LEGISLATIVE HEARING ON H.R. 3584; H.R. 3644; H.R. 3649; H.R. 4424; H.R. 5530; H.R. 6324; H.R. 6373; H.R. 7347; H.R. 3225; H.R. 5794; H.R. 3303; AND H.R. 5247

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED EIGHTEENTH CONGRESS

SECOND SESSION

THURSDAY, MARCH 21, 2024

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C O N T E N T S

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STATEMENTS FOR THE RECORD

LEGISLATIVE HEARING ON H.R. 3584; H.R. 3644; H.R. 3649; H.R. 4424; H.R. 5530; H.R. 6324; H.R. 6373; H.R. 7347; H.R. 3225; H.R. 5794; H.R. 3303; AND H.R. 5247

THURSDAY, MARCH 21, 2024

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2:49 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meek [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meeks, Radewagen, Rosendale, Murphy, LaLota, Brownley, and Deluzio.

Also present: Representative Dingell, and Underwood.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. The legislative hearing of the Subcommittee on Health will now come to order. I want to welcome all members of the subcommittee and our witnesses. It is a pleasure and a privilege to collaborate once more on crucial matters affecting our veterans.

Today we will be discussing 12 bills, each aimed at improving various aspects and critical needs of veterans' whole health care. These bills range from increasing the availability of assistive mobility devices for veterans living with paralysis to guaranteeing appropriate compensation for providers of essential transportation services and other pressing concerns.

I would like to discuss my bill, H.R. 3584, the Veterans Cannabis Analysis Research and Effectiveness, or CARE Act.

For years we have heard anecdotal firsthand accounts from veterans who have experienced decreased Post-traumatic Stress Disorder (PTSD) symptoms and pain through medical cannabis.

My bill would create a research framework for exploring the potential health benefits of cannabis for treating PTSD and chronic pain. Through rigorous research the Veterans Health Administration (VHA) can explore a new evidence-based treatment option that may have the potential to enhance the lives of those who have served our Nation and to treat the invisible wounds of war.

My bill also has a commitment to preserving data for future research which underscores a long-term vision for evidence-based treatment options. It is important not to let old stigmas interfere

with the healthcare treatment veterans are receiving if a therapy is proven to be safe, effective, and improve veterans' quality of life. I am proud to introduce this bill so that we can gain insight into new therapies that could help those who need it most.

Today we will also discuss Representative Van Orden's bill on alternative therapies. H.R. 7347 would direct the Department of Veterans Affairs (VA) secretary to report to Congress on whether VA will include emerging breakthrough therapy drugs in the VA's list of pharmaceuticals after U.S. Food and Drug Administration (FDA) approval.

I look forward to a productive discussion today on my legislation, as well as the rest of the bills on today's agenda, and the positive impact they promise.

Thank you to our witnesses and those organizations that submitted statements for the record for their thoughtful feedback on my bill and the other bills we will discuss today.

Ensuring the highest standard of care for our veterans is more than our responsibility. It is a profound honor. I look forward to our discussion on the merits and challenges of all the legislation before us today and the impact they could have on VA operations and, most importantly, on veterans' lives. Thank you again for all being here.

Because of the interference with votes for our hearing today, we will come back to Ranking Member Brownley for her opening remarks. We have a full agenda today so I will be holding everyone to 3 minutes per bill to get through it in a timely manner.

This morning we are joined by several colleagues who are going to testify about their bills. We are extremely grateful for their work in serving our Nation's veterans.

With that, I ask unanimous consent that all non-committee members be waived on to speak on their bills from the dais. Hearing no objection, we will move forward.

I now recognize Representative Bergman. You are now recognized for 3 minutes.

STATEMENT OF JACK BERGMAN

Mr. BERGMAN. Thank you, Madam Chair. I would like to start by briefly mentioning two bills that the committee will discuss today, Congresswoman Dingell's VA Peer Review Neutrality Act, which I am proud to be the Republican colleague for and Congressman Van Orden's bill to require VA to make a formulary determination for psychedelic therapies within 6 months of FDA approval. Both are important pieces of legislation. I look forward to hearing their sponsors' testimonies.

I would also like to take a few seconds to show my appreciation for one of our witnesses in particular, Ms. Brittany Elliot, as well as her full time caregiver and father, Morgan Elliot. I have had the opportunity to spend a wonderful amount of time with both of them, hear their story, and gain a sense of the difficulty that currently exists for our Spinal Cord Injury or Disorder (SCI/D) veterans. We will talk about that acronym later.

Brittany is strong, determined, and undaunted by the bureaucracy she has been forced to deal with, and as a fellow Marine I

would expect nothing less. Welcome to both and Brittany I look forward to hearing your testimony.

The Veterans' Spinal Trauma Access to New Devices or Veterans STAND Act, takes commensurate steps to improve care for veterans with spinal cord injuries or disorders and ensure they are assessed for and provided with assistive devices that they are already clinically eligible to receive.

First, the bill would codify the requirement that VHA provides an annual spinal health assessment for SCI/D veterans and includes specific requirements for proactive outreach to those who are eligible.

Second, the bill takes steps to ensure veterans are informed of and assessed for assistive technology that can help their independence and mobility. As many veterans will tell you, despite both of these measures already existing on paper at VA, the actual experience of SCI/D veterans has varied widely and in many cases VA has outright failed to meet their needs. This is why the bill also takes steps to improve transparency and accountability at VA, including by requiring the secretary to submit reports to Congress on the extent to which veterans are actually being provided with these life-changing technologies.

Finally, the bill would direct VHA to consult with veterans' advocates, medical specialists and device experts and manufacturers when developing clinical procedure guidelines for assistive devices, something that will only become more important as the rate of technological advancement continues to increase exponentially and new devices enter the marketplace. The fact is that we are systematically failing those veterans paralyzed from service by denying them simple and rapid access to essential assistive technology. Veterans like Brittany who have received these devices have often only been able to do so through extensive self-advocacy, months of delays, and hundreds of miles of travel to find a VA doctor and facility willing to meet their needs.

I am grateful to Chairman Bost, Subcommittee Ranking Member Brownley and Congresswoman Dingell for helping me introduce this bipartisan bill, as well as the other committee members who have joined as co-sponsors. I have also heard that Senators Moran and Tester, the ranking member and chairman of the Senate VA Committee, have introduced a Senate companion bill today. I wholeheartedly welcome any and all constructive input to make sure we advance the best possible bill to improve the lives of veterans with spinal cord injuries and disorders.

However, as I hope you learn from Ms. Elliot's testimony, our current way of doing things is not working for many veterans with spinal cord injuries. That being is unacceptable and Congress must act.

I yield back.

Ms. MILLER-MEEKS. Thank you.

The chair now recognizes Ranking Member Brownley for her opening statement.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Madam Chair, and thank you for being patient with me being slightly late. Thank you very much for convening today's hearing. I look forward to our discussion of the 12 bills on today's agenda. I know many of the sponsors of legislation on today's agenda are planning to be here to present their bills, and I am eager to hear from our witnesses so I will aim to keep these remarks brief and highlight just a few of the bills.

I am pleased we are considering H.R. 6373, the Veterans' Spinal Trauma Access to New Devices, or Veterans' STAND Act. I am proud to be co-leading this bill with Representative Bergman, Bost and Dingell. H.R. 6373 will codify VA's existing policy of providing annual preventive health assessments for veterans with spinal cord injuries or diseases. These exams are vitally important because they can help identify and treat health issues before they become too serious.

Second, our legislation aims to increase veterans' access to state-of-the-art assistive technology known as personal exoskeletons. Ms. Elliot, a veteran who is testifying on our second panel, has a great deal to share about her personal experience with this technology and her attempts to access it through the VA. We look forward to hearing from her.

Advancements in technology can provide revolutionary options to help paralyzed veterans lead their lives to their fullest potential, and the Veterans' STAND Act will help ensure VA remains at the forefront of innovation and medical treatment,

I understand that VA has some concerns about the bill, but I hope the department will work with us to make those improvements.

I am also pleased that we are considering Representative Underwood's bill, H.R. 3303, the Maternal Health for Veterans Act. This legislation builds upon the Protecting Moms Who Served Act also sponsored by Representative Underwood which was enacted in 2021.

In addition to codifying VA's maternity care coordination (MCC) program, the Protecting Moms Who Served Act mandated a Government Accountability Office (GAO) report on maternal health outcomes among veterans. That report was issued in January of this year, and I ask unanimous consent to enter this report into the hearing record.

Ms. MILLER-MEEKS. No objection.

Ms. BROWNLEY. GAO analyzed VA data on deaths and severe maternal morbidity among pregnant and postpartum veterans from fiscal years 2011 through 2020, the most recently available data. The findings are concerning. Among other things GAO found that the severe maternal morbidity rate among veterans increased between 2011 and 2020 and this rate was highest among black or African American veterans.

H.R. 3303, the Maternal Health for Veterans Act, will require VA to report annually on activities related to maternity care coordination. These reports must include data on veterans' maternal health outcomes along with recommendations for improving them.

Further, this bill authorizes funding through Fiscal Year 2028 for VA's maternity care coordination program. I am pleased that Ms. Melissa Bryant of Minority Veterans of America (MVA) is here today to testify on this legislation. As you will hear from her, there have been many positive outcomes of VA's maternity care coordination program since it was established in 2012, but there are still many areas for improvement.

Just yesterday I participated in a roundtable with Ms. Bryant and other women veterans where we discussed VA's implementation of the Deborah Sampson Act, which was signed into law just over 3 years ago. While the Deborah Sampson Act made significant improvements in the delivery of benefits and health care for women veterans, it is clear there is more work to do and we need to continue advancing additional legislation like Ms. Underwood's bill.

I understand Representative Deluzio and Ms. Dingell will also be here, I see Ms. Dingell right here, in support of their bills, H.R. 3225, the Build for Veterans Act and H.R. 5794, the VA Peer Review Neutrality Act. I will defer to both of them to provide more detailed explanations of their bill, but I want to express my support for each.

I will yield there, Madam Chair.

Ms. MILLER-MEEKS. Thank you very much, Ranking Member Brownley.

We are going to go back to presentation. I now recognize Representative Deluzio for 3 minutes.

STATEMENT OF CHRIS DELUZIO

Mr. DELUZIO. Thank you, Madam Chair. Thank you Ranking Member Brownley for the kind words about my bill, the Build, Utilize, Invest, Learn, And Deliver for Veterans Act, the BUILD for Veterans Act, a common sense piece of legislation to modernize and streamline the delivery of VA medical facilities and other infrastructure projects, strengthen the workforce, save public money by expediting the disposal or repurposing of unused or vacant buildings that the VA owns.

I think it is badly needed. We all know across the country in our districts the VA opens lots of new or remodeled facilities every year but the need for more modern facilities is much greater than its current operational tempo, budget, or frankly, infrastructure workforce. Those VA facilities on average are around 60 years old and the VA has around 180 billion in backlogged infrastructure projects, a backlog that is growing faster than VA can address them.

This bill continues to build off historic infrastructure investments of Ranking Member Takano's The Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, and I am proud to say there is a companion effort in the Senate led by Chairman Tester. Specifically, the BUILD for Veterans Act works to tackle workforce issues, establishing a staffing model to ensure a base level of capital asset staffing through new recruitment and retention incentives on infrastructure streamlining.

The bill requires VA to implement a more concrete schedule to eliminate repurposed, unused, or vacant buildings to ensure there

is an adequate office and staff, or offices, excuse me, and staff to efficiently manage capital assets at all levels by implementing systems review of the climate resilience of all capital assets.

There is also an oversight section in the bill requiring VA to provide an annual budget for Congress to monitor the plan's performance data over a 10-year period, requiring a submission of a strategic plan that improves VA's delivery and management of capital assets and requiring an examination and reporting of VA-related capital asset improvement from the VA Inspector General.

The bill is supported by many Veterans Service Organizations (VSO), including Veterans of Foreign Wars (VFW), Disabled American Veterans (DAV), Paralyzed Veterans of America (PVA), the Legion, Iraq and Afghanistan Veterans of America (IAVA). I think this is a good bill, one that I hope my colleagues will support. The BUILD for Veterans Act strengthens VA's capacity to deliver veterans the state-of-the-art care that they all have earned and saves public money in the process.

Madam Chair, I yield back. Thank you.

Ms. MILLER-MEEKS. Thank you Representative Deluzio.

I now recognize Representative Bost, Chairman Bost, for 3 minutes.

