THE INDEPENDENT BUDGET

Veterans Agenda for the 117th Congress

CRITICAL ISSUES


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U.S. AIR FORCE

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PARALYZED VETERANS OF AMERICA


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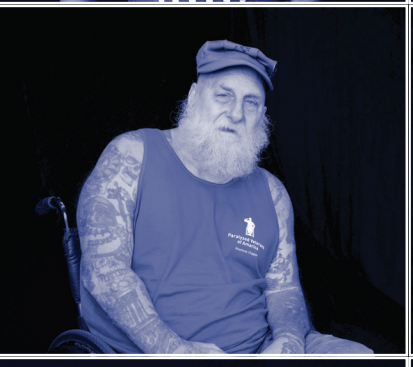

KANDI KANE
Paralyzed Veterans of America

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Veterans Agenda for the 117th Congress

A Policy Document
Created by Veterans for Veterans

DAV Paralyzed Veterans of America VFW

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Preface

After nearly two decades of war, the commitment of a grateful nation to its veterans who have borne the battle and their families and survivors remains strong. Passage of Public Law 115-182—the VA MISSION Act of 2018— resulted in the development of a Veterans Community Care Network, created an urgent care benefit, and expanded the Department of Veterans Affairs' (VA) Program of Comprehensive Assistance for Family Caregivers to severely injured and ill veterans of all eras. During the 116th Congress, the Independent Budget veterans service organizations (IBVSOs)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars (VFW)—devoted considerable resources to overseeing the implementation of this important legislation aimed at modernizing VA's system of care and benefits.

The 117th Congress will be responsible for continued oversight and support to complete the modernization efforts associated with implementation of the VA MISSION Act—in addition to confronting the challenges associated with the global health and economic crises caused by the novel coronavirus (COVID-19). Just as it has for every other health care system, COVID-19 has upended customary health care practices, putting additional demands on medical staff, and causing a reassessment of health care delivery and business practices, including critical purchasing and supply practices in VA. Thus far, the VA has cared for thousands of veterans who have contracted COVID-19. It has also assisted state and community nursing homes with obtaining essential personal protective equipment, as well as developing appropriate care delivery and safety protocols to better protect veterans and manage this highly infectious disease.

> **"VA thus far has cared for thousands of veterans that contracted COVID-19**

The IBVSOs remain committed to advocating and overseeing a unique system upon which so many of our nation's veterans rely to recover and rehabilitate from the wounds of war and health consequences of military service. Our decades of experience make us uniquely qualified to make recommendations for the issues this Congress and a new Administration will confront in meeting the specialized health care and benefits needs of those who have served. ◆

Critical Issues Introduction

We are pleased to present The Independent Budget (IB) Critical Issues for the 117th Congress. With the release of our last policy agenda at the start of the 116th Congress in January 2019, we focused significant attention on the implementation of the VA MISSION Act, which was the sole critical issue identified for that Congress by the IBVSOs.

Although we fully support the policy recommendations we put forth in our previous agenda and will continue to closely follow the implementation of the VA MISSION Act, our focus for the 117th Congress will be on 11 critical issues. The IBVSOs have determined that each issue must be addressed to ensure veterans, their families, and survivors have access to the care and benefits they earned. Our critical issues span areas ranging from VA health care and benefits to employment and education.

In addition to these critical issues, each IBVSO has a robust policy agenda covering a wide range of issues. We invite members of Congress and Administration leaders to consult our respective agendas for additional information regarding our policy priorities. ◆

Benefits Critical Issues

❶ Increase Transparency & Reform for VA Claims

Department of Veterans Affairs (VA) disability benefits provide monthly compensation to veterans with service-connected conditions. They are also the gateway to VA health care eligibility for most veterans. Although the 2017 Appeals Modernization Act has significantly reduced VA's appeals backlog, veterans face serious obstacles to establishing successful claims. First, VA has repealed its longstanding policy of permitting accredited service officers to review claims decisions prior to formal promulgation. Additionally, many veterans with health conditions for which there exists a presumption of service connection are unaware of their entitlement to VA health care and benefits.

Reintroduce Pre-decisional Review (48-Hour Review)

In April 2020, VA repealed its decades-long pre-decisional review policy, colloquially known as "48-hour review." This policy was outlined in VA's M21-1 Adjudication Procedures Manual[1] and was an essential feature of the VA claims process. During the review process, accredited service officers had the opportunity to inspect VA decisions in the 48-hours preceding formal promulgation to ensure that all claimed conditions had been addressed and properly adjudicated. This process served as an independent quality control check prior to VA's internal review procedure, known as Systematic Technical Accuracy Review.

After reviewing a rating decision, service officers were permitted to notify VA of any irregularities, missed conditions, typographical errors, or other mistakes before a disability rating was formally promulgated. This process allowed for errors to be resolved without requiring veterans to seek redress in the time-consuming and often costly claims appeals process. In sum, the 48-hour review procedure ensured the timely delivery of veterans' benefits and reduced the workload of VA's appeals infrastructure.

VA formerly permitted this same quality review in a paper-based system, during which time service officers were granted the opportunity to physically review individual claims folders for accuracy at each VA regional office. Once the service officer was satisfied that a rating

was correct, or discussed necessary changes with the rater, the service officer then endorsed the rating to signify concurrence before it was forwarded for promulgation. Both the necessity for and efficaciousness of this review process as a means of ensuring quality control had remained unchanged by the advent of digital claims filing.

A recent report from the VA Office of Inspector General, Report #20-02825-242,[2] demonstrates just one example of the necessity for reimplementing a 48-hour review. The report found that of the 3,200 claims established from April 7 through April 20, 2020, Veterans Benefits Administration (VBA) staff failed to apply date of receipt guidance in an estimated 98 percent of claims.[3] More specifically, the report notes that VBA staff "failed to use the postmark date of mail as the date of receipt, failed to use a date of receipt of February 29, 2020, when the postmark date was unavailable, and failed to document the reasons for estimates of date of receipt on mail with partially legible postmarks."[4] These errors are significant because they can cause a veteran to receive an improper effective date for a claim or a denial for untimeliness. However, a service officer could identify and recommend a correction for these types of errors through a 48-hour review.

> **"A recent OIG report demonstrates just one example of the necessity for a 48-hour review**

Establish Claim Dates for VA Treatment

Title 38 of the Code of Federal Regulations recognizes over 125 types of presumptive diseases based on several different types of exposures, places of service, and chronic diseases diagnosed within 12 months of service.

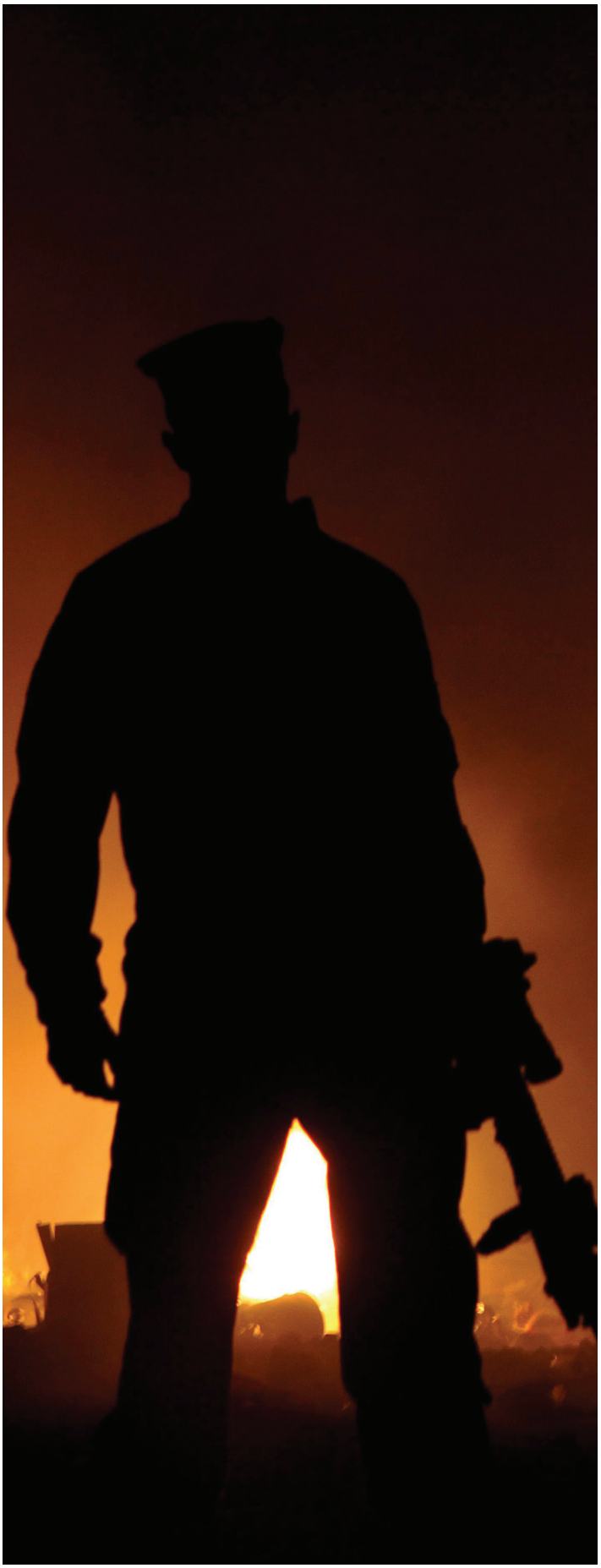
Veterans suffering from diseases such as cancer, diabetes, and other chronic conditions may not be aware that the diseases may be eligible for presumptive service connection. Many VA medical facilities are not currently staffed or equipped to provide appropriate counseling to veterans or their families on how to file a claim for service-connected benefits, specifically for presumptive diseases.

The Court of Appeals for Veterans Claims held in Bell v. Derwinski, 2 Vet. App. 611 (1992) that VA is deemed to have constructive knowledge of all VA records. Such records are considered evidence of record at the time a decision is made.

It follows that if VA is providing treatment for a diagnosed, recognized presumptive disease, they have constructive knowledge of the diagnosed disease and that it is a presumptive condition. Congress should enact legislation to establish a date of claim based on VA health care treatment and diagnosis for recognized presumptive diseases. ◆

The IBVSOs Recommend:

- Congress enact legislation to permit service officers to review VA disability benefits ratings 48-hours prior to their formal promulgation.
- Congress enact legislation to establish a date of claim based on VA health care treatment and diagnosis for recognized presumptive diseases.



❷ Ensure Benefits to Veterans Exposed to Toxic Substances

Millions of active duty service members have been exposed to environmental, toxic, and airborne hazards throughout history. These exposures include mustard gas during WWI and WWII, tropical diseases during WWII, extremely cold temperatures in Korea, nuclear atmospheric testing, Agent Orange in Vietnam, contaminated water at Camp Lejeune, as well as burn pits and other hazards in Southwest Asia during the Persian Gulf War and after September 11, 2001.

When service members are subjected to toxins and environmental hazards, our sense of duty to them must be heightened. Many of the illnesses and diseases due to these toxic exposures may not be identified for years, even decades, after completing their service. Although there has been some notable progress achieved over the past two decades, veterans who suffered illness due to toxic and environmental exposures have yet to receive the recognition and benefits they deserve.

Add Presumptive Diseases When Science Provides Positive Association

The Department of Veterans Affairs (VA) has established several toxic exposures as presumptive with conceded exposures and diseases scientifically linked to the exposure. Some established presumptive processes have statutorily required future reports to continue assessing the long-term negative health impacts. However, over the past four years, VA has failed to add diseases that have been determined to have a positive scientific association with those known exposures. Recently, it took Congress to add three diseases that have been pending with VA for four years. However, two diseases still remain pending with VA.

