STATEMENT OF
TERESA BOYD, DO
ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH
FOR CLINICAL OPERATIONS
VETERANS HEALTH ADMINISTRATION (VHA)
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH

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Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee. Thank you for inviting us here today to present our views on several bills that would affect VA health programs and services. Joining me today are Dr. Patricia Hayes, Chief Consultant, Office of Women's Health Services, and Dr. David Carroll, Executive Director, Office of Mental Health and Suicide Prevention.

Madame Chairwoman, while it is not on today's agenda, we have taken the opportunity to include in this testimony VA's views on H.R. 3495, the Improve Well-Being for Veterans Act, because of the urgency of addressing the issue of Veteran suicide. H.R. 3495 would fulfill a critical legislative component of the Administration's multi-faceted program to prevent Veteran suicide.

H.R. 1163 VA Hiring Enhancement Act

Section 2 of this bill would amend title 38, United States Code (U.S.C.), by adding a new section 7414 to restrict the applicability of non-VA covenants not to compete to the appointment of certain VHA personnel, specifically those appointed under 38 U.S.C. section 7401. Section 2 would further require an individual appointed to such a position to agree to provide clinical services at VA for a duration beginning from the date of their appointment and ending on the latter of either 1 year after the date of appointment, or the termination date of any covenant not to compete that was entered into between the individual and the non-VA facility. The Secretary would have the authority to waive this particular requirement.

VA has concerns with section 2 of this proposed bill and requests the opportunity to discuss the bill further with the committee.

Section 3 of the bill would amend section 7402 to permit VHA to make a contingent appointment as a VHA physician on the basis of the physician completing their residency training.

VA also has concerns with this section and requests an opportunity to further discuss. With regard to section 3, VA recommends removing the language regarding the completion of a residency leading to board eligibility, subsection (b)(1)(B)(i), since the requirement for residency training is provided in the published VA physician qualification standard (VA Handbook 5005, Part II, Appendix G2). Physicians must have completed residency training or its equivalent, approved by the Secretary in an accredited core specialty training program leading to eligibility for board certification. Approved residencies are as follows:

- Those approved by the accrediting bodies for graduate medical education, the Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA), in the list published for the year the residency was completed; or
- Other residencies or their equivalents which the local Professional Standards Board determines to have provided an applicant with appropriate professional training. The qualification standard also allows for facilities to require VA physicians involved in academic training programs to be board certified for faculty status.

VA also recommends removing the language regarding an offer for an appointment on a contingent basis, subsection (b)(1)(B)(ii), since VA may currently provide job offers to physicians pending completion of residency training. There are no restrictions in statute or VA policy on making job offers contingent upon completing residency training and meeting other requirements for appointments as physicians within VHA. If this needs to be clarified in statute, VA suggests including the information in a new subsection (h) as follows: Section 7402 of title 38, U.S.C., is amended by adding at the end the following subsection (h): "(h) The Secretary may provide job offers to physicians pending completion of residency training programs and completing the requirements for appointments under subsection (b) by not later than 2 years after the date of the job offer."

H.R. 1527 Long-Term Choice Veterans Care Act

H.R. 1527, the Long-Term Care Veterans Choice Act, would amend section 1720 to add a new subsection (h) providing authority for the Secretary to pay for long-term care for certain Veterans in Medical Foster Homes (MFH) that meet Department standards. Specifically, the bill would allow Veterans, for whom VA is required by law to offer to purchase or provide nursing home care, to be offered placement in homes designed to provide non-institutional long-term supportive care for Veterans who are unable to live independently and prefer to live in a family setting. VA would pay MFH expenses by a contract or agreement with the home. VA would be limited to furnishing care and services, and paying for MFH care, to no more than a daily average of 900 Veterans in any year. One condition of providing support for care in an MFH would be the Veteran's agreement to accept Home Based Primary Care or Spinal Cord Injury Home Care program furnished by VA. These amendments would take effect October 1, 2020, and VA would be authorized to carry out this program for a period of 3 years.

VA endorses the concept of using MFHs for Veterans who meet the appropriateness criteria to receive such care in a more personal home setting. VA endorsed this idea in its Fiscal Year (FY) 2018, 2019, and 2020 budget submissions and appreciates the Committee's consideration of this concept. Our experience has shown that VA-approved MFHs can offer safe, highly Veteran-centric care that is preferred by many Veterans at a lower cost than traditional nursing home care. VA currently manages the MFH program at over two-thirds of our medical centers, partnering with homes in the community to provide care to nearly 1,000 Veterans every day. However, Veterans are solely responsible for the expenses associated with MFH care today. Of the 1,000 Veterans in MFHs currently, 200 would be eligible for care at the MFH at VA expense under this bill. Our experience also shows that MFHs can be used to increase access and promote Veteran choice-of-care options. We appreciate that the bill would provide VA more than 1 year to implement this new benefit, as this would provide VA sufficient time to ensure contracts or agreements are in place, and that policies and regulations, if needed, are in effect.

While VA fully supports the MFH concept, we would look forward to working with you to resolve a few technical issues in this bill. For example, the limitation in proposed subsection (h)(2), regarding a limit "in any year" of a "daily average" of 900 or fewer Veterans receiving care, is ambiguous; it is unclear how the limitation to a given year qualifies the daily average and how VA could operationalize this effectively. VA would like to work with the Committee to ensure VA can effectively incorporate MFHs into the continuum of authorized long-term services and support available to Veterans. We are happy to provide the Committee with technical assistance on this matter and are available for further discussion.

VA estimates that, if enacted, this bill would cost approximately $6.2 million each year for administrative expenses associated with the program, with total administrative expenses reaching $18.72 million. However, we estimate that the resulting savings from paying for MFH care in lieu of nursing home care would result in net savings of $16.10 million in FY 2021, $29.21 million in FY 2022, and $43.03 million in FY 2023 for a total net savings of $88.34 million over the 3-year program.

H.R. 2628 VET CARE Act of 2019

H.R. 2628 contains two substantive sections affecting VA's provision of dental care benefits. Section 2 of the bill would amend section 1712 to include a new subsection (d) that would authorize VA to furnish administrative support (including information for the provider to share with Veterans regarding the VA Dental Insurance Program) to persons providing dental care to Veterans separate from VA's authority.

VA strongly supports this section, if amended. We sought similar authority for a community partnered collaboration to expand dental care for Veterans in the FY 2020 budget request. VA has limited statutory authority to furnish dental care to Veterans. This section would authorize VA to provide administrative support for the provision of needed dental care in the community to Veterans who are not eligible to receive that dental care from VA. The section would authorize VA staff, in the scope of their normal duties, to work with community dental providers approved by the Secretary to coordinate and schedule dental appointments for these Veterans in the community.

We believe the bill should be amended, however, to not limit the provision of administrative support to providers of dental care; we anticipate that in many cases, VA medical support assistants or providers would be offering administrative support directly to Veterans, advising them of the availability of pro bono or other services from community providers furnishing care independently from VA. We would be happy to work with the Committee to provide the necessary amendments for this purpose. We also recommend a technical amendment to replace the "; and" with a period at the end of subsection (d)(2)(B), as that subparagraph is not followed by a subparagraph (C) and subsection (e), as redesignated, would not logically be connected to or qualify the rest of subsection (d)(2).

We estimate this section would have no cost to the Department.