STATEMENT OF MIKE BOST

Mr. BOST. Thank you, Madam Chairman. I am glad to be here today to speak on my bills, H.R. 5530, and VA Energy Transportation Access Act and H.R. 6324, the Fiscal Year 2024 Veterans Affairs Majority Medical Facility Authorization Act.

H.R. 5530, the VA Emergency Transportation Access Act, would help veterans keep access to emergency transportation services. I know firsthand that quick access to emergency transportation services can be the difference between life and death in rural and remote areas of this United States.

My commonsense bill would require VA to work with ground and air ambulance providers to develop a plan that protects and expands rural veterans' access to emergency service first.

Right now, VA's proposed rule would slash reimbursement for good companies that provide vitally important ground and air emergency transportation services. VA plans—reverts to the outdated medical reimbursement schedule that is based on data from 1998 and 2002.

My bill would ensure that veterans, especially rural veterans, have access to transportation for timely medical care. It would guarantee that transportation companies are reimbursed fairly for their services.

My bill also would create a simple and sensible process for VA to make needed changes in reimbursements. This bill is about protecting our veterans so that they have access to care they need when they need it.

Next, I would like to speak about bill, H.R. 6324, the Fiscal Year 2024 Veterans Affairs Major Medical Facilities Authorization Act. This bill would authorize over $4.6 billion in important major medical facilities projects that would modernize VA medical facilities across the country, building on the personal commitment to bring

VA into the—my personal commitment to bring VA into the 21st century.

This legislation would authorize a number of key construction projects across country that we know VA medical facilities need. These projects range from the construction of new healthcare centers to the expansion of mental health facilities. My bill would allow VA to replace outdated community living centers and update existing facilities with the latest earthquake resistant technology.

By continuing to modernize VA facilities we will ensure that the veterans have access to the high quality modern medical care that they deserve. It is vitally important that we address critical construction projects in a timely and fiscally responsible manner. I look forward to ensuring my legislation does exactly that.

Madam Chairman, I yield back.

Ms. MILLER-MEEKS. Thank you, Mr. Bost. I was ready, willing, and able to yield you another 3 minutes but you spoke on both H.R. 5530 and H.R. 6324. Thank you.

I now recognize Representative Dingell for 3 minutes.

STATEMENT OF DEBBIE DINGELL

Ms. DINGELL. Thank you, Madam Chair. I want to start by thanking you and the ranking member for including H.R. 5794, the VA Peer Review Neutrality Act, as part of today's hearing. I am leading this bill alongside my good friend and colleague from Michigan, Representative Jack Bergman, and I appreciate his support and partnership on this very important issue.

I care deeply, like all of you do, about our Nation's veterans so when they come to me with problems I listen. When I started hearing concerns from veterans and employees at the John D. Dingell VA Medical Center in Detroit, I knew these problems were serious and immediately started sounding the alarm.

I personally went to the Veterans Affairs secretary and I want to thank him here for listening. These efforts led to a review by the VA Inspector General into allegations of misconduct at the Detroit VA Medical Center. Unfortunately, the review uncovered findings of misconduct in a pattern of substandard surgical care, which included the manipulation of external peer reviews.

The top three administrative leaders at the facility have since been removed, and under new leadership the VA has made progress in restoring trust and accountability. Still, it is critical we never allow this kind of misconduct to happen again at any VA hospital across the country, and a Member of Congress should not have to go directly to the VA secretary.

With the VA Peer Neutrality Act we can take concrete steps to strengthen accountability and neutrality within the VA's peer review process. This bill will codify a VA policy that ensures members of a VA facilities peer review committee cannot participate in peer reviews of cases they were involved in or cases that present a conflict of interest.

Our veterans deserve the best care and this legislation will better strengthen accountability and oversight within the VA medical facilities that serve them. I look forward to continuing to work with this subcommittee on this very important legislation.

I yield back, Madam Chair.

Ms. MILLER-MEEKS. Thank you, Representative Dingell.

The chair now recognizes Representative Van Orden for 3 minutes.

STATEMENT OF DERRICK VAN ORDEN

Mr. VAN ORDEN. Thank you, Madam Chair. I am a Navy veteran of 26 years and 22 of those were spent as a SEAL. My entire adult life has been spent operating next to some of the greatest men and women in the world, actually. Although most of us have survived combat, many of us come back home and we are unable to deal with the issues that presented us in that very difficult environment.

Today, with the passing of a senior chief, to date I have had 21 of my friends commit suicide, and we just had another Navy SEAL commit suicide 2 weeks ago. These things do not make the press, you know, but we have a very tight-knit group of folks. His name will never be made public I do not think.

I did not know him but, you know, who did? His family and his teammates, and we do not forget our brothers and sisters who, unfortunately, make a permanent decision over a temporary problem.

We have given the Veterans Administration $16.5 billion last year and $150 billion since 9/11 for veterans suicide and the suicide rate continues to increase. I mean, Dr. Scavella here, who has an incredibly impressive academic record and an absolutely terrible practical record of preventing veterans from committing suicide, so we have to try something different. We simply do.

We have got these incredibly brilliant scientists and doctors and all this stuff, and what they are doing is not working. We know that because more veterans are committing suicide now than they have in the past.

I have introduced H.R. 7347 and that is to make sure that we are able to mandate the Veterans Administration to report back to us within 180 days on its plans to incorporate psychedelics into treatments upon FDA approval. I will tell you what, honestly, I am not 100 percent sold on this. I am not.

Do you know what? It works for some of our veterans. It does. Some of our veterans on this committee actually have done psychedelic treatment to prevent or to help them deal with PTS, and it worked for them. We are going to be an all-of-the-above if it is going to help a single veteran even as a bridging mechanism from preventing themselves from committing suicide.

I am 100 percent sold on faith-based programs because they are proven to work also. I am asking everybody, Ms. Brownley and Madam Chair, I am asking all to vote for this, understanding that it is not a do-all fix-all for everybody but it is going to help at least save one veteran's life so that I do not have to go to their funeral and get on my knees one more time and speak to these fatherless children. Look at their widow and try to explain to him why we did not do everything we possibly can to prevent their husband from committing suicide.

I am imploring my colleagues to please vote this. Get it through the subcommittee to the full Committee to the House and let us actually do what we say we are here to do and that is to prevent veteran suicide.

With that, I yield back, Madam Chair.

Ms. MILLER-MEEKS. Thank you Representative Van Orden.

The chair now recognizes Representative Underwood for 3 minutes.

STATEMENT OF LAUREN UNDERWOOD

Ms. UNDERWOOD. Thank you, Madam Chair. Thank you for inviting me to speak today and for considering my legislation, the Maternal Health for Veterans Act. While I currently sit on the House Appropriations Committee, I previously had the honor of serving on House Veterans Affairs in the 116th and 117th Congress, and I hope to be back next Congress, but serving veterans is one of the greatest privileges we have as Members of Congress. I am honored to serve veterans both on and off this committee.

The United States is in the middle of a maternal health crisis that is getting worse not better and veteran moms are dying. America has the highest pregnancy-related mortality ratio of any high income country and significant disparities in outcomes. To solve this crisis I introduced the "Momnibus," a set of 13 bills including the Maternal Health for Veterans Act that comprehensively address our Nation's maternal mortality crisis.

Last Congress we had the first bill from the Momnibus enacted, the Protecting Moms Who Served Act which invests in world class care, maternity care for our veterans. I was so excited to go to the White House and see President Biden sign the Protecting Moms Who Served Act into law, but even then I knew that the Protecting Moms Who Served Act was only the beginning.

Now earlier this year, the GAO released the report we commissioned in the Protecting Moms Who Served Act and their findings were devastating, but not surprising. In less than 10 years the number of veterans suffering severe pregnancy complications almost doubled. Pregnant veterans are more likely to have physical and mental health conditions that may lead to adverse maternal outcomes or complications. For veterans, just like the general population, mental health conditions increase the risk of severe maternal death complications—I am sorry—severe maternal health complications including the risk of maternal death by suicide.

We have a lot more work to do to live up to the promises we made to our veteran families. They served our country and our job is to serve them, and that is why I introduced the Maternal Health for Veterans Act. This legislation builds on our success advocating for quality maternal health care for our veterans.

It authorizes $15 million per year for the next 5 years for VA's maternity care programs, and it requires recommendations and annual public reporting on maternal health from the VA. Our veterans are not just our heroes. As moms they are also the heroes of their families.

During the vulnerable pregnancy and postpartum periods they rely on us to ensure that they have access to high quality maternity care. We owe them the best. I urge this committee to pass the Maternal Health for Veterans Act without delay and send it to the House floor this spring. Thank you so much for your time and consideration.

I yield back.

Ms. MILLER-MEEKS. Thank you, Representative Underwood.

The chair now recognizes Dr. Murphy for 3 minutes.

STATEMENT OF GREG MURPHY

Mr. MURPHY. Thank you, Madam Chair, and I hope everybody was listening with what Representative Van Orden just said. It was quiet words but extremely powerful.

I have 3 Marine bases in my district of 21,000 military retirees, 50,000 active military family members. I am honored today and fully believe in the bill I am introducing today.

I have supported it since I came to Congress in 2019. I have worked on this same issue in the North Carolina State House with really good results.

I have been working for years, despite being a urologist, to help find treatments and procedures, et cetera, to help PTSD and Traumatic Brain Injury (TBI). This is an absolute criminal act by this country that we have an increasing number of suicides despite statistical manipulation.

The Committee knows better than anybody else that a cure for PTSD and TBI is elusive. We must examine every treatment option that has the potential to help our suffering veterans. H.R. 3649, the Veterans National Traumatic Brain Injury Act, requires the Department of VA to implement a 5-year pilot program to furnish under the Veterans Community Care Program, hyperbaric oxygen therapy (HBOT) to veterans with traumatic brain injuries, TBI, or traumatic stress disorder, PTSD.

I strongly recommend that we examine this issue. I am happy to say that in the North Carolina House now the legislature has funded many veterans to undergo this treatment, and I have seen personally, personally, veterans who have been aided with this when literally they have hit the wall and nothing else has been able available to them.

I am actually supportive of the hallucenogenics that Representative Van Orden was speaking. This must be an all hands on deck approach. Just a few weeks ago I was at a large gala for this particular issue with Secretary Mike Pompeo. He is onboard with this.

A 2021 report by the North Carolina Community Foundation of North Carolina East said to the legislature that there is "an impressive number of successes through the HBOT program and treatments in North Carolina veterans."

My bill is bipartisan. Don Davis, Marilyn Strickland, Representatives Kiggans, Pappas, Duncan, Timmins, Bill, Huizenga, Moreland are all co-sponsors, as well are multiple other VSOs. My intent is to offer another treatment.

Reading the response to the VA in the opposition, I am very disappointed. It is an absolutely bureaucratic response. All hands on deck. All hands on deck to stop this absolute scourge which is happening with our veterans. I think the debate on risk is absolutely overstated. I have used this as a surgeon for close to 30 years and, yes, there are risks with any procedures . There are risks with an IV stick. When it has come to the end of the road, at the end of the road when our veterans have no other option that they choose suicide, all hands on deck. Whatever treatment we can as a Vet-

erans Administration institution is owed to our veterans. I ask for your support.

Thank you. I yield back.

Ms. MILLER-MEEKS. Thank you, Dr. Murphy.

The chair now recognizes Representative LaLota for 3 minutes.

STATEMENT OF NICK LALOTA

Mr. LALOTA. Thank you, Chairman Miller-Meeks, Ranking Member Brownley and members of the Veterans Health Committee for hosting this important hearing today and for allowing me to waive on.

Vietnam veterans have a much greater chance of contracting, suffering from, and dying from the liver fluke parasite and yet the VA does not cover their health-related coverage. The correlation between the liver fluke parasite and service in Vietnam is obvious.

In fact, a first of its kind study was conducted back in 2018 at the Northport VA Medical Center using a 50-veteran sample size. The initial results of that study highlighted three basic things, the substantial need for greater study of the issue, the development of standardized treatment options, and broader accessibility of care for veterans at VA facilities across the country.

The VA conducted another study and after years of delays that study recently found there was a 30 percent greater risk of mortality from this bile duct cancer from Marines who served in the Vietnam War as compared to Marines who served elsewhere, 30 percent. However, the VA still says that the study is not enough.

It is clear to me, a Navy veteran and countless Vietnam veterans who have been suffering from and dying from the liver fluke parasite, that there should unequivocally be a designation of service connection for these veterans. That is why I am here today, Madam Chairwoman, to speak in favor of my legislation, H.R. 4224, the Liver Fluke Cancer Study Act, which would require the VA in conjunction with the Centers for Disease Control and Prevention (CDC) to conduct a study to determine the prevalence of liver fluke amongst the Vietnam veteran population.