The National Academies of Science, Engineering and Medicine (NASEM) update, "Veterans and Agent Orange," in 2016, noted that although VA has not found hypertension to be presumptively related to service in

Vietnam, the committee reaffirmed the conclusions of previous studies that hypertension should be placed in the category of limited or suggestive evidence of association. In 2018, NASEM concluded there was sufficient evidence of an association between hypertension, monoclonal gammopathy of undetermined significance (MGUS), and Agent Orange.

VA has not included hypertension and MGUS as presumptive diseases although these conditions were scientifically associated with Agent Orange more than two years ago. In January 2020, VA indicated that they are relying on two internal VA studies the Vietnam Era Health Retrospective Observational Study, or VE-HE-ROeS, and the Vietnam Era Mortality Study. In December, VA announced the studies will not be available until mid-2021.

Thousands of veterans suffering from the ill effects of these diseases deserve health care, compensation benefits, and justice. Congress again must intervene and enact legislation.

Include Locations of Recognized Exposures

Most presumptive conditions that are based on toxicity have locations that are linked to toxic exposure. For veterans who participated in radiation risk activities, the locations of exposure are vital. Similarly, Agent Orange exposure is conceded for those veterans who served in Vietnam, the waters offshore, and the Korean Demilitarized Zone (DMZ).

VA has yet to recognize Agent Orange exposure in Thailand via statute or regulation. A Department of Defense (DOD) 1973 report, "Contemporary Historical Examination of Current Operations Southeast Asia Report: Base Defense in Thailand 1968-1972," acknowledges the use of tactical herbicides on Thai Royal Air Force and Army bases. In 2019, DOD and VA released an update on locations of Agent Orange Exposure locations, which now officially includes Thai bases.

Despite that update, there are no current statutes or VA regulations to automatically concede veteran exposure to Agent Orange while serving in Thailand during the Vietnam era. VA's manual does recognize herbicide exposure for specific military occupational specialties on the perimeter of eight Thai Royal Air Force bases. However, limiting exposure to only these specific occupations on the perimeter is unfairly restrictive and provides an unnecessary obstacle to veterans serving in this location and potentially exposed to Agent Orange.

Establish Research on Toxic Exposures

Our service members are consistently exposed to dangerous locations and harmful environments with contaminants and toxins. It is important to note that not all of the harmful exposures have been recognized or even studied sufficiently. It has taken decades for most presumptive exposures and diseases to be established.

For example, VA established eight presumptive diseases related to contaminated water at Camp Lejeune in

2017. These conditions were established over 60 years from the first date of exposure and 30 years after the last exposure date.

The men and women exposed to these hazards cannot wait decades for the studies, research, and science. There are still no definitive studies on veterans exposed to the toxic hazards at Karshi-Khanabad Air Base, Fort McClellan, and Guam. DOD has released new data showing that more than 600 military sites and surrounding communities could be contaminated with perfluorinated chemicals–far more installations than Pentagon officials have previously disclosed.

Veterans suffering from these exposures need a process now that will study these current and future exposures. Waiting is not an option. Congressional action is needed to ensure DOD and VA develop a consistent and timely method for expanding known exposures and study the adverse long-term health effects of other toxic exposures.

Frame the Presumptive Decision-Making Process

As evidenced through this article, inconsistencies delay recognition of exposures, the establishment of studies and research, and the provision of critical health care and benefits to veterans exposed while in service to this nation.

The Independent Budget veterans service organizations (IBVSOs) are concerned Congress and VA will continue to provide piecemeal legislation or regulatory provisions without addressing these much larger issues facing exposed veterans today and in the future.

An overall presumptive process framework needs to be established by Congress to provide consistency. A new framework must: 1) improve DOD and VA data collection and record-keeping; 2) establish a concession of exposure or recognition of the toxic exposure; 3) require statutorily mandated future studies on known exposures; 4) provide a time requirement for action by the VA Secretary; 5) maintain the standard of positive association vs. causation; and 6) update the classifications of scientific association. ◆

> **“An overall process framework needs to be established by Congress to provide consistency**

The IBVSOs Recommend:

- Congress enact legislation to include hypertension, and MGUS as presumptive diseases linked to Agent Orange exposure.
- Congress enact legislation to codify the concession of Agent Orange exposure to all Vietnam era veterans with service on military bases in Thailand, regardless of military occupational specialty.
- Congress provide oversight and new legislation to develop scientific studies and research on the long-term negative health of toxic exposures.
- Congress establish a presumptive process framework that applies to all future exposures and presumptive diseases. The framework should include: requirements for future studies on all presumptive toxic exposure-related diseases; a time requirement for action from the VA Secretary; and an upgrade of the classifications of scientific association.

❸ Improve Benefits for Survivors

Since Dependency and Indemnity Compensation (DIC) was created in 1993, major improvements have been legislated only once in 2003. While minor enhancements have been implemented there is still much that can be done to improve benefits for the survivors of America's veterans. DIC rates have failed to keep up with the cost of living and fallen short of what federal employees' survivors receive. In addition, many veterans pass away from nonservice-connected conditions prior to the eligibility period; thus, leaving their families with nothing. Improvements are needed for those left behind to assist with their education and provide benefits to help survivors rebuild their lives. Now that we see the combined effects of a pandemic, plus a war that has spanned almost two decades, the urgency for these improvements is dire.

Increase DIC Rates

DIC is a benefit paid to surviving spouses of service members who die in the line of duty or veterans who die from service-related injuries or diseases to provide surviving families with the means to maintain some semblance of economic stability after the loss of their loved ones. When a service-disabled veteran passes away, not only does the surviving spouse have to deal with the heartache of losing their loved one, but they also have to contend with the loss of their veteran's compensation. This loss to a survivor's budget is devastating, especially if the spouse was also the veteran's caregiver and dependent on that compensation as their sole income source.

The rate of compensation paid to survivors of service members who die in the line of duty or veterans who die from service-related injuries or diseases was established in 1993 and has been minimally adjusted since then. Currently, the rate of compensation paid to a veteran's survivors is significantly lower than the monthly benefits for survivors of federal civil service retirees. This creates inequity for survivors of our nation's heroes compared to survivors of federal employees.

> **"Improvements are needed to assist with education & benefits to help survivors rebuild**

Reduce the 10-Year Rule for DIC

Veterans who are rated 100 percent disabled or have individual unemployability due to their service-connected disabilities are unable to work in full-time occupations, if at all. In recognition of the severity of many disabilities and the impact on veterans and their families, if a veteran is 100 percent disabled, to include individual unemployability, for 10 consecutive years before the veteran's death, surviving spouses and minor children are eligible for DIC benefits.

However, if a veteran dies due to a non-service-connected condition before they reached 10 consecutive years of being totally disabled, their dependents are not eligible to receive the DIC benefit. This happens even though many of these survivors put their careers on hold to act as primary caregivers for the veteran, and now with the loss of their veteran, could potentially be left destitute.

The Independent Budget veterans service organizations (IBVSOs) agree that the requirement of 10 years seems arbitrary. The DIC program would be more equitable for all survivors if there was a partial DIC benefit starting at five years after a veteran is rated totally disabled and reaching full entitlement at 10 years. This would mean if a veteran is rated as totally disabled for five years and dies, a survivor would be eligible for 50 percent of the total DIC benefit increasing until the 10-year threshold and the maximum DIC amount is awarded.

Reform Life Insurance

In 1951, the Service-Disabled Veterans Insurance (S-DVI) program was designed to provide affordable life insurance coverage to disabled veterans unable to purchase private insurance due to their service-connected disabilities. Since then, the cost and benefits of this insurance have seriously eroded. Rates are based on contemporaneous mortality tables and have failed to remain competitive with commercial insurance. Current actuarial data should be used to lower premiums and the benefit payout should be increased to adjust for inflation.

The IBVSOs recognize that Congress has attempted to address inflation through the passage of Public Law 111-275, the Veterans Benefits Act of 2010, which authorized an increase from $20,000 to $30,000 in the supplemental amount available. However, many of these veterans cannot purchase supplemental commercial life insurance due to their service-connected disabilities, and this is an inadequate sum of money. If the original amount of $10,000 offered in 1951 were adjusted for inflation, it would be closer to $100,000 in 2018.

With the passage of the Johnny Isakson and David P. Roe, M.D. Veterans Health Care and Benefits Improvement Act of 2020, changes were made to update the S-DVI, including raising the payout to $40,000.

The IBVSOs want the premiums of S-DVI to be lowered in accordance with current insurance data. Veterans are paying much higher rates for insurance premiums while receiving fewer benefits. The IBVSOs recommend Congress enact legislation lowering the premiums using current mortality tables. Lastly, any legislation aimed at improving this benefit needs to retain the ability for veterans rated 100 percent totally and permanently disabled to retain the premium waiver for basic coverage currently authorized.

Improve Dependents Educational Assistance

Spouses and surviving spouses eligible for educational benefits under Dependents Educational Assistance only have 10 years to apply and complete these education programs, beginning either from the date the veteran is rated permanently and totally disabled or the date of the veteran's death. Due to circumstances such as the demands of raising children alone or needing to re-enter the workforce to supplement the loss

of the decedent's income many are unable to apply in a timely manner.

Far too many times, when a spouse is ready to utilize the benefit, the time period has lapsed, leaving these men and women without the ability to further their education and improve their living circumstances. The IBVSOs urge Congress to remove the 10-year delimiting date for spouses and surviving spouses to utilize their Chapter 35 benefits.

Require COVID-19 Medical Opinions

As of October 2020, over 3,500 veterans have died from COVID-19 without a medical opinion stating whether their service-connected conditions contributed to their death. Certain service-connected disabilities have proven to be comorbid with COVID, including diabetes, hypertension, and heart disease, and may be overlooked as contributing factors in the veteran's death. Thus, veteran families may be denied important survivor benefits. The IBVSOs advocate for the Secretary of the VA to require a medical opinion on all veterans who die due to the novel Coronavirus and have a service-connected disability.

Waive the 8-Year Requirement for Surviving Spouses to Receive the DIC "Kicker"

Title 38, United States Code, Section 1311(a)(2) allows an additional DIC monthly payment of $288.27 to survivors in the case of a veteran who at the time of death was in receipt of or was entitled to receive compensation for a service-connected disability that was rated totally disabling for a continuous period of at least eight years immediately preceding death. This monetary installment is commonly referred to as the DIC "kicker." Amyotrophic lateral sclerosis (ALS) is an aggressive disease that leaves many veterans totally incapacitated and reliant on family members and caregivers. Individuals diagnosed with ALS have an average lifespan of between two to five years. Sadly, many veterans are unable to meet DIC's eight-year requirement. VA already recognizes ALS as a presumptive service-connected disease and due to its progressive nature, automatically rates any diagnosed veteran at 100 percent once service connected. We recommend extending these increased DIC payments to surviving spouses of veterans who die from ALS regardless of how long they had ALS prior to death. ◆

The IBVSOs Recommend:

- Congress index the rate of compensation for DIC to 55 percent of a 100 percent disabled veteran's compensation to parity what federal survivors receive.
- Congress replace the current 10-year period for eligibility for DIC with a graduated scale that begins at 5 years and reaches full entitlement at 10 years.
- Congress enact legislation that lowers S-DVI premiums using current mortality tables but without sacrificing the ability for veterans rated 100 percent totally and permanently disabled to waive their premiums.
- Congress enact legislation that would remove the 10-year delimiting date for spouses and surviving spouses to utilize their Chapter 35 benefits.
- Congress enact legislation that would require the Secretary of the VA to seek a medical opinion when a service-connected veteran dies of COVID-19.
- Congress extend increased DIC payments to surviving spouses of veterans who die from ALS regardless of how long they were service-connected with ALS prior to death.


