bills on the agenda today have a more direct impact on homeless veteran services; S. 612 the "Improving Housing Outcomes for Veterans Act of 2021," S. 796 the "Protecting Moms Who Served Act of 2021," and the Chair's "Building Solutions for Veterans Experiencing Homelessness Act of 2021." We do not oppose legislation that is not included in NCHV's views, however, we have abstained from offering comments on legislation outside our scope of expertise.

S. 612: Improving Housing Outcomes for Veterans Act of 2021

NCHV supports the intent of S. 612, the "Improving Housing Outcomes for Veterans Act of 2021." However; it is unclear that a legal mandate for VHA to communicate with local staff working on homelessness would address any major issues the bill sponsor was attempting to address. We do acknowledge that not all VAMCs are participating robustly in local HMIS and reserving vouchers for veterans on the local prioritization lists. NCHV recommends technical changes to this legislation to require that HUD and VA jointly develop a mechanism for effectively sharing and reporting data between HUD's nearly 30 HMIS systems and VA's HOMES system. We further recommend that addition funding be appropriated to VA's HCHV program to enhance coordinated entry specialist support at each VAMC. VAMC catchment areas often overlay multiple HUD Continuums of Care (CoC), meaning that some VA Coordinated Entry Specialists are responsible for maintaining partnerships with multiple CoCs. NCHV supports improved provider access to information and looks forward to working towards those ends with the committee.

Draft bill: Building Solutions for Veterans Experiencing Homelessness Act of 2021

NCHV commends the Chairman specifically for his draft legislation, "Building Solutions for Veterans Experiencing Homelessness Act of 2021." It is my pleasure to, on behalf of NCHV, let the Chairman know that he will be awarded NCHV's 2021 Policy Award at our annual conference being held this very week, for his enduring and tireless efforts on behalf of homeless veterans across the nation. Your responsive and proactive governance has proven itself time and

again, allowing an open flow of information from providers on the front lines. On behalf of NCHV and all of our members across the nation, thank you.

NCHV supports this bill. More specifically NCHV appreciates the flexibilities Congress granted to make it easier for current grantees to take advantage of GPD Capital Grants to decongregate their facilities. NCHV has requested future rounds of capital grants, in regular, non-emergency funding to allow time for appropriate planning and construction. We support their continuation, in order to allow remaining congregate providers the opportunity to reconfigure facilities. All grantees will benefit from continued waivers of VA real property disposition and matching requirements. Certain restrictions in the most recent Capital Grant NOFO (notice of funding opportunity) prevented certain grantees from making full use of this opportunity due to the caps on per unit cost being low for acquisition in certain communities and new construction in communities where aging stock makes construction more affordable. Further, the overall grant award caps prevented larger program operators from utilizing the opportunity as the funding available was insufficient to support decongregation of larger facilities.

Another major concern amongst service providers relates to the availability of sufficient per diem funding to support 24/7 staffing operations at multiple sites for providers that were unable to decongregate beds without adding to their physical footprint. With an increase in the rate above the 115% authorized in P.L. 116-315, organizations would have a fighting chance at addressing staffing needs at multiple locations. Grant and Per Diem (GPD) recipients and grantees have found current GPD rates are insufficient to run these types of programs well in higher cost of living/rent areas.

NCHV supports increasing the GPD rate and requests that you require VA to identify a way to decouple payments to GPD operators from the State Home Per Diem Rate. NCHV requested GPD caps be maintained at 300% post-emergency or until a more responsive formula can be developed. Another important factor to note is that while the CDC has relaxed masking guidelines for many activities and types of locations, its guidelines for congregate shelter remain unchanged.[1] They continue to recommend decongregating, keeping isolation and quarantine beds available, and adequate distancing measures in congregate facilities, even as much of the country goes back to more normal operations. While certain bed models will continue to run deficits on a regional basis with the bills proposed 200%, this is an important step toward GPD providers maintaining program solvency as they have been funded off of an entirely separate program's formula. Most programs will not receive anywhere near these elevated rates as these are merely caps, under which any provider would have to justify an approved reimbursement rate.

[1] https://www.cdc.gov/coronavirus/2019-ncov/community/homeless-shelters/plan-prepare-respond.html. National Center for Immunization and Respiratory Diseases (NCIRD), Division of Viral Diseases. 6/8/2021

Additional technical assistance is needed across most of HPO's homeless programs as the amount provided has not changed since their authorizations. Rather than updating specific dollar amounts we support the legislation setting aside 2 percent of yearly funding. These additional flexibility for TA funding will allow VA to be proactive in their implementation of program adjustments in real time. NCHV supports the effort to provide further public transportation services for veterans as proposed by the pilot programs.

NCHV supports report language gathering more information on the recently expanded SSVF Shallow Subsidy program and the requested report language. The more we know about the impact of this more recent addition the better we can calculate need and benefits of future expansions. Health care navigators implemented and hired during the emergency for the Supportive Service for Veteran Families (SSVF) program should be continued as they have been a success with service providers, improving veteran outcomes and transition among programs and should be expanded to include housing navigation as well. Halting navigator assistance to veterans would jeopardize a provider's ability to increase positive outcomes for homeless veterans. Veterans need this assistance, including those participating in other VA programs, and Congress can close this gap by approving the Chairman's bill. NCHV thanks the chair for including this valuable asset in his bill. This program has been a success during the pandemic, as its flexibility has allowed for innovative collaboration.

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 reintegration efforts will be crucial to stabilize an anticipated influx of unemployed veterans through an expanded Homeless Veteran Reintegration Program re-authorized at $75 million though 2025. In a recent veteran employment hearing, the newly minted Veteran Rapid Retraining Assistance Program (VRRAP) revealed it has seen a generous uptake with program administrators claiming they will expend the $386 million allotted, halfway to the program's goal of 17,250 participants. This displays a deep well of need for veteran employment programs. The economic crisis will deepen when unemployment benefits sunset. Similarly, the housing crisis will deepen when the eviction and foreclosure moratoriums sunset. Nearly 15 million Americans have accrued over $50 billion in missed rental and mortgage payments, and veterans are among them. Of which over 6 million renter households will immediately be added to the "at-risk" category of homelessness if unable to access enough emergency rent assistance or other homelessness prevention funding. Adequate funding for programs that prevent homeless ness and lift up veterans through quality employment are direly needed.

S. 796 – Protecting Moms Who Served Act of 2021

NCHV supports this legislation. We note that research from the Urban Institute has found that among a sample of civilian women experiencing homelessness in Massachusetts found that 48

percent of women were pregnant and 52 percent experienced pregnancy in the year prior to shelter entry.[2] The study found that these women accessed less ambulatory prenatal care, more emergency care, and were more likely to experience health complications during and immediately after giving birth. To that end, we request that Section 4(b)(1) of the bill be amended to require the report to also include not only recommendations for improving care for pregnant homeless veterans, but also identification of any correlation between the housing status of veterans and maternal outcomes.

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 are in the middle of an emergency and veterans experiencing and at-risk of homelessness need safe housing now more than ever. We thank you for your attention as we work collectively to lessen the impact that COVID-19 will have on veterans experiencing or at-risk of homelessness.

[2] https://housingmatters.urban.org/research-summary/pregnant-and-homeless-how-unstable-housing-affects-maternal-health-outcomes. Robin E. Clark, Linda Weinreb, Julie M. Flahive, Robert W. Seifert. 3/20/2019

STATEMENT OF
MR. MARIO MARQUEZ
DIRECTOR, NATIONAL VETERANS AFFAIRS & REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
ON
PENDING LEGISLATION

JUNE 23, 2021

Chairman Tester, Ranking Member Moran, and distinguished members of the committee, on behalf of our National Commander, James W. "Bill" Oxford, and our nearly 2 million members, we thank you for inviting The American Legion to comment on the pending legislation before this committee. Whenever The American Legion testifies, those within the military and veteran community have a direct voice in the legislative process. As a resolutions-based organization, The American Legion's position on legislation is guided by more than 100 years of advocacy that originates at the grassroots level of our organization. We hope you will take into consideration The American Legion's position as well as recommendations.

S.372 – Ensuring Quality Care for Our Veterans Act

To require the Secretary of Veterans Affairs to enter into a contract or other agreement with a third party to review appointees in the VHA who had a license terminated for cause by a state licensing board for care or services rendered at a non-VHA facility and to provide individuals treated by such an appointee with notice if it is determined that an episode of care or services that they received was below the standard of care.

In 2018, the Government Accountability Office (GAO) released a report based on an investigation of incidents at Department of Veterans Affairs (VA) hospitals with different employment practices and standards.[1] According to the report, VA leadership stated that each facility makes their hiring decisions and ascertains whether their clinicians meet VA's licensing standards. In one specific incident, a doctor was not hired due to an official reprimand that led to a medical license forfeiture. That same doctor was later hired at a different VA medical center in a different regional network. VA was not able to explain why the two different facilities came to different conclusions about hiring the same doctor.

In another case, a VA facility hired a registered nurse who had a reprimand on his license due to substance use. He was hired in 2002 and received the reprimand in 2008 whereupon the VA center learned about prior undisclosed convictions. This nurse also had three DUI convictions between 1984 and 1999, an assault conviction in 1998, and a disorderly conduct conviction in 2006. The GAO report said the nurse is still working at VA. Department policy stated that a reprimand on a license does not disqualify someone from employment if they have at least one full, current, active

[1] Office, U.S. Government Accountability. Department of Veterans Affairs: Actions Needed to Address Employee Misconduct Process and Ensure Accountability, Jul 19, 2018. https://www.gao.gov/products/gao-18-137.

and unrestricted license. The registered nurse did not tell VA about his license reprimand until September 2008, but officials told GAO they did not discipline him for not disclosing his prior convictions. Currently, there is no standard for all Veterans Health Administration (VHA) medical centers to follow.

The *Ensuring Quality Care for Our Veterans Act* will fix this problem by requiring VA to contract with an organization outside the federal government to conduct a clinical review for quality management of hospital care or medical services furnished by covered providers within VA. It would mandate the Secretary of Veterans Affairs ensure that each review of a covered provider is performed by an individual who is licensed in the same specialty as the covered provider. With respect to hospital care or medical services furnished by a covered provider, if a clinical review for quality management determines that the standard of care was not met, VA shall notify the individual who received care from the covered provider.

This legislation will mitigate bad actors within VA by ensuring third-party reviewers are assigned to cases and that negligent providers do not continue providing care. By assigning a third-party reviewer, the case receives an extra look from an entity outside of VA, providing an unbiased analysis and recommendation for the case. The American Legion supports legislation designed to mitigate bad actors within VA by conducting a clinical review of VA covered providers who had their license terminated. Through Resolution No. 377: *Support for Veteran Quality of Life*, The American Legion supports Congress and VA enacting legislation and programs within VA that will enhance and preserve benefits for veterans and their dependents, including, but not limited to, timely access to quality VA health care.[2]

The American Legion supports S.372 *as currently written*.

S.539

To direct the Secretary of Veterans Affairs to submit to Congress a report on the use of video cameras for patient safety and law enforcement at medical centers of the VA.

Seven veteran homicides occurred within 11 months at the Louis A. Johnson VA Medical Center, in Clarksburg, West Virginia, at the hands of a nursing assistant via intentional lethal insulin injection to non-diabetic veterans. When law enforcement officials conducted an investigation, the lack of eyewitness or security footage was a complicating factor. Later, it was learned that the hospital ward did have cameras in the common areas and supply room where the insulin was stored; however, they were not working properly. This tragic crime exposed the inadequate maintenance, upkeep, and oversight that exists within the Department of Veterans Affairs (VA) physical surveillance program. Legislation like S.539 will aid in ensuring these tragedies do not happen again.

[2] The American Legion Resolution No.377 (2016): *Support for Veteran Quality of Life*.

S.539 requires VA to submit a report to Congress on the placement, maintenance, and authority for supervisors to review video feed when protecting veterans, staff, and visitors. Within the report, it must include an analysis of how cameras are used to monitor staff and patients, the procedures regarding the positioning of cameras, and the specific units within medical facilities in which the use of cameras is prioritized to protect patient safety. Furthermore, it must include recommendations to improve patient safety and consideration of the extent to which cameras monitor locations where drugs are stored to ensure that drugs are accounted for.

This legislation will enhance oversight of VA video camera policy to ensure patient safety. Previously, The American Legion has supported legislation like the *VA Policy Improvement and Accountability Act* to increase the use of cameras used at Veterans Health Administration (VHA) medical facilities. We have routinely supported oversight and encouraged further Government Accountability Office (GAO) and Office of Inspector General (OIG) reports.

The American Legion supports S.539 *as currently written.*

S.544

To direct the Secretary of Veterans Affairs to designate one week each year as Buddy Check Week for the purpose of outreach and education concerning peer wellness checks for veterans, and for other purposes.

Suicide continues to be a significant concern within the veteran community. Unfortunately, the COVID-19 pandemic has exacerbated this issue by increasing isolation for veterans already struggling with their mental health.[3] This past year, the Centers for Disease Control and Prevention confirmed this when it reported the results of a survey that demonstrated the physiological and emotional impact of the pandemic. These outcomes included a tripling of reported anxiety since 2019 and a quadrupling of reports of depression.[4]

To combat this issue, The American Legion is dedicated to taking care of members of the military, their families, caregivers, and veterans throughout the various stages of life and ensuring these mental health struggles do not go untreated. This is why, in March 2019, we launched "Buddy Check Weeks" where Legionnaires call fellow veterans to connect and if necessary, offer support and assistance such as getting their groceries and medications delivered, driving them to doctors' appointments, and connecting them to VA resources such as the Veterans Crisis Line.

S.544 would ensure this effort becomes permanent by directing the Department of Veterans Affairs (VA) to designate one week annually as "Buddy Check Week" for the purpose of encouraging

[3] Panchal, N., Kamal, R., Orgera, K., Cox, C., Garfield, R., Hamel, L., & Chidambaram, P. *The implications of COVID-19 for mental health and substance use.* Kaiser family foundation. (2020). Retrieved from: https://www.kff.org/coronavirus-covid-19/issue-brief/the-implications-of-covid-19-for-mental-health-and-substance-use/

[4] Czeisler, Mark É., Rashon I. Lane, Emiko Petrosky, Joshua F. Wiley, Aleta Christensen, Rashid Njai, Matthew D. Weaver et al. "Mental health, substance use, and suicidal ideation during the COVID-19 pandemic—United States, June 24–30, 2020." *Morbidity and Mortality Weekly Report* 69, no. 32 (2020): 1049.

outreach and peer wellness checks by veterans. It would require VA to collaborate with Veterans Service Organizations (VSO) and mental health experts to provide educational opportunities for veterans which includes a script on how to conduct a buddy check and training on how to transfer a call directed to the Veterans Crisis Line.

This initiative creates space to have an open and candid dialogue with a veteran peer who has had similar experiences and potentially make them aware of resources at VA or in the community. This week will be VA-led but not VA-coordinated. The success of the Buddy Check Week will be reliant on grassroots efforts by veterans reaching out to veterans they served with and letting them know they are part of a community that cares about them.

A VA-led national "Buddy Check Week" will reach, support, and aid significantly more veterans than The American Legion would otherwise be able to on its own. Through Resolution No. 18: *Buddy Check,* The American Legion supports the establishment of a formal "Buddy Check Week" and we urge Congress to take expeditious action on S.544 to ensure no veteran is left behind.[5]

The American Legion supports S.544 *as currently written.*

S.612 – Improving Housing Outcomes for Veterans Act of 2021

To require the Under Secretary for Health of the VA to provide certain information to medical center staff and homelessness service providers of the Department regarding the coordinated entry processes for housing and services operated under the Continuum of Care Program of the Department of Housing and Urban Development.

Homeless veterans comprise 16 percent of the U.S. homeless adult population. Simultaneously, there are challenges related to shortages of Department of Veterans Affairs (VA) case managers, rising housing costs and availability, and transportation limitations that are hindering service providers that cover large geographic regions. Unfortunately, the Department of Labor (DoL) does not have a written policy on its process for validating performance data, which has impacted their ability to obtain reasonable assurance that these are the most accurate and reliable data available.

Exacerbating this issue is local VA staff and service providers who are misunderstanding how program data is used in assessing performance, while others are unaware of VA's feedback processes on performance measures. The result is less veterans are served. The *Improving Housing Outcomes for Veterans Act* requires VA to provide staff of VA medical centers and homelessness services providers with information related to best practices with respect to the collaboration between VA medical centers, homelessness services providers, and local partners.

