



National Service & Legislative Headquarters
807 Maine Avenue SW
Washington, DC 20024-2410
tel 202-554-3501
fax 202-554-3581

**STATEMENT OF
JON RETZER
DAV ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
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Chairwoman Miller-Meeks, Ranking Member Brownley and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at today's legislative hearing of the Subcommittee on Health. DAV is a congressionally chartered non-profit veterans service organization (VSO) comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. DAV is pleased to offer our views on the bills under consideration today by the Subcommittee.

H.R. 1182, the Veterans Serving Veterans Act of 2023

H.R. 1182, the Veterans Serving Veterans Act of 2023, would amend the Department of Veterans Affairs (VA) Choice and Quality Employment Act and direct the Secretary of Veterans Affairs to establish a vacancy and recruitment database to facilitate the recruitment of certain members of the Armed Forces to satisfy the occupational needs of the VA to establish and implement a training and certification program for intermediate care technicians within the Department.

Specifically, this legislation would amend Section 208 of the VA Choice and Quality Employment Act (Public Law 115-46; 38 U.S.C. 701 note); the VA Secretary shall establish and maintain a single searchable database (to be known as the Departments of Defense and Veterans Affairs Recruitment Database) and that with respect to each vacant position, the military occupational specialty or skill that corresponds to the position, as determined by the VA Secretary, in consultation with the Secretary of Defense; and each qualified member of the Armed Forces who may be recruited to fill the position before such qualified member of the Armed Forces has been discharged and released from active duty.

The database established regarding each qualified member of the Armed Forces would contain the following information:

- The name and contact information of the qualified member of the Armed Forces;

- The date on which the qualified member of the Armed Forces is expected to be discharged and released from active duty; and
- Each military occupational specialty currently or previously assigned to the qualified member of the Armed Forces.

Information in the database shall be available to VA offices, officials, and employees to the extent the VA Secretary determines appropriate. The VA Secretary shall hire qualified members of the Armed Forces who apply for vacant positions listed in the database and may authorize a relocation bonus, in an amount determined appropriate by the VA Secretary to any qualified member of the Armed Forces who has accepted a position listed in the database.

The VA Secretary shall implement a program to train and certify covered veterans to work as intermediate care technicians in the department. The VA Secretary shall establish centers at medical facilities selected by the VA Secretary for carrying out the program.

The Veterans Health Administration (VHA) faces rising challenges to meet the needs of a rapidly growing and changing health care system, which is plagued with staffing shortages to provide much needed veteran-centric health care needs. For VHA, this database and list of potential qualified candidates from the ranks of the Department of Defense would provide another selection pool of qualified and potentially peer support clinical specialists and providers. VHA must be able to not only retain their highly trained staff but aggressively look at all means to successfully recruit highly trained and dedicated professionals to ensure and deliver sustainable quality health care and continual performance improvement for the nation's veterans.

DAV supports H.R. 1182, in accordance with DAV Resolution No. 056, as it supports a simple-to-administer alternative VHA personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that compete with the private sector and urges VA to consider campaigns to target service members in health care and other appropriate occupations separating from the military and develop systems for expedited hiring and credentialing to onboard them.

H.R. 1278, the DRIVE Act

H.R. 1278, the Driver Reimbursement Increase for Veteran Equity (DRIVE) Act, would increase the mileage reimbursement rate for veterans receiving health care from the Department of Veterans Affairs (VA).

Congress passed legislation in 2010 to set the mileage reimbursement rate at a minimum of \$0.41 per mile, which was comparable at the time to rates federal employees were reimbursed for work-related travel. This law also gave the VA Secretary the authority to increase rates going forward to be consistent with the mileage rate for federal employees for the use of their private vehicles on official business, as

established by the Administrator of the General Services Administration (GSA). Since the enactment of this law, the VA travel mileage reimbursement rate has not kept pace with increasing gas prices and costs of auto maintenance and insurance, which have significantly increased in the most recent years. Meanwhile, the GSA rate has increased over time to \$0.655 per mile.