Madam Chairman, our Vietnam veterans are dying every day and we do not have the luxury of time. Too much time has passed already and we went through a similar terrible situation with our Blue Water Navy veterans and Agent Orange. Let us not make the same mistake twice.

I urge all of my colleagues to support this legislation, and I want to thank the chairwoman and ranking member again for allowing me to testify in front of this committee, and I look forward to working with you and this entire committee to see this problem solved. Thank you.

I yield back.

Ms. MILLER-MEEKS. Thank you. We also have two additional bills that we may hear about today, H.R. 3644, Addressing Care Timelines (ACT) for Veterans Act by Representative Latta and H.R. 5247, Expedited Hiring for VA Trained Psychiatrist Act of 2023 by Representative Cartwright. They have both submitted statements for the record.

As is our practice we will forgo a round of questioning for the members. I now invite our first panel to the table.

Thank you. Joining us today from the Department of Veterans Affairs is Dr. Ajit Pai, the Executive Director of the Office of Rehabilitation and Prosthetic Services at the Veterans Health Administration. Accompanying Dr. Pai today are Dr. Michael Brennan, Executive Director at the Office of Construction and Facilities Management, Veterans Affairs; Dr. Wendy Tenhula, Deputy Chief Research and Development Officer, Office of Research and Development, Veterans Health Administration; and Mr. David Perry, Chief Officer of Workforce Management and Consulting, Veterans Health Administration.

Dr. Pai, you are now recognized for 5 minutes to present the Department's testimony.

STATEMENT OF AJIT PAI

Dr. PAI. Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee. We are grateful for the opportunity to appear before you today to discuss this pending legislation. Joining me are Dr. Michael Brennan, Executive Director of the Office of Construction and Facilities Management; Dr. Wendy Tenhula, Deputy Chief of the Office of Research And Development; and Mr. David Perry, Chief Officer of Workforce Management and Consulting.

VA supports several items of proposed legislation before us today. While VA's views on all the bills are detailed in my written testimony, including areas of concern and support, I would like to highlight a few bills that would have profound effects on modernizing our delivery of services to veterans, their family members, and caregivers.

First, VA supports, to include with amendments, H.R. 3303, the Maternal Health for Veterans Act; H.R. 3584, the Veterans CARE Act; H.R. 5794, the VA Peer Neutrality Act of 2023; and H.R. 6324, the FY 2024 VA Major Medical Facility Authorization Act.

VA appreciates H.R. 3303 because it aligns with VA's current efforts to enhance the health outcomes of pregnant veterans. We note there is some ambiguity in the bill text as it would require VA to provide data on the maternal health outcomes of veterans who receive medical care or services furnished by VA when no VA medical facility furnishes maternity care.

Although too prescriptive in its design, H.R. 3584 would authorize VA to conduct research in certain forms of cannabis on the health outcomes of veterans. I also want to thank the subcommittee for their efforts to improve the health outcomes of veterans through the introduction of several bills including H.R. 4424, the Vietnam Veterans Liver Fluke Cancer Study Act; H.R. 5247, the Expedited Hiring of VA Trained Psychiatrists Act of 2023; H.R. 7347, the reporting on the determination to include newly approved or licensed psychedelic drugs in the VA formulary bill; and certain sections in H.R. 3225, the BUILD for Veterans Act of 2023.

I want to emphasize that VA recognizes the congressional intent behind these bills, but many of the activities mandated are already being carried out or completed.

For instance, with regards to H.R. 3225, VA is already identifying properties annually via the disposal and reuse report, providing the total 10-year-long range action plan capital requirement

and the major construction 5-year development plan requirements annually in the President's budget request, and incorporating recommendations from the Office of the Inspector General (OIG), the Comptroller General, and others on how to detect and prevent waste, fraud, and abuse.

With many reporting requirements and provisions in this bill, VA is best suited with extended deadlines and congressional acknowledgement of staffing needs and the availability of appropriations.

Also, VA is currently conducting research to better understand the health risks and conditions of veterans who served in combat areas or were otherwise placed at higher risk due to do their military service.

An analysis of Vietnam-era Veterans' deaths from 1979 to 2019 due to cholangiocarcinoma is in its final stages of preparation for submission to a peer-reviewed scientific journal. VA fully supports the need to continue conducting research in this area, however, we believe the bill's requirements are already satisfied.

Another example is that VA currently has the authority proposed in H.R. 5247, to initiate the appointment process for psychiatrists before they complete a residency.

Last, VA would like to address our concerns with H.R. 3649, the Veterans National Traumatic Brain Injury Treatment Act, and H.R. 6373, the Veterans STAND Act.

Regarding H.R. 3649, if enacted into law in its current form, the bill could have a negative impact on the lives of veterans. Extensive research conducted by VA, the Department of Defense, and others on the effectiveness of hyperbaric oxygen therapy, or HBOT, for traumatic brain injuries has shown no significant improvements, especially in cases of mild TBI.

Studies comparing HBOT to a control intervention reveal that HBOT was linked to decreased quality of life during long-term follow up at 2 and 3 years. Furthermore, aside from the lack of patient improvement, there is insufficient evidence to warrant the use of HBOT as a treatment for post-traumatic stress.

We recognize that the advancement of assistive technology has significantly enhanced the lives of our Nation's veterans. However, H.R. 6373 as currently written, could hinder VA's ability to safeguard veterans' well-being and undermine the integrity of the clinical decision-making process.

Additionally, mandatory consultation with specific manufacturers or entities could create conflicts of interest that might jeopardize patient safety.

VA providers collaborate closely with veterans to assess their needs and suggest the most suitable solution. Exoskeletons which can weigh up to 51 pounds are complex medical devices. Clinicians trained in exoskeleton use consider various factors when prescribing this equipment.

For safety reasons and due to the device complexity, the Food and Drug Administration, FDA mandates that individuals using this technology have a companion present. Unfortunately, many individuals do not have access to a suitable companion.

We appreciate the congressional intent and welcome the opportunity to work closely with Congress on all of the bills on today's

agenda. My colleagues and I are happy to respond to any questions you may have.

[THE PREPARED STATEMENT OF AJIT PAI APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. Pai, for your testimony.

I now yield myself 5 minutes. Typically I go at the end but today is an unusual day. Dr. Pai, the VA's Therapeutic Advisory (TA) included the request to initiate additional scientifically peer-reviewed clinical trials. Is the authority granted in the Veteran CARE Act not broad enough to conduct multiple trials?

Dr. PAI. Thank you for the question. I would like to defer to Dr. Tenhula.

Dr. TENHULA. Good afternoon. Thank you for the question and your interest in this issue. The bill as written, our concern is that it is too prescriptive in the framework that is laid out. What we would request is to make several amendments and work with the committee staff on those.

Ms. MILLER-MEEKS. You know, we deliberately tried to make it less prescriptive so that the VA could conduct and organize trials, given their expertise in that rather than have that be directed from Congress, but we would be happy to work with you in that endeavor.

Dr. Pai, what coordination is necessary between the VA and other Federal agencies to effectively conduct research under the Veteran CARE Act, or maybe Dr. Tenhula?

Dr. TENHULA. I would be happy to take that question. What we would be interested in is working with other Federal agencies in developing a plan for an observational study that would allow us to understand cannabis use among not only veterans but a broader population, and not only veterans that seek care in the VA healthcare system.

Allowing us to work with other Federal agencies on those efforts would allow for more unbiased data collection, and would provide data that could inform those clinical trials that you mentioned and advise us in what direction to go with those trials.

Ms. MILLER-MEEKS. Is there not already observations? As a physician, is there not already observational data that is available?

Dr. TENHULA. There is not adequate observational data that has been——

Ms. MILLER-MEEKS. Even from overseas?

Dr. TENHULA. I am not aware of the data from overseas. I would take that for the record and get more information.

Ms. MILLER-MEEKS. Then either Dr. Pai or Dr. Tenhula, what effect will the Medical Marijuana and Cannabidiol (CBD) Research Expansion Act have on Veterans CARE Act and VA research into CBD and cannabis?

Dr. TENHULA. That act in particular, as I understand it, will not have direct impact on VA's ability to do this research. We already have the authorities in place that we need to be able to do that work.

Ms. MILLER-MEEKS. Thank you very much.

I now recognize Ranking Member Brownley for any questions you may have.

Ms. BROWNLEY. Thank you, Madam Chair.

My first question is to Dr. Pai. Thank you for being here. I wanted to talk to you about H.R. 6373, the Veterans STAND Act. I am frustrated that the VA opposes this bill.

I suppose I can understand why you might be concerned about the provision that would require consultation with the manufacturers of assisted technologies and the potential of conflict of interest this could raise. I think we could work with you on that.

However, I am confused as to why the Department would oppose the rest of the bill to include codification of the annual preventive exams that VA should already be providing for veterans with spinal cord injuries and disorders.

The VA also takes issue with the bill's definition of the term assistive technology. Could you elaborate on why VA has difficulty with our definition and how we could possibly amend the bill to address your concerns? Can we also at the end of the day have your commitment to working together to get this bill on the right path and moving forward?

Dr. PAI. Thank you, ma'am. To answer your second question about the definition of assistive technology, it is an overly broad term to be used. Assistive technology is not only for mobility devices and technologies for mobility devices but also for speech and swallowing, communication.

In this case specific to this bill it may be more appropriate to utilize assistive walking mobility or adaptive assisted mobility technologies, something very specific to mobility.

With regards to your first concern or question about annual evaluations and codifying them, VA's spinal cord injury and disorders system of care looks at the care for veterans with spinal cord injuries in a way that they are very committed to the comprehensive lifelong care of those veterans from an evidence-based manner using innovative and specialized care techniques.

For all veterans with spinal cord injury they highly encourage those veterans to participate in annual evaluations. It is not a requirement of veterans because we want to make sure that we give veterans choice in their care, just as in anything else. By codifying the annual evaluations, that can create challenges for those specific veterans.

Ms. BROWNLEY. Well, if we codified it, it must, in what you are saying, it must be causing problems right now, right, because that is the policy and the directive.

Dr. PAI. For annual evaluations—

Ms. BROWNLEY. Yes.

Dr. PAI. Correct.

Ms. BROWNLEY. Yes.

Dr. PAI. They are offered to all veterans with spinal cord injuries and disorders.

Ms. BROWNLEY. Right. Okay, very good.

Mr. Perry, VA also opposes H.R. 5247, the Expedited Hiring For VA Trained Psychiatrists Act. You said in your written testimony that it already has the authority to begin the appointment process for a psychiatrist prior to completion of their residency. Could you please elaborate on this? What authority does VA currently use to directly hire psychiatry trainees and to what extent can you also

use this authority to directly hire physicians in other specialties who have trained at the VA?

Mr. PERRY. Thank you, Representative Brownley, for that question. Yes. We do not support this legislation because, as you stated, we have that authority now. Under Title 38 we have expedited hiring authority which allows us up to a year to go ahead and proactively identify psychiatrists and other medical professionals that are in training in residency programs.

We have the authorities now to do that under our current statute, so we really do not see any benefit for adding this additional legislation.

Ms. BROWNLEY. Can you share some data on how many clinical trainees convert to VA employment immediately upon completion of their residencies?

Mr. PERRY. I would tell you not as many as we would like. We absolutely identify that the trainee pipeline is our biggest source and conduit that we should be pulling from and so I do not have the exact number that we pull from each year, but we are aggressively targeting that pipeline for our trainees.

Ms. BROWNLEY. Can you give me a rough idea? Is it 10 percent or 20 percent or 50 percent?

Mr. PERRY. I think it varies by year. I do not think it is that high. I can tell you we train 70 percent of the residents that come through our VA institutions, but yes, we are not anywhere close to where we want to be in those targets, so we definitely have area for improvement.

A lot of time our decisions around hiring are budget-driven and timing can be a factor as well, but we do like to target as advanced out as possible to hire these clinicians.

Ms. BROWNLEY. Okay. Dr. Brennan, and I understand from your testimony that VA is undertaking the creation of facilities methodology, but you have concerns with meeting the timeline. Do you have a sense of when VA will be able to complete the staffing model?

Dr. BRENNAN. Good afternoon and thank you for that question. You know, if we are referring to Section 101 of the bill, in particular, the current organizational structure of VA includes staff who are responsible for all the functions that are set forth. One of the things we have done in parallel with probably the development of this bill has really been focusing on the strategy of integration of all the facilities functions and personnel that we have across the Department be better integrated to gain efficiencies.