It mandates VA clearly communicate with VA employees whose responsibilities are related to homelessness assistance programs regarding how to obtain and provide feedback about performance measures and the measurement of performance of such programs by the VA Homeless Programs Office. This legislation will assist in creating clearer lines of communication

[5] The American Legion Resolution No.147 (2016): *Buddy Check*.

between VA and the Veterans Health Administration (VHA) programs that are in operation to fight veteran homelessness while also ensuring providers are more aware of existing programs there to aid them.

Over time, The American Legion has continued to support efforts of public and private sector agencies and organizations that aid homeless veterans and their families by supporting sustained and coordinated efforts to achieve this. In July 2018, The American Legion testified before Congress on U.S. Department of Housing and Urban Development-VA Supportive Housing (HUD-VASH), Supportive Services for Veteran Families (SSVF), and Homeless Veterans Rehabilitation Program (HVRP) where we reiterated that veteran homelessness remains a special priority for the organization. Through Resolution No. 319: *Expanding Veterans Employment and Homeless Services within the VA*, The American Legion advocates for efforts to centralize information to provide more cohesiveness between the VHA, VA medical centers, HUD, and DoL.[6]

The American Legion supports S.612 *as currently written*.

S.613 – PAWS for Veterans Therapy Act

To direct the Secretary of Veterans Affairs to carry out a pilot program on dog training therapy and to amend title 38, the United States Code, to authorize the Secretary to provide service dogs to veterans with mental illnesses who do not have mobility impairments.

The *PAWS for Veterans Therapy Act* makes service dogs accessible to veterans wanting an alternative post-traumatic stress disorder (PTSD) treatment option. Currently, the Department of Veterans Affairs (VA) does not fund service dogs or recognize the use of therapy service dogs as a possible treatment method for veterans suffering from PTSD. There have been multiple studies proving that service dogs can provide mental healing to veterans suffering from physically invisible wounds of war.

This legislation would create a five-year pilot program that pairs veterans who served on active duty in the Armed Forces on or after September 11, 2001, with eligible therapy service dogs if they have been diagnosed with PTSD severe enough to warrant treatment. Eligible veterans must have also completed an evidence-based treatment program and remain significantly symptomatic by clinical standards.

The American Legion supports this legislation because it allows for an alternative form of treatment to injured veterans returning home from war with traumatic brain injury (TBI) and PTSD. Service dogs can act as an effective complementary therapy treatment component, especially for those veterans who suffer daily from the physical and psychological wounds of war.

[6] The American Legion Resolution No.319 (2016): *Expanding Veterans Employment and Homeless Services within the VA*.

PTSD has become an epidemic, and VA has estimated that between 11 and 20 percent of veterans who served in Afghanistan or Iraq have PTSD.[7]

While VA continues to stall with their dog-based therapy studies, veterans are being denied alternative forms of treatment. As VA is continually accused of over-prescribing medications to veterans, and as veterans continue to complain about over-prescription, it is time that VA, and the federal government, look at alternative options.[8] Through Resolution No. 160: *Complementary and Alternative Medicine*, The American Legion supports any legislation that provides oversight and funding to the VA for innovative, evidence-based, complementary and alternative medicine in treating various illnesses and disabilities.[9]

The American Legion supports S.613 *as currently written*.

S.727 – CHAMPVA Children's Care Protection Act of 2021

To amend title 38, United States Code, to increase the maximum age for children eligible for medical care under the CHAMPVA program, and for other purposes.

The provisions of this bill fall outside the scope of established resolutions of The American Legion. As a large grassroots organization, The American Legion takes positions on legislation based on resolutions passed by the membership or in meetings of the National Executive Committee. With no resolutions addressing the provisions of the legislation, The American Legion is researching the material and working with our membership to determine the course of action which best serves veterans.

The American Legion has no position on S.727.

S.796 – Protecting Moms Who Served Act of 2021

To codify maternity care coordination programs at the VA, and for other purposes.

The American Legion has been a constant supporter of improving women's healthcare. We have also testified on numerous occasions in support of maternal care. Our members are persistent in the fight to provide women veterans with quality gender-specific care by introducing and passing Resolution No. 37: *Improvements to VA Women Veterans Programs*[10] and Resolution No. 147: *Women Veterans.*[11] Currently, the Department of Veterans Affairs (VA) offers: full exams after

[7] "VA.gov: Veterans Affairs." How Common is PTSD in Veterans?, July 24, 2018. https://www.ptsd.va.gov/understand/common/common_veterans.asp.
[8] Lawrence, Quil. "Veterans Kick The Prescription Pill Habit, Against Doctors' Orders." NPR. NPR, July 11, 2014. http://www.npr.org/sections/health-shots/2014/07/11/330178170/veterans-kick-the-prescription-pill-habit-against-doctors-orders.
[9] The American Legion Resolution No. 160 (2016): *Complementary and Alternative Medicine*
[10] The American Legion Resolution No.37 (2016): *Improvements to VA Women Veterans Programs*
[11] The American Legion Resolution No.147 (2016): *Women Veterans*.

the first positive pregnancy test, prenatal education, screenings, ultrasounds, genetic testing, specialty consultations, and necessary medication and supplements, such as prenatal vitamins.

These services are all offered to ensure a safe and successful birth for the veteran mother. VA's additional services include the first seven days of newborn care, breastfeeding support, social services, and mental health services. Studies show that women veterans are at a higher risk for major depression, post-traumatic stress disorder (PTSD), urogenital issues, and hormone imbalance, which may lead to infertility or miscarriage. Subsequently, VA offers services in cases of miscarriage or stillbirth. There is a gap in research about maternal mortality within the women veteran population and even less research on women veterans of color.

As well, there is a shortage of women providers as care coordinators for veterans who choose to obtain maternity care from VA. The American Legion strongly supports the allocation of additional funds to improve maternity care coordination for women veterans. We also recommend further research into women veterans' exposure to potentially harmful substances during service, race and ethnicity statistics, maternal death rates, maternal death causes, and other correlations.

The American Legion supports S.796 *as currently written.*

S.887 – VA Supply Chain Resiliency Act

To make certain improvements relating to the supply chain of the VA, and for other purposes.

The COVID-19 pandemic presented innumerable challenges to Department of Veterans Affairs (VA) as it struggled to maintain the fidelity of its supply chain. Obtaining critical medical supplies in the early phases of the pandemic became especially difficult for many VA medical facilities as global supply chains constricted and manufacturers shut down. Additionally, dependence on foreign sources for essential medical and safety equipment became problematic as countries limited exports to meet increased domestic demand.[12]

VA became abruptly aware of the vulnerabilities and lack of resiliency built into its supply chain as it struggled to acquire critical medical supplies throughout the pandemic. The lack of a comprehensive strategy for its supply chain management modernization efforts and inefficient acquisition management procedures were primarily responsible for the lack of resiliency. Additionally, the nation's healthcare systems dependence on foreign sources for critical medical and safety equipment served to further exacerbate the issue.

An effective medical supply chain that can deliver the correct item, at the right time, to the right place, in a time of crisis requires a comprehensive approach. VA has multiple interrelated supply

[12] During a hearing before the U.S.-China Economic and Security Review Commission July 31, 2019, in testimony provided by the Hastings Center, it was pointed out that "If China Shut the Door on Exports of Medicines and Their Key Ingredients and Raw Materials, U.S. Hospitals and Military Hospital and Clinics Would Cease to Function Within Months, If Not Days. A natural disaster, global health crisis, or adverse foreign government action could disrupt the supply of medicinal ingredients and finished drugs. Surgeries could not be performed at Walter Reed National Military Medical Center" and other hospital systems, which would include VA.

chain modernization initiatives underway that are intended to improve its acquisition management. However, without a comprehensive strategy communicating how each interrelated initiative will move VA forward, VA risks wasting resources and missing opportunities to build resilience into its supply chain. To ensure VA is able to deliver critical items in the face of future national emergencies will require a comprehensive and multifaceted approach.

The *VA Supply Chain Resiliency Act* requires VA to identify critical supply items and anticipate the needs of VA medical system in the event of future public health or national emergencies. Additionally, it requires VA to participate in the Department of Defense (DoD) Warstopper Program and thereby "ensure the maintenance and stability of items are identified as critical." Furthermore, this legislation mandates VA partner with manufacturers and distributors to secure a supply of critical items rather than holding physical inventories.

This comprehensive, multi-faceted, and forward-looking strategy ensures VA is better prepared to provide essential life-saving care to veterans in the face of the next national emergency. The American Legion supports efforts to expand contracts and agreements with producers to ensure the availability of critical items and encourages VA to partner with domestic business to ensure increased supply chain resiliency. Through Resolution No. 13: *Support "Buy American" Policy within the Federal Government to Create Opportunities for Veterans*,[13] The American Legion "supports legislation and policy that incentivizes the return of manufacturing from overseas and the creation of more domestic manufacturers. The government, through its collective purchasing power, can programmatically incentivize the return of domestic manufacturing of emergency supplies to prevent supply chain breakdowns in future national emergencies."

The American Legion supports S.887 *as currently written.*

S.951 – Puppies Assisting Wounded (PAWS) Servicemembers Act of 2021

To direct the Secretary of Veterans Affairs to make grants to eligible organizations to provide service dogs to veterans with severe post-traumatic stress disorder, and for other purposes.

In November 2020, the Department of Veterans Affairs (VA) published an annual report on the veteran suicide prevention using data collected from 2005-2018.[14] According to the report, mental health disorders were associated with an increased risk for suicide and as of 2018 17.6 veterans were dying by suicide daily. A mental health survey conducted by The American Legion in 2019 corroborated these unfortunate statistics when it found 76 percent of participants never sought mental health care from a VA medical center, 80 percent never sought mental healthcare outside of a VA facility, and 84 percent never sought mental healthcare at a Vet Center facility.

[13] The American Legion Resolution No.37 (2020): Support "Buy American" Policy within the Federal Government to Create Opportunities for Veterans

[14] U.S. Department of Veteran Affairs. (2020). *National Veteran Suicide Prevention Annual Report.* Office of Mental Health and Suicide Prevention. Retrieved from: 2020 National Veteran Suicide Prevention Annual Report (va.gov)

However, a recently published VA study found a 3.7 point drop in post-traumatic stress disorder (PTSD) symptom scores as measured by the PCL-5 over an 18-month period for veterans who used service dogs.[15] These results indicated veterans paired with service dogs had less suicidal ideation and an improvement in overall mental health than those paired with emotional support dogs. Offering a wider variety of mental health treatment options encourages help seeking behavior because it allows the veteran to choose their preferred method of treatment.

Research suggests when individuals desire control, choice over treatment alternatives improves treatment effectiveness by enhancing personal control.[16] The *PAWS Act* makes this a reality by establishing a three-year program where the Secretary of Veterans Affairs would provide grants of up to $25,000 per veteran to organizations to pair veterans suffering from severe PTSD with service dogs. Grants would cover a veterinary health insurance policy for the life of the dog, service dog hardware, and payment for travel expenses for the veteran to obtain the dog.

Through Resolution No. 134: *Service Dogs for Injured Service Personnel and Veterans with Mental Health Conditions*, The American Legion believes legislative action to ensure veterans have access to VA provided service and guide dogs to aid in treating mental health illnesses is critical.[17] The *PAWS Act* will no doubt aid in decreasing the stigma surrounding veterans seeking treatment for their mental health issues and a ensure proven form of alternate treatment is accessible for those in need.

The American Legion supports S.951 *as currently written*.

S.1040

To amend title 38, United States Code, to expand eligibility for hospital care, medical services, and nursing home care from the VA to include veterans of World War II.

Approximately 325,000 of the 16 million Americans who served in World War II are still alive and as many as 296 pass away every day.[18] Under VA regulations, there are guidelines in place that determine a veteran's eligibility for healthcare benefits based on factors related to income level, disability rating, and military service history. Because of this, not all veterans are eligible for VA healthcare services. By way of the Veterans Health Care Eligibility Act of 1996, all veterans of the Spanish-American War and World War I are exempt from the means test required to enter the VA healthcare system.

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[15] National Academies of Sciences, Engineering, and Medicine. 2021. *Letter Report on Review of Department of Veterans Affairs Monograph on Potential Therapeutic Effects of Service and Emotional Support Dogs on Veterans with Post Traumatic Stress Disorder*. Washington, DC: The National Academies Press. https://doi.org/10.17226/26039.

[16] Geers, A. L., Rose, J. P., Fowler, S. L., Rasinski, H. M., Brown, J. A., & Helfer, S. G. (2013). Why does choice enhance treatment effectiveness? Using placebo treatments to demonstrate the role of personal control. Journal of Personality and Social Psychology, 105(4), 549–566. https://doi.org/10.1037/a0034005

[17] The American Legion Resolution No.134 (2016): *Service Dogs for Injured Service Personnel and Veterans with Mental Health Conditions*

[18] McCarthy, Niall, and Felix Richter. "Infographic: When Will the U.S. Lose Its Last WWII Veterans?" Statista Infographics, May 25, 2020. https://www.statista.com/chart/13989/when-the-us-will-lose-its-wwii-veterans/.

Yet, World War II veterans are not and as a result some veterans previously enrolled in VHA healthcare prior to 1996 VA eligibility reforms were dropped or are now subjected to a means test. It is unacceptable some veterans of the Greatest Generation do not have access to benefits they earned due to loopholes in federal law. S.1040 would fix this problem by expanding automatic eligibility to all World War II veterans so veterans who currently do not qualify for VHA healthcare will have access to VA hospital care, medical services, and nursing home care.

Previously, The American Legion has submitted letters directly to the Secretary of Veterans Affairs concerning the lifting of current means test standards for the aging World War II veteran cohort in order to get all remaining WWII veterans' full access to VA healthcare. Through Resolution No. 3: *WWII Veterans Hospital and Medical Eligibility*, The American Legion supports extending the exemption from a means test to World War II veterans and urges VA to place all World War II veterans in Priority Group Category 5.[19] Members of the Greatest Generation deserve equitable access to care and rescinding this loophole will honor their bravery and courage.

The American Legion supports S.1040 *as currently written.*

S.1198 – Solid Start Act of 2021

To amend title 38, United States Code, to improve and expand the Solid Start program of the VA, and for other purposes.

Based upon Department of Veterans Affairs (VA) publicly available data, roughly 17.6 veterans die by suicide daily.[20] On average, 60 percent of them have had no consistent contact with VA services.[21] A 2019 American Legion mental health survey revealed 40 percent of veterans were not sure whether they were eligible or not for VA mental health services.[22] These concerning statistics are supported by a *Journal of the American Medical Association* study conducted on almost two million servicemembers who were separated from service. The study found those who identified as male, younger, and with shorter lengths of service, or were separated from the Marine Corps or Army, had a significantly higher risk of suicide after separation.[23]

In 2018, the Trump Administration issued Executive Order 13822 to stem veteran suicide by improving access to mental healthcare and suicide prevention resources to recently transitioned

[19] The American Legion Resolution No.3 (2017): *WWII Veterans Hospital and Medical Eligibility*
[20] U.S. Department of Veteran Affairs. (2020). National Veteran Suicide Prevention Annual Report. Office of Mental Health and Suicide Prevention. Retrieved from: 2020 National Veteran Suicide Prevention Annual Report (va.gov)
[21] Shane III, Leo. "VA Success Story - New Veterans Answering Calls Checking In." Military Times, March 4, 2020. https://www.militarytimes.com/news/pentagon-congress/2020/03/03/va-success-story-new-veterans-answering-calls-checking-in/.
[22] The American Legion. 2019 Mental Health Survey Executive Report (2019). Retrieved from: https://www.legion.org/publications/248320/2019-mental-health-survey-executive-report
[23] Ravindran, Chandru, Sybil W. Morley, Brady M. Stephens, Ian H. Stanley, and Mark A. Reger. "Association of suicide risk with transition to civilian life among US military service members." *Journal of the American Medical Association network open* 3, no. 9 (2020): e2016261-e2016261.

servicemembers the year following their discharge, separation, or retirement.[24] After the Executive Order was published, VA devised a Joint Action Plan for better screenings, identification, and warm hand-offs to peer support programs.[25] By December 2019, the VA Solid Start Program was launched to proactively engage all newly separated servicemembers at least three times during their first year of transition from the military to establish a strong relationship and promote awareness of VA benefits and services.