According to the U.S. Department of Energy (DOE), the average price for a gallon of regular gas during the week of March 1, 2010, when VA's mileage rate was last increased, was \$2.671 per gallon. During the week of February 13, 2023, the average was \$3.390 per gallon, and on the West Coast, it was \$4.106 per gallon.

The DRIVE Act would require the VA to ensure the Beneficiary Travel reimbursement rate is at least equal to the GSA reimbursement rate for federal employees. This will ensure VA's reimbursement rates keep up with the cost of inflation and properly account for fluctuations in gas prices over time.

Veterans who are seeking care for service-connected conditions or veterans with service-connected conditions rated at least 30% are among veterans who are eligible for beneficiary travel pay—which may include reimbursement for mileage, tolls and additional expenses, such as meals or lodging.

Unfortunately, the current mileage rates for beneficiary travel do not always cover the actual expenses for gas and the associated costs of using a personal vehicle. The difference in the current mileage rate for reimbursement for veterans (41.5 cents) compared to federal employees using personal vehicles for business (65.5 cents) highlights the inadequacy of the rate for veterans' travel. Such expenses may serve as a barrier to care, especially when gas prices are high. However, the DRIVE Act would tie veterans' mileage reimbursement to the rate of government employees receive for using their personal vehicles for government business.

Veterans should not have to choose between getting the care they've earned and deserve, and the rising cost of travel to access their needed care. This legislation would provide much needed improvement by ensuring that veterans are not burdened with travel expenses, in particular low-income veterans and rural area veterans who heavily depend on VA's travel reimbursement program.

DAV supports H.R. 1278, the DRIVE Act, in accordance with Resolution No. 432, which calls for adopting the General Services Administration increased mileage rate for veterans' beneficiary travel.

H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023

H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023, would improve suicide and mental health care for veterans by launching the Zero Suicide Initiative Pilot Program at the Department of Veterans Affairs (VA).

In 2019, there was an average of more than 17 U.S. veterans dying from suicide per day at a rate 52.3% higher than non-veterans. 40% of veteran suicides were among active VA patients. For veterans who have served since September 11, 2001, the rate is even more alarming, with 30,117 active-duty service members and veterans dying by suicide, over four times the number of combat deaths over the past two decades. These statistics support the need to pilot alternative intervention methods at VA facilities to improve veteran care, diminish the risk of suicide, and help keep safe those who have sacrificed to serve our nation.

Congress and the VA must do everything in their power and authority to address the epidemic of veteran suicide. Every day, 17 veterans take their own lives, and we must work collectively until we get that number down to zero. Our nation has an obligation to ensure that our veterans get the health care, including mental health care, they need.

This legislation would initiate pilot program to implement the Zero Suicide Institute curriculum to improve veteran safety and suicide care that stems from the Henry Ford Health Care System, built on the belief that all suicides are preventable through proper care, patient safety, and system-wide efforts. The model has delivered clear decreases in suicide rates through innovative care pathways to assess and diminish suicide risk for patients across care systems. In consultation with experts and veteran service organizations, the VA Secretary would select five medical centers to receive training and support under the pilot program to demonstrate the effectiveness of the Zero Suicide Framework to better combat suicides across the entire VA.

The VA Zero Suicide Demonstration Project Act would bolster clinical training, assessments, and resources to test the effectiveness of implementing the Zero Suicide Model at five VA centers. This model has proven successful in decreasing suicide rates in other health care settings through innovative care pathways, as noted in the Henry Ford Zero Suicide Prevention Guidelines.

Losing one service member or veteran to suicide is one too many. Our veterans have served our nation, and they have earned the right to affordable, accessible and high-quality VA mental health care. This bipartisan legislation will take a positive step by establishing the Zero Suicide Initiative Pilot Program and bolstering the mental health care services that our hero veterans receive.