We are undergoing that right now. Along the same pathway, VHA is in the early stages of facility staffing methodology that will inform by standard performance metrics. They believe it will require 450 days to develop a firm model.

Ms. BROWNLEY. How many days did you say? I did not——

Dr. BRENNAN. It may require more than the 450 days to develop the model.

Ms. BROWNLEY. Okay, thank you.

I yield back.

Mr. MURPHY. [Presiding.] I spoke a little bit earlier about my disappointment in the VA's opposition to these and actually several of the other bills that we have in present. You know, I will be first

to say that as a surgeon of now close to 35 years I understand the complexities that occur with hyperbaric oxygen. I have dealt with it many, many times and I understand the complexities here.

As Representative Van Orden said point blank, we are failing our veterans and I see an extremely bureaucratic response to this in opposition as with some of these other bills as to why it cannot be done.

Dr. Pai, think this is your area of expertise. I would love to hear your comments upon this so that we can have a, you know, a respectful discussion in the opposition probably.

Dr. PAI. Certainly. Completely agree with Representative Van Orden with regards to suicidality and suicide being a problem, right, a major problem. It is our number one healthcare priority.

With regards to hyperbaric oxygen therapy, it has not been shown to decrease suicide ideation from a PTSD standpoint. It has not been shown to provide significant improvements. What we are really focused on are those treatment options that do treat PTSD, prolonged exposure, evidence-based—or eye movement desensitization and reprocessing (EMDR).

, as well as cognitive processing therapy.

We want to make sure that we are focused on treatments that are evidence-based for PTSD and we are not diverting resources to interventions that are not proven for PTSD.

Mr. MURPHY. Well, I am going to respectfully disagree because in the State of North Carolina now where we are doing this, we are seeing tremendous results. We have a huge veteran community in eastern North Carolina especially, especially in Durham, North Carolina, in the center of the State and in the northeast corner with Dr. Moreno. They are seeing tremendous results with these.

You know, again, we are going to get back to where this is literally the end of the road for individuals. I was very skeptical of psychedelics. Read the literature, very proponent of this. I am not a fan of marijuana in a general sense, but I am absolutely a fan if it is going to help our veterans, and it is very restricted.

I am just seeing, you know, I am reading in here one of the things that might take—veterans may have to travel for this. Well, if the option is traveling to a cemetery than traveling to a VA to go get this therapy, by God we ought to be knocking down the doors of hell to do it. It is critical.

Yes, I understand that there is discussion about this, but we have several different avenues to choose from and I am adamant, and I am a scientist at first, at heart, and I am adamant that this makes the lives of individuals who are hitting the wall.

I think the Veterans Administration must pursue every single opportunity because statistical manipulations in a decrease in suicides in this country is not acceptable to effectually lowering that number. I would urge you, and it is going to maybe have to be in this committee's purview to rethink this to literally, as I said, all hands on deck for our veterans.

When they are hitting the wall and they are committing suicide we have to open up every door. Any other considerations? I will tell you, with Mr. Van Orden and Mr. LaLota's bills I am in full support of those things. I hate for us to be in an adversarial role here. I think we have good individuals. I know your hearts are all in the

right place, but it is our supervisory role to assist the VA, sometimes nudgingly, in what we are doing for our veterans.

I thank you. This is the end of this subcommittee.

I want to thank all witnesses for the hearing today. You are now excused, and we will wait while the second panel comes the witness table.

Mr. MURPHY. Thank you to all members. We would like to start our second panel today. On our second panel we have Mr. John Retzer, assistant national director for Disabled Veterans, Mr. Roscoe Butler, senior health advisor at the Paralyzed Veterans of America, Ms. Brittany Elliot, a Marine Corps veteran and advocate, and Ms. Melissa Bryant, chair of the directors of boards of Minority Veterans of America.

Mr. Retzer, you are now recognized for 5 minutes. Thank you.

STATEMENT OF JON RETZER

Mr. RETZER. Thank you, Chair Murphy, Ranking Member Brownley, and members of the subcommittee. Thank you for inviting DAV to testify at this legislative hearing. We appreciate all the beneficial pieces of proposed legislation on agenda today that are focused on improving timely access and quality of services for our Nation's veterans, in particular service-disabled veterans.

Throughout the past decade the VA has experienced significant growth and difficulty implementing reforms that guarantee veterans receive access to quality healthcare. For VA to maintain its role as a primary provider of timely and quality care, it must address the challenge of an aging infrastructure by improving its internal capacity through the construction and modernization of facilities.

Unfortunately, VA facilities have a median age of nearly 60 years which poses a challenge with renovations. Facilities of this era were not designed to accommodate the technological and design innovation needs that support a modern healthcare system. That is why DAV supports the BUILD for Veterans Act, H.R. 3225, which aims to enhance the VA's capital assets program by improving planning and oversight, providing more consistent funding, and strengthening capability to start and complete projects.

Another key aspect of providing quality care is safe and effective innovations and delivery of evidence-based treatments. The Veterans Care Act, H.R. 3584, would require the VA to conduct and support research on medicinal cannabis for treating veterans with PTSD, chronic pain, and other conditions.

While many veterans are currently using cannabis, it is important for medical research to continue exploring the safety and efficacy of cannabis usage for medical purposes. Despite being able to talk about their cannabis use with VA clinicians, veterans cannot receive recommendations or prescriptions for cannabis from VA clinicians. Our Nation's veterans deserve access to the most effective treatments and therapies available, including alternative options, which is why DAV supports H.R. 3584.

Now, to address the needs of the fastest growing cohorts of veterans using VA healthcare services. There are over 650,000 women veterans using VA, half of them being childbearing age. In fact,

since 2014, VA has seen an 80 percent increase in maternity care services.

Last month DAV released our new report, Women Veterans, the Journey to Mental Wellness. They found that there can be an increased risk for mental health diagnosis and suicidality during pregnancy and up to 1 year after giving birth. The report emphasized the need for strong support systems and coordination during and after pregnancies. For these reasons, DAV strongly supports the Maternal Health for Veterans Act, H.R. 3303, which addresses the need to strengthen the VA oversight and expand funding to coordinate support and resources for women veteran mothers.

To bolster VA mental health staffing to help reduce veteran suicide. DAV is pleased to support H.R. 5247, the Expedited Hiring for VA Trained Psychiatrists Act. A 2023 VA Inspector General report revealed that more than half of VA's 139 medical facilities face a severe shortage of psychiatrists. The bill aims to reduce wait times for veterans seeking mental health care by allowing the VA to fast track the hiring of psychiatrists who have completed residency at VA facilities,

Another bill DAV supports is H.R. 3644, the ACT for Veterans Act which would extend the time for veterans to notify VA after emergency care at non-VA facilities by an extra 24-hour period to ensure coverage under the Veterans Community Care Program.

Currently, VA does not guarantee payment if a veteran does not contact the view within 72 hours of receiving non-VA emergency care. Veterans suffering medical emergencies should not have to worry about whether VA will deny coverage or refuse payment because of administrative notification time requirements.

Finally, for far too long, government reimbursement rates for emergency transportation have been significantly lower than the true cost of providing that service. Earlier this year the VA finalized a proposed rule to change, or to change to cut its reimbursement rate for emergency air medical transportation. During health emergencies this reduction could put an estimated 4.7 million veterans living in rural and remote communities who already struggle to get reliable access to healthcare at even greater risk.

To address this concern, DAV supports H.R. 5530, the VA Emergency Transportation Access Act, which would limit VA's ability to reduce payment rates for transporting veterans on specialized transportation modes.

Chairman, this concludes my testimony. I am pleased to answer your questions you or members of the subcommittee may have.

[THE PREPARED STATEMENT OF JON RETZER APPEARS IN THE APPENDIX]

Mr. MURPHY. Thank you, Mr. Retzer.

Mr. Butler, you are now recognized for 5 minutes.

STATEMENT OF ROSCOE BUTLER

Mr. BUTLER. Chairman, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America would like to thank you for this opportunity to present our views on some of the legislation that the subcommittee will be examining today.

PVA strongly supports the BUILD Act, which seeks to improve staffing to manage construction of VA assets and ensure that there

are concrete plans to improve the planning, management, and budgeting of VA construction and capital asset programs.

Among its many provisions, the BUILD Act requires the VA to implement a more concrete schedule to eliminate or repurpose unused and vacant buildings, develop and execute a plan to hire construction personnel, examine infrastructure budgeting strategies, and identify required reforms and provide annual budget requirements over a 10-year period.

It also directs the VA to report to Congress on the Department's current and future anticipated long-term care needs and models of care for women veterans, veterans with spinal cord injuries and disorders, and other veteran population with unique needs. This is particularly important to paralyzed veterans as VA's current number of long-term care beds for veterans with SCI/D is woefully inadequate for an aging veteran population where care needs are not readily met in the community.

As of January, only 169 of VA's 181 SCI/D long-term care beds were actually available, and only one of VA's six specialized long-term care facility lies west of the Mississippi River. Until construction projects at the Dallas and San Diego VA medical centers are completed, only 12 long-term care beds are available for the thousands of SCI/D veterans that reside in this area of the country. We urge Congress to pass this bill as soon as possible.

PVA also supports the Expedited Hiring for VA Trained Psychiatrists Act, which would help VA fill critical psychiatrist vacancies sooner. Many SCI/D centers lack the direct support of a psychiatrist, forcing the staff to submit intra and inter-facility consults for all veterans with SCI/D requiring psychiatric care. The response time to these consults are lengthy, delaying essential psychiatric care and services for these veterans. We believe the change authorized by this legislation could help veterans receive the essential psychiatric care they need sooner.

Last year VA announced a proposed final rule establishing a new payment methodology which would dramatically lower ground and air ambulance reimbursement rates. Part of the problem is that proposed rule relies on outdated data for air and ground transportation. PVA supports the VA Emergency Transportation Access Act because it would help ensure changes in reimbursement rates do not adversely impact veterans.

Finally, we support the STAND Act, which would first ensure that veterans with SCI/Ds are offered an annual medical examination. These annual assessments are important because it allows the veteran's physician to identify and treat health issues before they worsen, review any changes that have occurred over the last year, and identify risk factors that could lead to future health problems, and offer expert advice on how to mitigate them.

Some VA facilities do not—some VA facilities do an excellent job reaching out to SCI/D veterans to offer them an annual assessment, but not all. There is room for improvement in this area. The bill also directs the VA to ensure veterans are assessed for and briefed on the types of assistive technologies that they may be eligible for during these annual exams.

Advancement in technology could provide life-changing options for veterans with SCI/Ds so it is extremely important that they are

made aware of anything that could improve their mobility, functionality, or independence.

Thank you again for this opportunity to share our views on some of the legislation being reviewed today. I would be happy to answer any questions you may have.

[THE PREPARED STATEMENT OF ROSCOE BUTLER APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. [Presiding.] Thank you.

Ms. Elliot, you are now recognized for 5 minutes.

STATEMENT OF BRITTANY ELLIOT

Ms. ELLIOT. Madam Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of this subcommittee, my name is Brittany Elliot and I am a medically retired U.S. Marine Corps veteran. I am honored to join you today to discuss the critical importance of H.R. 6373, the VA Spinal Trauma Access to New Devices Act, or the STAND Act. I am joined here today by my father, full-time caregiver, and exoskeleton companion Morgan Elliot.

By way of background I am a medically eligible veteran in terms of VA healthcare and I am fully paralyzed from my chest down as a result of a head-on collision with a drunk driver on July 3, 2015 and was placed in a wheelchair. Since you have my longer history in my written testimony I will skip forward to 2017 when I was introduced through social media and other means, not by the VA, to a device that I thought may have some utility for me if I were to ever regain the ability to stand and walk, the ReWalk personal powered exoskeleton.

I approached my care providers at the Memphis VA and started pushing to gain access to this technology. After significant hesitation by my local providers, I was finally able to get them to agree to enroll me in the VA's landmark study on the technology.

The VA co-op study was being undertaken at several VA facilities across the country but not in Memphis, so I was forced to travel on my own resources to the St. Louis VA Medical Center at Jefferson Barracks. I spent 3 weeks undergoing intensive training on the device. I might add this is an 8-week process but I am a Marine after all, and successfully completed this trial, at which point I was able to take the device home and start using it.

I took it everywhere. Unfortunately, my story does not end there. When I returned to the St. Louis VA in 2018, my provider, the very same provider who entered me into the trial, informed me that she would not support my continued use of this device and to this day has failed to provide sufficient rationale for that decision.