Succeeding the success of this new VA pilot program, the *Solid Start Act of 2021* was introduced. The *Solid Start Act of 2021* would permanently fund the Solid Start Program, codify it into law, and require the Government Accountability Office (GAO) to assess the program's efficiency and effectiveness in meeting its goals. Specifically, it requires the GAO to review VA's ability to prioritize outreach to veterans who access mental health resources prior to separation and collect up-to-date contact information during the transition process. Additionally, the GAO would need to review whether VA was calling each veteran at least twice annually in the first year after separation and was including programmatic information in VA booklets, on their website, and through other resources.

The American Legion has staunchly advocated for mental health services for veterans recovering from the invisible wounds of war through legislation like the *Debra Sampson Act* and the *Cmdr. John Scott Hannon Veterans Mental Health Care Improvement Act*. Through Resolution No. 12: *Accountability and Enhancements of Transition Assistance Program, Outcomes and Delivery for Today's Digital Transitioning Servicemembers*, The American Legion believes Congress must require VA to conduct assessments on the efficiency of delivering "for life" support to veterans and transitioning servicemembers.[26] Transitioning from military to civilian life can be extremely stressful for new members of the veteran community. Any period of uncertainty elevates the risk of suicide. Passing legislation such as the *Solid Start Act of 2021* will help ensure that risk is as low as possible.

The American Legion supports S.1198 *as currently written*.

S.1220 – United States Cadet Nurse Corps Service Recognition Act of 2021

To amend title 38, United States Code, to recognize and honor the service of individuals who served in the United States Cadet Nurse Corps during World War II, and for other purposes.

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[24] "Executive Order 13822-Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life." Executive Order 13822-Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life | The American Presidency Project, January 9, 2018. https://www.presidency.ucsb.edu/documents/executive-order-13822-supporting-our-veterans-during-their-transition-from-uniformed.

[25] "Joint Action Plan for Supporting Veterans During Their Transition from Uniformed Service to Civilian Life." va.gov, May 3, 2018. https://www.va.gov/opa/docs/joint-action-plan-05-03-18.pdf.

[26] The American Legion Resolution No.12 (2018): *Accountability and Enhancements of Transition Assistance Program, Outcomes and Delivery for Today's Digital Transitioning Servicemembers*

The U.S. Cadet Nurse Corps (CNC) was created in July 1943 to help alleviate the nursing shortage that existed during World War II. The program was open to all women between the ages of 17 and 35 who were in good health and had graduated from an accredited high school. At the time, CNC was the largest of the federal nurse-training programs, allowing young women to serve their country in uniform while being protected by law against discrimination. It operated from 1943 to 1948 and during this period, more than 124,000 student nurses graduated from participating nursing schools. Now, it serves as the only uniformed service from World War II whose members are not recognized as veterans for Department of Veterans Affairs (VA) purposes.

The American Hospital Association credited the cadet student nurses with helping to prevent the collapse of civilian nursing in the U.S. during the war. However, it is their ongoing status as "civilians" that has prevented them from receiving VA benefits. Legislation like the *United States Cadet Nurse Corps Service Recognition Act* will rectify this issue by recognizing service in the CNC with an honorable discharge "active duty" for the purposes of eligibility and entitlement to VA benefits.

It also directs the Secretary of Defense to issue honorable discharge certificates to former CNC members if their service record meets the appropriate criteria necessary for an honorable discharge. This legislation will ensure the large population of women veterans who are not enrolled in VA healthcare, who feel they lack gender specific services, will have their needs met. To fix this problem, The American Legion supports VA's obligation to develop and expand healthcare services for women, the fastest growing demographic in the veteran community.

Through Resolution No. 147: *Women Veterans*, The American Legion supports legislation ensuring the current women veteran population needs are met by VA services and programs.[27] We also support legislation directing VA to provide full comprehensive health services for women veterans' department-wide of all ages. Passing the *United States Cadet Nurse Corps Service Recognition Act* will achieve this outcome and better serve the tens of thousands of older women veterans who need adequate healthcare services.

The American Legion supports S.1220 *as currently written*.

S.1280 – Veteran Families Health Services Act of 2021

To improve the reproductive assistance provided by the DoD and the VA to certain members of the Armed Forces, veterans, and their spouses or partners, and for other purposes.

As of 2021, the Centers for Disease Control and Prevention has reported six percent of women aged 15-44 showed signs of infertility compared to nine percent of men aged 25-44 who reported they or their partner sought advice, testing, or treatment for infertility.[28] This statistic is more

[27] The American Legion Resolution No.147 (2016): *Women Veterans*.
[28] U.S. Department of Health & Human Services. (2021). *Reproductive Health: Infertility Frequently Asked Questions.* Centers for Disease Control and Prevention. Retrieved from: https://www.cdc.gov/reproductivehealth/infertility/index.htm#:~:text=About%206%25%20of%20married%20women,to%20term%20(impaired%20fecundity).

alarming in the veteran population. A 2014 infertility study showed the frequency of lifetime history of infertility was 15.8% for women and 13.8% for men serving in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF).[29] Yet, less than 2% of OEF and OIF women veterans received infertility diagnoses from the Department of Veterans Affairs (VA) and of those 22% received an infertility assessment or treatment.[30]

While VA does offer infertility services, such as in vitro fertilization (IVF), to eligible veterans they are limited and do not include surrogacy and the use of donated genetic material. Currently, IVF services are only offered to veterans enrolled in VA care, legally married with service-connected conditions causing infertility, and the couple must be able to use their own genetic material.[31] The *Veteran Families Health Services Act of 2021* would provide access to these reproductive, surrogacy, and adoption assistance services. This legislation would require coordination between the Department of Defense (DoD) and VA on information sharing, referrals, and genetic material when a servicemember transfers into VA care.

It mandates fertility treatment and counseling be covered for veterans, spouses, partners, or gestational surrogates of covered veterans without regard to the sex, gender identity, sexual orientation, or marital status. Additionally, it would provide adoption assistance and direct a report to be completed on fertility treatment and counseling with a required demographic breakdown of collected data. .[32] The *Veteran Families Health Services Act of 2021* will allow for greater access to comprehensive fertility treatments for veterans looking to expand their families.

As well, the research requirement will provide necessary information on infertility assistance so further VA infertility policy can be informed by evidence-based knowledge. Through Resolution No. 16: *Reproductive Assistance and Pregnancy Counseling*, The American Legion supports legislative efforts to ensure VA provides adequate and appropriate reproductive assistance services to include IVF for all veterans with a service-connected loss of reproductive dysfunction.[33] It is a morale imperative that veterans who have had their ability to reproduce impacted by their service be provided with the same options as their civilian counterparts.

The American Legion supports S.1280 *as currently written.*

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[29] Katon JG, Cyple Y, Raza M, et al. (2014) *Self-reported infertility among male and female Veterans serving during OEF/OIF*. J Womens Health; 23(2):175-183.
[30] Mattocks K, Kross-Desrosiers A, Zephyrin L, et al. (2015). *Infertility care among OEF/OIF/OND women Veterans in the Department of Veterans Affairs*. Med Care; 53(4 Suppl 1):S68-S75.
[31] Department of Veteran Affairs. (2017). *Infertility brochure: VA infertility services*. Retrieved from: https://www.womenshealth.va.gov/WOMENSHEALTH/docs/InfertilityBrochure_FINAL2_508.pdf#
[32] Department of Veteran Affairs. (2017). *Infertility brochure: VA infertility services*. Retrieved from: https://www.womenshealth.va.gov/WOMENSHEALTH/docs/InfertilityBrochure_FINAL2_508.pdf#
[33] The American Legion Resolution No.16 (2021): *Reproductive Assistance and Pregnancy Counseling*

S.1319 – VA Quality Health Care Accountability and Transparency Act

To direct the Secretary of Veterans Affairs to make certain information publicly available on one internet website of the VA.

The Department of Veterans Affairs (VA) has a long history of major issues with the complexity of their numerous websites which makes it difficult for many veterans to navigate their VA records and manage their care. These sites include My HealtheVet, eBenefits, and now Cerner's new database for the electronic health record modernization. This complexity is only exacerbated by VA's history of patient wait times, quality of care, and frequent staffing shortages. A Government Accountability Office (GAO) report found VA failed to disclose wait time, patient safety, and quality of care information in an easily accessible and usable manner.[34]

The American Legion has a long-standing tradition of holding VA accountable for providing the quality of care this nation's veterans deserve. This includes ensuring information regarding key aspects of VA care is easily accessible to guarantee the high standards we expect from VA are maintained as well as enabling the identification of best practices and areas VA can improve. Each year, The American Legion conducts a series of site visits to VA medical facilities and Regional Offices. While on site, they meet with veterans, their families, and VA administrators and employees to discuss successes, challenges, and limitations at each site. These observations are compiled annually in a report titled System Worth Saving that is distributed to VA officials, members of Congress, and the President of the United States.

This draft legislation would improve the overall quality of VA care through enhanced accountability and transparency of services by streamlining how information is disclosed. This will be achieved by ensuring certain information, such as staffing and patient wait time information, is publicly available on a single, easily accessible website. The bill would also require the information be updated regularly and there are regular audits and reports of the information to ensure accuracy. Through Resolution No. 194: *Department of Veterans Affairs Veteran Integrated Service Networks,* The American Legion supports legislation which would mandate studies and reviews of Veterans Health Administration (VHA) "in order to better provide timely access and quality healthcare for veterans."[35]

The American Legion supports S.1319 *as currently written*.

[34] Government Accountability Office. *VA Should Improve the Information It Publicly Reports on the Quality of Care at Its Medical Facilities.* (2017). [online] Available at: https://www.gao.gov/assets/gao-17-741.pdf. [Accessed April 8, 2021]

[35] The American Legion Resolution No.194 (2016): *VA Veteran Integrated Service Networks*

S.1467 – VA Medicinal Cannabis Research Act of 2021

To direct the Secretary of Veterans Affairs to carry out a series of clinical trials on the effects of cannabis on certain health outcomes of veterans with chronic pain and post-traumatic stress disorder, and for other purposes.

In 1970, the Controlled Substances Act was signed into law combining all previously existing federal drug laws into a single statute.[36] The statute regulated the manufacturing and distribution of controlled substances including stimulants, narcotics, depressants, and hallucinogens.[37] These substances were further categorized into five classifications based upon the potential for abuse. According to the Drug Enforcement Administration (DEA), Schedule I drugs have the highest potential for abuse and severe psychological and/or physical dependence.[38] By definition, the DEA looks at these types of Schedule I substances as having no accepted medical use and a high potential for abuse. This is why other Schedule I drugs include heroin, ecstasy, and lysergic acid diethylamide (LSD).

Marijuana (cannabis) is currently listed as one of these Schedule I substances. Designating cannabis as a Schedule I substance makes it extraordinarily challenging to conduct necessary research on the use of medical marijuana as a treatment option for veterans suffering from chronic pain and mental health conditions. Legislation like the *VA Medicinal Cannabis Research Act of 2021* will help alleviate these stringent guidelines by directing the Secretary of Veterans Affairs to carry out a series of clinical trials on the effects of medical grade marijuana on certain health outcomes of veterans with chronic pain and post-traumatic stress disorder (PTSD)

Clinical trials would include an evaluation of the effects of the use of cannabis on osteopathic pain, the reduction/increase in opioid use/dosage, sleep quality, agitation, and quality of life to name a few. With respect to covered veterans diagnosed with PTSD, an evaluation would be directed on the effects of the use of cannabis on the symptoms of PTSD as established by or derived from the clinician administered PTSD scale, the PTSD checklist, and other applicable methods of evaluating PTSD symptoms. This legislation ensures there is adequate and appropriate research done on the impacts of medicinal cannabis.

Through Resolution No. 11: *Medical Marijuana Research,* The American Legion supports efforts to enhance medical cannabis research, urges Congress to remove cannabis from the Schedule I controlled substance list, and believes the DEA should license privately funded medical marijuana production operations in the U.S.[39] Any medical cannabis research legislation should take into consideration clinical trials that track the developing of symptoms related to Cannabis Use Disorder. Enabling safe and efficient cannabis drug development research is vital to providing

[36] Hudak, J. (2016). RICHARD NIXON FIRES THE OPENING SHOTS IN THE WAR ON DRUGS. In *Marijuana: A Short History* (pp. 49-58). Washington, D.C.: Brookings Institution Press. Retrieved from http://www.jstor.org/stable/10.7864/j.ctt1hfr1qj.8

[37] Reuters, T. (2019). *The Controlled Substances Act: Overview.* Retrieved from https://criminal.findlaw.com/criminal-charges/controlled-substances-act-csa-overview.html

[38] United States Drug Enforcement Administration. (n.d.). *Drug Scheduling.* Retrieved from https://www.dea.gov/drug-scheduling

[39] The American Legion Resolution No.11 (2016): *Medical Marijuana Research*

innovative evidence-based, complementary, and alternative medicine to veterans in the treatment of chronic pain and mental health disorders. It is imperative that VA continue to explore alternative treatments to ensure those suffering from PTSD and chronic pain are provided the best possible care.

The American Legion supports S.1467 *as currently written.*

S.1863 – Guaranteeing Healthcare Access to Personnel Who Served Act

A bill to amend title 38, United States Code, to improve access to healthcare for veterans, and for other purposes

The future of VA healthcare is a hybrid and agile system that can fully leverage all the tools at its disposal to address the needs of an increasingly diverse veteran population. Passage of the American Legion-supported *VA MISSION Act of 2018* has given the Department of Veterans Affairs (VA) important tools to improve access to high-quality care either in person at VA facilities, virtually through tele-health, or with increased community care options. The means by which VA delivers care may change, but one thing won't: VA should continue to deliver the best care anywhere to our nation's veterans.

Access standards are crucial to the MISSION Act's success and must be applied uniformly to VA and to community providers in the Third-Party Administrator (TPA) networks. In recent years, VA has developed online tools and mobile applications to help veterans self-schedule internal Veterans Health Administration (VHA) care. In the case of community care, veterans are only able to self-schedule community care appointments online in limited instances and must be assigned to a Veterans Integrated Services Networks (VISN) that has proactively enabled the function. VA has expanded self-scheduling for community care but has not made the technological advances necessary to streamline and efficiently roll out self-scheduling online.

In most instances, VA provides an authorization letter the veteran presents to the community provider to schedule an appointment if the veteran is interested in self scheduling. These have led to inefficiencies within the system and created roadblocks for veterans in rural areas. The American Legion encourages a well-defined and consistent community care coordination program, policy and procedure that includes a patient-centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account. Every veteran does not live within 30 minutes of a VHA facility and not every VHA facility has the staff and resources to schedule an appointment for the veteran within 20 days.

Veterans in rural areas face more severe problems with access and The American Legion has supported more service programs benefiting rural people to fulfill The American Legion's commitment of service to all veterans. This legislation codifies existing access standards for the Veterans Community Care Program (VCCP) eligibility and creates uniformed patient-centered standards for community care across the different regions and TPAs. With codification, future generations of veterans will be more assured of access to community care when it makes sense for

them. This ensures access for the veteran, regardless of if they live in a rural or urban community, in cases where VHA facilities are scarce, or drive-times are too great for reasonable access.

Through Resolution No. 46: *VA Non-VA Care Programs*, The American Legion supports legislation to require VA to develop a well-defined and consistent non-VA care coordination program, policy and procedure that includes a patient-centered care strategy which takes veterans' unique medical injuries and illnesses as well as their travel and distance into account.[40]

The American Legion supports S.1863 *as currently written*.

S.1875 – Veterans' Emergency Care Claims Parity Act

A bill to amend title 38, United States Code, to provide a deadline of 180 days for the filing of claims for payment for emergency treatment furnished to veterans, and for other purposes.

Claims for non-Department of Veterans Affairs (VA) care are processed through the Claims Adjudication and Reimbursement (CAR) Directorate under VA's Office of Community Care (OCC). According to a 2019 Office of Inspector General (OIG) report, VA audit team's nationwide accuracy review found an estimated 31% of denied or rejected non-VA emergency care claims were inappropriately processed by CAR staff.[41] It also found approximately 17,400 veterans, with bills totaling at least $53.3 million, were negatively affected during the audit period.[42]

If corrective action is not taken, the OIG report noted these errors could result in $533 million in improper underpayments to claimants over five years. Now, because of inappropriately processed claims, veterans are forced to carry the financial burden of covering expensive services rendered like emergency care bills. The *Veterans' Emergency Care Claims Parity Act* would help fix this problem by extending the timeline to submit claims for veterans from 90 to 180 days and relinquish veterans from any liability to pay for emergency treatment if the claim for direct payment was submitted after the deadline due to administrative error.