Paralyzed Veterans
of America

Health Care Critical Issues

❹ Rebuild VA Infrastructure

The Department of Veterans Affairs (VA) health care system provides direct medical care to more than seven million veterans every year through an integrated system of over 1,750 access points, including medical centers, outpatient clinics, Vet Centers, and community living centers. VA's health care infrastructure includes more than 5,600 buildings and 34,000 acres, much of which was built more than 50 years ago. For more than two decades, funding for construction, repairs, and maintenance of VA's health care facilities has lagged even the most conservative estimates of the actual needs. A long list of seismic deficiencies remains a significant concern that VA has failed to address. Efforts to develop long-term plans have proven ineffective as parochial politics and fiscal challenges have proven insurmountable. The inclusion of the Asset and Infrastructure Review (AIR) process in the VA MISSION Act provides VA, the Administration, and Congress with an opportunity to establish and implement a comprehensive plan to rebuild and realign VA's infrastructure to better meet veterans' needs for accessible health care. Its success, however, will depend on fully and faithfully implementing the AIR process that has already begun in true partnership with veterans and veterans service organizations (VSO) stakeholders.

> **"COVID-19 forced VA to make significant health care changes to protect veterans & personnel**

Amend AIR for COVID Delays & Lessons Learned

Congress structured the VA MISSION Act so that VA would establish new community care networks (CCNs) and allow them to stabilize before beginning AIR. However, the slow transition from Choice third-party administrator (TPA) provider networks to the new MISSION Act TPA provider network was only recently completed. Furthermore, VA has yet to complete the market assessments or deliver the "Strategic Plan to Meet Health Care Demand" required by the MISSION Act. Moreover, even in markets that have transitioned, the year-long novel coronavirus (COVID-19) pandemic has interfered with veterans' normal health care utilization and reliance patterns. Without accurate and reliable data on how veterans are utilizing CCNs after full implementation and what their preferences are for receiving health care, it would be premature to make decisions about the number, size, and scope of facilities VA will require in the future.

Furthermore, COVID-19 forced VA to make significant health care delivery changes to protect veterans and health care personnel. VA must evaluate the impact on health outcomes due to pandemic changes in order to ensure VA has the best model of health care in the future. While we are amid the pandemic, it is also too early to assess the significant lessons about the safest and most effective ways to deliver health care, and how health care delivery may have been irreversibly altered.

Revise the Market Assessment Process to Fully Engage Veterans & VSO Stakeholders

Although VA had begun market assessments in preparation for building a replacement for the Choice network before the MISSION Act was passed in June 2018, the law mandated two sets of VA market assessments: one to guide the development of new CCNs and one to guide AIR. After enactment, VA chose to combine them and conduct only one set of market assessments for both purposes. Now, more than two years after the MISSION Act was signed and over three years since VA began conducting these market assessments, neither VSOs nor

veterans have been adequately consulted about their preferences for receiving health care.

Develop a Joint Communications Plan for AIR

Previous attempts by VA to realign its infrastructure, including the Capital Asset Realignment for Enhanced Services initiative, conducted more than a decade ago, failed due to public and congressional opposition. While VA has begun to consult with VSOs about certain aspects of the AIR process, there has been no outreach to collaborate with them on a joint communications strategy. With our combined memberships and social media reach, VSOs can play a critical role in educating veterans about the upcoming AIR process and its overall success.

Fix Scoring Problem with Building Leases

As a result of decisions by the Office of Management and Budget (OMB) and interpretations by the Congressional Budget Office (CBO), current congressional Pay-As-You-Go (PAYGO) rules require Congress to offset the full 10-year lease cost of new or extended leases during the first year; thereby, scoring it the same as new construction. As a result, Congress has been severely challenged to overcome PAYGO requirements and VA has had tremendous difficulty leasing new or extending existing leases for health care facilities.

Increase VA's Internal Capacity to Maintain Existing Infrastructure & Build New Facilities

VA's ability to manage a growing portfolio of construction projects is dependent on the number and capability of its construction management staff. To manage a larger, more complex project portfolio and the impending AIR process, VA must have sufficient personnel—both within the VA Central Office and onsite throughout the VA system. Further, there is a need for more rigorous and forward-looking training and certification programs to utilize construction funding effectively and efficiently.

Plan for Institutional Long-Term Care (LTC) Facilities

VA supports institutional LTC for aging and severely disabled veterans by operating 131 Community Living

Centers (CLCs), providing grants and per diem support to 157 State Veterans Homes (SVHs), as well as providing per diem support for veterans in hundreds of community nursing facilities. While VA has developed strategic plans to increase and rebalance the use of noninstitutional services and support, there continues to be a growing number of aging veterans who require institutional care. VA currently supports approximately 30,000 LTC beds in skilled nursing and domiciliary facilities within the CLCs and SVHs, a tiny fraction of the overall number that aging veterans require today and will require in the future. There are also unique challenges maintaining adequate numbers of LTC facilities for veterans with spinal cord injuries and disorders (SCI/D) that must be addressed.

While VA must continue to expand its noninstitutional, home-based services and support, there will always remain a significant number of veterans who will require institutional care.

NOTE: Additional recommendations of long-term care programs are addressed in the next Critical Issue.

Explore & Expand New Models of Shared Health Care Facilities

VA has explored many shared health care facility models over the years to supplement VA's normal construction programs, including the Public-Private Partnership and the Communities Helping Invest through Property and Improvements Needed for Veterans models. Both of these VA construction programs seek to match private investment with VA funding for new facilities. Given the high cost of constructing new facilities coupled with the increasing integration of non-VA providers into VA community care networks, VA should consider leveraging existing health care relationships with other federal agencies (the Department of Defense and the Indian Health Service), and academic affiliates, as well as sharing arrangements with private providers in VA's community care networks. ◆

The IBVSOs Recommend:

- Congress extend the AIR timeline by at least one year to ensure that the delays and lessons learned from the COVID-19 pandemic can be fully incorporated into VA's infrastructure planning.
- VA fully engage with veterans and VSO stakeholders on a national and local level to ensure veterans' preferences are paramount both in designing local community care networks and during the implementation of the AIR process.
- VA partner with VSOs on a communications plan to educate veterans, the public, and the media about the upcoming AIR process before critical decisions are made.
- Congress modify PAYGO rules or enact legislation to change how VA leases are approved and scored to reflect the actual funding required annually.
- Congress increase VA's internal capacity and expertise to manage and expand infrastructure and lease facilities by hiring additional personnel, and implementing training curriculum and certification programming required by the VA MISSION Act.
- VA 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, it should develop a plan to build, maintain, and subsidize sufficient LTC facilities within the VA's nursing homes (CLCs), and SVHs.
- VA explore additional opportunities to expand partnering arrangements to supplement VA's health care infrastructure.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❺ Ensure Veterans Access to Long Term Care & Support Services

The Department of Veterans Affairs (VA) supports institutional LTC for aging and severely disabled veterans by operating 131 Community Living Centers (CLCs), providing grants and per diem support to 157 State Veterans Homes (SVHs), and providing per diem support to veterans in hundreds of community nursing facilities. While VA has made strides to increase and rebalance the use of noninstitutional services and support, there remains a growing number of aging veterans who will require long-term institutional care. Through its CLCs and SVHs, VA supports approximately 30,000 LTC beds in skilled nursing and domiciliary facilities, a tiny fraction of the overall number that aging veterans require today and will require in the future. While VA must continue to expand its noninstitutional, home-based services and support, there remains a significant number of veterans who will require institutional care in the days ahead. The VA must develop a strategic plan that estimates the number of veterans who will require institutional LTC and the number that VA will support. VA must also plan to build, maintain, and support sufficient LTC facilities within its CLC and SVH systems.

Increase Support for Aging Veterans & Veterans with Significant Disabilities

Additionally, veterans with significant disabilities, like spinal cord injuries, require specialized care that far exceeds VA's LTC bed capacity. According to VHA Directive 1176, Appendix F,[1] VA is required to maintain 198 authorized LTC beds at spinal cord injury or disorder (SCI/D) Centers to include 181 operating beds. When the demand for VA LTC beds exceed VA's LTC bed capacity, VA has the authority to place the veteran in a community nursing home facility. However, VA often finds it difficult to place them in a community nursing home facility due to their SCI/D. VA must expand the number of VA LTC facilities and LTC SCI/D beds across the VA health care system.

Support Additional Models of Institutional Care

SVHs operate skilled nursing and domiciliary care programs; however, recent changes to VA regulations threaten the continued viability of domiciliary care programs currently helping thousands of veterans. Leadership from SVHs has requested that VA consider supporting additional institutional care models, including enhanced domiciliary care and assisted living, to help fill the gap between VA Home and Community-Based Services (HCBS).

According to a U.S. Government Accountability Office (GAO) February 2020 report[2], "*entitled Veterans' Use of Long-Term Care Is Increasing, and VA Faces Challenges in Meeting the Demand*," the VA provides or purchases LTC for eligible veterans through 14 LTC programs. From fiscal years 2014 through 2018, VA data showed that veterans receiving care through these programs increased 14 percent (from 464,071 to 530,327 veterans). The obligations for these programs increased 33 percent (from $6.8 to $9.1 billion). VA projects the demand for LTC will continue to increase, driven in part by growing numbers of aging veterans and veterans with service-connected disabilities. Expenditures for LTC are projected to double by 2037. According to VA officials, the department plans to expand veterans' access to noninstitutional programs, when appropriate, to prevent or delay nursing home care and to reduce costs.[3]

Add Oversight of Geriatrics & Extended Care (GEC)

GAO's February 2020 report included the following three recommendations: 1) The Secretary of VA should direct GEC leadership to develop measurable goals for its efforts to address key LTC challenges (workforce shortages, geographic alignment of care, and difficulty meeting veterans' needs for specialty care); 2) the Secretary of VA should direct GEC leadership to set time frames for and implement a consistent GEC structure at the VA Medical Center (VAMC) level; and 3) the Secretary of VA should direct GEC leadership to set time frames for and implement a VAMC-wide standardization of the tool for assessing the noninstitutional program needs of veterans.

GAO also indicated the VA currently faces three key challenges meeting the growing demand for LTC: 1) finding enough workers; 2) providing care where geograph-

ically needed; and 3) providing specialty care. GAO further noted that VA identified issues with inconsistency in managing the 14 LTC programs at the VAMC level that could lead to inefficient and inequitable decisions across VA. While GEC has taken some steps to address the challenges it faces in meeting the demand for LTC, it approved a strategic plan in March 2019 that shows it has not yet established measurable goals to address these three key challenges.

Specifically, GEC has not established measurable goals for its efforts to address workforce shortages, such as specific staffing targets necessary to address the waitlist for the home-based primary care program, or defining the number of rural providers it expects to train through the Geriatrics Scholar program.

> **“ VA must continue to expand its noninstitutional, home-based services**

The Independent Budget veterans service organizations (IBVSOs) believe that GEC must establish measurable goals to address the geographic alignment of care, such as specific targets for providing LTC within the Home Telehealth and Veteran-Directed Care programs. GEC also must establish measurable goals for its efforts to address difficulties in challenges meeting veterans' needs for specialty care, such as specific targets for the number of available ventilators or the number of caregivers educated to help veterans with dementia.