DAV supports H.R. 1639, the VA Zero Suicide Demonstration Project Act of 2023, in accordance with DAV Resolution No. 059, which calls for legislation to support program improvements, data collection and reporting on suicide rates among service members and veterans; improved outreach through general media for stigma reduction and suicide prevention; sufficient staffing to meet demand for mental health services; and enhanced resources for VA mental health programs.

H.R. 1774, the VA Emergency Transportation Act

H.R. 1774, VA Emergency Transportation Act, would reimburse veterans for the cost of emergency medical transportation to a federal facility.

The Veterans Transportation Service (VTS) provides safe and reliable transportation to veterans who require assistance traveling to and from VA health care facilities and authorized non-VA health care appointments. This program offers these services at little or no cost to eligible veterans.

VA's Beneficiary Travel (BT) program reimburses eligible veterans for costs incurred while traveling to and from VA health care facilities. The BT program may also provide pre-approved transportation solutions and arrange special mode transportation (SMT) at the request of VA. Veterans may be eligible for common carrier transportation (such as bus, taxi, airline or train) under certain conditions.

The Highly Rural Transportation Grants (HRTG) program provides grants to VSOs and state veteran service agencies. The grantees provide transportation services to veterans seeking VA and non-VA approved care in highly rural areas.

Since 1987, DAV has donated 3,665 vehicles to VA and Ford Motor Co. has donated 256 vehicles at a cost of more than \$92 million. DAV operates a fleet of vehicles around the country to provide free transportation to VA medical facilities for injured and ill veterans. DAV stepped in to help veterans get the care they need when the federal government terminated its program that helped many of them pay for transportation to and from medical facilities. The vans are driven by volunteers, and the rides coordinated by more than 156 DAV Hospital Service Coordinators around the country.

However, none of the above transportation services address the needs during a medical emergency to seeking immediate medical attention that was reasonably expected to be hazardous to life and health.

This legislation would amend Section 1725 of title 38, United States Code by redefining emergency treatment as services and that such services include emergency treatment and emergency transportation. The bill would codify emergency transportation to mean transportation of a veteran by ambulance or air ambulance by a non-Department provider to a facility for emergency treatment; or from a non-Department facility where such veteran received emergency treatment to a Department or other federal facility, which would expand access and eligibility to much needed service for reimbursement of emergency care related to ambulance transportation.

DAV supports H.R. 1774, in accordance with DAV Resolution No. 148, which supports legislation to simplify the eligibility for urgent and emergency care services paid for by the VA and urges the Department to provide a more liberal and consistent

interpretation of the law governing payment for urgent and emergency care and reimbursement to veterans who have received emergency care at non-VA facilities.

H.R. 1815, the Expanding Veterans' Options for Long Term Care Act

H.R. 1815, the Expanding Veterans' Options for Long Term Care Act, would require the Secretary of Veterans Affairs to carry out a pilot program to provide assisted living services to rapidly growing population of aging or disabled veterans who are not able to live at home.

This legislation would require the Secretary of Veterans Affairs to carry out a three-year pilot program to assess the effectiveness of providing assisted living services to eligible veterans who are currently receiving nursing home care through the department in not fewer than six VA Veterans Integrated Service Networks.

Title 38, United States Code, subsection 1720C(a)(1), (2) notes that “the Secretary may furnish medical, rehabilitative, and health-related services in noninstitutional settings for veterans who are eligible under this chapter for, and are in need of, nursing home care for veterans who are in receipt of, or are in need of, nursing home care primarily for the treatment of a service-connected disability; or have a service-connected disability rated at 50 percent or more.”

Over the next two decades, an aging veteran population, including a growing number of service-disabled veterans with specialized care needs, will require long-term care (LTC). While the overall veteran population is decreasing, the number of veterans in the oldest age cohorts with the highest use of LTC services is increasing significantly. For example, the number of veterans with disability ratings of 70% or higher, which guarantees mandatory LTC eligibility, and who are at least 85 years old is expected to grow by almost 600%—therefore, costs for LTC services and supports will need to double by 2037 just to maintain current services.