It calls for the Secretary of Veterans Affairs to publish, on at least one publicly available internet website, a list of all authorities to authorize emergency care from non-VA providers and their corresponding deadline for submission of claims, a summary of steps so non-VA providers can assure compliance with the claims-filing process, and their associate contact information. This legislation will address the financial burden faced by many veterans who visit an emergency department by ensuring they do not have to pay for more than they are required.

In the past, The American Legion has worked to fix this issue by joining other Veterans Service Organizations (VSO) in sending a letter to the Secretary of Veterans Affairs urging him to compel

[40] The American Legion Resolution No.46 (2012): *VA non-VA care programs*
[41] Department of Veterans Affairs Office of Inspector General. (2019). *Non-VA Emergency Care Claims Inappropriately Denied and Rejected.* Retrieved from https://www.va.gov/oig/pubs/VAOIG-18-00469-150.pdf
[42] Department of Veterans Affairs Office of Inspector General. (2019). *Non-VA Emergency Care Claims Inappropriately Denied and Rejected.* Retrieved from https://www.va.gov/oig/pubs/VAOIG-18-00469-150.pdf

VA to reimburse veterans for emergency medical expenses incurred at non-VA facilities.[43] Through Resolution No. 2: *Uniform Payment Policy for Emergency Care at Non-Department of Veteran Affairs (VA) Medical Center*, The American Legion believes VA must promptly pay non-VA providers for emergency care furnished to veterans. Veterans will no doubt benefit from the implementation of the *Veterans' Emergency Care Claims Parity Act*.[44]

The American Legion supports S.1875 *as currently written.*

S.1965 – Planning for Aging Veterans Act

A bill to direct the Secretary of Veterans Affairs to improve long-term care provided to veterans by the VA, and for other purposes.

During a House Committee on Oversight and Reform hearing, the Department of Veterans Affairs (VA) testified that 50 percent of all veterans currently enrolled in the Veterans Health Administration (VHA) healthcare system are 65 years old or older, with enrolled veterans aged 75 and older, projected to increase by 46 percent between 2018 and 2028.[45] Under the 85 years-of-age and older demographic, VHA enrolled veterans increased almost 300 percent between 2003 and 2018 with projections showing the expectation of a 500 percent surge by 2038. One of the results of this is an increase in demand for long-term services and support. Previously, this support has been provided by family members with women providing most of the care.

Unfortunately, the consequence is VA continues to face challenges meeting the demands for future long-term care for aging veterans because they have not yet fully addressed its inconsistencies in management of its long-term programs. Moreover, they have struggled with the standardization process across all VA medical centers to enter into sharing agreements with State Veteran Homes (SVH), geriatric psychiatry assistance, SVH inspection reports, and working with public housing authorities and local organizations to assist aging homeless veterans. The *Planning for Aging Veterans Act* fixes these issues by paving the way for future investments in long-term care, improving VA's relationship with SVH's, and expanding the care veterans receive in SVH's.

This legislation requires VA to develop a strategy addressing current and future long-term care needs of aging veterans to identify areas for future investment and standardizes the process VA-wide for medical centers entering into sharing agreements with SVH's. It requires any deficiencies during SVH inspections be reported to VA and inspection reports be publicly published on VA website. As well, it would create a pilot program to provide geriatric psychiatry assistance to eligible veterans in SVH's and instruct VA to work with public housing authorities and local

[43] The American Legion. (2021). *American Legion, VSOs urge VA Secretary to reimburse veterans.* Retrieved from https://www.legion.org/veteransbenefits/251841/american-legion-vsos-urge-va-secretary-reimburse-veterans
[44] The American Legion Resolution No.2 (2009): *Uniform payment policy for emergency care at non-VA medical center facilities*
[45] "Statement Of Dr. Teresa Boyd Assistant Under Secretary for Health for Clinical Services VHA Department of Veterans Affairs Before The House Committee on Veterans Affairs Subcommittee on Health." Veteran Health Administration (VHA), July 29, 2020. https://www.congress.gov/116/meeting/house/110943/witnesses/HMTG-116-VR03-Bio-BoydT-20200729.pdf.

organizations to assist aging homeless veterans in accessing existing housing and supportive services.

Additional bill provisions include directing each VA medical center to use a standardized process when entering sharing agreements with SVH's and instructing the waiver of prescription copayments for catastrophically disabled veterans residing within SVHs. Furthermore, it would codify a GAO recommendation by requiring, no less than quarterly, the Secretary of Veterans Affairs to review SVH inspection results. This legislation will improve long-term care provided to veterans by ensuring better VA quality assurance initiatives at SVH's.

In 2008, The American Legion testified before Congress and advocated VA discontinue the collection of copayments from veterans deemed catastrophically disabled because this practice is unconscionable and warrantless when measured against the sacrifices veterans made in serving this nation. Today, The American Legion has an active Homeless Veterans Task Force to coordinate and direct assistance and advocacy. Through Resolution No. 140: *Policy on SVH Inspections,* The American Legion supports effective and judicious SVH inspections through a consolidated process.[46]

The American Legion supports S.1965 *as currently written*.

S. 2102 - Supporting Expanded Review for Veterans in Combat Environments (SERVICE) Act

A bill to direct the Under Secretary for Health of the VA to provide mammography screening for veterans who served in locations associated with toxic exposure.

Breast cancer is the single greatest cause of cancer deaths among women under 40 and a significant cause of mortality for women in the U.S. Armed Forces. In the U.S. alone, it is estimated there will be over 280,000 new cases of breast cancer by the end of 2021. Those within the veteran and military population are estimated to be at a 20 to 40 percent higher risk than the general population. Those female servicemembers exposed to toxic substances during service are also found to have higher rates of breast cancer. A 2021 study published through Department of Veterans Affairs (VA) showed breast cancer rates have tripled from 1995 to 2012.

Under current law, VA's policy on breast cancer mammogram screening for veterans advises screening based on age, symptoms, or family history – Not based on toxic exposures. Further worsening the issue is a high percentage of female veterans are not enrolled in VA due to the lack of those gender-specific services. Legislation such as the *SERVICE Act* helps to bridge this gap. It would revise the current guidance to include female veterans who served in areas associated with burn pits and other toxic exposures and direct VA to conduct a mammogram screening for female veterans who served in areas associated with burn pits.

[46] The American Legion Resolution No.140 (2008): *Policy on SVH Inspections*

Mammograms can detect breast cancer up to two years before the tumor can be felt by an individual or doctor.[47] Authorizing mammogram screenings for female veterans in relation to geographic locations of toxic exposure can increase the chances of identifying the presence of cancer early. An early diagnosis of breast cancer can both increase treatment options and the chances of survival. Every female veteran deserves the chance to prevent premature death because of an illness obtained while serving their country.

In 2010, The American Legion testified in support of the *Armed Forces Breast Cancer Research Act* which would have required the Department of Defense (DoD) and VA to collaboratively study the incidence rate of breast cancer in servicemembers and veterans. Through Resolution No. 239: S*upport Research About Breast Cancer*, The American Legion supports efforts to urge VA to develop a comprehensive study to determine if breast cancer is increasing at a faster rate for military personnel exposed to toxins compared to the civilian population.[48]

The American Legion supports the discussion draft *as currently written*.

Discussion Draft – the Building Solutions for Veterans Experiencing Homelessness Act

To improve grants, payments, and technical assistance provided by the Secretary of Veterans Affairs to serve homeless veterans, and for other purposes.

Veteran homelessness has been a persistent issue which has only been further aggravated by the COVID-19 pandemic. A lack of affordable housing in many communities has contributed as well. In some cases, the Grant and Per Diem Program (GPD) has been grossly understaffed and unable to properly accommodate the needs of the increased homeless veteran population. Even those who do receive GPD assistance have been found to not fully understand the service and lack the technical skills to utilize it. At the same time as these homeless veterans are facing housing insecurity, they are often struggling with other substance use disorders because of PTSD.

This has created a need for the modernization of the GPD program and additional substance abuse treatment resources for homeless veterans. This discussion draft bridges those gaps by directing the Department of Veterans Affairs (VA) to allot no less than 2% of program VA GPD funding to provide help in the form of training and technical assistance to grant awardees. It would increase Homeless Veteran Reintegration Programs funding to $75 million and extend it to 2025. Furthermore, it would establish a pilot program using grants for substance use disorder treatment and authorize an evaluation of the shallow subsidy program for veteran families.

Other provisions include requiring an evaluation to outline the availability of affordable housing for veteran through the VA Homeless Programs and creating a program composed of navigators who assist homeless veterans navigating housing and health related resources. This legislation benefits those most at risk of experiencing homeless by providing additional assistance they would

[47] Cancercare. (2021). *Breast Cancer: Understanding Risk Factors and Screening*. Cancercare.org. Retrieved from: https://www.cancercare.org/publications/82-breast_cancer_understanding_risk_factors_and_screening
[48] The American Legion Resolution No.239 (2004): *Support research about breast cancer*

not otherwise have. Increasing access to resources for the most at-risk veterans, including those who are homeless, is vital to the overall health of the individual veteran.

The American Legion has long advocated in support of legislative efforts to reduce veteran homelessness. We continue to support increasing access to technical assistance for GPD providers and expanding programs and resources to meet a demonstrated need for services to end veteran homelessness. As well, we support assisting veterans struggling with substance abuse disorders via programs like the Veterans Treatment Courts and veteran mentor programs. Through Resolution No, 24: *Support Funding and Changes to the VA Grant and Per Diem Program*, The American Legion supports efforts to enhance funding for VA grant and per diem programs.[49]

The American Legion supports the discussion draft *as currently written*.

Discussion Draft – Department of Veteran Affairs Provider Accountability Act

To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to enforce licensure and related requirements for healthcare professionals of the VAs, and for other purposes.

A troubling 2018 Government Accountability Office (GAO) report revealed a startingly trend of Department of Veterans Affairs (VA) facilities failing to report providers who made major medical errors to the National Practitioner Data Bank and the relevant state licensing boards responsible for tracking dangerous practitioners.[50] In many cases, these practitioners can go into private practice or move across state lines without disclosing prior mistakes to patients or state regulators while continuing to provide substandard care.[51] To ensure veterans receive consistent care, VA must hold its healthcare professionals to a dependable standard. Corrective action must be taken after identifying healthcare professionals that meet generally accepted standards of clinical practice.

The *Department of Veteran Affairs Provider Accountability Act* achieves this outcome by directing the Secretary of Veterans Affairs to monitor VA medical centers to confirm they are complying, verifying, and reviewing documentation for every healthcare professional employed. Documentation includes licensure, certification, and registration. As well, this documentation would cover whether they are registered with the Drug Enforcement Administration and their education, training, experience, malpractice history, and clinical competence. Additionally, it would mandate training take place no less than twice a year on duties including compiling, validating, and reviewing the credentials of healthcare professionals, the quality of clinical care, and determinations relating to disciplinary actions.

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[49] The American Legion Resolution No.24 (2018): *Support Funding and Changes to the VA GPD Program*

[50] Silas, Sharon M., Randall B. Williamson, Marcia A. Mann, Kaitlin M. McConnell, Summar C. Corley, Krister Friday, Jacquelyn Hamilton, Vikki Porter, and Brienne Tierney. *VA HEALTH CARE: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*. Report no. GAO-18-63. Government Accountability Office. 1-32.

[51] Cassidy B. (2021). *Cassidy, Colleagues Introduce Bipartisan Legislation to Hold VA Providers Accountable.* Retrieved from https://www.cassidy.senate.gov/newsroom/press-releases/cassidy-colleagues-introduce-bipartisan-legislation-to-hold-va-providers-accountable-

When generally accepted medical standards are upheld, quality-of-care increases. This legislation will ensure a consistent continuity of high-quality care conducted by healthcare professionals with adequate and appropriate training and credentials. More importantly, it will ensure no person will receive care from a healthcare professional who is negligently concealing a negative professional background. Veterans deserve better and it is the responsibility of Congress to fix this issue as soon as possible.

To this day, we remain concerned about the lack of accountability within VA and have supported similar legislation to S.1307 that provides the Secretary of Veterans Affairs the legal authority to better manage all VA employees and hold them accountable when they fail to perform their duties in a manner befitting of a federal employee who veterans have entrusted their care too. Through Resolution No. 377: *Support for Veteran Quality of Life*, The American Legion supports this legislation.

The American Legion supports S.1307 *as currently written*.

Conclusion

As always, The American Legion thanks this committee for the opportunity to explain the position of the nearly 2 million veteran members of this organization. For additional information regarding this testimony, please contact Mrs. Olivia Babine at (202) 861-2700 or OBabine@legion.org

Questions for the Record

Department of Veterans Affairs (VA)
Questions for the Record
Committee on Veterans' Affairs
United States Senate
Hearing on Pending Legislation
June 23, 2021
Questions for the Record from Ranking Member Jerry Moran

Virtual Care for Veterans in Rural and Highly Rural Areas

Question 1. **Dr. Upton, my staff and I have repeatedly shared our concerns with the Department regarding issues for veterans in rural and highly rural areas in obtaining high-quality virtual care from the VA during the pandemic. The primary answer we have received from VA on a solution is that the Department is giving 5G-enabled iPads to veterans, though connectivity barriers continue to persist for veterans in VA's care who reside in rural and highly rural areas. Do you have anything more, besides giving iPads to veterans and the ATLAS partnership, you can share with the Committee on how VA is trying to find innovative solutions for our rural and highly rural veterans?**

VA Response: VA plans to utilize fiscal year (FY) 2022 funding to maximize highquality virtual care options for Veterans through VA's continuing efforts to improve access to broadband-delivered services on three fronts. First, VA will continue to improve the telehealth capacity of our highly rural community-based outpatient clinics to facilitate equitable, clinic-based access to both primary and specialty care services in hard-to-reach rural and highly rural communities. Second, through our participation in the Administration's multi-agency Rural Health Interagency Policy Committee (IPC) and Rural Prosperity IPC, VA will continue to vigorously advocate for expanding broadband service into rural and highly rural communities. Finally, VA will continue to expand services in our 18 Clinical Resource Hubs (CRH), which already provide primary and mental health care to thousands of rural Veterans every day, to capture specialty care services that are increasingly difficult to find in rural and highly rural communities. VA's commitment to specialty care in our CRHs is reflected in its expansion from FY 2021's access to 9 different specialty care services to more than 20 specialties in FY 2022 in all 18 CRHs. These specialties include Immunology, Cardiology, Endocrinology, Oncology, Geriatrics, Infectious Disease Care and 15 more, all focused on ensuring rural Veterans have equitable access to the highest quality virtual care.

"Warstopper" Program / Supply Chain Item List, Strategy, and Costs

Question 2. **You have previously said that the use of a program like the DLA's "Warstopper" Program reduces the risk of impacts to the delivery of healthcare and strengthens the responsiveness and the reliability of VA's supply chain by ensuring dedicated availability of products while minimizing financial exposure for products that are most needed during emergency operations.**

Question 2a. **What is the delay in providing an item list to this committee and DoD?**

VA Response: Executive Order (EO) 14001, A Sustainable Public Health Supply Chain (January 21, 2021), directed multiple agencies, including VA, to identify critical materials, treatments and supplies. VA requires the results of that work to determine critical items, as described in section 2(a) of the "VA Supply Chain Resiliency Act." The Executive Office of the President is awaiting the signatures of the Secretaries of Defense and Homeland Security on the Pandemic Supply Chain Resilience Strategy (Strategy). The Secretaries of VA and Health and Human Services signed the Strategy on July 20, 2021. Following acceptance by the President, the Supply Chain IPC will begin meeting biweekly to address the implementation approach for the Strategy and the associated industrial base expansion. VA recommends the "VA Supply Chain Resiliency Act" allow 365 days from completion of the cost estimate of the EO 14001 process to deliver the "description of the items and types of items the Secretary considers critical." This will ensure that VA aligns with the President's Strategy to develop a public health supply chain that can withstand, adapt to and recover from disruptions.