The device was returned to the VA and I was left in a chair. I was also told you should get used to it because that is all you can expect. Well, as a trained warfighter that is simply not good enough.

For the next 4 years, that is right, a 4-year battle with—I was engaged with a battle and a local and regional battle to regain access to the device that had already so profoundly changed my life.

Finally and thanks to a forward-thinking and supportive clinician at the Sonny Montgomery VA Medical Center in Jackson, Mississippi, I was seen, reevaluated over the course of weeks, again on

my own dime, and ultimately provided a new device which I still have and use every day of my life.

I am eternally grateful to this provider as his disposition was not one that lent itself to the bureaucracy, but one that carefully considered the entirety of the evidence and the utility of this device for me, a young, vibrant, and motivated Marine. This fight never needed to happen, but the system in many cases it seems to me is built to protect itself instead of the veterans it serves.

I am so grateful to General Bergman for his authoring, and I want to personally thank Chairman Bost, Ranking Member Brownley, and Congresswoman Dingell for their willingness to co-lead this effort. I would also personally like to thank Senators Tester and Moran for their companion bill that was introduced this morning.

My thanks as well to those who have agreed and continue to agree to co-sponsor the STAND Act. In my view, this bill is critical for a few reasons. As you all know, this bill seeks to codify what the VA is already supposed to be doing in the way of performing annual examinations . I can tell you with certainty they are not. I have had five exams over the last 8 years and had to push for several of those myself.

Additionally, I think it is imperative that VA assess the viability of assistive technologies for all veterans with SCI, not simply forcing them to stay in chairs if they are clinically eligible for other devices is simply not good enough. The STAND Act mandates this type of assessment.

One thing I have learned over my years of fighting the VA is that clinical behavior is often very difficult to change. One way to accomplish change, however, is to demand accountability for those responsible for making clinical decisions. This bill seeks to accomplish this by two means, make the VA reportable to Congress on their success against the metrics I mentioned and hold Veterans Integrated Services Networks (VISN) leadership accountable through their annual performance evaluations on these same metrics.

In conclusion, Madam Chairwoman, Ranking Member Brownley, and members of this subcommittee, I am very thankful to you and to all those who have supported this bill as it can be truly life-changing for those like me who have faithfully served their Nation. A lack of system capacity and widespread unwillingness of VA clinical leadership to allow veterans to enter the community for training and just flat out bureaucratic red tape continue to hamper other veterans' ability to gain access to these important technologies that can be truly life-changing.

I can proudly stand in strong support of this bill and I believe its impact can be truly immeasurable for those who are simply trying to rebuild their lives and who are seeking the VA's support to get them there. With your collective help, this will be an easier path. I truly appreciate the opportunity to appear before you today and I am happy to respond to any questions you may have.

[THE PREPARED STATEMENT OF BRITTANY ELLIOT APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Elliot.

Ms. Bryant, you are now recognized for 5 minutes.

STATEMENT OF MELISSA BRYANT

Ms. BRYANT. Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the subcommittee, I am Melissa Bryant and I am honored to appear before you today on behalf of Minority Veterans of America where I serve as the chair of the board of directors .

As an organization dedicated to advocating for the unique needs of minority veteran service members and their families, we appreciate the opportunity to provide testimony and to contribute the unique perspectives of those we serve to today's discussion. The focus of today's testimony will be on H.R. 3303, the Maternal Health for Veterans Act.

MVA is dedicated to creating belonging and advancing equity and justice for our Nation's historically marginalized and underserved veterans, racial and ethnic, gender, sexual, religious and non-religious minorities. MVA works on behalf of more than 10.2 million minority veterans, and through our suite of programs directly serve thousands of veteran service members and their families each year.

Of MVA members 52 percent identify as women, 7 percent as gender diverse, 60 percent are traditional reproductive ages of 18 to 45, and 30 percent are survivors of military sexual trauma. As a former Army officer I have witnessed firsthand the challenges of pregnancy for soldiers as a carryover for those soldiers when they become veterans, especially those who had to be administratively separated from active duty due to those challenges.

We are grateful to be here today to represent their unique lived experiences and perspectives, stories highlighted within my written testimony of Dez Lincoln, Khadija Smith, Gracie Mangual, and others.

Maternal health for veterans is a critical aspect of care that addresses the unique needs of veterans who are navigating pregnancy, childbirth, and postpartum care. Veterans who use VA for care faced obstacles in accessing timely and appropriate maternal care due to the limited availability of onsite obstetric services and poor care coordination between VA and community-based providers.

Those challenges are compounded by the unique health issues veterans face, including physical and mental health conditions resulting from their service which can impact their pregnancy and birth experiences. Complexities such as traumatic brain injury or even musculoskeletal injuries, mental health conditions like PTS and depression, and even toxic exposures have been shown to have long-term consequences that impact reproductive health and pregnancy.

The challenges minority veterans face are rooted in systemic inequities such as poverty, structural racism, implicit bias, and language and cultural barriers that impede access to essential prenatal, labor, delivery, and postpartum care. Minority veterans often contend with higher rates of comorbidities like hypertension, diabetes, and mental health disorders, complicating their pregnancy and childbirth experiences and contributing to disparities in maternal health outcomes.

These historical contexts and associated social determinants of health can significantly impact access and utilization of maternal health services within VA. As Ms. Brownley mentioned in her opening statement, GAO recently found that severe maternal mortality rate was highest amongst black veterans, highlighting pronounced disparities in maternal health outcomes.

LGBTQ plus veterans also face additional hurdles and access and maternal health services within the VA system, including harassment and systemic discrimination in care settings, in addition to disparate discharge statuses under policies like do not ask, do not tell, which impede VA access to care or access to VA care, further exacerbating disparities in maternal health experiences and outcomes.

The MCC program has served a pivotal role in enhancing access to comprehensive maternal care services, improving the care experience for pregnant and postpartum veterans and addressing the unique healthcare needs of this population within the VA healthcare system.

High utilization rates, its critical role in pregnancy care, a centralized telehealth program at the VISN level, and enhanced mental health support are among the key successes of the MCC program, but several areas for improvement remain, including remedy and limited access to comprehensive maternity care, the lack of specialty care providers, fragmented care coordination, inadequate screening and risk assessment, limited mental health support, insufficient data collection and analysis, barriers to minority and rural veterans, and limited support for postpartum care.

Issues unique to minority veterans include persistent racial inequities and insufficient training for LGBTQ plus support, requiring targeted interventions and outreach to address these disparities.

MVA strongly supports H.R. 3303, recognizing its potential to significantly enhanced maternity care coordination for veterans throughout pregnancy and 1 year postpartum within VA services. We urge Congress to strengthen this legislation by improving provisions specifically targeting the unique needs of minority veterans accessing maternal health services within the VA healthcare system.

MVA also recommends enhancing cultural competency training, enhancing data collection analysis, strengthening community partnerships, improving language access services, and expanding access to doulas and culturally competent midwives, as doulas can provide care services that include offering emotional support to pregnant veterans through childbirth and enhance their agency and self-advocacy and have shown to mitigate preventative causes of maternal morbidity as doulas can also uniquely provide trauma-informed care to our most vulnerable pregnant veterans.

Addressing maternal health disparities among veterans is paramount for future generations who will return from service to start families. Again, we wholeheartedly support this bill. We thank you for the opportunity to testify today and I look forward to any questions you all may have.

[THE PREPARED STATEMENT OF MELISSA BRYANT APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Ms. Bryant, and I would like to thank all of our witnesses for their very thoughtful input.

As is my practice, I will recognize myself at the end of questioning. Ranking Member Brownley, you are now recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair.

My first question is to Ms. Bryant. In your testimony you shared some very poignant stories from your members about their need for more support during and after their pregnancy, and certainly I am excited about H.R. 3303 as I know you are. I know that there is so much more that the needs to be done to support our veterans who are pregnant or who have given birth.

In your mind is there a theme to the support needed in these stories that we should focus on to make sure these veterans get the support that they need?

Ms. BRYANT. Yes, Ranking Member Brownley. I believe that the through line that was really identified and outlined throughout our testimony is that the wraparound services need to be there and they need to be culturally competent, whether it is for someone who cannot access care because they need an interpreter or whether it is someone who just needs that assistance in self-advocacy we have now seen.

We have data. We have the GAO report on top of VA, excuse me, VA's own data that show when you give those wraparound services, especially for those of us who are vulnerable, who are facing mental health challenges that will mitigate very preventable issues that could happen when you are experiencing issues in accessing care within VA. That can assist in your childbirth outcomes.

Ms. BROWNLEY. Very good. What is a wraparound? What does wraparound services look like? Just——

Ms. BRYANT. Wraparound services should address the social determinants of health. As you saw from some of our member stories within our testimony, they are experiencing financial instability. They are experiencing——

Ms. BROWNLEY. Got it.

Ms. BRYANT [continuing]. housing insecurity. Those are the types of things that we should include within our wraparound services.

Ms. BROWNLEY. They are all interconnected?

Ms. BRYANT. It is all inextricably linked.

Ms. BROWNLEY. Yes, yep, yep. Thank you for that.

Ms. Elliot, it is very nice to have you here with us today and I certainly want to applaud your father as your caregiver. I have a caregiver bill going through Congress right now and hopefully we can bring more veterans to get their healthcare needs, disabled and aging veterans to get their healthcare in their homes and to also provide help and support to the caregivers who are taking care of our Nation's veterans. Wherever your father is, I applaud you.

It is a challenging and rewarding job, but it is a job I think where sometimes the caregiver needs to have a little rest himself or herself so, but I really thank you, Ms. Elliot, for being here.

I was really looking forward to seeing you and your exoskeleton because I have never seen it before. Alexis just showed me some pictures so I sort of have an idea, but I was really looking forward to it. I understand that got damaged by the airlines flying here.

Ms. ELLIOT. It got damaged in transit, yes, ma'am. I was looking forward to presenting it today to you and to the rest of the subcommittee but it was, unfortunately, damaged to a point that we could not utilize it today.

Ms. BROWNLEY. Yes, that is really too bad. I also have a bill. I sit on the Transportation Committee and I also have a bill to try to address this problem where so many people who have any kind of medical device, I am sure they have not seen many exoskeletons but, you know, wheelchairs, motorized wheelchairs, and so forth that get damaged too frequently on airplanes and people are lost with without their devices.

Ms. ELLIOT. Yes, ma'am. I have personally also experienced those type of losses through an airline with my travel, so I do completely understand that.

Ms. BROWNLEY. Very good. I think, you know, I think I am happy that you are here to, you know, support the STAND Act. Can you just expand on why annual exams for veterans with spinal cord injuries are so crucial and actually need to be codified in this line? I mean, I am sure you heard the VA testify that they wanted to make it a choice, but can you expand on that?

Ms. ELLIOT. For me that is the only way I can get, you know, issues with my chair resolved or issues, other unresolved health issues sometimes is through my annual exam. Those are crucially important in things like wheelchair maintenance and also just various health needs that the spinal cord injury and disease veterans face that are specific to our needs.

Those are crucially important as part of longevity of life and ease of life. I mean, if my chair is broken for, you know, 6 months out of the year and I cannot get into an appointment that is a big inconvenience.

Ms. BROWNLEY. You mentioned in your testimony, too, that you have had five out of eight of your annual appointments?

Ms. ELLIOT. Right.

Ms. BROWNLEY. Did I understand that correctly? That you said you had to really, kind of, push to get some of those appointments?

Ms. ELLIOT. Yes, ma'am.

Ms. BROWNLEY. Does that mean three times you were unsuccessful in getting your appointment?

Ms. ELLIOT. Yes, ma'am, and it is not COVID's fault that I could not get all those appointments. I did have one virtual through COVID so that was not the reason that I did not have all of the appointments that was necessary.

Ms. BROWNLEY. These annual appointments, when you leave an annual appointment there is not the next annual appointment scheduled for you?

Ms. ELLIOT. No, not usually.

Ms. BROWNLEY. I see that my time is up and the chair is anxious and so I will yield my time back. Thank you.

Ms. MILLER-MEEKS. Thank you very much, Ranking Member Brownley.

The chair now recognizes Representative Bergman for 5 minutes.

Mr. BERGMAN. Thank you, Madam Chair.

I want to first thank our witnesses from Paralyzed Veterans of America and Disabled American Veterans for being here today. Your presence makes a big difference.

I know that you have worked with my office as we developed the Veterans STAND Act, and I was grateful to be able to discuss it with PVA President Thomas when he testified during our joint VSO hearing over at the Senate a few weeks ago. In that same vein, I am going to take advantage of the opportunity to talk directly with Ms. Elliot while she is here today in that same vein as I spoke with PVA President Thomas.