Section 3 would require VA to carry out a pilot program to provide outpatient dental services and treatment, and related dental appliances, to participating Veterans at no cost to these Veterans. The purpose of the pilot program would be to determine whether there is a correlation between Veterans receiving such services and treatment, and the Veterans suffering fewer complications of chronic ailments, thereby yielding a lower cost of care. To be eligible to participate in the pilot program, a Veteran would have to be: (1) enrolled in VA health care; (2) ineligible for dental care under section 1712; (3) not receiving regular periodontal care; (4) between 40 and 70 years of age; and (5) diagnosed with type 2 diabetes. Eligible Veterans would have to elect to apply for the program, and any eligible Veteran who applies for the pilot program would receive an initial periodontal evaluation, including vertical bitewing radiographs. If an eligible Veteran diagnosed with periodontal disease required surgery, the Veteran would be disqualified from participating in the pilot program. Subsection (c) would require VA to enroll at least 1,500 eligible Veterans for the pilot program, giving preference to Veterans with service-connected disabilities that increases in accordance with the Veterans' disability ratings in a manner that ensures one-third of eligible Veterans enrolled in the pilot program have been diagnosed with no or mild periodontitis, and two-thirds of eligible Veterans enrolled in the pilot program have been diagnosed with moderate to severe periodontitis. VA would have to begin the pilot program within 180 days of the date of the enactment of this Act and carry out the pilot program for a 4-year

period. VA would have to carry out the pilot program in five VA facilities, with one such facility in each of five Veterans Integrated Service Networks (VISN) the Secretary considers appropriate for the pilot program. Each facility would have to serve not more than one-fourth and not fewer than one-sixth of the Veterans enrolled in the pilot program, in approximately even proportions of Veterans categorized under subsection (c). VA would be required to make timely and appropriate periodontal therapy available to Veterans with moderate to severe periodontitis. Each eligible Veteran who elected to receive treatment would receive an annual dental evaluation, during which the periodontal health of the Veteran would be reassessed and recorded for purposes of determining the severity of the Veteran's periodontitis. VA would have to collect and record data regarding the health of treated Veterans, including events, treatments, and outcomes; these data would have to be made available for analysis by qualified researchers. VA would have to provide standardized instructions to all physicians and dentists who work in facilities selected for the pilot program to ensure consistent evaluation and care for Veterans enrolled in the pilot program. VA would also have to provide each Veteran enrolled in the pilot program with an orientation and information before any care was provided under the pilot program, as well as an exit interview that includes information regarding how such Veterans may obtain dental services and treatment after the pilot program ends. VA would have to notify institutions of higher education that offer degrees in periodontology about the pilot program so that such institutions may engage in similar studies regarding private periodontal care for Veterans. VA would have to submit a report of findings to Congress within 18 months of the conclusion of the pilot program. Finally, VA would be required to administer the pilot program under such regulations as the Secretary would prescribe, including best practices regarding informed consent and study registration.

VA does not support section 3 of the bill. We are concerned the bill would create disparities in the overall application of dental eligibility under section 1712 by expanding access to these benefits to Veterans in participating locations but not elsewhere. We believe this could have the unintended consequence of Veteran dissatisfaction. We have serious concerns about the provision in the bill that would disqualify from treatment a Veteran who has been comprehensively examined and for whom surgery

has been deemed necessary. This would be unethical and against VA's core values and professional standards of care. Dis-enrolling Veterans who have advanced periodontal disease after examination could be a stressor on Veterans who believed VA had their best interests in mind in treating their conditions. Also, as a time-limited program, VA is concerned about how it would manage care authorized near the end of the pilot program, as some Veterans may actually be worse off if they received only a portion of a fuller episode of care.

We also believe the bill is far too prescriptive in terms of its requirements. For example, the bill provides that an eligible Veteran is one between 40 and 70 years of age. This could result in a situation where a Veteran is eligible at the beginning of the pilot program but becomes ineligible during the course of the pilot program (e.g., the Veteran is 68 years old at the start of the pilot but turns 70 during the pilot program). As written, the Veteran would no longer be eligible and could no longer receive benefits under this program, which could result in fragmentation of care. The requirements concerning enrollment and prioritization in subsection (c) are ambiguous and appear to conflate two different decision criteria: level of service-connected disability and severity of periodontitis. It is also unclear what VA would be required to do if there was insufficient interest among Veterans meeting the specific eligibility criteria such that VA could not enroll 1,500 Veterans in the pilot program. The criteria for selecting facilities are similarly ambiguous and could result in unintended consequences, if, for example, one facility (particularly a smaller or rural facility) simply could not keep up with demand at larger (particularly urban) facilities and fell below the one-sixth threshold. The preceding is not an exhaustive list of our technical concerns with the bill, but it is demonstrative that the bill is too prescriptive to be implemented effectively.

Finally, we believe Section 3 of the bill is unnecessary because the dental literature already strongly supports the cost-effectiveness of preventive dental care. There is a large volume of scientific evidence supporting preventive dental care for individuals with conditions such as Type II diabetes to reduce the morbidity of tooth loss associated with periodontal disease. It is unclear how this proposed pilot program would further advance science and reduce overall health care costs. A controlled, well-defined, and sanctioned research project would be a more appropriate vehicle. The

proposed legislation would not provide scientifically rigorous and valid findings because it does not adopt the structure and methodology of a controlled research project. The purpose of the legislation is to "determine" if there is a correlation based on treatment, but we do not believe VA could make such a determination given the parameters of the pilot program in the bill.

VA estimates that section 3 would cost $3.72 million in the first year, $3.83 million in the second year, and $15.56 million over 4 years.

H.R. 2645 Newborn Care Improvement Act of 2019

H.R. 2645 would amend section 1786 to increase from 7 to 14 the number of days after the birth of a child for which VA may furnish covered health care services to the newborn child of a woman Veteran who is receiving maternity care furnished by the Department and who delivered the child in a facility of the Department or another facility pursuant to a Department contract for services related to such delivery. Not later than 31 days after the start of each fiscal year, VA would be required to submit a report to Congress on such services provided during the preceding fiscal year, including the number of newborn children who received such services during that fiscal year.

VA supports H.R. 2645, subject to the availability of appropriations. A newborn needing care for a medical condition may require treatment extending beyond the current 7 days that are authorized by law. Additionally, the standard of care is to have further evaluations during the first 2 weeks of life to check infant weight, feeding, and newborn screening results. Pending these results, there may be a need for additional testing and follow-up. There are also important psychosocial needs that may apply, including monitoring stability of the home environment or providing clinical and other support if the newborn requires monitoring for a medical condition. Extending care to 14 days would provide time for further evaluations appropriate for the standard of care, as well as sufficient time to identify other health care coverage for the newborn.

We estimate the bill would cost $12.9 million in FY 2020, $13.9 million in FY 2021, $69.6 million over 5 years, and $142.3 million over 10 years. The FY 2020 President's Budget did not include any funding for H.R. 2645 in FY 2020 or FY 2021.

H.R. 2681 Report on Prosthetic Items for Women Veterans

H.R. 2681 would require VA, not later than 1 year after the date of the enactment of this Act, to submit to Congress a report on the availability from VA of prosthetic items made for women Veterans, including an assessment of the availability of such prosthetic items at each VA medical facility.

VA provides comprehensive prosthetic and sensory aids and services that support and optimize the health and independence of all Veterans, regardless of gender. VA defines the term "prosthetic" as an item that replaces a missing or defective body part. For women Veterans, specifically, prosthetic items include: post-mastectomy items; wigs for alopecia; long-acting reversible contraception (e.g., intrauterine devices); maternity support belts items; and vaginal dilators.

While VA supports providing Congress clear information at the end of each fiscal year on the types of prosthetic items, quantities of such items, and the amount expended on women Veterans, VA does not support providing an assessment of the availability from VA of prosthetics made for women Veterans because the report required by this bill would be incongruent with current clinical practice and procurement processes. The provision of a prosthetic item begins with the Veteran's appointment with a VA or community provider, who assesses the Veteran's prosthetic needs and submits a prescription or consult for a prosthetic item to the local VA medical center (VAMC) Prosthetic and Sensory Aid Service (PSAS). The type and variety of prosthetic items that a local facility maintains onsite will vary based upon their patient population, patients' needs, and the uniqueness of prosthetic items. Most prosthetic items are purchased from commercial sources. As a result, the report would not provide meaningful information as to the availability of these items for women Veterans.

H.R. 2752 VA Newborn Emergency Treatment Act

H.R. 2752 would expand the scope of benefits for newborn children of women Veterans by authorizing VA to furnish transportation necessary to receive covered health care services. The bill also would allow VA to furnish more than 7 days of health care services to a newborn child and to provide transportation necessary to

receive such services, if such care is based on medical necessity, including cases of readmission.