Question 2b. **Do you commit that after July 20, 2021, you will share your strategy and its costs with this committee?**

VA Response: After the Strategy is accepted by the President, the participating agencies will identify critical materials, treatments and supplies required to maintain a supply chain that is flexible, equitable and provides adequate access during a pandemic or other emergency. VA can then initiate the cost estimate and strategy development, ensuring VA aligns with the President's Strategy. Additionally, VA/ Defense Logistics Agency require an industrial base analysis to determine the best method(s) to support VA readiness.

Foreign Medical Program

Question 3. **Dr. Upton, the last update made to the VA's Foreign Medical Program was a law passed in the year 2000. The world and America's veteran population look very different now. With many thousands of veterans living overseas I am interested in how best we can reach them with care and support more on par with veterans living within the United States. Could you speak to the Department's awareness of any disparities amongst veterans or administrative challenges to overseas veterans in using the Foreign Medical Program?**

VA Response: In June 2018, VA updated its regulations concerning the Foreign Medical Program (FMP). 83 FR 29448. The authorities for medical care and services provided under the FMP differ from those for Veterans receiving care and services within the United States. The existing statute, 38 U.S.C § 1724 (Hospital care, medical services and nursing home care abroad), generally authorizes care and services only for treatment of a service-connected disability or as part of a rehabilitation program under Chapter 31. As a result of this, a Veteran residing abroad may not receive reimbursement for care and services for the treatment of all their medical conditions.

Many providers outside of the U.S. require patients to pay upfront before services are rendered. VA cannot provide advance payment under FMP and must wait for a bill to determine if there will be reimbursement. Some providers do not issue itemized bill invoices that have all the required information needed for FMP reimbursement. Without the detailed information, VA cannot determine if the care meets the requirements for care under FMP and can be reimbursed.

Statements for the Record

STATEMENTS FOR THE RECORD

STATEMENT OF

TAMMY BARLET, ASSOCIATE DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

FOR THE RECORD

UNITED STATES SENATE
COMMITTEE ON VETERANS' AFFAIRS

WITH RESPECT TO

"Pending Legislation"

WASHINGTON, D.C. June 23, 2021

Chairman Tester, Ranking Member Moran, and members of the Senate Committee on Veterans' Affairs, on behalf of the men and women of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on these important pieces of legislation pending before the committee.

S. 372, Ensuring Quality Care for Our Veterans Act

The VFW supports this legislation that would require the Department of Veterans Affairs (VA) to conduct a clinical review of care furnished by VA health care professionals who had their licenses to practice terminated for cause.

It is unacceptable to endanger the lives of our nation's veterans by hiring health care professionals with suspended licenses. There have been several egregious examples of VA doctors who commit malpractice under VA's watch, but should never have been allowed to provide care to veterans. This bill would rightfully ensure that VA health care professionals who had their licenses terminated in the past and are currently employed by VA are providing high quality care. If not, VA would be required to provide a clinical disclosure of adverse events to impacted patients. Doing so would ensure patients know their rights and options for recourse.

S. 539, A bill to direct the Secretary of Veterans Affairs to submit to Congress a report on the use of video cameras for patient safety and law enforcement at medical centers of the Department of Veterans Affairs.

The VFW supports this proposal to assess VA medical center video camera equipment and the appropriate placement of such equipment.

VA police officers protect veterans, their families, and VA employees by deterring and

preventing crime, maintaining order, and investigating crimes. However, VA police officers cannot be everywhere all the time. VA medical center video cameras provide eye-in-the-sky surveillance for public safety. This legislation would provide a review of VA's policies and procedures of camera placement, surveillance, equipment maintenance, data storage, and any gaps or barriers VA faces in providing a sense of security and trust to veterans, their families, and VA staff.

S. 544, A bill to direct the Secretary of Veterans Affairs to designate one week each year as "Buddy Check Week" for the purpose of outreach and education concerning peer wellness checks for veterans, and for other purposes.

This past year taught us to check in with each other more so than we ever have before. The pandemic forced isolation and social distancing from our friends and families, which led to a higher rate of loneliness and depression. Last spring, VFW Post 12063 in Westcliffe, Colorado, devoted time and resources to buddy checks. Not only did the calls provide an opportunity to check in with other local veterans, but the VFW members also relayed information regarding food assistance and other resources.

The VFW supports this legislation that would establish a designated week annually to promote outreach and education of wellness checks. Providing scripts and training both online and in-person will provide veterans the tools and knowledge for successful buddy checks.

S. 613, PAWS for Veterans Therapy Act

With such a high ratio of veterans who have defended our nation being diagnosed with post-traumatic stress disorder (PTSD), VA must provide veterans mental health care options that work best for them. Recent studies show service dogs provide positive health care outcomes in veterans with PTSD. Such studies illustrate a reduction in symptoms from the PTSD checklist, lowered effects of anxiety and depression disorders, as well as a reduced need for psychopharmaceutical medications.

Many studies and anecdotal notes have found veterans with service dogs decrease their use of medications such as opioids for chronic pain linked to PTSD. Veterans who have service dogs also experience increased participation in social settings and overall satisfaction with life. Also, ensuring the veterans actively participate and receive training will give them accountability and a sense of purpose in their treatment.

The VFW supports this legislation to authorize VA to provide service dogs to veterans with mental illnesses who do not have mobility impairments through grants to eligible organizations. Also, the VFW strongly supports the continuance of care this legislation would require to maintain canine health insurance eligibility. Continuation of care is crucial to overcome any illness successfully, whether it is physical or mental. VA maintaining coverage of a service dog only if the veteran continues to see their physician or mental health care provider every six months helps to ensure more consistent and open communication between the medical provider and veteran.

S. 727, CHAMPVA Children's Care Protection Act of 2021

The VFW supports this legislation to cover young adult children up to age 26 and eligible for medical care under the CHAMPVA program at no additional cost. Extending medical care coverage to adult children under the age of 26 is a significant benefit of the Affordable Care Act that touches many families. Unfortunately, families with children eligible for CHAMPVA were not bound by this requirement. This proposal would eliminate that barrier to care and provide the same benefits as those families who use employer-based plans.

S. 796, Protecting Moms Who Served Act of 2021

The VFW supports this proposal to structure VA's maternity care coordination programs to provide community maternity care providers with training and support concerning the unique needs of pregnant and postpartum veterans. This legislation would also require a report on maternal mortality and severe maternal morbidity among veterans, infant mortality rate, and additional outcomes focused on racial and ethnic disparities in maternal health.

Women veterans of childbearing age comprise the second largest age group enrolled in VA health care. VA covers 5,000-6,000 deliveries per year. A small percentage of women veterans who responded to a VFW survey stated they received prenatal care from VA, and 75% of them continued to receive VA health care after pregnancy. The VFW asks VA and the Center for Women Veterans to continue to use targeted outreach for postpartum women veterans to ensure they continue their care at VA.

This legislation would provide an understanding of fertility and infertility of women veterans, and shed light where gaps and barriers may exist. VA can use this information to support the vital programs and policies to assist women veterans with healthy pregnancies, deliveries, and postpartum care.

S. 1198, Solid Start Act of 2021

The VFW supports this proposal to evaluate and continue to support the Solid Start program.

To help bridge the gap and ensure veterans are making a successful transition, the VA Solid Start program makes three attempts to contact the veteran over the first year of separation. According to VA, within the first year the VA Solid Start program connected with almost 70,000 recently separated veterans, which was 60 percent of those veterans separated in fiscal year 2020. During the conversation, the veteran is made aware of the benefits offered by VA and how to access mental health care and suicide prevention resources. The transparency of the Solid Start program can shed light on gaps that remain for transitioning veterans.

S.1280, Veteran Families Health Services Act of 2021

The VFW would like to thank Senator Murray for expanding fertility and adoption benefits for severely wounded veterans who have lost their ability to reproduce due to their service-connected injuries.

This legislation would create a report and transparency of the fertility treatment and counseling provided by VA, which would provide the answers and identify gaps to meet the long-term reproductive health care needs of veterans. It is important to know who was diagnosed with clinical infertility, received fertility treatment or counseling, self-reported fertility difficulty or successfully carried a pregnancy to term, or was exposed to chemical or biological toxins. The key components to the transparency of the program are cost factor and average wait time for fertility treatment and counseling, the number of available providers within VA and in the community, and the average time for claims payment.

Service-connected injuries, toxic exposures, and other health issues can destroy a veteran's dream of having a family. VA's current in vitro fertilization treatment eligibility excludes certain veterans from using this program to achieve that dream. The VFW supports this legislation to improve, expand, and make permanent reproductive assistance for veterans and their spouses or partners.

S. 1467, VA Medicinal Cannabis Research Act of 2021

This legislation would require VA to conduct scientific studies on the efficacy of medicinal cannabis. The VFW is proud to support this important bill and thanks this committee for its consideration.

Prescribed use of opioids for chronic pain management has unfortunately led to addiction for many veterans, as well as for many other Americans. VA uses evidence-based clinical guidelines to manage pharmacological treatment of PTSD, chronic pain, and substance use disorder because medical trials have found opioids to be effective. To reduce the use of high-dose opioids, VA must expand research on the efficacy of non-traditional medical therapies, such as medicinal cannabis and other holistic approaches. Veterans who use medical cannabis and are also VA patients are doing so without the medical understanding or proper guidance from their coordinators of care at VA.

Medicinal cannabis is currently legal in 36 states and the District of Columbia. This means veterans are able to legally obtain cannabis for medical purposes in more than half the country. The Centers for Disease Control and Prevention's data show synthetic opioid deaths over the past year increased by more than 38 percent. Although, a recent study in the *British Medical Journal* found counties in the United States that increased from one to two dispensaries had a 17 percent decrease in opioid deaths.

Many states have conducted research for mental health, chronic pain, and oncology at the state level. A comprehensive study by the National Academy of Sciences and the National Academies Press also concluded that cannabinoids are effective for treating chronic pain, chemotherapy-induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia, all of which are prevalent in the veteran population. While VA has testified that it has the authority to study Schedule 1 drugs, it has failed to do so and veterans are tired of waiting for VA. This bill would prevent VA from further delaying needed research.

Veterans Health Administration (VHA) Directive 1315, Access to VHA Clinical Programs for Veterans Participating in State-Approved Marijuana Programs, provides protections for veterans who use medicinal cannabis. This directive is for those veterans fortunate to live in states with approved marijuana programs, but not for all veterans who use VHA. Veterans who discuss their use of medicinal cannabis with their doctors perceive they will ostracized and have their medications changed or discontinued. The fear of reprisal for medicinal cannabis prevents veterans from disclosing information to their VA health care providers, which can lead to problems caused by drug interactions. The VFW recommends VA to create clear and concise policies and procedures for medical marijuana use and to make that information widely available.

The VFW supports the *VA Medicinal Cannabis Research Act of 2021.* This legislation would move VA toward understanding the therapeutic potential of cannabis for veterans. VFW members tell us that medicinal cannabis has helped them cope with chronic pain and other service-connected health conditions. They cannot receive these services at VA because of VA's bureaucratic hurdles.

S.1863, Guaranteeing Healthcare Access to Personnel Who Served Act

The VFW supports the intent of this bill to improve access to health care for veterans. However, we caution against setting into law access standards based on data collected from the past two years. Half that time period was during a global pandemic when all health care systems were pivoting to provide care in a safe and timely manner. This legislation would ask the Secretary to not take VA telehealth appointments into consideration when referring care to the community. A veteran has the choice of in-person or telehealth appointments, with the understanding that not all specialties work best through telehealth. Although, the veteran should be made aware of VA telehealth appointment options before being referred to the community care network.

The remaining sections of the legislation provide multiple opportunities for veterans to advocate and be active participants in their health. The ease of e-booking either a VA or a community care network appointment alleviates the anxiety of waiting on hold and the time constraint of calling into the scheduling call center. An e-booking platform would provide the veteran with a visual of the available appointments instead of listening to a scheduling call center staff member state what dates and times are available. In addition, a centralized location for an online health care education portal can assist the health care providers to empower and educate veterans on their health and well-being.

VA telehealth video appointments increased by 1000 percent in the first few months of 2020 due in part to the COVID-19 pandemic. The VFW is proud to be part of the solution. Through Accessing Telehealth through Local Area Stations (ATLAS) pod sites, the VFW has worked with VA and Philips to leverage VA's anywhere-to-anywhere authority to expand telehealth options for veterans who live in rural areas or who may lack access to the internet, necessary equipment, and knowledge to facilitate VA Video Connect (VVC) appointments. In addition to secure and private VVC connectivity, the ATLAS locations contain a full suite of telehealth devices, such as blood pressure cuffs, scales, oximeters, thermometers, and glucose monitors. So far, there are five VFW post ATLAS locations nationwide. Therefore, a report analyzing the

effectiveness of health care services through telehealth, veteran satisfaction, identifying VA's challenges to deliver telehealth care, strategies to overcome connectivity issues, and ways to strengthen telehealth services would be beneficial for future outreach and initiatives.

Veterans with a service-connected disability living abroad and who receive medical care for their disability can file a claim with the Foreign Medical Program (FMP). They are a niche veteran population that is too often forgotten. The VFW has members who live abroad and utilize the FMP. Their great concern is access to the COVID-19 vaccine, especially if they cannot quarantine and travel round trip to the Philippines. This legislation outlines a report to understand the veterans, caregivers, and FMP, and to identify the challenges, gaps, and barriers to care.

S.2102, A bill to direct the Under Secretary for Health of the Department of Veterans Affairs to provide mammography screening for veterans who served in locations associated with toxic exposure.

The VFW supports the *Supporting Expanded Review for Veterans in Combat Environments (SERVICE) Act of 2021*, which would direct VA to provide mammograms for women veterans who served in locations identified with burn pits and other toxic exposures. Currently, VA conducts mammograms based on age, symptoms, or family history, but this legislation aims to include toxic exposed women veterans. The bill would also require VA to track and report rates of breast cancer among their veteran population.

The VFW recommends one adjustment to this legislation, which is to expand the eligibility language to include individuals who are eligible for inclusion in the Airborne Hazards and Open Burn Pit Registry, and those who served in locations of possible exposure as identified by the Secretary of Defense.

FEDERATION OF
STATE MEDICAL BOARDS

June 23, 2021

The Honorable Jon Tester
Chairman, Senate Committee on Veterans' Affairs
311 Hart Senate Office Building
Washington, DC 20510

The Honorable Jerry Moran
Ranking Member, Senate Committee on Veterans' Affairs
521 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Tester and Ranking Member Moran:

On behalf of the Federation of State Medical Boards (FSMB), thank you and the members of the Senate Committee on Veterans' Affairs for including the *Department of Veterans Affairs Provider Accountability Act (S. 2041)* during your legislative hearing on June 23, 2021.

The FSMB applauds the noble mission and dedication of the VA in serving the nation's veterans and believes strongly that veterans and their dependents deserve the same level of quality care, regulatory oversight and accountability that is available to the general public. The sharing of detailed information from the VA with the National Practitioner Data Bank (NPDB) and appropriate state medical board(s) to expeditiously and efficiently identify unsafe health care providers operating within the VA system as required in *S. 2041* is a positive step toward achieving this goal. The FSMB also appreciates the provisions of the bill requiring verification of licensure and other credentials as well as training for VA employees on compliance with reporting requirements.

Improved information sharing will significantly help the boards protect patients, both within and outside of the VA system. Health providers who have been deemed unqualified or unsafe to practice by the VA should not be allowed to practice outside of the VA, nor be able to conceal their disciplinary actions with discreet settlement arrangements. Proper notification will help ensure that unsafe and dangerous physicians are not able to practice unnoticed outside of the VA.

The FSMB is pleased to offer its strong support for *S. 2041*, and the Committee's efforts that would improve the quality and safety of health care both within and outside of the VA system. We commend you and Senators Manchin, Cassidy, Collins, and Boozman for your bipartisan

leadership on this important issue and welcome the opportunity to work with you and Congress on this very critical issue.

Respectfully submitted,

Lisa Robin
Chief Advocacy Officer

Founded in 1912, the FSMB is the national non-profit organization representing the 70 state medical and osteopathic boards of the United States, its territories and the District of Columbia. The FSMB serves as a resource and voice on behalf of state medical boards and provides services and initiatives that promote patient safety, quality health care and regulatory best practices.