In order to meet the exploding demand for LTC for veterans in the years ahead, Congress must provide VA the resources to significantly expand home- and community-based programs, while also modernizing and expanding facilities that provide institutional care. The VA must focus on addressing staffing and infrastructure gaps in order to maintain excellence in skilled nursing care. The VA also needs to expand access nationwide to innovative and cost-effective home- and community-based programs, such as veteran-directed care and medical foster home care. Unfortunately, funding for home- and community-based services in recent years has not kept pace with population growth, demand for services or inflation. For noninstitutional care to work effectively, these programs must focus on prevention and engage veterans before they have a devastating health crisis that requires more intensive institutional care.

DAV supports H.R. 1815, in accordance with DAV Resolution No. 016, which supports legislation to improve the VA's program of long-term services and supports for service-connected disabled veterans irrespective of their disability ratings, and urges

the Department to ensure each VA medical facility is able to provide service-connected disabled veterans timely access to both institutional and noninstitutional long-term services and supports.

H.R. 2683, the VA Flood Preparedness Act

H.R. 2683, the VA Flood Preparedness Act, would authorize the Secretary of Veterans Affairs to make certain contributions to local authorities to mitigate the risk of flooding on local property adjacent to VA medical facilities.

This legislation would amend Section 8108 of title 38, United States Code, by adding language to mitigate the risk of flooding, including the risk of flooding associated with rising sea levels adjacent to VA medical facilities.

The bill would require the VA Secretary to submit to the House and Senate Veterans' Affairs Committees a report that includes an assessment of the extent to which each medical facility is at risk of flooding, including the risk of flooding associated with rising sea levels; and whether additional resources are necessary to address the risk of flooding at each such facility.

DAV does not have a specific resolution to authorize the VA Secretary to make certain contributions to local authorities to mitigate the risk of flooding on local property adjacent to medical facilities of the VA as outlined in H.R. 2683 and takes no formal position on this bill.

H.R. 2768, the PFC Joseph P. Dwyer Peer Support Program Act

H.R. 2768, the PFC Joseph P. Dwyer Peer Support Program Act would require the Secretary of Veterans Affairs (VA) to establish a grant program to be known as the "PFC Joseph P. Dwyer Peer Support Program" under which the Department shall make grants to eligible nonprofit organization having historically served veterans' mental health needs, congressionally chartered veterans service organization and state, local, or tribal veteran service agency, director, or commissioner for the purpose of establishing peer-to-peer mental health programs for veterans.

The recipient of a grant would receive an amount that does not exceed \$250,000 and would be required to carry out a program that meets the standards to hire veterans to serve as peer specialists to host group and individual meetings with veterans seeking nonclinical support; provide mental health support to veterans 24 hours each day, seven days each week; and hire staff to support the program.

The VA Secretary would be required to establish an advisory committee for the purpose of creating appropriate standards applicable to programs established using grants under this section. The standards would include initial and continued training for veteran peer volunteers, administrative staffing needs, and best practices for

addressing the needs of each veteran served, with an authorized appropriation of \$25,000,000 to carry out the program during the three-year period.

Over a century of service, DAV's main goal has been to provide the best, most professional claims representation to all injured and ill veterans and their families and survivors. An integral part of that goal is fielding a knowledgeable, well-trained nationwide corps of national and transition service officers who can extend our advocacy and outreach to those who need our services not only as fellow veterans but also injured/ill veterans who have navigated and use the VA. This has provided an opportunity to build trust in not only the benefits claims/appeals process but also the confidence of the quality of care VHA provides to include mental health care, through our own personal experiences we share as veterans through our advocacy of being service officers. This relationship of veterans serving veterans has assisted in bridging the complexity and bureaucracy of the VA benefits and health care systems for fellow veterans to know they are not alone with their VA journey.