Cover Costs of Medical Foster Homes (MFHs)

Many veterans with a disability due to complex chronic diseases or traumatic injuries may not be able to safely live independently or may have care needs that exceed the capabilities of their families. Traditionally, this situation was resolved by nursing home placement. However, many veterans prefer to live in a home-like setting rather than a nursing home. With the proper support, many veterans who previously would have been placed in nursing homes can continue to live in a home and delay, or totally avoid the need for nursing home care. To address this need, VA implemented the medical foster home (MFH) program. A MFH is a private home where a MFH caregiver, who must own or rent the MFH and reside there with assistance from relief caregivers, provides a safe environment, room and board, supervision, and personal assistance, as appropriate, for each veteran. The choice to become a resident of a MFH is a voluntary one on the part of each veteran, and the veteran is responsible for paying the room and board charges of the MFH.

One challenge veterans encounter with the MFH program is under current law: it does not cover the MFH care payment. Therefore, the care provided through the program is at the expense of the veteran and his/her family or legal representative. In 2019, the 116th Con-

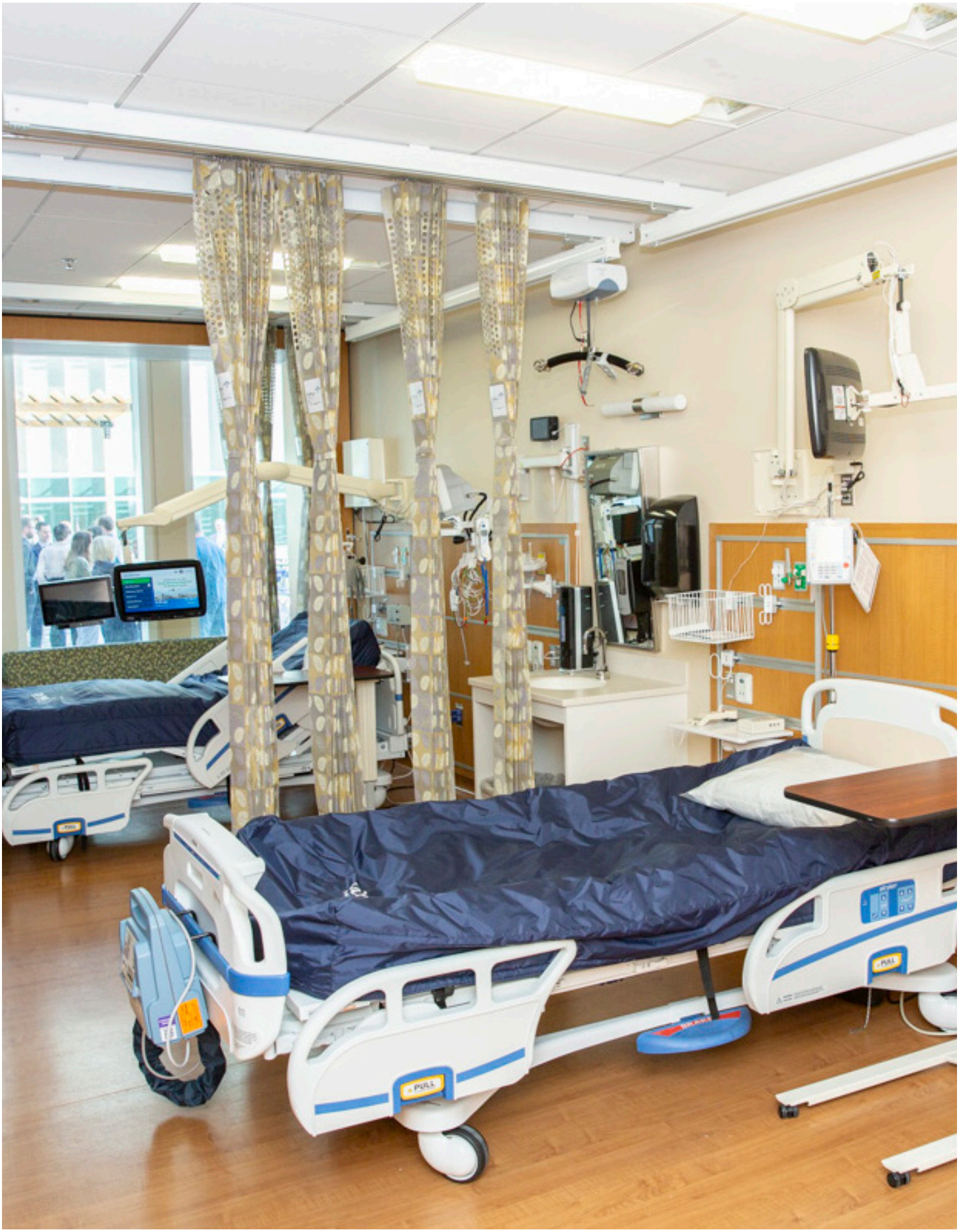
gress introduced H.R. 1527, titled "The Long-Term Care Veterans Choice Act."[4] The bill would have amended title 38, United States Code, to authorize the Secretary of VA to enter into contracts and agreements for the placement of veterans in non-Department MFHs for certain veterans who are unable to live independently at VA expense. However, the bill was never enacted into law.

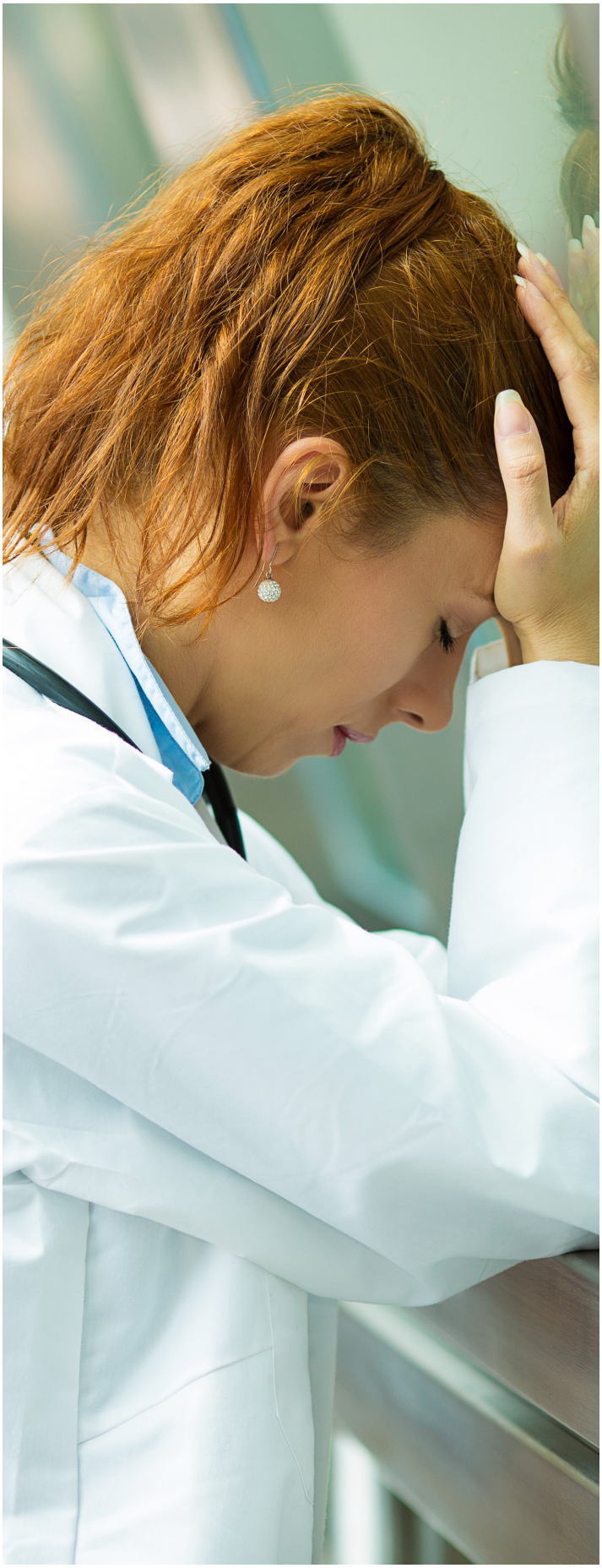
Accelerate Caregiver Program Expansion

The VA MISSION Act outlined a two-phase approach for implementing the caregiver expansion. The law required the first phase to begin on October 1, 2019, approximately 16 months after the law was enacted. However, due to Information Technology delays and failures, VA did not begin the first phase – which includes eligible veterans who became severely injured or ill on or before May 7, 1975 – until October 1, 2020, a full year later than the law required. As a result, the second phase – which will include veterans who became severely injured or ill between May 8, 1975, and September 10, 2001 – will not begin until October 1, 2022, two years later as required by the law. However, there are no logistical or operational impediments to moving up the second phase of the caregiver expansion to October 1, 2021, as Congress intended. VA has confirmed that its new caregiver IT system does not require any additional functionality or capacity to handle the increased workload anticipated during phase II and VA can easily hire the additional 700 staff over the next year. Veterans and their caregivers should not have to continue waiting for this critical support. ◆

The IBVSOs Recommend:

- Congress conduct rigorous oversight on VA LTC to ensure VA GEC services meet the needs of veterans by reducing service gaps in VA HCBS, offering newer innovative models of care, and transforming policies and infrastructure that govern VA Long Term Services and Supports. Management should include a GAO request to conduct a follow-up report on the availability of, and veterans' access to VA HCBS, as well as VA's justification for its LTC budget requests.
- Congress direct VA to establish standards for and implementation of a VAMC-wide standardization tool for assessing the noninstitutional program needs of veterans.
- Congress require VA to establish a pilot program to allow SVHs and domiciliary care programs to offer varying levels of care, to include assisted living programs. Each program would be eligible for enhanced levels of per diem, construction grants, and other appropriate VA support.
- VA direct GEC to set time frames and implement a consistent GEC structure at the VAMC level.
- VA establish measurable goals for efforts to address key LTC challenges including workforce shortages, geographic alignment of care, and meeting veterans' needs for specialty care.
- VA make a sustained commitment to request and allocate sufficient resources for successful LTC rebalancing and adopt appropriate incentives to motivate the VA's LTC system's rebalancing.
- VA adopt an evidence-based needs assessment instrument to determine the sufficient level of HCBS needed for veterans and caregivers to remain active participants in their communities.
- Congress pass legislation authorizing VA to enter into contracts and agreements for the placement and payment of MFHs for veterans unable to safely live independently.
- Congress enact legislation to begin phase two of the caregiver program expansion on or before October 1, 2021.