Written Statement for Legislative Hearing In Support of the SERVICE Act

June 18 Hearing

Kate Hendricks Thomas, PhD
www.DocKate.com
Marine Corps veteran
Researcher, University of Alabama Center for Evaluation
Adjunct Faculty, George Mason University's Department of Global and Community Health

June 17, 2021

My name is Dr. Kate Hendricks Thomas, and I am a public health professional whose research focuses on the well-being of military-connected women. My recent book is titled *Invisible Veterans: What Happens When Military Women Become Civilians Again*, and much of my scientific literature focuses on health promotion for military women. I will share research and one or two statistics with you in this written testimony, but the truth is that a great deal of my work is informed by my own experiences as a woman veteran, and that story is the focus of this testimony.

Long before I became an academic, I was a Marine Corps Military Police Officer. I served from 2002-2012 in garrison commands, overseas in Iraq, and aboard Parris Island, the training command where the Marine Corps makes Marines. I loved the Marine Corps; it was my identity, and Marines are my people. Unfortunately, I did not know that my military service came with significant risks of toxic exposure. In 2005, as I ran laps around the burn pit in Fallujah, I never imagined that I would be diagnosed with a terminal cancer before I turned 40.

My watch as a Marine is over, but I still feel a tremendous responsibility to the community I call home. We need to raise awareness about toxic exposures so that other women veterans know their risks and push for early screenings. For this reason I strongly support the SERVICE Act put forward by Senator Boozman and Senator Wyden.

Issue Background

Military women have important challenges when discussing adverse health outcomes post-service. Women constitute approximately 15% of the armed services (Murdoch et al., 2006), and represent a fast-growing segment in the veteran population (Albright, at al., 2019). Female service members and veterans have complex healthcare needs (Carlson, Stromwall, & Lietz, 2013). Duhart (2012) indicated that female veterans returning from deployment were more likely than their male counterparts to report mental health concerns such as posttraumatic stress (PTS), depression, and suicidal thoughts. Additionally, women veterans are more at risk for breast cancer than civilian women, with incidence rates falling between 20-40%, compared to 12% in civilian women (McDaniel, Diehr, Davis, Kil, & Thomas, 2018). According to a study focused on cancer occurrence at Walter Reed Army Medical Center, military personnel were found to be nearly 40 percent more likely to develop breast cancer than non-military people (Zhu, et al., 2009).

My Story

My deployment to Iraq fell in 2005. I was stationed in Fallujah but convoyed often to Baghdad, al Hillah, and Ramadi. The burn pits of Al Anbar province were a constant, ignored presence. After all, I was 25 and invincible – I knew Improvised Explosive Devices were a risk, but paid no mind to the flaming poison surrounding me.

I left the service and returned to school, along the way marrying a wonderful man and having a son. I was at an annual primary care appointment at my local VHA in 2018 when my provider made an odd comment. "I want you to go get a mammogram, Kate. Based on where you've been stationed it is a good idea to do it early." That mammogram led to a diagnosis of metastatic breast cancer; I had terminal cancer at 38 and a three-year-old at home.

I now know that we have known since 2009 that women like me face a 20-40% incidence rate for breast cancer (Zhu, et al., 2009). I could have used that information much earlier than I acquired it. We should be telling military women these things and arranging the standard of care for preventive medicine around these increased odds ratios. Put simply, I needed that mammogram sooner.

My oncologist expressed surprise at the heterogeneity and aggressiveness of my cancer. She ran tests and next-generation sequencing and we learned that I have no genetic risk factors for this; my cancer is an anomaly. For this reason, my oncologist told me that she believed my cancer was exposure-related, as such cancers tend to behave aggressively, mutating often. I don't have one type of breast cancer; I have three.

The Way Forward

Passage of the SERVICE Act will increase awareness within the VA and within the veteran patient population about our elevated risk factors for breast cancer. We care for the women who come behind me by taking up such legislation. Consider me grateful to connect with you, and to support your efforts in the future in any way I can.

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NATIONAL ASSOCIATION OF STATE VETERANS HOMES

"Caring for America's Heroes"

Statement for the Record on
S. 1965 – Planning for Aging Veterans Act of 2021

Melissa Jackson, President
National Association of State Veterans Homes (NASVH)

Senate Veterans' Affairs Committee
June 23, 2021

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

Thank you for the opportunity to provide the views of the National Association of State Veterans Homes (NASVH) on S. 1965, the Planning for Aging Veterans Act of 2021. As you may know, NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life of veterans and families in State Veterans Homes (SVHs) through education, networking, and advocacy.

The State Veterans Homes program is a partnership between the federal government and state governments. SVHs receive basic per diem payments from VA for providing skilled nursing care, domiciliary care, and adult day health care (ADHC) to eligible veterans. Since enactment of Public Law 112-154, VA also pays a higher prevailing rate for veterans who need nursing home care due to a service connected disability or for veterans with service-connected disabilities rated at 70 percent or higher. VA also provides State Home Construction Grants, covering up to 65 percent of the cost to build, renovate and maintain SVHs, with states required to provide at least 35 percent in matching funds.

Today, there are 158 State Veteran Homes located in all 50 states and the Commonwealth of Puerto Rico, with over 30,000 authorized beds available, making the SVH program the largest provider of long term care for our nation's veterans. A recent GAO report (GAO-20-284, February 2020) confirmed that, "State Veterans Homes had the highest average daily census and provided over half of all institutional care based on the average number of veterans for which VA funded nursing home care on any given day during the year." However, SVHs comprise only about a quarter of VA's total annual budget request to support institutional long term care.

NASVH supports S. 1965, the Planning for Aging Veterans Act, which would help to improve long term care options for aging veterans and strengthen the ability of SVHs to provide high quality care. NASVH commends Senator Murray for introducing this legislation and we offer the following comments and recommendations on specific sections of the bill.

Section 2 of the bill would require VA to develop a long term care strategy for the provision of both institutional and non-institutional care options, including home and community based services. With the number of aging veterans continuing to increase over the next decade, VA is going to need all its resources and creativity to provide veterans the long term services and supports they desire and have earned. Importantly, the VA strategic plan will cover both traditional bed-based care as well as graduated levels of care that support veterans who choose to remain in their communities and homes.

As mentioned above, State Veterans Homes are the largest provider of VA-supported skilled nursing care. A number of SVHs also operate domiciliary care programs that provide alternative long term support for veterans who are not in need of skilled nursing care, but who need shelter and supportive services. In addition, a few SVHs offer adult day health care (ADHC) programs, which provide a non-institutional alternative to a skilled nursing facility for aging veterans who have sufficient family support to remain in their own homes, but who need or will benefit from services available during a day program at a State Veterans Home.

In order to fully utilize State Veterans Homes' resources and capabilities to support aging veterans, VA must commit itself to a true partnership. Too often, SVHs have been an afterthought in VA's planning and budgeting processes. One example is the lack of representation by SVHs on VA's Geriatrics and Gerontology Advisory Committee (GGAC), despite NAVSH nominating three highly qualified State Home administrators in recent years. State Veterans Homes need a seat on the GGAC and at the table whenever VA is engaged in long term care planning.

NASVH supports Section 2 but recommends that language be added to specifically require VA to consult with State Veterans Homes throughout the development of the long term care strategy.

Section 3(a) of the bill would require VA to develop a standardized process for VA to enter into sharing agreements between State Veterans Homes and VA medical centers (VAMCs) to facilitate the purchase and provision of medical supplies and services for veteran residents in SVHs. For example, while State Veterans Homes are not required to provide specialized services (such as urology, cardiology, oncology, etc.) to their residents, they will often arrange for their local VAMC to either directly provide such care, or provide it themselves and seek reimbursement from VA. While many SVHs have been able to negotiate both purchase and/or sharing agreements with their local VAMCs, there is no national directive mandating that VAMCs must reach such agreements, nor adequate communication or training about when and how to reach such agreements. In fact, during annual inspection surveys, some SVHs have been cited for lacking such agreements, notwithstanding that the local VAMC had not agreed to enter into one or has had proposed agreements stuck in general counsel review for years.

NASVH supports Section 3(a) to develop a national policy to assure State Veterans Homes can easily enter into standardized sharing and/or purchase agreements with VA. We recommend language be added requiring VA to consult and collaborate closely with NASVH to develop this national policy, as well as standardized agreement templates. We further recommend that VA be required to implement internal communication and training plans for VAMC personnel involved to assure greater consistency in reaching such agreements with SVHs throughout every VISN.

Section 3(b) would clarify that veterans who are catastrophically disabled and residing in State Veterans Homes are not required to make copayments for medications. NASVH agrees that catastrophically disabled veterans who would not be required to make copayments for medications if they lived at home should not be required to do so if they are residing in a SVH. We recommend that this provision include language to clarify that SVHs would not be required to cover the cost of such copayments.

Section 3(c)(1) would require VA to more closely monitor the performance of contractors performing inspections of State Veterans Homes by requiring quarterly reviews of the quality of these inspections. In order to fulfill its mandate to inspect SVHs, VA has engaged contractors to conduct these inspection surveys.

NASVH has no objection to this provision but recommends that VA develop quality control and assurance systems to ensure these inspection surveys are accurate, fair, and consistent throughout the country. VA inspection surveys must also be consistent with inspection surveys conducted by the Centers for Medicare and Medicaid (CMS) for SVHs who are also CMS-certified. The current lack of consistency can be challenging for SVHs who must comply with both inspections, especially when they are conducted around the same time but yield different results.

Sections 3(c)(2) and 3(c)(3) would require that all deficiencies noted during inspections of State Veterans Homes must be reported to VA and that survey inspection reports must be publicly available on VA's website. NASVH has no objection to these provisions and notes that State Veterans Homes had requested several years ago that VA include their quality metrics on VA's "Nursing Home Care for Veterans" website to allow easy comparisons with VA's Community Living Centers (CLCs) and contracted community nursing homes.

As required by law, VA performs a comprehensive inspection survey of each State Veterans Home annually to assure resident safety, high-quality clinical care, and sound financial operations. This inspection survey is typically an unannounced week-long comprehensive review of the SVH's facilities, services, clinical care, safety protocols and financial operations.

VA has extensive regulations covering every aspect of State Veterans Homes' operations, per 38 C.F.R. Part 51, Subpart D, sections 51.60 through 51.210, which provides a description of the standards for skilled nursing facilities that every State Veteran Home must comply with to ensure resident rights, quality of life, quality of care, nursing services, dietary services, physician services, specialized rehabilitative services, dental services, pharmacy services, infection control, and the physical environment of the Homes. In total, there are more than 200 clinical standards reviewed during VA's annual inspection survey, in addition to dozens of fire and life safety standards, which are outlined in the National Fire Protection Association (NPFA) Life Safety Codes and Standards. VA survey inspections also include a financial audit to ensure proper stewardship of federal resources and residents' personal funds.

When these inspections find deficiencies, State Veterans Homes are required to resolve or rectify them as a condition of maintaining their recognition as a SVH and continue their eligibility to receive VA per diem. As GAO confirmed in its July 2019 report (GAO-19-428), *"...VA required*

SVHs to produce corrective action plans and tracked the SVH's progress until they were resolved." The local VAMC of jurisdiction will normally re-inspect State Veterans Homes to ensure that all necessary corrections were properly completed and that SVH is in full compliance with all VA regulations.

If a State Veterans Home does not agree with a cited deficiency, it may challenge the deficiency by filing an Informal Dispute Resolution with VA's Office of Geriatrics and Extended Care (GEC), which will decide whether to uphold, reduce or withdraw the deficiency.

NASVH agrees with the intention of these two subsections of the bill, to provide VA, states, and veterans with greater information about the quality of care provided by State Veterans Homes. However, to ensure a complete and accurate representation of the inspection of the SVH, VA must also include SVHs' Corrective Action Plans and any pending or resolved Informal Dispute Resolutions whenever publishing or disseminating SVH inspection surveys or deficiency reports.

Section 4 of the bill would create a geriatric psychiatry pilot program at State Veterans Homes to explore new methods of providing long term care for elderly veterans who have significant behavioral and mental health needs. NASVH supports this section and has previously discussed with GEC officials the interest of several SVHs' to help develop and participate in such a program.

Aging veterans with severe mental health and behavioral issues represent a challenge for both VA and SVHs due to the high level of supervision and intensive care required, particularly for veterans who pose a danger to themselves or others. Specialized geriatric psychiatry services are not typically provided in nursing home units and would best be provided in dedicated wards or units that includes appropriate social, rehabilitative, and primary care services. Ideally, these units would have private rooms and private baths, as well as a secure outdoor area for freedom of movement. The units should be specifically designed to reduce the opportunity for self-harm and harm to others through specific modifications, such as rounded doors and tables; no sharp corners; breakaway privacy curtains and window treatments to prevent hanging or strangulation; weighted furniture so it cannot be picked up and used as a weapon; shatter proof glass for windows, mirrors, etc.; and a wireless call bell system. Most State Veterans Homes lack these types of physical layouts that are necessary to isolate and provide intensive supervision -- often one-to-one -- to safely care for such veterans.

Even with the right physical layout, most SVHs cannot afford and/or are unable to recruit, a qualified geriatric psychiatrist to work on staff. The geriatric psychiatrist would not only provide psychiatric services, including counseling and medication management, but would also educate SVH nurses and other staff on how to deal with disruptive behaviors and set up a crisis response team for acute mental health situations. The goal is for the SVH staff to develop the knowledge, skills, and abilities to reduce and prevent the need for emergency room visits and inpatient psychiatric placement for these veterans. This can only be accomplished by having a psychiatrist and a specially trained team help the veteran identify triggers that could cause an acute mental health crisis, adjust medications and their environment to prevent or mitigate a crisis.

For the pilot program to be successful, VA must provide State Veterans Homes with support in three areas. First, VA must provide sufficient funding to SVHs to cover the cost of modifying existing or building new specialized units as described above. Second, VA must provide additional financial support to the SVH to pay for the increased number of personnel necessary to provide adequate supervision and care for these veterans, as well as train existing SVH staff. Third, VA must either directly provide comprehensive geriatric psychiatry services to the veterans in the program – ideally onsite, but potentially via telehealth options -- or cover the cost for such care provided by the SVH itself or through a community provider.

NASVH looks forward to working with the bill's sponsor and the Committee to help develop such a pilot program to explore innovative new models of care that State Veterans Homes might be able to offer for this very challenging veterans' population.

Section 5 of the bill seeks to expand homeless prevention programs and services for aging veterans by requiring VA to work with public housing authorities and local organizations and authorizing VA to pay for non-VA supportive services for these at-risk veterans. NASVH has no objection to this provision, which could provide another form of support for aging veterans and would be interested in exploring other ways to leverage the SVH infrastructure to expand support for aging veterans at risk of homelessness.

That concludes our testimony. NASVH thanks this Committee for its continued focus on expanding long term care options for veterans and strengthening State Veterans Homes.

June 22, 2021

Senator Jon Tester
Chairman
Committee on Veterans' Affairs
United States Senate
825-A Hart Senate Office Building
Washington, DC 20510

Senator Jerry Moran
Ranking Member
Committee on Veterans' Affairs
United States Senate
412 Russell Senate Office Building
Washington, DC 20510

Dear Chairman Tester and Ranking Member Moran:

On behalf of the 52 undersigned organizations representing the Nursing Community Coalition (NCC), we commend the Committee for including the United States Cadet Nurse Corps Service Recognition Act of 2021 (S.1220/H.R.2568) in tomorrow's hearing and urge you to support and pass this bipartisan bill before the end of this year. This bill recognizes the nurses who served as members of the U.S. Cadet Nurse Corps during World War II and provides them with honorable veteran status, a service medal, a burial plaque or grave marker, and other privileges. The NCC is a cross section of education, practice, research, and regulation within the nursing profession, representing Registered Nurses (RNs), Advanced Practice Registered Nurses (APRNs),[1] nurse leaders, students, faculty, and researchers. Together, we support this vital legislation.

From 1943 to 1948, nearly 120,000 nurses answered the call by honorably caring for servicemen and women during World War II. These nurses helped shape the foundation of the profession and should be recognized for their invaluable service. The NCC commends the commitment and efforts to honor these heroic women. As we commemorate their legacy, it is imperative that this legislation is passed and the dedication of those who served in the U.S. Cadet Nurse Corps is acknowledged.