Expanding peer specialist support through to eligible nonprofit organization having historically served veterans' mental health needs, congressionally chartered veteran service organization and state, local, or tribal veteran service agency, director, or commissioner can be of great support to the veterans and to the VA.

Trained peer specialists can help veterans to reach identified personal goals for their recovery and wellness. Peer specialists serve as role models to veterans. And can share their personal recovery stories, model skills that help recovery, help with personal goal setting and problem solving, help learn new coping strategies and improve their self-management over their mental health problems.

DAV supports H.R. 2768, in accordance with DAV Resolution No. 059, which calls for legislation to support mental health program improvements, data collection and reporting on suicide rates among service members and veterans.

H.R. 2818, the Autonomy for Disabled Veterans Act

H.R. 2818, the Autonomy for Disabled Veterans Act, would increase the amount of funding available to disabled veterans for improvements and structural alterations provided to them by the VA for home improvements related to their disability.

Veterans who need and receive Home Improvements and Structural Alterations (HISA) grants because of a service-connected disability receive up to \$6,800 and those who are rated 50% service connected or greater may receive the same amount even if a modification is needed because of a nonservice-connected disability. Veterans who are not service connected but are enrolled in the VA health care system can receive up to \$2,000 for needed home modification. These are the maximum amounts an eligible veteran can receive in their lifetime. HISA rates have not changed since Congress last adjusted them in 2010. However, the cost of home modifications and labor has risen more than 40% during the same timeframe.

This bipartisan legislation would increase the amount of funding for VA grants for disabled veterans to make necessary modifications to their homes to fit their needs, including wheelchair ramps, structural changes, medical equipment, and would adjust the amount to account for inflation.

Veterans have made incredible sacrifices for our nation's freedom and bear the scars of their service every day. Therefore, it is only fitting that this nation, Congress and VA keep the promise to ensuring that they are adequately provided for and to ensuring that they can all lead high quality lives.

DAV supports H.R. 2818, in accordance with DAV Resolution No. 326, which calls for a reasonable increase in HISA benefits for veterans.

H.R. 3520, the Veterans Care Improvement Act of 2023

H.R. 3520, the Veterans Care Improvement Act of 2023, would make numerous changes to the Veterans Community Care Program that offers veterans the option to use non-VA health care providers when VA is unable to provide medically necessary care in a timely or accessible manner.

Section 2 of the bill would codify current access standards that VA adopted via regulation as required by the VA MISSION Act of 2018. Current access standards for primary care, mental health care, and extended care are 20 days waiting time or 30 minutes driving time; access standards for specialty care are 28 days waiting time or 60 minutes driving time. As required by the VA MISSION Act, the department reviewed those access standards in 2021 and made no changes to them.

This section would add a new access standard for residential treatment and rehabilitative services for alcohol or drug dependence: 10 days waiting time or 30 minute driving time.

As history has shown, establishing arbitrary or unachievable access standards does not improve health outcomes. We are not convinced that codifying already existing access standards, and creating new ones for drug and alcohol treatment, while at the same time limiting future regulatory flexibility to adjust them, will lead to better health outcomes.

In addition, this section would remove the requirement that VA provide veterans with, "...relevant comparative information that is clear, useful, and timely, so that covered veterans can make informed decisions regarding their health care."

DAV believes that providing comparative information about the quality and timeliness of care is critical for veterans to make truly informed decisions about where to receive their care.

Section 3 would add a new requirement that VA provide written notification of community care eligibility to all veterans who seek care from VA or who VA determines are eligible for care from VA. We have concerns about the cost and administrative burden for this requirement.

Section 4 would add a new provision to require the VA to give consideration to the preference of each veteran seeking community care. It also requires VA to give consideration to whether a veteran has a caregiver when determining eligibility for community care. It is not clear how or why VA would consider a caregiver in determining community care eligibility.

Section 5 would require VA to provide formal notification in writing within two days of every determination that a veteran is not eligible for community care.

Section 6 would require VA to inform veterans eligible for community care of options for telehealth care, when considered medically-appropriate, both from VA and from community care providers.