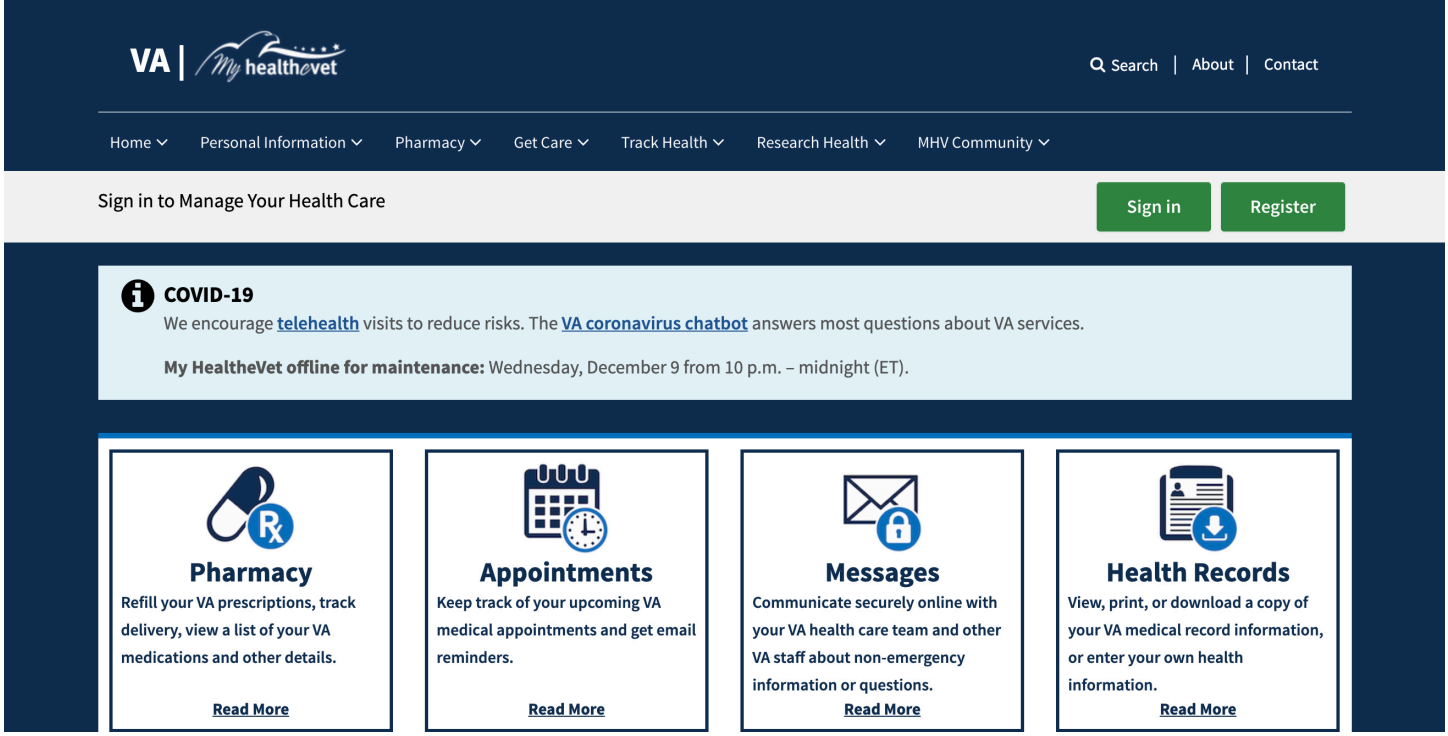
6 Improve VA Scheduling System, Supply Chain, & Fourth Mission

The Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) operates one of the nation's largest health care delivery systems, with over 160 medical centers and more than 1,000 outpatient facilities. Over the past decade, VA has struggled with appointment scheduling challenges and staffing shortages, which helped contribute to VA's wait-time scandal in 2014. The department also has longstanding problems with its medical supply chain, which according to the U.S. Government Accountability Office (GAO), includes ineffective purchasing of medical supplies and lack of reliable data systems.[5] This became a significant issue during the novel coronavirus (COVID-19) pandemic when the VA experienced critical supply shortages in personal protective equipment.

In 2018, VA signed a 10-year, $10 billion-dollar contract with Cerner Corp to develop an electronic health record (EHR) system that would mesh seamlessly and securely with the Department of Defense (DOD) and private sector systems. However, as VA approaches the launch of its new EHR program, lawmakers continue to worry about the program's rollout and its interoperability with DOD's health record modernization efforts. During a September 30, 2020, congressional hearing on EHR modernization's progress, Rep. Jim Banks, R-IN, the subcommittee's ranking member, expressed serious concerns about the system's future course and requested a revamped timeline from VA to ensure it would be able to be interoperable with DOD.[6]

Simultaneous to the EHR system launch, VA will deploy a new Cerner patient portal, *My VA Health*, which will replace *MyHealtheVet*, a portal veterans have used since 2003.

In addition to providing health care to more than nine million of our nation's veterans, VA's "Fourth Mission" is to provide backup health care for veterans and civilians in a



national emergency. No other health care system is faced with similar challenges and VA must find ways to minimize risk while managing its massive health care portfolio.

Decrease Excessive Wait Times

On August 7, 2014, in the wake of the wait-time scandal, the VA Choice program was passed by Congress and enacted into law. The Choice program was designed to allow veterans more timely access to care outside VA at the department's expense.

However, the Choice program was confronted with many challenges from its inception. An examination by GAO found numerous factors adversely affected timely access to care through the Choice program. These factors included: 1) an administrative burden caused by complexities of the referral and appointment scheduling processes; 2) poor communication between VA and its medical facilities; and 3) inadequacies in the networks of community providers established by the department's third-party administrators (TPAs). Among the inadequacies listed were: an insufficient number, mix, or geographic distribution of community providers. VA took steps to address these factors, but some have not been fully addressed.[7]

On June 6, 2018, in an attempt to streamline its community care program, the VA MISSION Act was enacted into law and replaced the VA Choice program with the new Community Care Program.

Nearly seven years have passed since the 2014 wait-time scandal. Even after spending billions of dollars to improve access to care, House Veterans' Affairs Committee Chairman Mark Takano, D-CA, said the latest GAO findings again raise concerns about the role of the program during a September 30, 2020 hearing. "In the wake of the wait time scandal of 2014, access to care in the community was touted as the cure all," he said. "Yet this latest report suggests veterans are potentially waiting longer to access care in the community than if they opted to remain at VA because of an overly bureaucratic, administratively burdensome appointment scheduling process."[8] VA's present scheduling system requires VA staff to log-in to multiple software applications to coordinate calendars, clinicians, rooms, and equipment.

Improve VA's Supply Chain & Management System

In March 2019, GAO added VA Acquisition Management to its high-risk list due to longstanding problems such as ineffective purchasing of medical supplies and lack of reliable data systems.[9]

Testifying before the Senate Veterans' Affairs Committee on June 9, 2020, Richard Stone, D-MD, the VHA's executive-in-charge, told legislators that weaknesses in VA's system, combined with the inadequacy of the global supply chain during the pandemic, highlighted critical problems.

"For decades, the long-acclaimed, just-in-time supply system kept shelves stocked because there was always another delivery of material on the way, usually from a prime vendor who was acting as an intermedi-

ary between a manufacturer and the end-user," Stone explained. "This system has not delivered the responsiveness necessary to support the worldwide demand of health providers for medical supplies during this pandemic. More importantly, the pandemic forced us to recognize that we cannot depend on the global supply chain to equip VA just-in-time in a future disaster."[10]

Both VA officials and legislators noted that having enough supplies will do little good if the department does not have a functional supply chain management system in place. VA informed Congress that VHA has been working with DOD to replace its existing logistics and supply chain IT infrastructure. VA then adopted the Defense Management Logistics Standard Support system for a single health care logistics IT system for acquiring medical and surgical supplies.

Accelerate Response Time of VA's "Fourth Mission"

During national emergencies, VA must continue to serve its enrolled veterans' population and act as a backup to the public health care system to the greatest extent possible. VA must be properly prepared to respond to our nation's veterans' unique needs while maintaining readiness to support the health care needs of Americans when and if it becomes necessary to implement its Fourth Mission.

A White House proclamation issued March 13, 2020, declared the COVID-19 outbreak a national emergency beginning March 1.[11] However, VA did not announce its plans to open 50 beds for non-COVID-19 patients at its New York Harbor, Manhattan, and Brooklyn VA medical centers until March 29, four full weeks (or nearly one month) after the White House declaration.[12] ◆

The IBVSOs Recommend:

- VA ensure a user-friendly scheduling package, with the ability for veterans to schedule their own appointments, is included and implemented in concert with the implementation of its EHR.
- Congress require VA to develop a new staffing model that identifies and prioritizes staffing needs at the national level while supporting flexibility at the facility level.
- Congress continue to provide oversight of VA's plans to adopt DOD's health care logistics IT system for acquiring medical and surgical supplies, and ensure VHA provides Congress a realistic timeline for implementation.
- VA be required to provide timely notification to Congress whenever any elements of its emergency response plan are activated or implemented.

❼ Enhance Mental Health Services & Suicide Prevention

In fiscal year (FY) 2019, the Department of Veterans Affairs' (VA) Veterans Health Administration (VHA) provided mental health care services to 1.76 million veterans (about 29 percent of VA's enrolled patients). Veterans' need for mental health care and readjustment services has grown substantially over the last two decades in the wake of continued military deployments to Afghanistan and Iraq. In FY 2022, VA requested more than $10 billion to support its mental health programs, including inpatient, residential, outpatient, and telehealth settings, in addition to its Vet Centers.[13] It has developed counseling programs for LGBTQ veterans in recent years. It has also provided help with interpersonal violence, anger management, parenting, relationship counseling, and eating disorders. As part of its regular programming, it offers counseling services for readjustment, substance-use disorders, serious mental illness, homelessness, and post-traumatic stress disorder (PTSD).

In addition to the mental health issues experienced by the public at large, veterans have a higher risk of trauma exposure due to combat, military sexual trauma, and post-deployment readjustment challenges. Veterans are also at an elevated risk of suicide—with male veterans 1.5 times, and women veterans 2.2 times more likely to die by suicide—than nonveteran adult peers.[14] Veterans from recent deployments who enroll for VA care are more likely to seek mental health and substance-use disorder services and use them more often than veterans from earlier conflicts.[15] Still, even after VHA established suicide prevention as its top clinical priority; expanded access to care; and developed new mental health programs, clinical guidelines, and research initiatives, the rate of suicides among veterans has remained relatively constant.

Require Veteran Community Care Network (VCN) Providers to Receive Specialized Training

The VA MISSION Act required VA to establish a VCN or networks of providers and expanded veterans' access to care in the community. The Independent Budget veterans service organizations (IBVSOs) called on VHA to require Network providers to meet or exceed VA's clinical care standards and receive the same specialized training as VA mental health care providers for treating common mental health conditions among veterans.[16] VA has developed and trained about 15,000 VA providers in evidence-based practices to address PTSD and depression. Working with the Department of Defense, VA has also developed clinical practice guidelines for addressing certain issues, including managing veterans at high risk of suicide, substance-use disorders, use of opioids in managing chronic pain, traumatic brain injury (TBI), PTSD, and bipolar disorder.[17]

We believe that mandating training in evidence-based treatments will ensure community partners develop core competencies for addressing veterans' unique mental health care needs—specifically for conditions frequently associated with military service such as PTSD, depression, and TBI. Community partners can benefit from VA's vast and collective expertise in treating these conditions, deliver veteran-centric care, and demonstrate a commitment to delivering high-quality evidence-based mental health treatments to veteran patients.

Adopt Best-In-Class Practices Throughout the VHA

VA has programs, such as Primary Care Behavioral Health Integration, that serve as models for the health care industry. VHA also has an active Veterans' Crisis Line that receives hundreds of thousands of calls, texts, and chats annually, and has assigned at least one suicide prevention coordinator to serve at each VA medical center. Additionally, VA has developed guidance for its emergency departments—known as the Safety Planning for Emergency Department (SPED) initiative—to ensure veterans in crisis receive safety planning prior to discharge and follow-up contact post-discharge encouraging them to seek outpatient treatment associated with their suicidal ideation.[18] While the IB-

VSOs are pleased VA has distributed this guidance, it is not clear that it has been implemented with fidelity throughout VHA. All of VA's emergency rooms should adopt this best practice, which is associated with a significant reduction in suicidal behavior and an increase in engagement in outpatient behavioral health care post-discharge.