VA supports, in principle, providing medically necessary transportation benefits for newborns. The bill presents, however, a few technical concerns, such that we do not support the bill in its current form. For example, it would allow VA to "waive" a debt that a beneficiary owes for medically necessary transportation provided for a newborn that was incurred prior to enactment of this Act. VA would generally have no ability to waive such a debt because the debt would not be owed to VA; further, VA would not have been a party to the transportation agreement or arrangement entered into by the beneficiary and a third party. In addition, the bill's exception to the otherwise applicable 7-day limitation on the duration of services is sweeping in scope. We would welcome the opportunity to discuss this to better understand the Committee's intent.

We further note that if the Committee intends to advance both H.R. 2645 and H.R. 2752, steps should be taken to ensure that the changes proposed are consistent with each other. VA would be happy to work with the Committee to ensure the amendments made by the two bills are complementary and not contradictory.

H.R. 2798 Building Supportive Networks for Women Veterans Act

H.R. 2798 would direct VA to provide reintegration and readjustment counseling services, in a retreat setting, to women Veterans who are recently separated from service in the Armed Forces after prolonged deployments.

VA agrees that providing these retreats is beneficial to women Veterans; however, other Veteran and Servicemember cohorts could also benefit from this treatment modality. While VA appreciates the intent of this bill, we request that the bill language be amended to allow VA the ability to conduct these retreats for all Veteran or Servicemember cohorts eligible for Vet Center services and that appropriate resources be provided through the appropriations process. Examples include those who have experienced military sexual trauma, Veterans and their families, and families that experience the death of a loved one while on active duty. Also, rather than creating a separate biennial report, as would be required by the bill, VA recommends that this bill

amend section 7309 to include a report on this program as part of the annual report to Congress on the activities of the Readjustment Counseling Service.

We estimate the bill would cost approximately $483,000 in FY 2020, approximately $500,000 in FY 2021, $2.59 million over 5 years, and $5.67 million over 10 years. The FY 2020 President's Budget did not include any funding for H.R. 2798 in FY 2020 or FY 2021.

H.R. 2816 Vietnam-Era Veterans Hepatitis C Testing Enhancement Act of 2019

H.R. 2816 would require VA, not later than 180 days after the date of the enactment of this Act, to carry out a 1-year pilot program to make Hepatitis C testing available to covered Veterans at certain outreach events organized by Veterans Service Organizations (VSO). Covered Veterans would mean a person who served in the active military, naval, or air service between February 28, 1961, and May 7, 1975, and was discharged or released therefrom under conditions other than dishonorable, regardless of whether such person is enrolled in VA health care. VA would have to select five VISNs in which to carry out the pilot program, with two such networks predominantly serving rural areas and three predominantly serving urban areas. If at least 350,000 Veterans were tested for Hepatitis C by the termination of the pilot program, VA would be required to expand the program to all VISNs not later than 1 year after the date on which the pilot program ends. Not later than 180 days after the date on which the pilot program ends, VA would have to submit a report to Congress on the number of covered Veterans tested for Hepatitis C under the pilot program and a list of resources needed to expand the pilot program to all VISNs for the length of time necessary to test all covered Veterans for Hepatitis C. No additional funds would be authorized to carry out the requirements of this Act; VA would have to implement this authority using amounts otherwise authorized to be appropriated to VA for the express purpose of providing Hepatitis C-related care.

VA does not support this bill. Testing Vietnam Era Veterans and other Veterans at risk for chronic infection by the Hepatitis C virus (HCV), as well as Veterans who are not at increased risk but simply wish to be tested, remains a high priority for VA. The most recent HCV testing data for the general U.S. population show that as of 2016, only

14.1 percent of individuals born between 1945 and 1965 had been tested for HCV. By comparison, in 2016, 75.1 percent of Veterans in VA care had been tested for HCV.

We are concerned that VA would face significant legal, ethical, and practical barriers to implementation of this bill. As currently constructed, this bill raises a very serious ethical issue because it authorizes VA to test Veterans for HCV but not to provide anti-viral treatment, follow-up laboratory testing, or diagnosis and treatment of comorbidities (such as substance use and alcohol use disorders) that can interfere with anti-viral treatment. On a practical level, VA would need to have a mechanism to be notified by a VSO about when and where HCV testing outreach events would be held, with sufficient time to prepare for participation (e.g., ordering rapid test kits, logistics, etc.) and to provide for VA employees to attend these events outside of official duty hours and locations (e.g., clinician time/overtime pay, liability for use of a personal car/access to a VA car, etc.). The HCV testing model on which this bill is based involves holding HCV testing events at local VSO offices (e.g., an American Legion post). VA clinical staff and eligibility officers have attended such events, but the actual testing has been done by non-VA personnel because the individuals who come to the event are not known to be eligible for or enrolled in VA care. This bill uses a different model in which VA would perform the testing. This introduces the following very significant challenges:

- The VA laboratory would be using a rapid initial screening test that requires follow-up confirmatory testing for any positive results. There would not be any mechanism for logging, accessioning, and testing blood specimens for follow-up testing.
- Results from confirmatory testing are generally not available for several days. Again, because these individuals are not enrolled in VA care, there would not be a mechanism for contacting the Veteran to provide results.
- VA does not currently have authority to provide individualized follow-up assessments and counseling to individuals who test positive. This could create immediate and serious ethical conflicts for VA clinical staff. For example, if a Veteran who tests positive wants advice on informing his or her spouse, VA clinicians would have very limited (if any) ability to respond in detail.

- Performing the specified test requires oversight by a laboratory possessing a current, valid Clinical Laboratory Improvement Amendments (CLIA) certificate. It is not clear how willing VA laboratory directors would be to perform such testing outside of a VA facility because of legitimate concerns about jeopardizing the laboratory's CLIA certificate.

The automatic trigger provision in section 2(d) raises legal concerns as well. It states that if at least 350,000 Veterans are tested for Hepatitis C by the termination date, the Secretary shall expand the program to all VISNs not later than 1 year after the date on which the pilot program ends. However, this would create an uncertain legal authority for such expansion. By its terms, subsection (c) directs VA to act to expand the program not later than 1 year after the pilot program ends; however, subsection (a) would be VA's only authority to make Hepatitis C testing available to Veterans who were not enrolled in VA health care, and this authority is limited to the 1-year pilot program. Also, subsection (c) clearly provides that the program terminates 1 year after the program begins. Consequently, it does not appear the bill would provide VA an adequate statutory basis to furnish testing to Veterans who were not enrolled in VA health care after completion of the pilot program. This subsection also has technical issues that create further ambiguity, namely its failure to use the term "covered Veteran" and its failure to specify whether the 350,000 Veterans tested must be tested under the pilot program (rather than generally). As of December 31, 2018, VA had screened 78.2 percent of the approximately 2.4 million Vietnam Era Veterans currently in VA health care, and across the system, there are approximately 527,000 Vietnam Era Veterans remaining to be tested.

We further note that the reporting requirement in section 2(e)(2) would require VA to report to Congress a list of the resources needed to expand the pilot program to all VISNs for the length of time necessary to test all covered Veterans for HCV. However, not all Veterans who are eligible for testing are willing to be or interested in being tested. While VA can offer Hepatitis C testing to these individuals, it is a personal decision on the part of the Veteran to agree to testing; thus, VA cannot guarantee that all Veterans with HCV will be tested.

Finally, we note that the bill appears to be overly inclusive, as it applies to all Veterans who served on active duty during the Vietnam era, whether or not the Veteran served in the Republic of Vietnam. Under 38 U.S.C. 101(29)(B), the Vietnam era for Veterans who did not serve in the Republic of Vietnam began August 5, 1964, and ended May 7, 1975. The bill would create an inequity in terms of Vietnam era Veterans' access to benefits by using the earlier date of February 28, 1961, for all Vietnam era Veterans, regardless of their service in the Republic of Vietnam.

H.R. 2972 Improving Communications Related to Services for Women Veterans

H.R. 2972 contains two sections. Section 1 would require VA to expand the capabilities of the Women Veterans Call Center to include a text messaging capability.

VA supports the intent of section 1 but does not believe this section is necessary because VA already implemented text messaging capabilities at the Women Veterans Call Center in April 2019. Similar to the existing call line and online chat, women Veterans who text 1 (855) 829-6636 will be connected with Women Veterans Call Center representatives, who are all women, and who can answer general questions about benefits, eligibility, and services specifically for women Veterans. Text messaging is available Monday through Friday 8 a.m. to 10 p.m. EST, and on Saturdays from 8 a.m. to 6:30 p.m. EST.