Ms. Elliot, I am very familiar with your long-term struggle with dealing with the VA over your device. Given your role as an advocate and your routine interactions with folks can you, the VA folks, can you share with the committee the experience of other veterans who are currently in similar circumstances? We have heard yours but have you got any other stories to share with us?

Ms. ELLIOT. I actually do. Thank you for the question, Mr. Bergman. I have actually been working with a veteran as I also ski, and so I take my exoskeleton to the winter sports clinic. I actually had a veteran personally reach out to me while I was walking my device and he goes, can you help me? I said, what do you need help with, my friend? He said, I have been fighting the Richmond VA for years to get access to the ReWalk and I have only been given one option and that is not that one and I just need help. I need help with this bureaucratic tape that I am facing. I said, I wish I could.

I find that some of our veterans that I have worked very closely with they are all fighting Richmond VA for that same access, but they are not the only VA. I have had veterans that come to me personally and say, you know, I have been fighting this war for years. Is there any advice that you have? I said just do not give up. I will fight any way that it can to help you, but it is going to be a war because they would rather give you another chair than give you access to technologies that can truly change your life.

I stand by these guys. Most of them are young men, but I stand by these guys and offer support when they do get discouraged.

Mr. BERGMAN. Thank you. Do you know, do you think there are others or do you know personally of any others who may be clinically eligible already for the device but are simply being told no? Do you have any specifics there?

Ms. ELLIOT. Yes. Actually the one that was—he was clinically eligible for exoskeletons but they are only giving him one option, and he does not feel that that is the best option for his life. He intends to use it a whole lot more than just inside his house.

Veterans are acknowledging there is more than one technology available and want access to all the technologies, not just one that the VA specifically has decided to work beside for each VA center.

Mr. BERGMAN. Okay. Do you think that the Veterans Administration's resistance to using this device is an issue of local medical center capacity or, you know, who is passing the buck to who here? Any thoughts?

Ms. ELLIOT. That is where the community care network would be crucial to veterans like myself. I traveled 10 hours to get access to the technology on my dime and for most veterans that is just not

that is not possible. They cannot give up that kind of time away from their families and in their homes in order to get access to technology, but that is where a community care network would be crucially important in getting veteran access to the technologies and the training closer to home, not having to travel hours upon hours away from home and family to get access to this technology.

Mr. BERGMAN. You know, I think I saw a statement where the VA stated that the reporting requirements loaded on them will disallow them from doing their daily work with SCI veterans, so they are even currently meeting the mark in terms of the current workload.

There is kind of a workload balance here. They are claiming they have got too much so they cannot do this with that. If not, are there any professional resource centers available in the community, because you have referenced community care, that could be used to train veterans on this device so, you know, different entities?

Ms. ELLIOT. Even I personally trained with a community care provider in my own community post injury because it was so inconvenient for me to go to outpatient VA. Any outpatient VA center that—or outpatient community care provider who has already been deemed eligible to get community care services for veterans would be eligible to teach veterans how to use this technology.

Mr. BERGMAN. Okay. I see my time is just about up. I am not putting words in the mouth of Secretary McDonough, but when we traveled up in the Upper Peninsula of Michigan together in December and he spoke to VA hospital and a couple of clinics, he made it very clear that whatever the Veterans Administration did the veterans should not have to wait because the bureaucracy was doing its thing and not prioritizing the veteran. That was his intent.

Secretary McDonough is a man of his word and I, you know, he knows that he has got his hands full just like we have hands full. Thank you for the indulgence, Madam Chair.

Ms. MILLER-MEEKS. You are welcome. Thank you very much.

I now recognize myself for 5 minutes. It is interesting listening to all of your testimony, and I am going to deviate from my questions. I will ask the question, one of the questions I planned to ask but then I am going to deviate.

Mr. Butler and Mr. Retzer, can share what you have heard from your members about their experiences with therapeutic medicinal use of cannabis or cannabis-derived products?

Mr. BUTLER. We have not really received any information from our members directly about the product. We are interested in seeing the research go forward and the evidence that it provides efficacy to meet the clinical needs of veterans so that they can sustain their lives more. We are hopeful that the evidence will prove that it has efficacy in the support of clinical needs for the veterans.

Ms. MILLER-MEEKS. Mr. Retzer.

Mr. RETZER. Thank you for that question. Our membership actually has a resolution, as a resolution-based organization, where we call for the research of medical efficacy of cannabis for service-connected disabled veterans so it is very important to us.

We have also published multiple articles with regards to the cannabis studies and the innovations in the direction for needs for options for our veterans.

Ms. MILLER-MEEKS. I hear similar things from the veterans in my community as well.

Ms. Bryant, this is not necessarily a question. While I am not opposed to Representative Underwood's bill, it seems like we have a tremendous amount of data both with veterans and non-veterans. As a physician and former director of public health this is not an area that is unfamiliar to me.

It also seems like we have recommendations for how to reduce maternal morbidity and mortality. Do we really need another report to Congress or is it better that we utilize the money to implement practices and evidence-based practices that we feel will be effective?

Ms. BRYANT. In order to address the epidemic, as you stated, Chairwoman, that we are facing in this country, we have to have that information from VA as the representative of the largest integrated healthcare system in our country to contribute to the whole within our healthcare system.

Having regularly reported data, being able to see the intersectionality and the impact of intersectionality within maternal healthcare will be a boon for the rest of the entire industry in being able to address a lot of the issues that veterans face and all women face.

Ms. MILLER-MEEKS. Thank you.

Then where I am going to deviate is this. Ms. Elliot, I started my career in the military. I did medical surgical nursing and I did emergency room nursing and then I got assigned to Walter Reed Army Medical Center as a young lieutenant and I was assigned to neurosurgery at Ward 10 of Walter Reed. We did traumatic brain injuries which were not called that at the time. I flipped many of the Stryker frame. Both my husband and I did care after our time, so this is taking me back to my very early days as a nurse, although I did not do neurosurgery as a physician.

It is appalling to me that you were told to just get used to it. The VA is probably one of the premier institutions for prosthetic devices, and why we do not consider an exoskeleton or other devices to help our veterans become ambulatory, become independent, is hard for me to fathom. I am going to look at this as a physician and what are the consequences of being in a wheelchair when you could be somewhat ambulatory or upright?

I apologize for those of you who are not medical because some of this is rather, I do not consider it gross, but pressure sores, debridement of pressure sores, the cost of hospitalization, the cost of being bedridden, the cost of urinary tract infections, catheterization, the cost of impaction, all of those—and then not to count what it does to the veteran's individual mental health and that of their families when they could be productive and have active, engaged minds. I still visit and take care of people who have spinal cord injuries in the civilian world as well.

Thank you for mentioning the community care network and how crucially necessary it is. To me, given the VA's track record on prosthetic devices and helping our military and veterans be whole,

it is unfortunate that we would have to consider legislation for the VA to bring veterans back to a livelihood, a production, care for their families, interactions in their communities. I know I am pontificating, but I cannot thank you enough for being here today and for your testimony.

Ms. ELLIOT. Thank you, Madam Chairwoman.

Ms. MILLER-MEEKS. With that, that concludes our second panel.

Ranking Member Brownley, would you like to make any closing remarks?

Ms. BROWNLEY. I do not. I do not, but I just want to thank the panelists who are here today, and I think we have got a lot of good bills here that I hope we can move along and move over to the Senate.

Ms. MILLER-MEEKS. Well, on behalf of the committee I would extend my thanks to all of the witnesses today. I look forward to working with the stakeholders, my colleagues at the Department of Veterans Affairs to address the issues we discussed today.

The complete written statements of today's witnesses will be entered into the hearing record. I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and to include extraneous material. Hearing no objection, so ordered.

I thank the members and the witnesses for their attendance and participation today. This hearing is now adjourned.

[Whereupon, at 4:22 p.m., the subcommittee was adjourned.]

A P P E N D I X

PREPARED STATEMENTS OF WITNESSES

Prepared Statement of Ajit Pai

Good afternoon, Madam Chair, Ranking Member Brownley, and other Members of the Subcommittee, thank you for inviting us here today to present our views on several bills that would affect VA programs and services. Joining me today is Dr. Michael Brennan, Executive Director, Office of Construction and Facilities Management, Dr. Wendy Tenhula, Deputy Chief Research and Development Officer, Office of Research and Development, VHA, and Mr. David Perry, Chief Officer, Workforce Management and Consulting, VHA.

H.R. 3225 Build, Utilize, Invest, Learn, and Deliver (BUILD) for Veterans Act of 2023

The BUILD for Veterans Act of 2023 would support improvements of VA's capital asset programs' management and performance to better serve Veterans, their families, caregivers, and survivors. However, VA cites concerns with this bill.

Section 101(a)(1) of the bill would require VA, not later than 540 days from the date of enactment, to ensure that VA has dedicated offices or entities and sufficient staff, including at each VA medical center (VAMC), to conduct relevant critical responsibilities for the life cycle of capital asset management at the local, regional, and VA central office level. This could include ensuring such mix as VA considers appropriate of personnel with duties in the following categories: facility planning; long-range capital planning; management of certain projects and capital assets; property disposal or transfer, environmental remediation, and historic preservation; engineering, maintenance, and repair; the collection of views of Veterans and VA employees to understand VA's capital asset needs; and other relevant functions. VA would have to ensure, to the greatest extent possible, that these requirements would be assigned to a different individual or group of individuals so as to organize common work in a cohesive manner and not overburden a small number of staff. Within 180 days of enactment, VA would have to: designate and notify appropriate congressional committees one individual as the lead senior official responsible for the integration and coordination of, and accountability for, the evaluation of VA's capital asset workforce needs; a required staffing model; and the ongoing implementation and monitoring of actions to ensure adequate capital asset staffing across VA, including those at the field, regional, and central offices of VHA, the National Cemetery Administration, the Veterans Benefits Administration, and the Office of Acquisition, Logistics, and Construction (OALC). Within one year of enactment, VA would have to establish a staffing model for the relevant Administrations, Staff Offices, and other elements to carry out paragraph (1) that ensures a minimum base level of capital asset staffing and is adjusted based on the volume and complexity of capital asset work of a particular facility, catchment area, region, or central office responsibility. VA would have to update this staffing model regularly. In a State or territory where VA does not operate a full-service VAMC, VA would have to ensure, to the greatest extent practicable, that VA has a dedicated office or entity and sufficient staff at the largest VA medical facility in the State or territory.

Section 101(a)(6) would state that the purpose of this subsection is to ensure that field, regional, and central offices of VA have an appropriately sized and credentialed capital asset workforce to allow for efficient and effective execution of their relevant segment of capital asset work. It would further clarify that nothing in this section would be intended to mandate a realignment of capital asset workforce roles, responsibilities, and reporting structures.

Under section 101(b), VA would have to ensure that appropriate professional certifications, educational background, and other qualifications were in effect for individuals employed in a position at a required dedicated office or entity to manage the duties under subsection (a)(1).

Section 101(c) would define the duties of the dedicated offices or entities at VAMCs. Duties of offices or entities required at a VAMC could include the following, as VA considers appropriate to achieve efficient and effective capital asset manage-

ment and performance as it pertains to relevant activities at the field level: developing, monitoring, and implementing capital asset objectives in the area; coordinating capital asset management and planning with others in VA; delivering effectively capital asset projects; maintaining and repairing existing infrastructure; conducting capital asset disposal or transfer, environmental remediation, and historic preservation; monitoring regularly state-of-the-art best practices in health care capital asset delivery and management; monitoring constantly the needs of Veterans and employees for medical space and services including views and expectations expressed by relevant local or national Veterans Service Organizations (VSO); understanding and implementing capital asset policies; providing feedback to improve these policies; and understanding the importance of collaboration and coordination within VA to achieve success in all phases of capital asset management. VA would have to collect views and expectations through multiple channels, allow for anonymous and confidential submission of views, include diverse viewpoints, coordinate with existing VA efforts, and use these views and expectations to inform VA offices and leadership in the development of capital asset improvement.

Section 101(d) would require VA to develop a standardized process to solicit feedback regularly from VA employees on ways to improve VA's capital asset management program. To the degree practicable, VA would have to align this process with the performance of market area assessments under 38 U.S.C. § 7330C(a).

Under section 101(e), VA would have to use the results of the report required under section 202 of the BUILD for Veterans Act in establishing offices, entities, or organizational structures required under subsection (a) and carrying out the requirements of this section.