Mandate Suicide Prevention Training Protocols

In its efforts to further reduce veteran suicide, VA has initiated a safe storage of lethal means initiative to improve providers' counseling skills for at-risk veterans, touching on safe storage practices for prescription medication and firearms. According to VA's 2020 annual report on veterans' suicide, firearms were the method of self-harm most frequently used by veterans who died from suicide in 2018.[19] The report noted that veterans used firearms in 68.2 percent of completed suicides compared to 48.2 percent of deaths by suicide in the nonveteran adult population. Rates of suicide by firearm among male veterans were 69.4 percent compared to male nonveterans at 53.5 percent and 41.9 percent for female veterans compared to female nonveterans at 31.7 percent. Given these findings, counseling veterans in the safe storage of firearms is a critical component of suicide prevention that should be a part of any comprehensive public health strategy. To ensure proper management of suicidal risk behavior and improved health outcomes, VA should mandate this suicide prevention training protocol for all of VHA clinical staff, peer support specialists, and VCN providers.

Enhance and Diversify VA Staff and Peer Support

Finally, VA must redouble its efforts to diversify its staff to better reflect the veteran patient population it serves. Peer support specialists help create a more welcoming and personalized health care experience for new patients and veterans struggling with post-deployment mental health challenges. They can help veterans navigate the system, a large and often daunting bureaucracy, as well as promote engagement in treatment and recovery. Peer support specialists have often overcome similar challenges. They should represent subpopulations within the medical center's patient demographics, including—Black, Hispanic, Native American, Alaska Native, women, sexual minorities or other veterans who may need a more personalized and culturally sensitive approach when seeking recovery. ◆

The IBVSOs Recommend:

- Congress require mandatory suicide prevention training for all VA clinical staff and its community care partners to ensure proper screening, intervention, counseling (for lethal means safety and substance-use disorders), and treatment for veterans in mental health crises.
- Congress require that protocols included in VA's SPED initiative are mandatory for every veteran in a mental health crisis who seeks emergency care services from the VHA or a Network provider. SPED provisions include issuance and update of a mental health safety plan pre-discharge, and follow-up contact post-discharge to facilitate engagement in outpatient mental health care.
- VA continually update and plan enterprise efforts to train staff and community partners. Additionally, it should establish mental health clinical practice guidelines for commonly experienced conditions among veterans, including PTSD (related to combat and/or military sexual trauma), substance use disorders, depression, anxiety, TBI, and suicidal ideation.
- Congress permanently authorize peer retreats and create new peer support programs and integrative health treatment options that better reflect the demographics of its medical centers, including women, racial and ethnic minorities, and sexual minorities.

❽ Refine Services for Under-Served & Minority Veterans

As a system that has slowly evolved to meet the needs of an increasingly diverse population, the Department of Veterans Affairs (VA) has struggled to keep up with changing demographics in its patient population and the evolving trends in health care that may make it easier to serve disparate needs.

Women now make up approximately 10 percent of VA's enrolled veterans; racial and ethnic minority veterans account for about 20 percent of VA's patient population; and an estimated 5 percent identify as LGBTQ. While the VA health care system has made a concerted effort over time to meet the needs of its increasingly diverse patient population, differences exist in access, usage, and health outcomes among these groups. This underscores the need for continued focus on the causes of health disparities and implementing health care practices and policies to address them. For example, cultural barriers may impede the use of VA services by racial, ethnic, or sexual minorities, as well as travel times and geographic barriers, which frequently impede access to care by veterans who live in more rural and remote locations.

> **"Black & Hispanic veterans contracted COVID-19 at twice the rate of other veterans**

As the population of minority veterans grows and their access to VA services and benefits increases, VA needs to anticipate and address their known challenges. The global pandemic has focused a sharp lens on disparities in health care outcomes for many Americans, including

veterans. Black and Hispanic veterans have contracted the novel coronavirus (COVID-19) at twice the rate of other veterans regardless of underlying health conditions, where they live, or where they receive health care. Reasons for this disparity are unclear and must be explored.[20]

Minority veterans are far more likely to be homeless, unemployed (44 percent higher than nonminority peers), have chronic health conditions, and be less aware of VA benefits and services.[21] Addressing these disparities among minority veteran populations will require comprehensive and systemic changes. We urge VA to adopt culturally sensitive and representative outreach strategies to increase veterans' awareness and eligibility for VA health care, benefits, and services.

Ensure Equity of Access to Care & Improve Health Outcomes for Minority Veterans

Real or perceived bias may affect health outcomes for veterans in minority groups. A recent survey of veterans and VA medical providers found that 69 percent of respondents believe that minority patients receive lower-quality health care—but veterans and clinical providers had very different perspectives about the reasons. According to the study findings, patients attributed differences in quality primarily to provider behavior, whereas providers attributed it to patients' socioeco-

nomic and lifestyle factors. Regardless, providers believe that the VA and other health care organizations have the responsibility to help reduce identified disparities. The authors of the study concluded that effective interventions offer providers concrete ways to help reduce disparities in minority populations, rather than simply raising awareness of disparities and their contributions to them.[22] Another article found that Black veterans perceived racial bias in both verbal and nonverbal cues during VA mental health care encounters. These perceptions influenced their trust in providers, engagement in treatment, and satisfaction with care. The study authors proposed diversifying staff and using patient-centered approaches to address these perceptions.[23] Outreach and environments of care must also be culturally sensitive. Specifically, awareness campaigns and outreach materials need to include veterans of different service eras, genders, races, and ethnic backgrounds.

According to Dr. Michael Kauth, co-director of the Veterans Health Administration's (VHA) LGBTQ program, after facing discrimination and stigma in military service, LGBTQ veterans may also have perceptions of bias in VA that affect their ability to develop trusting relationships and fully engage in treatment.[24] Research indicates that LGBTQ veterans using VA report experiencing gender preference-based discrimination in health care, which can affect their comfort in disclosing their LGBTQ identity to providers. This may, in turn, jeopardize their care and subsequent education about potential health risks that differ from other veteran groups—such as a higher risk of suicide. Within this population, some veterans have a higher risk of HIV/AIDS, high blood pressure, obesity, tobacco use, and overuse of other substances which can also affect care outcomes. Creating a welcoming and inclusive environment of care and building providers' core competencies in communicating and addressing this population's needs with respect and knowledge are key to addressing these issues.[25]

Diversify the VHA Workforce

In 2020, 105 VA medical centers participated in the Healthcare Equality Index survey that demonstrates equitable treatment and inclusion for sexual and gender minority patients and staff. The VHA's current Health Equity Action Plan aims to advance and achieve equitable health services and outcomes and assure providers can deliver the highest quality of care to all veterans who use the VHA. To improve cultural competency, VHA must also improve the diversity of its health-related workforce. VA should confirm its effort to work toward the goal of a more diversified VHA staff as part of improving health equity for minority veteran populations.

Women veterans are yet another rapidly growing segment of VHA patients and they too are more likely to be from racial or ethnic minorities than male peers. While racial and ethnic disparities have been documented in the general population, prior research conducted in the VA focused primarily on male veterans. Additional studies are needed to assess health care disparities among women VA patients. Women veterans face a variety of unique issues that often leave them feeling outnumbered and less supported within the VA health care system. Women may require different diagnostic and treatment approaches to meet etiological, sociological, and cultural needs different from those of men. For example, a recent study of male and female veterans who attempted suicide indicated that women's reasons often stem from poor self-esteem. In contrast, men are more likely to believe "others" have let them down, and they can no longer fight the systems that have failed them.[26]

These perspectives require nuanced, gender-tailored interventions that address appropriate treatments and coping strategies.

VA continues to improve access to women's programs and services, but problems remain in ensuring women have access to comprehensive care and services consistently throughout the system. Implementation of Comprehensive Women's Primary Care Clinics at all VA medical centers would help ensure that women's access to coordinated and high-quality services is more seamless and timely.

Improve Minority Veterans' Patient Care

The Veterans Experience Office (VEO) recently published its study of women's experience using VA health care.[27] The study identified five crosscutting themes to improve women's overall experience with care, including the need: 1) for respect and compassion in customer service; 2) for connection with their health care provider, health team, and other women veterans; 3) for health care not easily addressed by VA; 4) to address inequities between facilities by gender and employment status; and 5) to be involved in patient care experience improvements. We strongly recommend the VEO undertake similar studies of other minority veteran subpopulations, including Black, Latinx, LGBTQ, and rural veterans, and work to ensure actions are taken to redress the problems they identify.

Rural veterans often face a variety of barriers in accessing needed health services as well—including a lack of convenient hospitals and specialized health care services; geographic and distance barriers; and provider shortages—all of which can prevent them from accessing quality and timely medical care. VA is leading the nation in telemedicine advancement. Many rural veterans can now rely on improved telehealth technology to access clinical care from their homes or designated locations closer to where they live. However, roughly one in four rural residents say access to high-speed internet is a major problem in their area, according to PEW Research Center.[28] To help address this need, the VA's Office of Rural Health (ORH) collaborated with public and private partners in fiscal year 2018 to help expand broadband access to rural communities nationwide. Some retailers

have established onsite locations so that veterans can have secure and private telehealth access to VA providers in their communities. The ORH could support this type of innovation through a grant program expanding the number of sites available for veterans who need telehealth services but live in rural, remote areas, or urban deserts without sufficient broadband.

The VA Office of Tribal Government Relations must work to ease a troubled history between the Native American Nations and the federal government, which impacts tribal communities' perceptions and trust of VA. VA's Utilization Profile for 2017 indicates that Native American and Alaska Native veterans are significantly less likely than other minority veteran groups to use VA benefits, which may reflect this lack of trust and access challenges many of these primarily rural veterans face. VA must continue to work to build trust in these communities. It must also address ongoing challenges in partnering with the Indian Health Service and tribal councils and ensure it addresses logistical challenges to assist veterans with transportation and telecommunications needs to improve access to VA care, benefits, and support services.

Foster a Culture of Trust and Action

Finally, VA must continue to improve its culture to ensure that all veterans feel safe and welcome at VA facilities. Veterans, regardless of their race, ethnicity, sex, sexual orientation, or religion must know that they will be treated with respect and dignity in a system designed to serve them and meet their unique health care needs. For successful culture change, VA must expeditiously create anti-harassment policies for both VA staff and veteran patients. These policies must be highly publicized and reports of harassment quickly addressed and handled with the dignity and respect that should be afforded to those who served their country. All veterans must be part of the solution to ending stranger harassment in VA facilities.

Diversifying the composition of VA's staff is essential to ensuring VA's services are culturally sensitive and appropriate. Expanding the use of peer support specialists who reflect subpopulations, including racial and ethnic minorities, LGBTQ, and women can also help veterans by offering peer models from similar backgrounds who have often overcome challenges similar to their own. ◆

The IBVSOs Recommend:

- VA ensure that all veterans in its health care system have equitable access to care, specialized services, and positive health outcomes.
- VA review and update policies and directives in place to deliver improved services to minority, under-represented, and under-served veteran populations.
- VA expand research and data analysis to identify health utilization and attrition trends, health disparities, and outcomes among minority veteran populations. It must also ensure that all research endeavors include representative samples of minorities including geographically diverse, Black, ethnic, women, and LGBTQ veterans.
- VA investigate cultural differences that may be a barrier to care for veteran subpopulations and develop ways to improve outreach to groups at risk.
- VEO evaluate the overall patient care experience of minority and underserved veterans through focus groups to better understand the unique challenges they face in accessing VA benefits and health care services. The VEO should share that information with VA program offices to ensure that all veterans feel welcome and safe in VA facilities and that services are tailored to meet their needs.
- VA hire employees and veteran peer support providers that reflect the diverse veteran population VA serves to better understand and meet minority veteran populations' needs.