Section 2 would require VA to survey VA Internet Web sites and information resources in effect on the day before the date of the enactment of this Act and publish an Internet Web site that serves as a centralized source for the provision to women Veterans of information about the benefits and services available to them from VA. The Web site would have to provide to women Veterans information regarding all services available in the district in which that Veteran is seeking services, including with respect to each VAMC and Community-Based Outpatient Clinic (CBOC) in the applicable VISN, the name and contact information of each women's health coordinator; a list of appropriate staff for other benefits available from the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), and such other information as VA considers appropriate. VA would be required to ensure the information published on the Web site is updated not less frequently than once every 90 days. In carrying out this

section, VA would have to ensure that the outreach conducted under VA's suicide prevention program (outreach and education for Veterans and families) includes information regarding the Web site required by this bill. VA would be authorized to use only funds made available to it to publish information on VA Web sites to implement this requirement.

VA supports this section. VA has over 75 programs across VBA, VHA, and other business lines that offer transition benefits and services to transitioning Servicemembers. Transition programs that address the needs of women include the Women Veterans Health Care program in VHA; the Center for Women Veterans program within VA's Central Office; and the VA Transition Assistance Program (TAP) within VBA. VBA includes on its Web page, https://www.benefits.va.gov/persona/veteran-women.asp, information on VA benefits available to all Veterans (including women), links to women's health coordinators, links to health resources, and instructions on how to apply for VA benefits. VA TAP, which is offered through the Office of Transition and Economic Development (TED), recognizes the importance of providing programs and initiatives that support women Veterans. VA TAP Benefits and Services curriculum, for example, covers gender-specific health care to address the particular needs of female Veterans. The Participant Guide, which Servicemembers have as a reference as they continue their transition, includes more details on available services and programs for women Veterans. Should this section of the bill be enacted, TED would include directions for transitioning women Servicemembers to access the Web site in its TAP briefings. Also, VA has in place at each VAMC a Web site specific to women Veterans that highlights the services available and provides information for a point of contact at the facility. In addition, VA offers two national Web sites that offer facility location information.

VA does not believe this section would result in any additional costs.

H.R. 2982 Women Veterans Health Care Accountability Act

H.R. 2982 would require VA to enter into a contract with a qualified independent entity or organization to conduct a comprehensive study of the barriers to the provision of comprehensive health care by VA encountered by women Veterans. In conducting

this study, VA, through the contractor, would have to survey women Veterans who seek or receive care from VA, as well as women Veterans who do not seek or receive such care or services; administer the survey to a representative sample of women Veterans from each VISN; and ensure that the sample of women Veterans surveyed is of sufficient size for the study results to be statistically significant and a larger sample size than the National Survey of Women Veterans in FY 2007-2008. In conducting the study, VA would be required to build on the work of this survey from 2007-2008, as well as the Study of Barriers for Women Veterans to VA Health Care 2015. VA would be required to conduct research on the effects of the following on the women Veterans surveyed in the study: the perceived stigma associated with seeking mental health care services; the effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care; the availability of child care; the acceptability of integrated primary care, women's health clinics, or both; the comprehension of eligibility requirements for, and the scope of services available under, hospital care and medical services; the perception of personal safety and comfort in inpatient, outpatient, and behavioral health care facilities; the gender sensitivity of health care providers and staff to issues that particularly affect women; the effectiveness of outreach for health care services available to women Veterans; the location and operating hours of health care facilities that provide services to women Veterans; and such other significant barriers as VA considers appropriate. VA would be required to ensure that the head of the Center for Women Veterans and the Advisory Committee on Women Veterans reviews the results of the study, and that the head of each of these entities submits findings with respect to the study to the Under Secretary for Health. Not later than 30 months after the date of the enactment of this Act, VA would be required to submit to Congress a report on the study required by this bill. The report would have to include recommendations for such administrative and legislative actions as VA considers appropriate, including the findings of the Center for Women Veterans, the Advisory Committee on Women Veterans, and the Under Secretary for Health.

VA does not support this bill. VA conducted an extensive study of the barriers to health care for women Veterans in 2013 and released the results of the report to

Congress in 2015. The scope of this proposed legislation is a study identical to that 2013 study. VA is already implementing initiatives that address the identified barriers.

VA offers comprehensive primary care for women Veterans and ensures that any woman Veteran seeking VA care receives complete primary care from one primary care provider at her preferred site. VA has enhanced provision of care to women Veterans by focusing on the goal of developing Women's Health Primary Care Providers (WH-PCP) at every site where women access VA. VA has at least two WH-PCP at all of VA health care systems. In addition, 90 percent of CBOCs have a WH-PCP in place. VA is in the process of training additional providers to ensure that every woman Veteran has an opportunity to receive her primary care from a WH-PCP.

VA has responded to the growing number of women Veterans by offering a wide range of mental health services to meet their unique needs. Such services include psychological assessment and evaluation, outpatient individual and group psychotherapy, acute inpatient care, and residential-based psychosocial rehabilitation. Specialty services are offered to target problems such as PTSD, substance use problems, depression, sexual trauma, and homelessness.

VA launched an End Harassment program at every VAMC in the summer of 2017. Through increased awareness, education, reporting, and accountability, VA is working to address this issue. VA's efforts hinge on awareness and education, followed by accountability. We have launched messaging, including "it's not a compliment, it's harassment" directed primarily at educating male Veterans that these actions are harmful and unacceptable. Employees have been trained on these cultural change efforts, including an awareness of the experiences of women Veterans and ways to intervene and respond. Cultural change efforts continue as we develop updated resources, training, and associated messaging; accountability through the local VAMC Director is a critical element.

The End Harassment training was developed at the VA Central Office level as a tool for VA sites to use to create an awareness of and educate staff on the issue of women Veterans being harassed by male Veterans, as well as to introduce intervention strategies. Necessary variation exists at VA sites related to processes for staff training, as well as reporting and tracking of various types of Veteran complaints. As such,

leadership at the local level is responsible for identifying and communicating these processes and actions.

In 2019, in collaboration with research subject matter experts from the Women's Health Practice Based Research Network (PBRN), VA will conduct a more detailed care study in which PBRN sites will be asked to respond to questions about whether their facility delivered End Harassment training, which types of staff were trained, and how women Veterans can report incidents of harassment at their facilities.

H.R. 3036 Breaking Barriers for Women Veterans Act

H.R. 3036 contains five substantive sections. Section 2 would require VA to retrofit existing VA medical facilities with fixtures, materials, and other outfitting measures to support the provision of care to women Veterans. Not later than 180 days from the date of the enactment of this Act, VA would have to submit to Congress a plan to address deficiencies in the Environment of Care (EOC) for women Veterans at VA medical facilities. Subsection (c) would authorize the appropriation of $20 million to carry out this section, in addition to amounts otherwise made available for these purposes.

VA does not support section 2. VA has already recognized the importance of meeting the health care needs of our women Veterans. We recently updated VHA Directive 1330.01 to clarify definitions and provide objective privacy and dignity requirements that have been incorporated into updated facility design requirements through issuance of a design alert. Facilities are on course to fully address the health care needs and EOC privacy and dignity issues, regardless of the type of service or setting, through operational and non-recurring maintenance (NRM) funding sources, as appropriate. The NRM program is being used to make corrections for significant deficiencies. Also, physical facility compliance with privacy and dignity standards have been incorporated into VHA's EOC survey tool, which is used by all VA medical facilities to assess patient care spaces and identify any needed corrections or alterations. EOC survey tool results are tracked by both local facility and Network leadership, as well as oversight at the national level; existing survey tool reports can be used as a basis for informing Congress on compliance without the need for an additional report, as this bill

would require. The specific reporting requirements in subsection (b) would unnecessarily redirect resources needed for the delivery of care and maintenance of the patient EOC.

We estimate the one-time report required by section 2 would cost $450,000.

Section 3 would require VA to ensure that each VA medical facility has not fewer than one full-time or part-time WH-PCP whose duties include, to the extent possible, providing training to other VA health care providers on the needs of women Veterans.