Position: VA does not support section 101. In general, throughout this bill, OALC should be corrected to read the Office of Construction and Facilities Management (CFM). Currently, 38 U.S.C. § 312A gives the Executive Director of CFM authorities and responsibilities pertinent to this bill.

VA does not support section 101. Current organizational structure within VA includes staff who are responsible for the functions set forth in the section. This would require extensive analysis and clarification on the specific goal. VHA is in the early stages of a facilities staffing methodology that will be informed by standard performance metrics, and this may require more than 540 days to develop a firm model. VA does not support subsection (c), which would define specific duties for offices or entities at VAMCs and would locate the management outside of the program office in certain circumstances. Given that subsection (a) already sets forth more general (and less prescriptive) requirements, subsection (c) is unnecessary and would make implementation more difficult. VA also does not support subsection (d), which would require a standardized process for soliciting feedback. VA is improving and standardizing planning processes that should satisfy the intent of this section without detailing specific requirements or parameters in statute. Allowing VA to define these requirements will ensure VA is responsive to and able to adapt to changing circumstances. VA will be transparent on how we are organizing to support improvements of VA's capital asset programs management and performance to better serve Veterans, their families, caregivers, and survivors.

Section 102 would require VA, within 1 year of enactment, to develop goals and metrics to assess and monitor the performance of VA's capital asset management programs, including those carried out by a non-VA entity under 38 U.S.C. § 8103(e)(1), to make sound decisions regarding infrastructure decisions in alignment with VA's mission and budget. VA would have to develop an internal dashboard or other tool to monitor progress toward meeting those goals, establish and implement governance processes to direct necessary changes to improve performance and achievement of those goals, and submit to Congress a report on the development of those goals and metrics, the implementation of the internal dashboard, and the internal governance process.

Position: VA has no objection to section 102. VA supports section 102, and VA has developed actionable capital program and asset goals and metrics that will help inform VA capital decisions and enhance long-term improvement of VA's capital efforts. VA will continue to assess whether additional measures would be helpful as the effort continues. There are no costs associated with section 102.

Section 103 would require, within 180 days of enactment, VA and the Department of Defense (DoD) to add representatives from the Indian Health Service (IHS) and the Department of Health and Human Services (HHS) to the Capital Asset Planning Committee (CAPC) to facilitate Federal health infrastructure planning, coordination, and investment.

Position: VA supports section 103. VA supports section 103 but defers to IHS and HHS. There are no costs associated with section 103.

Section 201 would require VA to conduct a comprehensive review of the climate resilience of facilities, land, and other relevant capital assets that may be at risk due to changes in the climate. Within 540 days of enactment, VA would have to submit to Congress a report with respect to mission critical VA capital assets and the actions VA will take in response to the findings of such review. Within 1 year of submitting this report, VA would have to submit an additional report to Congress detailing the results of this review for all VA capital assets and the actions VA will take in response to the findings of such review. VA would have to provide an update to this report to Congress at least once every 5 years after the submission of the additional report described above.

Position: VA has no objection, if section 201 is amended, and subject to the availability of appropriations. VA supports the overall objectives of this section but would require an initial reporting deadline of 2 years (rather than 540 days) to allow VA sufficient time to develop requirements for the comprehensive assessment, conduct the assessment, and generate the recommendations for action as outlined in the bill. VA appreciates that the initial report in this version of the bill would be limited to assessing mission critical assets, which would still be a significant undertaking. VA would require additional staffing to meet these requirements. VA also recommends amending subsection (c)(2), which would require a report on all VA capital assets. VA recommends limiting this to only assets involving land in excess of 10 acres and buildings greater than 25,000 gross square feet under operation, ownership, and control by VA. The current language is very broad and would create requirements that are not feasible. Leases should be excluded if they are executed contracts that VA does not have unilateral ability to modify without reopening contract negotiations. VA estimates that the study of 152 VAMCs and 155 National Cemeteries will cost $134,510,000; owned assets only.

Section 202(a) would require VA, within 1 year of enactment, to submit to Congress a strategic plan (a "Strategic Plan to Improve VA's Delivery and Management of Capital Assets") to improve the planning, management, budgeting, staffing, capacity, and performance by VA related to capital assets. This plan would have to consist of at least two parts: the first focused on the human capital needs for VA's capital asset and related areas workforce, and the second covering the methods undertaken by VA to accomplish changes to improve the planning, execution, and delivery of VA's capital asset projects. Section 202(b) would require VA to submit subsequently two additional reports 3 years apart providing updates on changes, actions taken, and other plans.

Position: VA would have no objection, if section 202 is amended, and subject to the availability of appropriations. VA does not support the proposed Part 1 of the plan. VA is focused on the strategic initiatives needed to improve capital asset management, so redirecting that focus to reporting on individual positions would redirect resources allotted to the larger tasks at hand. While not in the detail requested, VA provides staffing figures in the organizational budget chapters within the President's Budget submission. We recommend Part 1 of the plan be removed.

VA does not object to the intent of the proposed Part 2 of the plan. VA is in the process of improving the planning, execution, and delivery of capital asset projects. VA submitted a report to the Subcommittees on Military Construction, Veterans Affairs, and Related Agencies of the Committees on Appropriations of the House of Representatives and the Senate in response to a request associated with the Fiscal Year (FY) 2020 appropriations act; we ask that the proposed Part 2 be revised to request an update to that plan with the same timeframe (1 year from enactment). VA believes these actions would require time to plan, program, and resource to meet this requirement. We also recommend removal of the subsequent reporting requirements under section 202(b). If these changes are made, VA would support this section. VA estimates Part 2 of the plan will cost $1.5 million.

Section 203(a) would require VA, within 1 year of enactment and to the greatest extent practicable, to centralize and consolidate the management and oversight of all disposal and reuse activities within one office or suboffice of VA which have the sole focus of property disposal, including reuse, transfer, and demolition. The office or suboffice would have to focus on developing and implementing a measurable plan with yearly goals to dispose of, reuse, or transfer relevant capital assets. To the greatest extent practicable, VA would have to consolidate the functions and employees of the office or suboffice within one organization element of VA so as to improve effectiveness, efficiency, and accountability. Within 1 year of enactment, VA would have to submit to Congress a report on its actions to carry out this subsection.

Section 203(b) would require VA to include as part of its annual budget submission a report containing a specific timeline to accomplish the disposal and reuse actions VA included in the disposal and reuse reports in the annual budget request.

Among other elements, VA would have to consider the need for a dedicated fund to handle these vacant or unused properties.

Section 203(c) would require VA, on an annual basis as part of its budget justification, to include a report on actions described in subsection (b).

Position: VA does not support section 203. VA does not support the overall objectives of this section. As the bill itself acknowledges, VA already identifies properties annually via the Disposal and Reuse Report. Challenges with vacant and underutilized property, such as the historic nature, the location potentially within a campus, and limited funding make additional requirements for vacant property overly rigorous. This section would create unfunded requirements that would detract from other VA capital asset management efforts. The proposed organizational alignment would not provide any efficiencies or change internally who works together on these projects. The reporting requirements would be contingent on multiple factors, many of which are not in VA's control, and which could jeopardize VA's ability to submit the reports, as required.

Section 204 would require VA to submit to Congress a report, not later than 180 days from the date of enactment, on potential options and alternatives to improve, reform, and provide more flexibility to VA's minor construction activities to increase effectiveness in commencing and delivering minor construction capital asset projects.

Position: VA has no objection, if section 204 is amended, and subject to the availability of appropriations. VA supports, if amended. Section 204(c) needs to be updated to reflect the $30,000,000 threshold for major medical facility projects/minor construction limitation as adjusted in section 5001 of the National Defense Authorization Act for Fiscal Year 2024 (P.L. 118–31).

Section 205 would require VA, not later than 180 days from the date of enactment, to report on any potential improvements to the alignment of funding for information technology to facilitate more effective and efficient activation of medical and other relevant space.

Position: VA has no objection, if section 205 is amended, and subject to the availability of appropriations. VA is working on improvement plans. VA would require an initial reporting deadline of 1 year, however, to allow sufficient time to complete the internal work and prepare a report. VA estimates this provision to include resources to cost $2 million.

Section 206 would amend 38 U.S.C. § 8120 to require VA to report, not later than 30 days after the end of the Fiscal Year and every 60 days thereafter through the fiscal year, detailed information on completed and planned key capital asset investments, including major construction, minor construction, non-recurring maintenance, leases, or other categories. VA would also be required to report on the same schedule described above, on the super construction projects carried out by the appropriate non-VA entity described in 38 U.S.C. § 8103(e)(1) during the year.

Position: VA has no objection to section 206, subject to the availability of appropriations. VA supports parts of section 206. VA provides information on planned major construction, minor construction, major leases, minor leases, and non-recurring maintenance projects in Volume IV of its annual budget. Data on future awards for major construction and leases is provided in the individual project prospectuses and status summaries. Due to the planning and execution cycles for minor construction, minor leases, and non-recurring maintenance projects, reporting would be limited to projects scheduled to be awarded in the current budget year. VA also does not support the proposed section 8120(a)(2)(A)(ix); the observations of best practices, impediments, and accomplishments would be addressed in the report VA has suggested in response to section 202. The frequency of the reporting requirements for this section would be onerous and inconsistent with reporting substantial progress on a large construction project; VA suggests a biannual frequency (every 180 days) instead. VA believes these actions would require time to plan, program, and resource to meet these requirements. VA has other clarifying technical assistance it can provide on this section as well. For the part the VA supports, VA estimates a cost of $1 million.

Section 207 would require VA, within 180 days of enactment and as part of its annual budget submission, to submit to Congress a report summarizing the projected amount of funding for infrastructure and capital assets needed over 10 fiscal years.

Position: VA does not support section 207. VA does not support section 207. VA already provides the total 10-year, long range action plan capital requirement and the major construction 5-Year Development Plan (FYDP) requirements annually in the President's Budget request, Volume IV. The FYDP identifies major construction projects on which VA has begun active planning and could require addi-

tional funding in the next 5 budget years. The FYDP provides appropriate rigor to the planning process to ensure that proposed major construction projects make the best case possible for why they should receive funding, and the requested funding is a valid estimate of the actual cost to complete the identified projects. The long-range action plan also consists of new (not funded or partially funded) investments and includes individual capital projects and lump sum resource requirements over a 10-year planning horizon focused on reducing gaps, increasing efficiencies, and providing better services to Veterans. VA does not support breaking down the long-range plan into individual annual capital program requirements beyond the budget year request. Project cost estimates include acquisition costs only, which will likely change as projects move through the investment process, and requirements become more refined. Long range action plan projects in years 2 through 10 and lump sum requirements are considered potential future year needs, and most cannot be credibly assigned a specific funding year while they are still being developed and prioritized.

Section 208 would require the Office of Inspector General (OIG), not later than 3 years after enactment and at least twice during the following 6-year period, to submit to Congress a report examining the management and performance of relevant VA capital asset projects.

Position: VA defers section 208 to OIG.

Section 209 would require the Comptroller General to report to Congress, not later than 3 years after the date of enactment and triennially thereafter until the date that is 9 years after the date of enactment, on VA's progress toward meeting VA's goals, metrics, and other plans under this Act, particularly under sections 101, 102, and 202.

Position: VA defers section 209 to the Comptroller General.

Section 210 would require VA, not later than 1 year after the date of enactment, to submit to Congress a report, disaggregated by VAMC or other relevant health care facility, on the physical infrastructure needed to provide dental services to eligible Veterans and the project-by-project cost and total cost to establish this physical infrastructure and an estimated timeline to complete such projects upon receipt of appropriate funding.

Position: VA does not support section 210. VA already provides much of the information required by this section through the Strategic Capital Investment Planning (SCIP) process. An additional report would be redundant.

Sections 210, 211, 213, and 214 would require a focused investment plan aligned to one single program area (dental, long-term care, women's health, and research); however, VA is working toward more comprehensive capital plans and strategies that include these areas. In some markets, VA may need to establish a new hospital, and in that capital strategy, dental, long-term care, women's health, and research would all be components of that larger plan, but costs for each would not be identifiable because they would be tied to a larger investment. Further, through VA's market area assessments and development of high-performing integrated health care networks, VA does not plan or assess individual components or programs like this. These sections aim to carve out distinct program areas and require development of capital investment needs focused on them, but these needs must be coordinated with the total market needs, larger facility master plans, and other development work. It is not feasible to provide the costs for specific components when these would be furnished as part of an integrated, larger, multi-focused capital plan.