Section 7 would mandate that a “best medical interest” determination by a veteran and their referring physician to provide that veteran medical care through a community provider cannot be overridden by any VA official, unless VA is legally prohibited from providing that care.

Section 8 would create new outreach requirements for VA to notify all enrolled veterans of how to request community care and how to file clinical appeals if they are not found eligible for community care. Along with public outreach efforts, VA would have to repeat its direct outreach to all veterans every two years.

Section 9 would mandate that VA begin using value-based reimbursement models in the Veterans Community Care Program.

Section 10 would extend the length of time community providers are allowed to submit claims to VA for payment from six months to one year following the date they provided care to a veteran.

Section 11 would require that VA determinations about whether veterans requesting residential treatment or rehabilitative services for alcohol or drug dependence be made within 72 hours after receiving such a request.

Section 12 would create a pilot program to provide incentives to community care providers who commit to meeting certain objectives to increase their participation in the community care program. However, VA would be prohibited from penalizing a participating provider, or third party administrator overseeing the provider, if they fail to meet the objectives of the pilot program.

Section 13 would require an assessment by the VA Inspector General three years after enactment of the law to assess the performance of each VA medical center in identifying and informing veterans eligible for the community care program, including telehealth, as well as delivering and coordinating such care.

While DAV strongly supported the VA MISSION Act and the creation of the Veterans Community Care Program, we have questions and concerns about some sections of this legislation.

The new notification and outreach requirements in the bill could add significant administrative burden and expense to VA's health care providers and place additional strain on VA's health care budget absent new and dedicated resources for those purposes. We also have serious concerns about whether a value-based reimbursement model for community care would improve the quality of care; particularly since VA has never been able to establish quality standards for private sector health care providers.

We certainly agree that whenever and wherever VA is unable to provide timely, accessible, and high-quality care to enrolled veterans, VA must provide other health care treatment options. At the same time, we believe it is critical to strengthen and sustain the VA health care system that millions of veterans choose and rely on for all or most of their care. As numerous studies continue to show, the care provided by VA is equal to or better than private sector care on average. For this reason, VA must remain the primary provider and coordinator for enrolled veterans' medical care. While we support the intention of improving the VA community care program, we do not support moving this legislation forward at this time.

H.R. 3581, the Caregiver Outreach and Program Enhancement (COPE) Act

H.R. 3581, the Caregiver Outreach and Program Enhancement (COPE) Act, would increase mental health resources available to caregivers who care for our nation's veterans.

Currently, the VA Program of General Caregiver Support Services (PGCSS) and the Program of Comprehensive Assistance for Family Caregivers (PCAFC) provide certifications and resources to veterans' caregivers.

Under PGCSS, general caregivers are defined as any person who provides personal care services to a veteran enrolled in VA health care who needs assistance with one or more activities of daily living and needs supervision or protection based on symptoms or residuals of neurological impairment or other impairment or injury.

General caregivers have access to training and support through online, in-person, and telehealth sessions; skills training focused on caregiving for a veteran's unique needs; individual counseling related to the care of the veteran; and respite care, giving caregivers short breaks.

The PFCAC program specifically targets family members or close friends who decide to take on caregiver responsibility for veterans. While its requirements are more stringent, the PFCAC provides stipends to caregivers that meet these requirements (in addition to the resources given to general caregivers).

The COPE Act would authorize the VA to provide grants to organizations whose mission is focused on the mental health care of participants in the PFCAC. This legislation would increase mental health resources available to caregivers through grant programs for entities that support caregiver mental health and well-being. Additionally, it requires that the VA must provide outreach to registered caregivers, as well as provide specific directives for meeting the needs of underserved populations.

DAV supports H.R. 3581, in accordance with DAV Resolution No.082, which calls for legislation to support mental health programs to provide psychological and mental health counseling services to family members of veterans suffering from post-deployment mental health challenges or other service-connected conditions.

This concludes my testimony on behalf of the DAV.