While VA supports the intent of this section, we do not support enactment because it is unnecessary. VA already has the authority to employ WH-PCP at all of our health care systems, and in addition, 90 percent of CBOCs have a WH-PCP in place. For many community sites, though, there is no justification to hire a full-time designated WH-PCP due to the small number of women Veterans assigned to the clinic. In these cases, VA trains an existing provider who will treat both men and women Veterans instead. There is approximately a 20-percent turnover each year for women's health providers, so training new providers is a constant need.

Section 4 would authorize to be appropriated $1 million for each fiscal year for the Women Veterans Health Care Mini-Residency Program to provide opportunities for participation in such program for primary care and emergency care clinicians. These amounts would be in addition to amounts otherwise made available for such training.

VA supports the concept of mini-residencies but does not believe this is necessary. VA's efforts to train clinicians to meet the needs of an ever-increasing number of women Veterans seeking care has included large scale initiatives to deploy core curricula covering the highest priority topics in women's health care through mini-residencies. VA has developed four mini-residency programs in recent years and trained more than 5,800 clinical providers since 2008. .The four programs are Women's Health Mini- Residency for Primary Care Providers (Physicians, NPs, PAs); Women's Health Mini- Residency for Primary Care Nurses (RNs/LPNs/LVNs); Women's Health Mini-Residency for Primary Care Providers and Nurses (Interprofessional curriculum designed for providers and RNs); and Women's Health Mini- Residency for Emergency Care Providers and Nurses (Interprofessional). VA offers mini-residency programs as large, national training conferences each year. Current mini-residencies held to date

have had waiting lists as demand has exceeded capacity. VA is also providing contract training to VA facilities through computer-based women's health modules completed in advance of the contract training team arriving at the clinic to deliver a 1-day training for interactive, hands-on activities, and breast and pelvic exam instruction. This training delivery will enhance the opportunity for clinicians to attend trainings and reduce the amount of time they need to be away from clinical care.

We estimate section 4 would result in additional costs of $1 million each year.

Section 5 would require, not later than 1 year after the date of the enactment of this Act, VA to establish a training module that is specific to women Veterans and make it available to community providers who furnish care on VA's behalf.

VA supports the intent of this section but does not believe it necessary. VA recognizes that women Veterans are more likely than their male counterparts to obtain care in the community, and VA is developing a training module for community providers who care for women Veterans to be attuned to their unique needs. Key competencies in the module will cover military history, caring for Veterans with complex medical conditions, coordinating care between VA and community providers, and identifying VA resources for help. This learning module will reside on a virtual platform available for providers furnishing care on behalf of VA.

Section 6 would require VA to conduct a study on the use of the Women Veteran Program Manager program at VA to determine if the program is appropriately staffed at each VAMC, whether each VAMC is staffed with a Women Veteran Program Manager, and whether it would be feasible and advisable to have a Women Veteran Program Ombudsman at each VAMC. Not later than 270 days after the date of the enactment of this Act, VA would have to submit to Congress a report on the study conducted under this section. Subsection (c) would require VA to ensure that all Women Veteran Program Managers and Women Veteran Program Ombudsmen receive the proper training to carry out their duties.

VA agrees that the information required by section 6 would be useful but does not support this legislation because it is unnecessary. VA has self-reported data on the Women Veteran Program at each VAMC. The Women's Assessment Tool for Comprehensive Health (WATCH) is an annual report that assesses the Women's

Health Program in VA medical facilities. The self-assessment enhances national and local strategic planning for the development of women's health programs. In addition, VA recently developed a women Veterans integrated project team (IPT) charged with focusing efforts on improving the experience of women Veterans by addressing capabilities impacting critical focus areas. The IPT is charged with transforming the culture and operation of VA by developing innovative solutions to create access to high quality health care with a respectful, safe, and welcoming environment for women Veterans by ending harassment and addressing capacity gaps, gender disparities, variation in women's health program implementation, and care coordination.

H.R. 3224 To Provide Increased Access to VA Medical Care for Women Veterans

H.R. 3224 would create a new section 1720J regarding medical services for women Veterans. Subsection (a) of this new section would require VA ensure that gender-specific services are continuously available at every VAMC and CBOC. Subsection (b) would direct the Secretary to conduct a study to assess the use of extended hours as a means of reducing barriers to care, the need for extended hours based on interviews with women Veterans and employees, and the best practices and resources required to implement the use of extended hours. Finally, subsection (c) would require VA submit to Congress by September 30 of each year a report on VA's compliance with subsection (a).

We agree with the aims of the legislation but do not support it as written. We fully agree with the intent of the legislation, to ensure that women Veterans are able to receive timely, high-quality care, but we are concerned that, as drafted, it is unworkable. Specifically, concerning the proposed section 1720J(a), we are concerned about the phrase "continuously available" and what it is intended to mean. Very few health care services within VA or any health care system are available around the clock, every day; even if the phrase was only meant to convey continuous availability during business hours, there is still no guarantee that providers would be constantly available, as there may be periods of time when a provider is on leave or when a vacancy has occurred that takes some time to fill. This could potentially have significant resource implications

depending upon the intended effect. We also note that the term "gender specific services" is unclear; this could apply to both men and women Veterans. It is also unclear if this is intended to refer to gender-specific primary care services for women or more advanced services such as obstetrics and gynecology (for women) or urology (for men). We note that VA recently implemented two provisions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, the Veterans Community Care Program under section 1703 and the urgent care benefit under section 1725A, that expand access to timely care, particularly urgent or emergent conditions. These new initiatives may relieve some of the need for VA facilities to have extended hours of operation.

We believe section 1720J(b) is unnecessary in part because VA has already established extended hours of care to reduce barriers to access and has promoted new modalities, such as telehealth, to make it easier for Veterans to obtain care. We can provide data, both quantitative and qualitative, regarding some of the elements of the study required by subsection (b), and we would be pleased to discuss our findings with the Committee.

We would greatly appreciate the opportunity to meet with the Committee further to discuss these and other issues to improve this legislation. Given the unclear scope of the legislation, we are unable to provide a cost estimate for this bill at this time but note that it could have significant resource implications depending on the intended effect.

H.R. 3495 Improve Well-Being for Veterans Act

H.R. 3495 would require VA to provide financial assistance to eligible entities approved under this section through the award of grants to provide and coordinate the provision of services to Veterans and Veteran families to reduce the risk of suicide. VA would award a grant to each eligible entity whose application was approved by VA. VA could establish a maximum amount to be awarded under the grant, intervals of payment for the administration of the grant, and a requirement for the recipient of the grant to provide matching funds in a specified percentage. VA would ensure, to the extent practicable, that financial assistance is equitably distributed across geographic regions,

including rural communities and Tribal land. VA also, to the extent practicable, would need to ensure that financial assistance is distributed to provide services in areas of the country that have experienced high rates or a high burden of Veteran suicide and to eligible entities that can assist Veterans at risk of suicide that are not currently receiving health care furnished by VA.

VA would have to give preference in the provision of financial assistance to eligible entities providing or coordinating (or who have demonstrated the ability to provide or coordinate) suicide prevention services or other services that improve the quality of life of Veterans and their families and reduce the factors that contribute to Veteran suicide. Each grant recipient would have to notify Veterans and Veteran families that services they provide are being paid for, in whole or in part, by VA. If a grant recipient provided temporary cash assistance to Veterans or Veteran families, the recipient would have to develop a plan, in consultation with the beneficiary, to ensure that any beneficiary receiving such temporary cash assistance is self-sustaining at the end of the period of eligibility for such assistance.

VA would require each grant recipient to submit an annual report describing the projects carried out with VA's financial assistance; VA would also specify to each recipient the evaluation criteria and data and information to be included in the report, and VA could require entities to submit additional reports as necessary. An eligible entity seeking a grant would submit a form to VA containing such commitments and information as VA considers necessary to carry out this section. Each application would have to include a description of the suicide prevention services to be provided, a detailed plan describing how the entity proposes to coordinate and deliver suicide prevention services to Veterans not currently receiving care furnished by VA (including an identification of community partners, a description of arrangements currently in place with such partners, and identification of how long those arrangements have been in place), a description of the types of Veterans at risk of suicide and Veteran families proposed to be provided suicide prevention services, an estimate of the number of Veterans at risk of suicide and Veteran families that would be provided services (including the basis for the estimate and the percentage of those Veterans not currently receiving VA care), evidence of the experience of the applicant (and the proposed

partners) in providing suicide prevention services (particularly to Veterans at risk of suicide and Veteran families), a description of the managerial and technological capacities of the entity, and other application criteria VA considers appropriate.