Again, the NCC appreciates the inclusion of S.1220/H.R.2568, the United States Cadet Nurse Corps Service Recognition Act of 2021 in tomorrow's hearing and we look forward to working with you to move it forward. If our organizations can be of any assistance, or if you have any questions, please contact the Nursing Community Coalition's Executive Director, Rachel Stevenson, at rstevenson@thenursingcommunity.org or at 202-463-6930, ext. 271.

Sincerely,

American Academy of Nursing
American Association of Colleges of Nursing

[1] APRNs include certified nurse-midwives (CNMs), certified registered nurse anesthetists (CRNAs), clinical nurse specialists (CNSs) and nurse practitioners (NPs).

American Association of Critical-Care Nurses
American Association of Heart Failure Nurses
American Association of Neuroscience Nurses
American Association of Nurse Anesthetists
American Association of Nurse Practitioners
American Association of Post-Acute Care Nursing
American College of Nurse-Midwives
American Nephrology Nurses Association
American Nurses Association
American Nursing Informatics Association
American Organization for Nursing Leadership
American Pediatric Surgical Nurses Association, Inc.
American Public Health Association, Public Health Nursing Section
American Psychiatric Nurses Association
American Society of PeriAnesthesia Nurses
Association for Radiologic and Imaging Nursing
Association of Community Health Nursing Educators
Association of Nurses in AIDS Care
Association of Pediatric Hematology/Oncology Nurses
Association of periOperative Registered Nurses
Association of Public Health Nurses
Association of Rehabilitation Nurses
Association of Veterans Affairs Nurse Anesthetists
Chi Eta Phi Sorority, Incorporated
Commissioned Officers Association of the U.S. Public Health Service
Dermatology Nurses' Association
Friends of the National Institute of Nursing Research
Gerontological Advanced Practice Nurses Association
Hospice and Palliative Nurses Association
Infusion Nurses Society
International Association of Forensic Nurses
International Society of Psychiatric-Mental Health Nurses
National Association of Clinical Nurse Specialists
National Association of Hispanic Nurses
National Association of Neonatal Nurse Practitioners
National Association of Neonatal Nurses
National Association of Nurse Practitioners in Women's Health
National Association of Pediatric Nurse Practitioners
National Association of School Nurses
National Black Nurses Association
National Council of State Boards of Nursing
National League for Nursing
National Organization of Nurse Practitioner Faculties
National Nurse-Led Care Consortium
Nurses Organization of Veterans Affairs
Oncology Nursing Society
Organization for Associate Degree Nursing
Preventive Cardiovascular Nurses Association
Society of Pediatric Nurses
Society of Urologic Nurses and Associates

CC:
Senator Elizabeth Warren

111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

June 23, 2021

The Honorable Jon Tester
Chairman, Senate Committee on Veterans Affairs
311 Hart Senate Office Building
Washington, DC 20510

The Honorable Jerry Moran
Ranking Member, Senate Committee on Veterans Affairs
521 Dirksen Senate Office Building
Washington, DC 20510

Dear Chairman Tester and Ranking Member Moran,

The National Council of State Boards of Nursing (NCSBN) is pleased to support the Department of Veterans Affairs Provider Accountability Act (S. 2041). We are encouraged to see legislation addressing provider accountability within the Veterans Health Administration (VHA), most notably the reporting of quality of care concerns to state licensing boards (SLBs) and National Practitioner Data Bank (NPDB) as well as continuous monitoring of health providers' credentials. NCSBN commends the Senate Committee on Veterans' Affairs for considering this legislation and addressing these critical patient safety issues.

NCSBN is an independent, non-profit association comprising 59 boards of nursing (BONs) from across the U.S., the District of Columbia and four U.S. territories. BONs are responsible for protecting the public through regulation of licensure, nursing practice, and discipline of the 5.1 million registered nurses (RNs), licensed practical/vocational (LPN/VNs), and advanced practice registered nurses (APRNs) in the U.S. with active licenses.

NCSBN has a longstanding relationship with the VHA, including working extensively with the Office of Nursing Services and Telehealth Services in support of regulatory changes that improve veterans' access to providers and the care they deliver. We strongly support VHA as they endeavor to care for our nation's veteran population and seek to serve as a partner and resource in the Department's efforts to improve quality of care and patient safety. With those goals in mind, our comments focus on two issues that we believe are critical to improving patient safety in the VA.

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111 E. Wacker Drive, Suite 2900 · Chicago, IL 60601-4277

Reporting of Quality of Care Concerns to State Licensing Boards (SLBs) and the National Practitioner Data Bank (NPDB)

NCSBN strongly supports the provision within this bill that would create a legal requirement that VA report quality of care concerns involving VA health care providers and contractors to SLBs, NPDB, and the Drug Enforcement Administration when applicable. It is crucial that actions taken against VHA providers, especially those that affect patient safety, are disciplinary in nature, or result in termination of employment, are reported to the NPDB and the appropriate SLBs. These measures will ensure that veterans are being treated by safe and competent providers that meet the same public protection standards as those in the private sector.

In November 2017, the Government Accountability Office (GAO) released a study entitled, "*Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns*."[1] The report found that between October 2013 and March 2017, the five VA Medical Centers under review had taken adverse privileging actions against nine providers that should have been reported to SLBs and NPDB. Of those nine providers, only one was reported to NPDB and none of them were reported to SLBs. The report exposed a major gap in public protection that exposes veterans and other patients to potentially risky care providers. GAO made four recommendations in the report, which included making sure that proper VISN oversight was in place to ensure timely reporting of providers to NPDB and SLBs.

NCSBN has long encouraged VHA to revise and update *VHA Handbook 1100.18 – Reporting and Responding to State Licensing Boards*, which outlines procedures that VHA facilities must follow when reporting providers to and interacting with SLBs. This section of the Handbook was originally drafted in 2005 and was scheduled for recertification in 2010. On January 28, 2021, VHA finally released a new directive (*VHA Directive 1100.18 – Reporting and Responding to SLBs)* updating VHA procedures for reporting licensed healthcare providers to the respective SLBs and NPDB. NCSBN is very pleased to see VHA take steps to address this issue, however, it is noteworthy that it took over a decade to make this update. We believe passage of this legislation will ensure that the directive is uniformly implemented and VHA staff are trained how to use it appropriately and effectively.

[1] GAO, VA Health Care: Improved Policies and Oversight Needed for Reviewing and Reporting Providers for Quality and Safety Concerns, GAO-18-63 (Washington, D.C.: Nov. 15, 2017). https://www.gao.gov/assets/690/688378.pdf.

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Continuous Monitoring of Provider Credentials

NCSBN strongly supports this bill's requirement that VHA continuously monitor the status of licenses, registrations, and other credentials held by its health care workforce. In February 2019, GAO released a report entitled, "*Greater Focus on Credentialing Needed to Prevent Disqualified Providers from Delivering Patient Care*."[2] The report identified several issues with how VHA reviews provider credentials, highlighted a need for ongoing monitoring of provider licensure, and recommended that VHA facilities periodically review provider licensure.

NCSBN has worked closely with the VA Office of Nursing Services and several VHA facilities to help them implement Nursys e-Notify, a free service that allows facilities to receive automated nurse license status updates. Through Nursys e-Notify, VHA facilities can continuously monitoring nurse licensure by enrolling each facility's RN and LPN/VN workforce in the service.

While NCSBN is pleased that some VHA facilities have individually undertaken efforts to implement procedures to continuously monitor provider credentials, many facilities have not. Passing this bill will require VHA to address this issue in a uniform manner, ultimately ensuring that our nation's veterans are being treated by safe, competent providers.

Conclusion

NCSBN encourages members of the Committee to support the Department of Veterans Affairs Provider Accountability Act (S. 2041) and work towards its passage in the Senate. We look forward to an ongoing partnership with the Committee, one that aims to guarantee veterans have the same patient safety protections as those in the private sector. If you have any additional questions, Elliot Vice, NCSBN's Director of Government Affairs, can be reached at evice@ncsbn.org and 202-624-7781.

Sincerely,

David Benton, RGN, PhD, FFNF, FRCN, FAAN
Chief Executive Officer
National Council of State Boards of Nursing

[2] GAO, Broken Promises: Assessing VA's System for Protecting Veterans from Clinical Harm, GAO 19-6, (Washington, D.C.: February 28, 2019). https://www.gao.gov/assets/700/697173.pdf.

STATEMENT FOR THE RECORD

PARALYZED VETERANS OF AMERICA

FOR THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

ON PENDING LEGISLATION

JUNE 23, 2021

Chairman Tester, Ranking Member Moran, and members of the Committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on pending legislation impacting the Department of Veterans Affairs (VA) that is before the Committee. No group of veterans understand the full scope of benefits and care provided by VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). PVA provides comment on the following bills included in today's hearing.

S. 372, the Ensuring Quality Care for Our Veterans Act
This legislation requires VA to establish a third-party process for the review of any instance in which a veteran has been treated by a VA provider later found to have a revoked license. It also requires VA to notify veterans if it is determined that an episode of care or services they received was below established levels for acceptable care. PVA supports this common sense approach to help protect the health and well-being of our nation's veterans.

S. 612, the Improving Housing Outcomes for Veterans Act of 2021
The Annual Homeless Assessment Report[1] released by the Department of Housing and Urban Development (HUD) revealed that veteran homelessness increased in 19 states between 2019 and 2020. The yearly study illuminates the unacceptably high figure that on any given night 37,252 veterans remain homeless. To effectively combat this problem, VA must harmonize its use of all of the individual programs at its disposal. We believe passage of the Improving Housing Outcomes for Veterans Act, which would streamline veteran homelessness assistance through the Coordinated Entry Program, will help get important resources to these individuals sooner.

S. 613. the PAWS for Veterans Therapy Act
This legislation would require VA to establish a pilot program to provide grants to 501(c)(3) organizations to test the effectiveness of addressing veterans' post-deployment mental health and post-traumatic stress disorder (PTSD) symptoms through training service dogs. Eligible organizations must provide service dogs to veterans with PTSD and be accredited by, or adhere to comparable standards of, an accrediting organization and have expertise in training service dogs and the use of service dogs. Grant recipients would also need to meet several requirements, some of which include covering all costs incurred in excess of the grant amount; agreeing to reaccept or replace the service dog, if necessary; providing a wellness certification for each dog; employing at least one

[1] The 2020 Annual Homeless Assessment Report (AHAR) to Congress (huduser.gov)

person with clinical mental health experience; and ensuring that veterans participating in the program receive training from certified service dog training instructors. Organizations must also agree to allow participating veterans to keep the dog unless the veteran and the veteran's health provider decide it is not in the best interest of the veteran. VA will have no additional responsibility to provide for any service dog benefits and will have no liability with respect to the dog. The bill also requires a congressional briefing and report by the Comptroller General of the United States.

Although PVA supports allowing VA to explore new therapies for veterans with PTSD to include training of service dogs, we are concerned about the pilot program's focus on providing these veterans with service dogs in addition to any benefits associated with training them. VA does not provide guide dogs or service dogs for veterans. Instead, organizations provide these animals and VA bares no direct cost. This bill would have VA provide grant funding for not only training opportunities but also for service dogs only for veterans with PTSD, excluding veterans with other mental health conditions and physical disabilities who could also benefit from having a service dog. We are also concerned that organizations eligible for the funds would not have to be accredited by Assistance Dogs International or the International Guide Dog Federation. Under Section 17.148 of Title 38 of the Code of Federal Regulations, VA will only provide veterinary health insurance and other ancillary benefits for guide dogs and service dogs used by veterans with physical disabilities who have dogs from organizations accredited by these organizations.

Although it already has the statutory authority (Section 1714 of Title 38 of the United States Code) to do so, VA has elected not to provide these benefits for veterans with mental health disabilities beyond those who are using a service dog to assist with a mental health mobility disability. Instead, VA has awaited additional evidence, including the completion of its study, on the efficacy of using service dogs to mitigate the effects of PTSD. Recently, VA completed this study. We believe that VA should expeditiously determine the next steps for deciding whether to provide veterinary health insurance and other ancillary benefits for service dogs to assist with mental illnesses, including PTSD. Specifically, we hope VA will amend its regulations to provide benefits for these dogs on par with guide dogs and other service dogs.

S. 727, the CHAMPVA Children's Care Protection Act of 2021

The Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) provides comprehensive health care benefits for dependents of permanently and totally disabled veterans, survivors of veterans who died because of a service-connected disability, survivors of veterans who at the time of death were permanently and totally disabled from a service-connected disability, and survivors of service members who died in the line of duty. Unfortunately, dependent children lose eligibility for CHAMPVA at age 18 if they are not a student or at age 23 otherwise.

Shortly after the passage of P.L. 111-148, the "Patient Protection and Affordable Care Act," commercial health insurance companies increased the age for covered dependents from 21 years of age to 26 years. In 2010, the Department of Defense increased coverage for TRICARE beneficiaries; so, the only qualified dependents that are not covered under a parent's health insurance policy up to age 26 are those of 100 percent service-connected disabled veterans covered under CHAMPVA. PVA strongly supports this

legislation and hopes it will be quickly passed by Congress to ensure that dependent children of severely disabled veterans are afforded the same health care protection as all other children.

S. 796, the Protecting Moms Who Served Act of 2021
This bill codifies the current maternity care coordination program at VA and directs the Secretary to provide community maternity care providers training and support with respect to the unique needs of pregnant and postpartum veterans, particularly regarding mental and behavioral health conditions relating to military service. Additionally, the legislation requires the Comptroller General of the United States to provide to Congress and make available to the public a report on maternal mortality and severe maternal morbidity among pregnant and postpartum veterans, with a particular focus on racial and ethnic disparities in maternal health outcomes for veterans.

PVA supports this legislation aimed at improving maternal mortality outcomes for women veterans. A recent research study found that among Post-9/11 women veterans, "Severe maternal morbidity affects a significant number of veteran women."[2] It noted, "VA is uniquely positioned to develop innovative comanagement strategies, especially in the area of perinatal mental health."[3] According to VA, since 2000, there has been a 14-fold increase in VA-funded deliveries. Twenty percent of women veterans have been diagnosed with PTSD which can lead to pregnancy complications such as a preterm birth, gestational diabetes, and preeclampsia.[4] There are also combat-related injuries that can impact fertility such as genital and pelvic trauma, and spinal cord injuries.[5] We note, however, that there is little research on the maternal mortality outcomes of women veterans with SCI/D and ask that, when possible, research, best practices, and information gathered include information on these veterans.

S. 887, the VA Supply Chain Resiliency Act
The response to COVID-19 exposed significant weaknesses in VA's supply chain, and some PVA members were affected by them. Early in the pandemic, VA was forced to limit supplies like gloves, gowns, and pads normally provided to SCI/D patients for critical procedures performed in their homes such as bowel, bladder, and wound care. This was a source of great concern when members who relied on VA to prescribe these items had to turn to the private sector to try to obtain them. The VA Supply Chain Resiliency Act could help prevent situations like this from happening again by including VA in the Department of Defense's Warstopper program. Inclusion in that program will give VA greater access to critical supplies like N95 masks, gloves, and gowns and compliment the Department's own efforts through its newly established Regional Readiness Centers.

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[2] Combellick, J. L., Bastian, L. A., Altemus, M., Womack, J. A., Brandt, C. A., Smith, A., & Haskell, S. G. (2020). Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans. *Journal of women's health (2002)*, *29*(4), 577–584. https://doi.org/10.1089/jwh.2019.7948

[3] *ibid*

[4] Veterans affairs. (2019, November 21). Retrieved April 11, 2021, from https://www.va.gov/HEALTHEQUITY/Women_Veterans_and_Pregnancy_Complications.asp

[5] Ginny L. Ryan, Investigator-Initiated Research 13-294 — Human Services Research & Development Study: Impact of Sexual Assault and Combat-Related Trauma on Fertility in Veterans, U.S. DEP'T OF VETERANS AFFAIRS (last visited June 14, 2019), https://www.hsrd.research.va.gov/research/abstracts.cfm?Project_ID=2141704065.