9 Ensure Sufficient VA Health Care Staffing

Before the pandemic, the Department of Veterans Affairs (VA) had roughly 45,000 unfilled vacancies, including about 2,500 primary care physicians, more than 700 psychologists, and 1,900 social workers. The pandemic brought on an increase in telehealth appointments for veterans to continue their care and amplified precautions for in-patient care. Therefore, additional VHA environmental quality assurance measures were carried out to stop the spread of the virus. VA called on retirees to come back to work and shifted staff among departments. By relaxing some of its own policies, the VHA was able to hire thousands of new employees, including 3,300 physicians and more than 12,400 registered nurses. The VHA has experienced chronic health care professional shortages for many years, which diminishes the department's ability to deliver timely, accessible, and high-quality care and, in some cases, places the health and well-being of veterans at risk. Even though VA has taken many steps to track and address staffing shortages, a more cohesive plan is needed to maintain adequate staffing levels for the timely delivery of veterans' care. Countless times, the most cited challenges to improving VHA staffing fell into three distinct categories: 1) the lack of qualified applicants; 2) noncompetitive salaries; and 3) high staff turnover.

> "Multiple gaps in VA training were found to put veterans' health at risk

Introduce Staffing Models

Over the years, VA's vacancy rate has remained a concern as VA seeks to provide efficient, high-quality care. Since 2015, the VA Office of Inspector General annual report on staffing shortages recommended VHA develop and implement staffing models, especially in critical need occupations.[29] Staffing models that consider work activity, labor hours, collateral duties, employee's time spent on tasks, the ratio of staff members to veterans enrolled in a specific catchment area, and calculation of cost, would allow VA to better assess their current workforce, and forecast necessary coverage and growth needs in the future. According to a U.S. Government Accountability Office (GAO) report from October 2019, one-third of VA employees who were on board as of September 30, 2017, will be eligible to retire by 2022.[30] VA can gauge when positions will be vacant due to retirement, maternity/paternity leave, or other predictable reasons. By being proactive and anticipating va-

cancy rates, along with projected estimates for veterans increased demand for care in specific needs and changes in the veteran population, VA can better manage employee retention and recruitment.

Increase Workforce Salary

Implementing the VA MISSION Act created and funded multiple opportunities for VA to explore alternative staffing models, as well as expand incentives to recruit and retain talented professionals and valuable nonclinical employees. Section 106 requires VA to perform market assessments of medical staff, salaries, incentives, and other benefits to gain better insight into where VA medical centers stand compared to their community health care systems. Medical professional associations and the Department of Labor can assist in accessing local and national competitive pay scales.

Like other health care systems, the VHA needs to continue to say abreast of the competition in the private sector. The cost of living through market assessments and additional studies can ensure VA employees earn a salary that allows them to live and work within the communities they serve. Certain areas, like Hawaii, Alaska, California, and New York City, have an extremely high cost of living. A specific locality pay formula that considers these extreme areas can make them more attractive and alluring, allowing them to fill their staffing vacancies.

Strengthen VA Oversight & Accountability

As the nation's largest integrated health care system, VA employs over 320,000 health care professionals and support staff. According to a February 2015 report, GAO added managing risk and improving VA health care to the High-Risk List. The GAO High-Risk List is comprised of programs that are vulnerable to fraud, waste, abuse, and mismanagement. One of the five concerns from this report was inadequate training for VA staff. Multiple gaps in VA training were found to have put veterans' health at risk. An excessive administrative burden can often contribute to health care professional burnout. To continue to nurture the highest quality providers, GAO recommended establishing performance pay goals for their providers. Oversight, accountability, and transparency need to continue until VA is off the High-Risk List.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Execute Effective Succession Planning

A continued stream of new health care professionals and nonclinical staff is needed for the VHA to maintain a robust and viable care system for our nation's veterans. Recently, VA informed Congress they would like to retain some of the modified procedures to help with recruiting once the national emergency is over. Although this may help in the near term, without a concerted effort by the VHA and Congress to improve incentives and address retention problems, the staffing shortages will persist and worsen. A March 2019 GAO report mentions that the lack of effective succession planning will hamper VA's ability to develop a pool of potential staff to meet its mission over the long term. Experienced and capable employees must be able to take on and continue VHA's mission. Many health professional trainees seek the opportunity to train in the nation's largest health care system, and VA prides itself on offering an education with cutting-edge and innovative technology. The Office of Academic Affiliations cultivates the important partnership between the VHA and academic institutions. Title III of the VA MISSION Act allows the VHA to make critical improvements to recruit health care professionals. Relationships with these health care professional associations and certifying boards can keep the VHA abreast of industries' wants, needs, and ambitions. Incentives to cultivate and retain nonclinical employees, such as the environment of care specialist, is vital for the VHA to continue to improve its services and make needed adjustments into the future related to the pandemic and its impact on the worlds nation systems.

> **"Lack of effective planning will hamper VA's ability to develop new staff**

Workplace safety is vital to the retention and recruitment of employees. VHA employees have the right to a safe and healthy work environment, free of all hazards, including sexual harassment. A GAO report from July 2020 released findings from a survey in which an estimated 22 percent of VA employees reported experiencing some form of sexual harassment. The GAO's recommendations were to: realign VA's equal employment opportunity (EEO) leadership, Veterans Benefits Administration, and the VHA EEO Program Managers realign initiative in accordance with VA policy; review existing policies to ensure alignment with VA's sexual harassment policy; finalize the Harassment Prevention Program (HPP) directive and handbook; require reporting procedures for all sexual harassment complaints; and require additional training to identify and address sexual harassment, including the HPP process. While VA concurred with the majority of the recommendations, it stated the completion date could be as late as 2024. We appreciate that the needle is moving forward but urge the VA to make this a priority and complete these needed changes prior to 2024. ◆

The IBVSOs Recommend:

- VHA develop and implement staffing models that correlate with the current needs of veterans. Ideally, this action would include: exploring new pay and compensation models, complete with lifting pay caps to help lure talented professionals in certain VA markets; producing research studies that examine the gaps in high cost of living areas; and developing a specific locality pay formula.
- Congress support VHA's efforts to provide additional pay, compensation, and retention incentives to make VA service more competitive with the private sector.
- VA design effective succession planning to ensure adequate VHA staffing is available in future years to meet veteran health care needs.

Employment & Education

⑩ Tackle Veteran Employment Challenges

According to the Bureau of Labor Statistics (BLS), prior to the 2020 novel coronavirus (COVID-19) pandemic, veteran unemployment numbers were some of the lowest in over 19 years. Unemployment numbers for veterans with disabilities; however, have continued to lag behind the rest of the veteran population. Currently, veteran unemployment numbers are much higher, with some studies finding that many veterans with disabilities have left the labor market altogether. The Independent Budget veterans service organizations (IBVSOs) recommend tailoring employment solutions to: better meet the needs of veterans with disabilities; ready job-seeking veterans into high-demand occupations; support organizations helping veterans find employment; improve the Department of Veterans Affairs' (VA) Veteran Readiness and Employment (VR&E) program; and help veterans and military spouses with credentialing and licensing issues. We also recommend better supporting Veteran-Owned Small Business (VOSB) and Service-Disabled Veteran-Owned Small Business (SDVOSB) programs to ensure veterans remain gainfully employed throughout and following the pandemic.

Improve Employment Support for Veterans with Disabilities

According to the Department of Labor (DOL), veterans with service-connected disabilities are less likely to participate in the labor force than veterans without disabilities.[1] Veterans with nonservice-connected disabilities experience similar challenges; only 37 percent are employed compared to more than 75 percent of veterans without disabilities.[2] Veterans with disabilities, especially those with catastrophic disabilities, often face significant challenges in finding and obtaining employment within their capabilities.

We have only seen these challenges exacerbated by the COVID-19 pandemic and current economic recession. Once the national pandemic took hold, the number of unemployed veterans almost tripled.[3] Fourteen percent of veterans are working in the top five industries most impacted by COVID-19.[4] A recent study by the Brookings Institute reports that 42 percent of jobs lost to COVID-19 are not returning.[5] And as of September 2020, data suggests that many individuals with disabilities are no longer on furlough or actively looking for work and are leaving the employment market.[6]

We cannot have a robust discussion around employment if we do not discuss the health benefits of mean-

ingful and gainful employment. The shelter in place orders resulted in a drastic rise in calls to the VA crisis line and increased mental health-related telehealth appointments. Isolation is a strong predictor of suicide and can lead to exacerbation of mental illness and disorder symptoms, and contribute to conditions such as depression, anxiety, and dementia.[7] Experts agree that employment can positively factor in recovery from illness and enhance mental wellness, especially when compared to unemployment. Meaningful employment provides daily structure and a sense of self-worth, as well as supports social engagement.[8] Thus, not only is it financially important to get veterans back to work, but it is also better for their overall health.

Additional employment challenges for veterans include age, gender, race, and geography. According to DOL's BLS, among the 284,000 unemployed veterans in 2019, 56 percent were ages 25 to 54, 39 percent were age 55 and over, and 5 percent were ages 18 to 24.[9] And according to a 2018 VA Report, minority veterans face a 44 percent higher risk of unemployment than nonminority veterans.[10] Working-age rural veterans (18 to 64 years old) had a lower employment rate than rural nonveterans and urban veterans.

Lastly, to be successful in employment or school, veterans with significant disabilities must have access to safe and reliable transportation. Congress authorizes VA to provide a one-time grant to eligible veterans to use toward the purchase of a new or used automobile to accommodate certain disabilities that resulted from a condition incurred or aggravated during active military service. The substantial costs of modified vehicles, coupled with inflation, present a financial hardship for many disabled veterans who need to replace their primary mode of transportation once it reaches its lifespan. The IBVSOs recommend Congress establish multiple automobile grants for veterans to use once every 10 years, totaling the current grant maximum in effect at the time of vehicle replacement.

Improve Employment Programs to Better Serve Veterans with Disabilities

Veterans with disabilities run the risk of adverse outcomes if they contract COVID-19 due to their comorbid conditions. Thankfully, COVID-19 has helped change the narrative around work-from-home and the productivity of employees. However, increased unemployment throughout the nation means veterans are now competing for work-from-home positions with hundreds of other candidates, resulting in significantly reduced public transportation schedules. Thus, veterans with disabilities will need additional support to plan their return to employment.

VA's VR&E program has successfully helped many service-connected veterans pursue employment and educational opportunities. However, the IBVSOs remain concerned about the high caseloads VR&E counselors maintain as it limits the amount of time they can spend with veteran clients assessing their current status, needs, goals, and what determines meaningful employment for that veteran. Congress should study changing the current program eligibility standards to determine if doing so would streamline the process by expanding eligibility to all veterans who have been awarded service-connected disability ratings, regardless of the degree of disability. Many veterans also continue to experience high turnover rates of their VR&E counselors, which can affect their long-term success in the program.

As a result, the IBVSOs would like to see the VA Office of Inspector General conduct an assessment of the VR&E program staff. This assessment will determine the average amount of time each counselor spends working with a veteran, the rate of staff turnover, the length of time between counselor engagement, and the length of employment for veterans placed into positions through VR&E. This will ensure that there are sufficient staffing levels and a low rate of attrition, which is vital to the success of this critical program. By pursuing education, training, or civic engagement, veterans will be better equipped to re-enter the workforce when the pandemic subsides or when they have work-from-home employment opportunities. The IB-

VSOs recommend eliminating the delimiting date of the eligibility period for veterans participating in the VR&E program to account for disruptions in the employment and educational process due to COVID-19 and the accompanying economic recession.