VA would be required to provide training and technical assistance to eligible entities under this section regarding the data that must be collected and shared with VA, the means of data collection and sharing, familiarization with and appropriate use of any tool to measure the effectiveness of the financial assistance VA provided, and how to comply with VA's reporting requirements. VA would have to establish criteria for the selection of eligible entities that have submitted applications. In establishing these criteria, VA would have to consult with Veterans Service Organizations (VSO), national organizations representing potential community partners of eligible grant recipients, organizations with which VA has a current memoranda of agreement or understanding related to mental health or suicide prevention, State Departments of Veterans Affairs, national organizations representing members of the reserve components of the Armed Forces, Vet Centers, organizations with experience in creating measurement tools for purposes of determining programmatic effectiveness, and other organizations VA considers appropriate.

VA would have to develop measures and metrics for grant recipients in consultation with the same group of entities or organizations. Before issuing a Notice of Funding Availability under this section, VA would have to submit to Congress a report containing the criteria for the award of a grant under this section, the tool to be used by VA to measure the effectiveness of the use of financial assistance provided under this section, and a framework for the sharing of information about entities in receipt of financial assistance under this section. VA could make available to grant recipients certain information regarding potential beneficiaries of services, including confirmation of the status of a potential beneficiary as a Veteran and confirmation of whether a potential beneficiary is currently receiving or has recently received VA care.

VA's authority to provide financial assistance would end on the date that is 3 years after the date on which the first grant is awarded. Not later than 18 months after the date on which the first grant is awarded, VA would have to submit a detailed report on the provision of financial assistance under this section. Not later than 3 years after

the date on which the first grant is awarded, VA would have to submit to Congress a follow up on the interim report containing the same elements and a final report on the effectiveness of the financial assistance provided through this authority, an assessment of the increased capacity of VA to provide services to Veterans at risk of suicide and Veteran families as a result of this financial assistance, and the feasibility and advisability of extending or expanding the provision of financial assistance.

Eligible entities would be: (1) an incorporated private institution or foundation that is approved by VA as to financial responsibility and no part of the net earnings of which incurs to the benefit of any member, founder, contributor, or individual and that has a governing board that would be responsible for the operation of the suicide prevention services provided under this section; (2) a corporation wholly owned and controlled by an organization meeting the same requirements; (3) a tribally designated housing entity (as defined in section 4 of the Native American Housing Assistance and Self-Determination Act of 1996 (25 U.S.C. 4103)); or a community-based organization that is physically based in the targeted community and that can effectively network with local civic organizations, regional health systems, and other settings where Veterans at risk of suicide and the families of such Veterans are likely to have contact. Suicide prevention services would be services to address the needs of Veterans at risk of suicide and Veteran families and includes outreach; a baseline mental health assessment; education on suicide risk and prevention; direct treatment; medication management; individual and group therapy; case management services; peer support services; assistance in obtaining any VA benefits for which the Veteran or Veteran family may be eligible; assistance in obtaining and coordinating the provision of other benefits provided by the Federal Government, a State or local government, or an eligible entity; temporary cash assistance (not to exceed 6 months) to assist with certain emergent needs; and such other services necessary for improving the resiliency of Veterans at risk of suicide and Veteran families as VA considers appropriate. Veteran family would mean, with respect to a Veteran at risk of suicide, a parent, a spouse, a child, a sibling, a step-family member, an extended family member, or any other individual who lives with the Veteran. VSOs would be those organizations recognized

by VA for the representation of Veterans included as part of an annually updated list available online.

VA strongly supports this bill. VA's efforts to reduce the incidence of suicidal ideations and behavior (and suicide completions) among all Veterans could be complemented by partnering with community-based providers who are able to replicate VA's suicide prevention programs in the community and to connect with Veterans that are currently beyond VA's reach. This novel approach would assist VA in reaching more of the 14 of the 20 Veterans dying each day by suicide who are not under VA care at the time of their deaths; effective partnering with eligible grantees would be key to our being able to reduce, if not prevent, the number of these tragic occurrences. Additionally, the legislation aligns with VA's proposal submitted with the President's FY 2020 budget. This proposal has been identified as the Secretary's top legislative priority and the legislation provides the necessary authorities clinicians believe will help the Department combat suicide among Veterans. Lastly, we note that the legislation is aligned with the President's strategic taskforce to combat suicides in the Nation. The taskforce will assist in planning and providing strategic guidance with our stakeholders allowing VA to operate and implement the grant program. The need for this legislation is evident and will enhance and increase the suicide prevention measures the Department is currently taking to combat and reduce suicides in the Nation.

We offer one comment for the Committee's consideration, but we emphasize that this is not an issue that would alter VA's position on the bill. The definition of "risk of suicide" in section 2(k)(4) would include exposure to or the existence of any of the specified conditions. We believe this definition is overly broad and recommend instead allowing the Secretary to implement this definition by regulation to include the addition of a process for determining degrees of risk of suicide based on consideration of the factors set forth in section 2(k)(4). Risk is obviously variable, ranging from no risk to high risk. Even without this recommended change, the bill would give VA sufficient authority to prefer applicants that ensure their services go to those Veterans who have the highest risk of suicide.

We estimate the bill would cost $19.10 million in FY 2021, $28.36 million in FY 2022, and $37.70 million in FY 2023, for a total cost of approximately $85.16 million over the 3-year period of the program.

H.R. 3636 Caring for Our Women Veterans Act

H.R. 3636 contains three substantive sections.

Section 2 of the bill would require VA to submit to Congress a report on the use by women Veterans of health care from VA. The first report would be required not later than 90 days after the date of the enactment of this Act, and VA would be required to submit annual reports thereafter. Each report would need to include the number of women Veterans who reside in each state; the number of women Veterans in each state who are enrolled in VA health care; the number of enrolled women Veterans who received VA health care at least one time in the previous year; the number of women Veterans who have been seen at each VA medical facility in the previous year; the number of appointments that women Veterans had at each VA medical facility; an identification of the medical facility in each VISN with the largest rate of increase in patient population of women Veterans (if known); and an identification of the medical facility in each VISN with the largest rate of decrease in patient population of women Veterans (if known).

We have no objection to this section; the data requested by Congress are currently collected by VA, and we believe producing the report would result in no additional cost.

Section 3 of the bill would require VA to submit to Congress a report on the use by VA of general primary care clinics, separate but shared spaces, and women's health centers as models of providing health care to women Veterans. The first report would be required not later than 90 days after the date of the enactment of this Act, and VA would be required to submit annual reports thereafter. Each report would need to include the number of VA facilities that fall into each model described disaggregated by VISN and state; a description of the criteria VA used to determine which model is most appropriate for each VA facility; an assessment of how VA decides to make investments to upgrade facilities to the next higher-level model; a description of any plans VA has to

upgrade facilities from the lowest-level model (general primary care clinics) to another model; an assessment of whether any facilities could be upgraded to the next higher-level model within planned investments under the strategic capital investment planning process (SCIP); an assessment of whether any facilities could be upgraded to the next higher-level model with minor modifications to existing plans under SCIP; and an assessment of whether VA has a goal for how many facilities should fall into each such model.

VA does not support this section. VA has empowered local facilities to determine the appropriate model of care with input from the women Veterans they serve. We emphasize that the same services are provided at all facilities, regardless of the model they use. We disagree with the assumption in this section that these models are inherently hierarchical with some better than others. The intent behind having three different models of care is to allow VA facilities to be flexible and responsive to local needs. Many factors, such as the patient population and available space, influence these decisions.