S. 951, the PAWS Act of 2021
This legislation would direct VA to carry out a program to provide service dogs to veterans with PTSD who have completed evidence-based treatment for PTSD but who continue to have a PTSD diagnosis. Although we support access to service animals for veterans with disabilities, we believe that the next course of action is for VA to expeditiously determine how its recently completed research on the effectiveness of service dogs to improve the quality of life for veterans with PTSD should be used to modify its existing regulations. We also have concerns about equity as this legislation would require VA to provide grants to organizations that provide service animals for veterans with PTSD but not to assist those with other disabilities. VA does provide veterans with guide, mobility, and hearing dogs with some benefits but does not provide assistance for an organization to provide and train the animal which can be very expensive and limits access.

S. 1040, to amend title 38, United States Code, to expand eligibility for hospital care, medical services, and nursing home care from the Department of Veterans Affairs to include veterans of World War II
PVA supports this bill which would expand eligibility for VA medical services and nursing home care to veterans of World War II (WWII) who are not already covered. VA believes about 300,000 of the roughly 16 million American WWII veterans were still alive as of February 2021, and unfortunately, about 370 of them die each day.[6] Statistics show the youngest WWII veterans are in their 90s and the oldest are over 100 years old. Unless they are already eligible for enrolment in priority group one through five, this bill would ensure WWII veterans are enrolled in priority group six, which at one time included the remaining veterans of the Mexican Border Period and World War I.[7]

S. 1198, the Solid Start Act of 2021
VA began the Solid Start Program in 2019 with the ambitious goal of contacting every veteran three times by phone in the first year after their separation from the military to check in on them and connect them to VA programs and benefits. PVA has supported this effort from the beginning because we saw the value of reaching out to these veterans at key points during their transition. To our knowledge, the program is working well, and in addition to providing information and assistance to veterans, it has saved lives. PVA supports S. 1198, the Solid Start Act of 2021, which would make the current program permanent with special emphasis to help women veterans connect with VA resources and ensure VA provides information to veterans about state and local resources, as well as connections to local chapters of veterans service organizations (VSOs).

S. 1280, the Veteran Families Health Services Act of 2021
This bill would expand fertility treatment available through VA and the Department of Defense (DOD). Specifically, it would allow servicemembers to cryopreserve their gametes before deployment to a combat zone or hazardous duty assignment and

[6] Statistics on Number of living WWII Veterans - How many World War 2 veterans are still alive in 2021? | Interesting Answers
[7] Enrollment Priorities, 38 CFR § 17.36 - Enrollment - provision of hospital and outpatient care to veterans. | CFR | US Law | LII / Legal Information Institute (cornell.edu)

following an injury or illness. It would also permanently authorize fertility treatment and counseling, including assisted reproductive technology (ART), including IVF, for veterans and servicemembers, as well as allow for the use of donated gametes. In addition, it improves the eligibility rules to ensure that veterans' and servicemembers' spouses, partners, and gestational surrogates are included, as appropriate. S. 1280 also includes language to provide support for servicemembers and veterans to navigate their options and find a provider that meets their needs, while ensuring continuity of care after a permanent change of station or relocation. Finally, it codifies the provision of adoption assistance and requires VA and DOD to facilitate research on the long-term reproductive health needs of veterans.

PVA strongly supports this legislation which goes a long way toward ensuring men and women who experience infertility due to injuries or illnesses incurred in service to this country are able to have families of their own and upholds the sacred responsibility Congress has in restoring to veterans what has been lost in service, to the fullest extent possible. Under the current restrictions on VA provided ART, many veterans who have service-connected infertility are left out. For example, a very small number of women veterans have service-connected injuries that preclude successfully caring a child conceived through IVF to term due to their disability. In such an instance, use of a surrogate may be their only option.

Sadly, veterans like these women have to pay out of pocket, dipping into retirement funds or going deep into debt in order to start or grow their family. Veterans should not have to risk future financial stability in order to have a family. They protected our families, and we should ensure they are able to have a family of their own.

Codifying and protecting the provision of ART services allows veterans to plan their families when the time is right for them. Conception is unpredictable. Veterans should not have the additional anxiety of rushing to have a family out of fear this service, which is currently dependent on year to year funding, might not be available in the future.

And finally, we are thankful for the research requirements included in S. 1280. There has been little research and attention given to female infertility and the impact of service on reproductive health from other military-related sources like toxic exposures from chemicals and burn pits. We hope that this bill would advance the understanding of how SCI/D affects the reproductive life cycle of women veterans and better understand the various factors that come into play in the reproductive continuum of men and women veterans with SCI/D such as race, ethnicity, gender, and disparities in care.

S. 1319, the VA Quality Health Care Accountability and Transparency Act

VA provides services directly to veterans, survivors, and other customers; so, clarity in all its communications is critical. This bill requires VA to make certain staffing and quality of care data publicly available on its Access to Care internet website (or a successor website). Among other elements, the information published on the website should include statistics related to patient wait times, effectiveness of care, and staffing and vacancy information. The website must be (1) directly accessible from the main VA website and the main websites of each VA medical center, and (2) understandable and usable by the public. VA would also be required to implement a self-auditing process to assess the

accuracy and completeness of data it posts, and through an agreement with the Inspector General of the VA or another entity, validate the results. Additionally, the Government Accountability Office (GAO) would be tasked with reviewing the website to assess VA's compliance and to provide recommendations on how to improve the website. VA currently publishes patient safety, quality of care, outcome measures and patient wait times on its Access to Care website. Also, staffing and vacancy information is publicly available as required by Public Law 115–182.[8] However, combining all this information on a single site with additional efforts to ensure the veracity of the data, make it more visible, and easier to access could be extremely beneficial for veterans and their families.

S. 1467, the VA Medicinal Cannabis Research Act of 2021
There is a growing body of evidence that cannabinoids are effective for treating conditions like chronic pain, chemotherapy induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia. S. 1467 directs the VA Secretary to carry out a clinical trial of the effects of cannabis on health conditions like these as well as PTSD. PVA supports evidence-based alternative treatments, including research into the efficacy of medical cannabis. A series of clinical trials on the use of medicinal cannabis would help to determine if it could provide any medical benefits for veterans.

S. 1863, the Guaranteeing Healthcare Access to Personnel Who Served Act
The Guaranteeing Healthcare Access to Personnel Who Served (GHAPS) Act would change current laws and regulations to improve veterans' access to health care, including access to VA's new Community Care Networks (CCNs).

Section 101 of the bill would codify VA health care access standards that were required by the VA MISSION Act of 2018 (P.L. 115-182). Specifically, the bill would make permanent the current access standards for primary care, mental health care, and non-institutional extended care services which are 20 days waiting time for an appointment or 30 minutes average driving time from the veteran's residence. For specialty care and services, the current access standards are 28 days waiting time or 60 minutes average driving time. The bill would also apply the same access standards for CCN providers; however, it would create a waiver process for the Third Party Administrators (TPAs) of the CCNs for geographic areas that had a scarcity of medical providers. This section would also require VA to review these access standards at least every three years.

PVA believes it would be premature to codify the Department's current access standards so we do not support this section. When VA released its rulemaking on access standards, PVA voiced concerns about VA's drive time access standards. Drive time standards were previously considered during the debate over the original Choice program and were a component of an earlier community care access pilot for rural veterans, Project ARCH. We agree access standards are critical in determining if VA and community health care providers are providing timely health care to veterans. However, according to VA's November 2020 Access Standard report to Congress, VA indicated that the drive time

[8] VA-wide workforce data, In accordance with Public Law 115-182, the VA Mission Act of 2018, Section 505.

and wait-time standards in the CCN were not fully aligned with the MISSION Act access standards. The CCN contractual network adequacy standards on drive time and appointment availability (a.k.a. "wait time") were based on prior utilization patterns, needs of the veteran population, and industry standard metrics for network sizing. While VA shared this report with Congress in November 2020, we have not seen any additional data that supports VA's access standards are the right measurements and are applied consistently throughout the Department.

We also have concerns about the waiver provision for VA's TPAs and the provision mandating that in determining a veteran's eligibility to receive community care, VA cannot take into consideration the availability of telehealth. PVA believes It is premature to authorize waivers for TPAs not meeting the access standards until such standards and quality standards for CCNs are equivalent to VA standards. We also think telehealth options should not be dismissed. During the pandemic, when VA discontinued routine appointments, and access to community care providers were cut, telehealth became the primary option for serving veterans health care needs. To dismiss telehealth from VA's access standards does not speak well of the Veterans Health Administration's (VHA) Telehealth program, and the efforts they took to ensure veterans had a viable option during the pandemic to meet their health care needs.

Section 102 requires VA to develop strategic plans to ensure continuity of care in the case of the realignment of a medical facility of the Department. The Asset and Infrastructure Review (AIR) Commission which is scheduled to get underway soon may recommend closing or realigning some VA facilities resulting in veterans being referred to the local community for care. It is evident that the intent of the language in this section is to ensure VA is prepared to address the handoff of care when or if that time comes. This effort is laudable, but we believe the language should be modified to ensure VA has operational plans verses strategic ones for the handoff to ensure an actual transition can take place. Also, a provision should be added to ensure VA does not close or reduce a facility before these operational plans are in place and have been fully tested to ensure veterans' continuity of care.

Sections 112 through 114 require VA to establish a pilot program that allows veterans to set their own appointments. PVA supports the test project and believes it should be included as a part of Cerner's scheduling package where veterans can have access to scheduling a VA or community care appointment.

PVA supports Sections 121 and 122 which would strengthen the credential verification process for CCN providers and ensure veterans are receiving proper care.

Section 201 requires VA in consultation with the Office of Connected Care, Executive Director of Telehealth, Office of Rural Health, and Office of IT Operations, to develop a strategic plan to ensure telehealth technologies and modalities delivered to veterans are effective and routinely monitored for quality control. As indicated above, veterans benefited greatly from VA's use of telehealth during the pandemic, and we have no doubt it will play a greater role in the way the Department delivers care in the future. Still, there are instances where the use of telehealth is the least desired means to deliver care. PVA

believes carefully assessing telehealth's capabilities and developing a strategic plan for its use is not only wise, but highly recommended.

PVA supports Section 202 which requires GAO to conduct a study of third-party transportation services available for rural veterans to determine if there are gaps that could and should be covered through additional programs and services. Our lone recommendation here is that language should be added to ensure the needs of catastrophically disabled veterans are considered as part of the study.

PVA supports Section 203 which requires GAO to assess VA's use of telehealth to serve rural veterans and inform Congress of any future legislative actions needed in this area.

PVA has no objections to Section 301 which directs VA to study the possibility of expanding its Program of Comprehensive Assistance for Family Caregivers (PCAFC) to the caregivers of veterans residing in the Philippines or to Section 302 directing GAO to study the quality and availability of care to veterans residing abroad. We recognize that service-disabled veterans residing in these areas may have undisclosed health care needs and the information derived from these studies could help VA provide better care for them.

Section 401 would require VA to complete an analysis of the feasibility and advisability of making repetitive transcranial magnetic stimulation (rTMS) available at all VA medical facilities and electro-convulsive therapy (ECT) available at one medical center located within each VISN for the treatment of veterans who have a diagnosis of treatment-resistant depression. rTMS and ECT are good programs for treatment resistant depression and PVA supports the use of emerging medical technologies to ensure the best care is available for veterans.

Section 402 would modify VA's resource allocation system (VERA) to include peer specialists. PVA strongly supports this provision as a means of expanding the use of peer support throughout VA.

Section 403 directs VA to complete a gap analysis study of its use of psychotherapeutic interventions that are highly recommended and widely used clinical practice guidelines. Defining and analyzing existing gaps could help VA ensure veterans continue to receive the highest quality mental health care.

PVA supports Section 501 which would create a one-stop online health care education portal where veterans can access interactive information on VHA processes and their rights. The online portal which VSOs will help design would include interactive modules for veterans to engage with VA.

Finally, Section 502 excludes VHA's research activities from the requirements of the Paperwork Reduction Act (P.L. 96-511) in the same manner that the National Institutes of Health receives for sponsored research. PVA strongly supports the elimination of this obstacle to critical biomedical research.

S. 1875, the Veterans' Emergency Care Claims Parity Act
PVA supports the Veterans Emergency Care Claims Parity Act which would extend the claim filing period to 180 days and prevent veterans from being charged for care if certain conditions are met. It also requires VA to regularly publish information pertaining to emergency care and the claims process on one or more publicly available websites.

S. 1965, the Planning for Aging Veterans Act of 2021
PVA endorses the Planning for Aging Veterans Act of 2021 which requires VA to develop a strategy addressing the current and future long-term care needs of veterans and identifying areas for future investment. We are especially concerned with VA's lack of long-term care beds and services for veterans with SCI/D. Many aging veterans with an SCI/D are currently in need of VA long-term care services. Unfortunately, VA is not requesting and Congress is not providing sufficient resources to meet the current demand. In turn, because of insufficient resources, VA is purchasing private nursing home care instead of providing sufficient in-house specialty long-term care for these veterans. However, it is difficult to find placement in the community for veterans who are ventilator dependent and those who require bowel and bladder care.

VA designated six specialized long-term care facilities because of the unique, comprehensive medical needs of veterans with SCI/D, which are usually not appropriately met in community nursing homes and non-SCI/D–designated facilities. SCI/D centers provide a full range of services and address the unique aspects of delivering rehab, primary, and specialty care. When hospitalized in an acute SCI/D center, these veterans require more nursing care than the average ambulatory hospitalized patient. In SCI/D long-term care units, the distribution of severely ill veterans is even more pronounced as a sizable portion require chronic pressure ulcer, ventilator, and bowel and bladder care due to secondary complications of SCI/D issues. Currently, the Long Beach VA Medical Center provides the Department's only SCI/D long-term care facility west of the Mississippi to serve 11 acute SCI/D centers. It has a capacity of 12 inpatient beds and because it is always at capacity, there are always veterans waiting for the opportunity to be admitted. Ongoing projects at the San Diego and Dallas VA medical centers will add future long-term care bed space, but these projects are years away from completion and will still not sufficiently address the existing need. We strongly recommend VA develop an SCI/D long-term care strategic plan as part of the larger long-term care strategy effort directed by this legislation.

Senate Discussion Draft, to direct the Under Secretary for Health of the Department of Veterans Affairs to provide mammography screening for veterans who served in locations associated with toxic exposure
As the title implies, this bill would direct VA to provide mammography screening for veterans who served in locations within specified dates associated with toxic exposure. Section 7322 of title 38, United States Code requires VA to begin screening women veterans with mammography for breast cancer at the age of 39 as well as directs VA to screen all veterans with other risk factors for breast cancer. Recognizing the role toxic exposure can play in increasing the risk of breast cancer, this bill adds specific locations and time frames for conducting mandatory mammography screening for all veterans. It also includes requirements for VA and DOD to report additional locations and time frames for possible inclusion in mandatory screening. And lastly, it requires comparisons of

breast cancer rates among those who served in the locations included in the bill versus those who served in the military at the same time but not at the listed locations. PVA supports this bill and knows the importance that screening has in identifying cancers quickly so they can be treated as soon as possible.

Senate Discussion Draft, the Building Solutions for Veterans Experiencing Homelessness Act of 2021

Getting veterans into stable housing as we recover from a pandemic that is not yet over will require specific and targeted efforts that empower nontraditional solutions. PVA supports this bill which would increase the rates of grants awarded by VA to states for comprehensive services provided to homeless veterans; establish grant programs for substance and alcohol use disorder for recovering homeless veterans; help meet the health care needs of elderly veterans who were previously homeless and are transitioning to permanent housing; and test the feasibility of a grant program to improve transportation services for veterans. We ask the Committee to keep in mind that within the grant process, organizations should be required to demonstrate their capabilities in servicing veterans with catastrophic disabilities, when feasible.

Senate Discussion Draft, the Department of Veterans Affairs Provider Accountability Act

PVA supports this draft bill which requires VA to report major adverse personnel actions involving certain health care employees to the National Practitioner Data Bank and to applicable state licensing boards. We believe the key to providing exceptional health care to veterans starts with quality providers. If those providers have major adverse personnel actions, they should be reported to the proper licensing authorities to ensure they are unable to practice elsewhere within the VA health care system. The draft bill also requires VA to train applicable employees on licensure, employment, and reporting requirements annually, and bars the Department from entering into a settlement agreement regarding a claim by a VA employee under which it would be required to conceal a serious medical error or lapse in clinical practice that constitutes a substantial failure.

PVA would once again like to thank the Committee for the opportunity to submit our views on some of the legislation being considered today. We look forward to working with the Committee on this legislation and would be happy to take any questions for the record.

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