Assist Veterans Return to Work Post-COVID-19

As we initiate efforts to help veterans get back to work, we must focus our valuable resources and time on getting them into jobs that are in demand. Thus, the IBVSOs strongly support programs like the Veterans Employment Through Technology Education Courses and the Rapid Retraining Program to strengthen existing retraining job opportunities and establish new resources to get veterans back on their feet. Congress should also authorize grants to third-party organizations that specialize in transition and employment services. We call on Congress to enact legislation expeditiously to support these types of initiatives.

No one entity can meet the needs of all disabled veterans. However, together, we can think beyond what we traditionally do for veterans seeking employment and

> **"COVID-19 helped change the narrative around work-from-home & productivity of employees**

adopt innovative ways forward to better help veterans with disabilities. This means offering robust training and upskilling programs, including paid training and internships, to bridge the financial gap as well as providing more guided employment programs to assist veterans with disabilities in exploring new career fields.

Support Certification & Licenses for Active Duty Personnel and Spouses

Research has shown that veterans who hold certificates and certifications generally receive higher wages than veterans who do not.[11] Still, they often face challenges in translating their military experience to civilian recognition. The Department of Defense (DOD) establishes, measures, and evaluates performance standards for every occupation within the armed forces, providing some of the nation's best vocational training to its military personnel. Unfortunately, that training is generally not recognized as fulfilling state and private sector certification and licensure requirements for civilian equivalent occupations. This means many former military personnel, certified as proficient in their military occupational specialty, are not recognized as certified or licensed to perform a comparable job in the civilian workforce once they leave the military.

The IBVSOs recommend DOD, in collaboration with states, unions, and certifying/licensing entities, expand its training curriculum to meet the various certification and licensure requirements of applicable civilian equivalent occupations. Congress must facilitate a national dialogue, working closely with DOD, VA, and DOL, as well as state governments, employers, trade unions, and licensure and credentialing entities. Together, they should establish clear processes so that military training meets civilian certification and licensure requirements for the states in which veterans choose to live once they leave military service.

Additionally, we are concerned about the unemployment of military spouses. The BLS does not track statistics on military spouse employment but other organizations estimate this rate is as high as 26 percent, more than seven times the national average.[12] Underemployment estimates among military spouses are as high as 51 percent. Many of these men and women move from state to state with their service member spouse and having interstate agreements for licensing portability would help support employment for military spouses.[13]

Improve Veteran-Owned Small Business (VOSB) and Service-Disabled Veteran-Owned Small Business (SDVOSB) Programs

Programs like the VOSB and SDVOSB contribute significantly to restoring veterans' quality of life while aiding

in their transitions from active duty to civilian life. However, many federal agencies have not reached the government-wide three percent goal of set-aside contracts.[14] Federal agencies must be held accountable to meet the federal procurement goals outlined by Executive Order No. 13360 and sections 15(g) and 36 of the Small Business Act, which gives agency contracting officers the authority to reserve certain procurements for SDVOSBs. Congress should enact legislation requiring the federal government to set-aside goals of no less than three percent mandatory objectives rather than goals. Additionally, Congress should require underperforming federal agencies to make up for shortfalls in achieving these objectives in the subsequent fiscal year. In addition, VA must hire and train a sufficient number of employees to quickly and effectively certify and recertify veterans' small businesses.

Veterans who have done the work to meet the many prerequisites to be awarded an initial federal contract present an additional challenge to their families and employees when they die. Accommodations must be made so businesses built and operated by ill and injured veterans can continue to thrive and support not only the owner's family, but also the families of those who are employed through these SDVOSBs. ◆

The IBVSOs Recommend:

- Congress establish multiple automobile grants for veterans to use once every ten years, totaling the current grant maximum in effect at the time of vehicle replacement as access to transportation is critical for both training and employment.
- Congress provide sufficient resources for VR&E to explore new methodologies to formulate a proper client-to-counselor ratio based on the challenges associated with more severely disabled veterans. They must: study changing the current program eligibility standards; and direct the VA OIG to assess the VR&E program.
- Congress introduce and pass employment programs aimed at getting veterans quickly back to gainful employment in high-demand fields as well as legislation to strengthen existing retraining job opportunities and establish new resources.
- Congress engage in a national dialogue with the public and private sector to establish clear processes, so that military training matches civilian certification and licensure requirements.
- Congress direct the DOL to track statistics related to military spouse unemployment and underemployment so that there is an understanding of the unique challenges they face.
- Congress enact legislation requiring the federal government to make set-aside goals of not less than three percent mandatory objectives rather than goals. Congress should require underperforming federal agencies to make up shortfalls in achieving these objectives in the subsequent fiscal year.
- Congress enact legislation to provide a reasonable transition period for all SDVOSBs to retain their status with the federal government following the death of a service-disabled veteran business owner via a surviving spouse, children, or heirs; thus, allowing the business to restructure over time without downsizing, laying off workers, or closing.

⓫ Upgrade GI Bill & Education Benefits

Implement Digital GI Bill Upgrade

The Department of Veterans Affairs (VA) has had shortcomings for years, specifically surrounding Information Technology (IT). There have been minor delays in processing claims and benefits, and there have been catastrophic failures such as the Forever GI Bill housing payment issue in the fall of 2018. Without adequate IT resources capable of performing critical administrative tasks, there will inevitably be more breakdowns in the delivery of veterans' benefits or services.

Many new IT systems were recently developed and implemented by the Veterans Benefits Administration (VBA) to support several program transformations. However, limited IT funding has caused delays in developing and deploying critical IT systems and programming each year. Critical IT systems are rarely fully developed before business process changes are implemented. Instead, they are phased in over several years, forcing the VBA to rely on an inconsistent mix of old and new IT systems, as well as an endless stream of suboptimal workaround solutions.

While it may be understandable from a budgetary perspective, it is a failure from a functional perspective. Providing only partial IT solutions inevitably results in a loss of productivity and often leads to lower quality and less accurate decisions on veterans' claims and appeals.

There are multiple platforms within VA's Education Services (VA ES) that need critical IT upgrades: programs that process original and supplemental claims; VA ES' interaction with the State Approving Agencies (SAA); VA-ONCE; and its Business Decision Network, which is a legacy system long overdue for replacement. These are just some of the platforms within VA ES that should be upgraded and streamlined into single programs to make customer service more efficient and cut costs.

The Independent Budget veterans service organizations (IBVSOs) propose the "Digital GI Bill '' upgrade as the best, most cost-efficient upgrade to bring VA ES into the 21st century. A one-time fully funded infusion of resources for VA's IT programs, specifically aimed at VA ES, would overhaul many of the long-needed platforms that the office is struggling to maintain. It would also allow VA ES to function properly, instead of consistently requiring workarounds and patchwork solutions to maintain functionality.

The Digital GI Bill would accommodate many requests Congress and veterans service organizations (VSOs) have been making for years. After the IT overhaul, VA ES would have a cleaner platform to replace VA-ONCE for School Certifying Officials, SAAs, and VA officials, so they can all have the ability to view one screen when interacting with each other instead of different individual platforms. The GI Bill Comparison Tool would be able to be upgraded regularly instead of housing years old information that is difficult to corroborate or edit once in place. It could provide a digital Certificate of Eligibility for GI Bill using similar automated technology as the VA Home Loan. It would also allow for platforms to be introduced that can accommodate the data-sharing agreements between VA and other agencies. Finally, it would be able to track GI Bill users so easier notifications can be made to all benefits users to deliver timely information regarding updates or changes.

> **"The Digital GI Bill upgrade is a long-overdue upgrade to a critical program office within VA**

The Digital GI Bill upgrade is a long-overdue upgrade to a critical program office within VA. Far too many times stakeholders, such as Congress and VSOs, have collectively overlooked IT resources for new programs and needed changes within VA ES. For example, a change to VA Work-Study was recently passed into law adjusting the payment schedule for work-study recipients. Unfortunately, VA does not have a current platform to calculate and deliver those new payments, and no additional IT funding was provided to support the program's changes. Unfunded mandates such as the work-study change will lead to VA ES trying to create yet another workaround, and to use already overworked and outdated systems to perform a new task for which they were not intended.

We believe that every new proposal going forward must include IT needs to accomplish program goals. Minor delays can be avoided by ensuring proper IT funding is added to all new proposals. Hopefully, we can avoid a repeat of what took place during the Forever GI Bill's final implementation.

A project initiative like the Digital GI Bill would set VA ES up for success for future years to come. It would also head off any delays by ensuring veterans receive their benefits to utilize some truly life-changing programs offered by VA.

Standardize Military Housing Allowance (MHA)

The current payment rate of GI Bill MHA for students attending school exclusively through Online Training is half the national average. In 2020, COVID-19 pushed most education classes to an online only format for certain periods of time. This highlighted the need to revamp the basic allowance for housing payment scale for online-only training. The IBVSOs recommend a standardized payment model for all online-only education training that sets a standard rate closer to the in-person payment rates for all GI Bill beneficiaries utilizing online or distance learning. ◆

The IBVSOs Recommend:

- VA request and Congress authorize and appropriate $250 million for the Digital GI Bill IT upgrade.
- Congress consolidate GI Bill MHA rates for online-only and in-person training students.


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1920
2020
A Century of
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For more than 30 years, The Independent Budget veterans service organizations (IBVSOs)—DAV (Disabled American Veterans), Paralyzed Veterans of America (PVA), and the Veterans of Foreign Wars of the United States (VFW)—have worked to develop and present concrete recommendations to ensure that the Department of Veterans Affairs remains fully funded and capable of carrying out its mission to serve veterans and their families, both now and in the future. Throughout the year, the IBVSOs work together to promote their shared recommendations, while each organization also works independently to identify and address legislative and policy issues that affect the organizations' members and the broader veterans' community.

Disabled American Veterans (DAV)

DAV (Disabled American Veterans) empowers veterans to lead high-quality lives with respect and dignity. It is dedicated to a single purpose: keeping our promises to America's veterans. DAV does this by ensuring that veterans and their families can access the full range of benefits available to them; fighting for the interests of America's injured heroes on Capitol Hill; linking veterans and their families to employment resources; and educating the public about the great sacrifices and needs of veterans transitioning back to civilian life. DAV, a non-profit organization with more than one million members, was founded in 1920 and chartered by the U. S. Congress in 1932. Learn more at **www.dav.org**.

Paralyzed Veterans of America (PVA)

Paralyzed Veterans of America (PVA), founded in 1946, is the only congressionally chartered veterans service organization dedicated solely for the benefit and representation of veterans with spinal cord injury or disease. For 75 years, the organization has ensured that veterans receive the benefits earned through their service to our nation; monitored their care in VA spinal cord injury centers; and funded research and education in the search for a cure and improved care for individuals with paralysis.

As a life-long partner and advocate for veterans and all people with disabilities, PVA also develops training and career services, works to ensure accessibility in public buildings and spaces, and provides health and rehabilitation opportunities through sports and recreation. With more than 70 offices and 33 chapters, PVA serves veterans, their families, and their caregivers in all 50 states, the District of Columbia, and Puerto Rico. Learn more at **www.pva.org**.

Veterans of Foreign Wars of The United States (VFW)

The Veterans of Foreign Wars of the U.S. (VFW) is the nation's largest and oldest major war veterans' organization. Founded in 1899, the congressionally-chartered VFW is comprised entirely of eligible veterans and military service members from the active, Guard and Reserve forces. With more than 1.6 million VFW and Auxiliary members located in 6,200 Posts worldwide, the nonprofit veterans' service organization is proud to proclaim "*NO ONE DOES MORE FOR VETERANS*" than the VFW, which is dedicated to veterans' service, legislative advocacy, and military and community service programs. For more information or to join, visit our website at **www.vfw.org**.

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