Section 4 would require VA to submit a report to Congress on VA staffing relating to the treatment of women. The first report would be required not later than 90 days after the date of the enactment of this Act, and VA would be required to submit annual reports thereafter. Each report would need to include the number of women's health centers; the number of patient aligned care teams relating to women's health; the number of full- and part-time gynecologists; the number of designated women's health care providers; the number of health care providers who have completed a mini-residency for women's health during the previous year and the number that plan to participate in such a mini-residency in the following year; and the number of designated women's health care providers who have sufficient female patients to retain their competencies and proficiencies. Data for all of these would need to be disaggregated by VISN and state, except for the number of women's health care providers, which would be disaggregated by facility.

We do not support this section because we do not believe it is necessary. VA has already implemented these requirements through WATCH.

H.R. 3798 Equal Access to Contraception for Veterans Act

H.R. 3798 would amend section 1722A to prohibit VA from requiring a Veteran to pay an amount for any contraceptive item or service for which coverage under health insurance coverage is required without imposition of any cost-sharing requirement pursuant to section 2713(a)(4) of the Public Health Service Act (42 U.S.C. 300gg-13(a)(4)).

VA supports this bill, subject to the availability of appropriations and technical amendments. We believe this bill would help further improve the access of contraceptives to Veterans, particularly those who have lower incomes.

We believe the bill language would exempt from copayment liability the provision of contraceptives. We are unsure, though, of the intended meaning of the phrase "or service," and whether this is meant to exempt from copayments the medical appointments related to the provision of contraception. The bill clearly exempts the medications from copayments by amending section 1722A. However, copayments for appointments related to the furnishing of medications, including contraceptives, are established for certain Veterans in a different statutory provision, section 1710, which is unamended by the bill. We note there may be significant administrative and technical difficulties in identifying and exempting only certain appointments from copayments, so if the Committee had this intent, we would appreciate the opportunity to discuss this further. We recommend the phrase "or service" be removed, as well as the cross-reference to section 2713(a)(4) of the Public Health Service Act (42 U.S.C. 300gg-13(a)(4)).

VA estimates the lost revenue for medication copayments would be approximately $396,000 in FY 2020, approximately $414,000 in FY 2021, $2.07 million over 5 years, and $4.18 million over 10 years. The bill would result in much greater losses of revenue if it exempted from copayment liability appointments related to contraceptive care. The FY 2020 President's Budget did not include the potential lost revenue for H.R. 3798 in FY 2020 or FY 2021.

H.R. 3867 Violence Against Women Veterans Act

H.R. 3867 contains five substantive sections.

Section 2 of the bill would state the purpose of this Act is to better integrate the medical, housing, mental health, and other benefits provided by VA with existing community-based domestic violence and sexual assault services to provide a more efficient and coordinated network of support for Veterans experiencing domestic violence or sexual assault and to better understand the impact of domestic violence and sexual assault on Veterans, particularly female Veterans.

VA has no comments on this section.

Section 3 of the bill would require VA to carry out a program to assist Veterans who have experienced or are experiencing domestic violence or sexual assault in accessing VA benefits, including coordinating access to medical treatment centers, housing assistance, and other VA benefits. VA would be required to carry out this program in partnership with domestic violence shelters and programs, rape crisis centers, state domestic violence and sexual assault coalitions, and such other health care or other service providers who serve domestic violence or sexual assault victims as determined by VA, particularly those providing emergency services or housing assistance. In carrying out this program, VA could conduct training for community-based domestic violence or sexual assault providers on identifying Veterans; coordinating with VA health care providers; and connecting Veterans with appropriate housing, mental health, medical, and other VA financial assistance or benefits. VA could also conduct assistance to service providers to ensure access of Veterans to domestic violence and sexual assault emergency services, particularly in underserved areas (including services for members of Indian tribes), as well as such other outreach and assistance as VA determines necessary. VA would be authorized to establish local coordinators to provide local outreach under this program; each coordinator would have to be knowledgeable about: (1) the dynamics of domestic violence and sexual assault, including safety concerns, legal protections, and the need for the provision of confidential services; (2) the eligibility of Veterans for VA benefits and services that are relevant to recovery from domestic violence and sexual assault, particularly emergency housing assistance, mental and other health care, and disability benefits; and (3) local community resources addressing domestic violence and sexual

assault. Each coordinator would be required to assist domestic violence shelters and rape crisis centers in providing services to Veterans.

VA does not oppose section 3 subject to the availability of appropriations, but we believe technical edits could improve the bill, and we would appreciate the opportunity to work with the Committee in this regard. VA is committed to serving Veterans whose health and safety may be at risk as a result of experiencing domestic or intimate partner violence. VA developed a plan for implementation of a domestic violence and intimate partner violence assistance program in 2013, before launching the program in 2014. We appreciate Congress' support of these efforts through the inclusion of $17 million in the FY 2018 and FY 2019 appropriations acts. Earlier this year, VA published a policy, VHA Directive 1198, *Intimate Partner Violence Assistance Program*, that mandates every VAMC identify a program coordinator and implement the full array of intimate partner violence-related programming in collaboration with internal and external stakeholders. This policy requires that every VA medical facility implement and maintain an Intimate Partner Violence Assistance Program (IPVAP), and that Veterans, their intimate partners, and employees impacted by intimate partner violence have access to services including resources, assessment intervention, and referrals to VA or community agencies as deemed appropriate and clinically indicated. During the VA Benefits and Services briefing of the Transition Assistance Program (TAP), all transitioning Servicemembers are provided information on VA's IPVAP and its available resources. The TAP briefing also explains gender-specific health care services available for women Veterans that address their unique health care needs; information on mental health care and emergency care services for women with actionable information is also provided. Central to the IPVAP is the need to provide screening for intimate partner violence to identify Veterans who are at risk, consistent with the U.S. Preventive Services Task Force recommendations to, at a minimum, screen all women of childbearing age. Screening allows our trained staff and providers to offer education, promote prevention, and identify those at risk to provide immediate crisis management and safety planning and intervention. The IPVAP works with the National Domestic Violence Hotline to offer outreach, resources, and safety planning for Veterans and their intimate partners, including hotline advocates who are available to chat every day. VA's

Women Veterans Call Center is also available to provide additional guidance on benefits and resources.

VA estimates section 3 would cost $21.1 million in FY 2020, $21.9 million in FY 2021, $113.85 million over 5 years, and $258.18 million over 10 years. The FY 2020 President's Budget did not include any funding for H.R. 3867 in FY 2020 or FY 2021.

Section 4 would require VA, in consultation with the Attorney General and the Secretary of Health and Human Services, to establish a national Task Force to develop a comprehensive national program, that includes integrating VA facilities, services, and benefits into existing networks of community-based domestic violence and sexual assault services, to address domestic violence and sexual assault among Veterans. The Task Force would be required to consult with representatives from not fewer than three national organizations or state coalitions with demonstrated expertise in domestic violence prevention, response, or advocacy, as well as such organizations or coalitions representing underserved or ethnic minority communities with such demonstrated expertise.

The Task Force would be required to review existing VA services and policies and develop a comprehensive national program to address domestic violence and sexual assault prevention, response, and treatment. It would also have to review the feasibility and advisability of establishing an expedited process to secure emergency, temporary benefits including housing or other benefits for Veterans who are experiencing domestic violence and sexual assault. It would also have to review and make recommendations regarding the feasibility and advisability of establishing dedicated, temporary housing assistance for Veterans experiencing domestic violence or sexual assault and identify any requirements regarding domestic violence assistance or sexual assault response and services that are not being met by VA, as well as make recommendations on how VA can meet such requirements. In addition, the Task Force would have to review and make recommendations regarding the feasibility and advisability of providing direct services, or contracting for community-based services, for Veterans in response to a sexual assault, including through the use of sexual assault nurse examiners, particularly in underserved or remote areas (including services for members of Indian tribes). The Task Force would also be responsible for reviewing the

availability of counseling services provided by VA and through peer network support and providing recommendations for the enhancement of such services to address the perpetration of domestic violence and sexual assault and the recovery of Veterans, particularly female Veterans, from domestic violence and sexual assault. Finally, the Task Force would have to review and make recommendations to expand services available to Veterans at risk of perpetrating domestic violence. The Task Force would be required to report annually to the VA Secretary and to Congress on its activities, including any recommendations for legislative or administrative action.

VA does not support this section because it is unnecessary given that VA convened a similar Task Force in 2012 and 2013. This earlier Task Force provided a very thorough review of the needs of Veterans and their partners, relevant research, and a review of resources leading to 14 recommendations for the implementation of a comprehensive, enterprise-wide program of integrated services for Veterans who experience or use intimate partner violence, their intimate partners, and VA employees impacted by such violence. VA's Intimate Partner Assistance Program has a national level leadership council that has many members from the original Task Force. Assembling a new Task Force would be duplicative, result in unnecessary costs, and could potentially deter the progress already being made. We also note that this section, as drafted, would appear to subject the Task Force to the Federal Advisory Committee Act (5 U.S.C. Appendix 2) in one or more ways. It is unclear if the drafters intended this result or not, but we would be happy to work with the Committee on this issue if needed.

Section 5 would require VA, in consultation with the Attorney General, to conduct a national baseline study to examine the scope of the problem of domestic violence and sexual assault among Veterans and spouses of Veterans.

We do not believe this section is necessary, but we do not oppose it. VA recognizes the value of proceeding with data-driven decisions for program expansion. VA investigators are already conducting research in this area and have been doing screening, although such work has not surveyed spouses of Veterans. We would appreciate the opportunity to discuss this work with the Committee to determine if any additional action is needed. Research to gather metrics around the various elements to be addressed, including intimate partner violence use and experience for men and

women Veterans, domestic violence experience, and types and prevalence of sexual assault inside and outside the context of intimate partner relationships is important, but there are many inherent challenges in conducting a Veteran-specific study on these sensitive issues. Such a project would require a well-funded research team to design and conduct the study, with specific costs contingent upon the scope, design, and length of the study.

Section 6 would amend the authorizing statute for VA's Advisory Committee on Women Veterans, 38 U.S.C. 542, by requiring the Advisory Committee on Women Veterans to include in its biennial report an assessment of the effects of intimate partner violence on women Veterans.

We do not support this section. We are concerned that an assessment of the effects of intimate partner violence would require identifying resulting issues, medical conditions, and other effects (such as homelessness, criminal behavior, or divorce) that could require judgments based on partial or incomplete information. This could result in data being skewed or statistically insignificant. These concerns would be further amplified through underuse of VA health care by women Veterans, such that the population analyzed is not representative of women Veterans as a whole.

H.R. 4096 Improving Oversight of Women Veterans' Care Act of 2019

Section 2 of H.R. 4096 would create a new section 1730D that requires VA to submit to Congress an annual report on the access of women Veterans to gender-specific services under contracts, agreements, or other arrangements with non-VA medical providers. The report would have to include data and performance measures for the availability of gender specific services, including the average wait time between the Veteran's preferred appointment date and the date on which the appointment is completed; the average driving time required for Veterans to attend appointments; and the reasons why appointments could not be scheduled with non-VA medical providers. Gender-specific services would be defined to mean mammography, obstetric care, gynecological care, and other services as considered appropriate.

VA does not support section 2. Many of the specific data points identified are not currently included in VA's contracts, agreements, or other arrangements for obtaining

community care; as a result, VA would have to renegotiate or modify these contracts, agreements, and other arrangements, which could be costly and would impose additional administrative burdens. Some providers may choose to drop out of network, rather than comply with these burdens, which would diminish Veterans' access to care. While VA does collect some of the data elements, other requirements, such as gender specific services (Mammography, obstetric care, and gynecological) are not specifically tracked or identifiable. Moreover, some Veterans eligible to receive community care choose to see providers who are farther away from their home; this could complicate any meaningful analysis of the reported data.

We estimate the costs of this section would exceed $1.5 million in FY 2020.

Section 3 of this bill would require VA establish a policy under which the EOC standards and inspections at VA medical facilities include an alignment of the requirements for such standards and inspections with the VHA women's health handbook; a requirement for the frequency of such inspections; a delineation of the roles and responsibilities of staff at the VAMC who are responsible for compliance; and the requirement that each VAMC submit to the Secretary a report on the compliance of the VAMC with the standards. The policy also would have to provide that, for the purposes of the End of Year Hospital Star Rating, no VAMC is eligible for a five-star rating unless it meets the EOC standards. Not later than 180 days after the date of the enactment of this Act, VA would have to submit a written certification to Congress that the required policy has been finalized and disseminated to all VAMCs.

VA does not support this section as written. VA believes amendments could be made such that VA would not oppose it. Specifically, we recommend amending section 3(a)(1)(C) to clearly assign responsibility to the VAMC Director and VISN Director for EOC compliance. VA further recommends section 3(a)(1)(D) be amended to have the Directors of each medical facility report to the Under Secretary for Health, rather than to the Secretary. The Under Secretary for Health is directly responsible to the Secretary for VHA operations. VA does not support section 3(a)(2) and recommends its omission. Compliance with EOC standards should not be determinative of whether a facility otherwise furnishes high-quality care that would earn a five-star rating under the Strategic Analytics for Improvement and Learning Value Model. Regarding section 3(b)

and the reporting requirement, we do not believe 180 days would be a sufficient amount of time to prepare this report. We recommend this be revised to provide VA 270 days.

Draft Bill Establishing the Office of Women's Health

The draft bill would create a new section 7310 that would require the Under Secretary for Health to establish and operate in VHA the Office of Women's Health, which would be located in VA Central Office. The Office would be led by the Director of Women's Health, who would report to the Under Secretary for Health. The Office would have to be provided the staff and support as necessary to carry out effectively its functions, including providing a central office for monitoring and encouraging VHA activities with respect to the provision, evaluation, and improvement of women Veterans' health care services; developing and implementing standards for care for the provision of health care for women Veterans; monitoring and identifying deficiencies in standards of care for the provision of health care to women Veterans, providing technical assistance to medical facilities to address and remedy deficiencies, and performing oversight of implementation of standards of care for women Veterans; monitoring and identifying deficiencies in standards of care for the provision of health care for women Veterans through the Veterans Community Care Program and providing recommendations to the Office of Community Care to address and remedy any deficiencies; overseeing distribution of resources and information related to women Veterans' health programs; promoting the expansion and improvement of clinical, research, and educational activities with respect to women's health care; providing recommendations with respect to the amount of funds to be requested for women Veterans, including, at a minimum, recommendations to ensure that such amount of funds either reflect or exceed the proportion of enrolled women Veterans; providing recommendations to the Secretary with respect to modifying the Veterans Equitable Resource Allocation (VERA) system to ensure that resource allocations reflect the health care needs of women Veterans; and carrying out other duties as the Under Secretary for Health may require.

VA would be required to implement each recommendation made by the Director with respect to modifying the VERA system; however, if the Secretary chose not to

implement such a recommendation, the Secretary would be required to notify Congress within 30 days of such a determination and provide the reasoning for the determination and an alternative to such recommendation. The bill would also establish the standards of care for the provision of health care for women Veterans in VA to include a requirement for at least one designated women's health primary care provider at each VA medical center and CBOC, training for all personnel at each VA medical facility on preventing and addressing harassment at VA medical facilities, and other requirements as determined by the Under Secretary for Health. The Director would have to provide to Congress an annual report on the actions taken by the Office, any identified deficiencies related to VA's provision of care to women Veterans and the standards of care established in this section, a description of the funding and personnel provided to the Office and whether additional funding or personnel are needed, and other information that would be of interest to Congress.

VA does not support the draft bill. VHA currently has an Office of Women's Health Services that reports to the Office of Patient Care Services under the Deputy Under Secretary for Health for Policy and Services. The Chief Consultant in charge of the Office of Women's Health Services is a member of the Senior Executive Service; creating a new Office and Director would merely be renaming a position that is currently encumbered, as the duties and functions would be the same. The current placement of the Office of Women's Health Services is strategically aligned to interact with all other clinical programs at the national level, and this alignment provides a conduit for coordination and collaboration where services are similar. This arrangement also supports the alignment of patient needs when primary care or specialty services are identified.

Conclusion

We note, as a general matter, that given the overlapping nature of some of the bills on the agenda today that the Committee proceed carefully in advancing legislation to ensure that any bills reported by the Committee make complementary changes to VA's authorities, rather than conflicting ones. We would be pleased to work with the Committee in this effort.

This concludes my statement. Thank you for the opportunity to appear before you today. We would be pleased to respond to questions you or other Members may have.