Section 211(a) would require VA, not later than 1 year after the date of enactment, to submit to Congress a report, disaggregated by VAMC or other relevant health care facility, on the physical infrastructure needed to support current and future anticipated long-term care needs and models of care for Veterans, including infrastructure needed to support the delivery of long-term care for women Veterans, Veterans with spinal cord injuries and diseases (SCI/D), Veterans with traumatic brain injury (TBI), Veterans with unique behavioral health needs, Veterans with memory loss, and other population groups with unique needs or projected future needs. VA would also need to include information regarding VA's plans to provide such care as VA builds internal capacity, but space is not yet available to meet the demand for such care, and with respect to any projects specified, the estimated individual project cost and total cost to accomplish those projects and the estimated individual project timeline to accomplish each such project upon receipt of appropriate funding.

Section 211(b) would require VA to include in the report required under subsection (a) information on how VA's infrastructure prioritization processes, such as the SCIP process, could be modified to include higher prioritization of projects that support the provision of a health care service that is not widely available, or is not

available in compliance with appropriate quality or access standards, from non-VA providers.

Section 211(c) would further require VA, in developing the report under subsection (a), to consult with relevant regional and national program offices in VHA with responsibility to manage the various health care services covered by the report, including long-term care and care relating to SCI/D, to ensure the report contains a holistic, comprehensive, and integrated plan to address the capital asset and other space needs for this population.

Section 211(d) would require VA, in the report under subsection (a), to indicate the projects that can be most efficiently and effectively accomplished through smaller individual infrastructure projects or through a larger medical facility replacement or new site of care.

Position: VA does not support section 211. VA does not support section 211 for reasons set forth above in discussion of section 210. VA already provides much of the information required by this section through both the SCIP process and various reports to Congress. An additional report would be redundant.

Section 212 would require VA to provide a report on the feasibility and advisability of requesting that Congress create a dedicated budget account from which VA would request funds based on relevant methodology, formulas, and percentages tied to the existing and future capital asset needs of VA, and if such funds are provided, to draw upon them to pay for maintenance, preventative maintenance, and repair of capital assets.

Position: VA does not support section 212. VA does not support section 212. The Medical Facilities account supports the maintenance, preventative maintenance, and repair of VHA real property capital assets and related personal services costs. This account includes 1,717 leases and is used to keep 5,598 owned buildings, parking lots, roads and walkways, and vehicles in good working condition, as well as maintaining a clean environment, linens, and medical equipment at all VHA facilities. Creation of a separate account would jeopardize the flexibility within the existing account to respond to changing workload demand requirements during the fiscal year.

Section 213 would require VA to continue submitting to Congress a report on an annual basis for a 10-year period (or until all projects have been completed) on the Women Veterans Retrofit Initiative, as initially required under section 5102 of the Deborah Sampson Act of 2020 (title V of P.L. 116–315; 38 U.S.C. § 8110 note). The report would require identification of funding provided specifically to support the retrofitting requirements under section 5102 (Women's Health), which segregates these improvements from a facility integrated master plan.

Position: VA does not support section 213. VA does not support this section for reasons set forth above in discussion of section 210. As part of the report required by section 5102, VA provides a list of projects to be funded in a given fiscal year, the status of those projects, and provides a 5-year plan that represents the items requested in subsection C that is being added. This section does not appear to expand beyond what is already provided and is duplicative.

To date, no additional funds have been provided so reporting has been limited to planned projects, but VA anticipates funding from normal appropriations. Expansion of reporting and more focused management on prioritization of these investments would require significant resources to fulfill this recurring requirement.

Section 214 would require VA, not later than 1 year after the date of enactment, to submit to Congress a report on the capital asset and information technology needs of VA's research and development facilities.

Position: VA does not support section 214. VA does not support section 214 for reasons set forth above in discussion of section 210. VA already provides much of the information required by section 214 through reports on facility infrastructure needs for research and development through the SCIP process, which is submitted to Congress annually. An additional report would be redundant.

Section 215 would require VA to review all relevant authorities, including those in 38 U.S.C. § 312A to determine whether the provisions of such authority are still meaningful, relevant, and reflect the current operational needs, organizational structure, and all other requirements for the full life-cycle of effective and efficient management of capital assets. VA would have to report to Congress, not later than 270 days after the date of enactment, on whether these authorities should be revised to align more closely with current and future projected operational needs.

Position: VA has no objection, if section 215 is amended, and subject to the availability of appropriations. VA supports the overall objectives of this section but recommends the reporting timeframe be adjusted until after the implementation of the efforts currently underway and otherwise proposed in this legislation.

If the due date were moved to 18 months from the date of enactment, this would allow VA time to continue enhancing enterprise integration and fully address any gaps in the legislation. VA believes these actions would require time to plan, program, and resource to meet these requirements. VA estimates this provision will cost $2 million.

Section 216 would require VA to submit to Congress a report, within 1 year of enactment, on actions VA is taking or plans to take to enhance VA's ability to prevent, detect, and report waste, fraud, and abuse occurring in capital asset projects. The report would have to include an assessment of whether new training or enhancements to existing training should be undertaken and recommendations for such legislative and administrative action as VA determines appropriate. In carrying out this section, VA would have to consult with OIG and the Comptroller General on matters relating to best practices and strategies to improve detection and prevention by VA of waste, fraud, and abuse in capital asset projects and management, and VA could consult with such other persons and entities as VA considers appropriate.

Position: VA does not support section 216. While VA agrees with the need to eliminate waste, fraud, and abuse in all VA programs and operations, including those involving capital asset projects, this section would provide VA no additional authority to handle such issues; portions of this section are also vague and unclear as to what would be within the scope of this section. VA already incorporates recommendations from OIG, the Comptroller General, and others on how to detect and prevent waste, fraud, and abuse, so it is unlikely that this section would result in any substantive improvements to VA's systems and processes. If Congress chooses to retain this section, VA recommends at least that the report be due not later than 1 year after submission of the OIG report required by section 208.

H.R. 3303 Maternal Health for Veterans Act

Section 2(a) of H.R. 3303 would require VA, not later than 1 year after the date of the enactment of this Act, and annually thereafter until September 30, 2028, to submit to Congress a report that contains a summary of the activities carried out by VA relating to the coordination of maternity health care, data on the maternal health outcomes of Veterans who receive VA care (whether in a VA facility or through the Veterans Community Care Program (VCCP), and recommendations to improve the maternal health outcomes of Veterans, with a particular focus on Veterans from demographic groups with elevated rates of maternal mortality, severe maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes.

Section 2(b) of the bill would authorize to be appropriated $15 million for each of FYs 2024–2028 for VA programs relating to the coordination of maternity health care, including the maternity care coordination program described in VHA Directive 1330.03; Maternity Health Care and Coordination. Amounts authorized would be in addition to any other amounts authorized for the coordination of VA maternity health care.

Position: VA supports, if amended, and subject to the provision of appropriations. Section 2 is in alignment with many of VA's current efforts to enhance health and health outcomes for pregnant Veterans, where we are gathering and analyzing data and focusing on high-risk groups. VA is disaggregating data on severe maternal morbidity (SMM) by Veterans' race and ethnicity, age, and residence (urban or rural area) on a quarterly basis and will evaluate trends over time; the first quarterly data was available for review in February 2024. This month, VA will finish developing and implementing a systematic process to compile and review data on VA Maternity Care Coordinators' (MCC) required completion of mental health screening and screening results.

VA is tracking severe maternal morbidity and mortality and has improved its data collection efforts to support real-time tracking of conditions and health outcomes. We recognize the critical importance of maternity care and have taken significant steps to improve the delivery of such care to Veterans. Every VHA facility offers maternity care coordination. VA MCCs understand the needs of Veterans and support them through every stage of pregnancy and the postpartum period. Beginning October 1, 2023, VA expanded the national MCC Program to include follow up of postpartum Veterans for 12 months after delivery, and VA increased the number of contacts with Veterans from 4 to 8 during this period. Through these contacts, MCCs screen pregnant and postpartum Veterans for social determinants of health, mental health risk factors, relationship health and safety, and health risks (such as gestational diabetes and hypertensive disorders of pregnancy). Identifying these maternal risk factors allows VA MCCs to connect pregnant and postpartum Veterans

with VA health care providers and resources, ensuring access to care and follow-up screening. This follow up has proven necessary because of the significant proportion of poor maternal outcomes that can happen in the late postpartum period.

VA has tremendous resources to offer pregnant and postpartum Veterans, including primary care, mental health care, treatment for substance use disorder, intimate partner violence assistance, housing assistance, and resources to address food insecurity. VA also identifies peri-pregnancy Veterans at increased risk to offer clinical intervention, connect them with resources, provide care, and reduce pregnancy-associated morbidity and death.

VA has also created a training module for community health care providers to establish a basic understanding of mental and physical health diagnoses common in Veterans, military culture, trauma-sensitive care principles, and suicide awareness and prevention. This web-based course is available 24 hours a day, 7 days a week, and offers a variety of accreditations to multiple health care disciplines.

Regarding the bill's specific requirements, VA can and does provide data requested by Congress, so an additional reporting requirement in statute is not technically necessary. We note there is some ambiguity in the bill text, as it would require VA to provide "data on the maternal health outcomes of Veterans who receive medical care or services" furnished by VA (whether in VA facilities or through VCCP). This language is not limited to Veterans who receive maternity care furnished by VA (we note for clarity that currently, no VA medical facility furnishes maternity care; all maternity care for eligible Veterans is authorized under VCCP). Instead, VA would be required to report on maternal health outcomes for any Veteran who receives any care from VA. VA would not have this data available unless it had authorized maternity care. In this light, the bill may be improved by amending this to refer to "data on the maternal health outcomes of Veterans who receive maternity care services furnished..." by VA. VA would be able to provide this information.

Regarding section 2(b), VA believes that its Fiscal Year 2024 President's Budget request is sufficient to implement its current authorities and programs without any additional funding. We would recommend the bill be updated to refer to Fiscal Year 2025–2029, as FY 2024 is already underway, and VA would face challenges in allocating any additional funds, even if appropriated, within this period of time to implement this bill. If this bill were to be enacted without updating to Fiscal Year 2025a, this would require a shift in resources from other programs to support these initiatives. This could entail the reallocation of funds from other high-priority efforts. VA estimates a total 5-year cost of $1.9 million to carry out this report.

H.R. 3584 Veterans Cannabis Analysis, Research, and Effectiveness (CARE) Act

Section 2(a) of the bill would require VA, in carrying out responsibilities under 38 U.S.C. § 7303, to conduct and support research relating to the efficacy and safety of certain forms of cannabis on the health outcomes of Veterans enrolled in VA care who are diagnosed with chronic pain, PTSD, and other conditions determined appropriate by VA. VA would have to ensure that such research is conducted in accordance with applicable regulations relating to the oversight of research, including regulations prescribed by VA's Office of Research and Development, HHS through the National Institute on Drug Abuse (NIDA), the Food and Drug Administration (FDA), the Drug Enforcement Administration, and the National Institutes of Health.

Section 2(b) would require that this research include a mechanism to ensure the preservation of all data, including all data sets collected or used for this research, in a manner that will facilitate further research.

Section 2(c) would define the forms of cannabis to be evaluated in the research required by subsection (a). Specifically, this would include varying forms of cannabis, including full plants and extracts, at least three different strains of cannabis with significant variants in phenotypic traits and various ratios of tetrahydrocannabinol (THC) and cannabidiol (CBD) in chemical composition, and other chemical analogs of THC. This would also include varying methods of cannabis delivery, including topical application, combustible and non-combustible inhalation, and ingestion.

Section 2(d) would require VA, before conducting and supporting such research, to submit a plan to Congress and to issue any requests for proposals VA determines appropriate for implementation.

Section 2(e) would require VA to submit annual reports to Congress during the 5-year period beginning on the date of the enactment of this Act on the implementation of this section.

Section 2(f) would define the term "covered veteran" to mean Veterans enrolled in VA health care.

Position: VA supports, if amended, and subject to the availability of appropriations. We are concerned that, as drafted, the bill is too prescriptive in its design. In particular, section 2(c) raises concerns as full plant products contain high levels of THC as well as other molecules that have undetermined therapeutic benefit or harmful effects.

VA generally supports efforts to study the effects of cannabis products on the health outcomes of users of such products to determine whether the use of such products can benefit Veterans who have been diagnosed with PTSD and who are experiencing chronic pain or other conditions as deemed appropriate by VA. We recommend extensive amendments to this bill, though, to ensure that its requirements would yield scientifically and clinically valid results. VA recommends convening subject matter experts from within VA and from other Federal entities (e.g., NIDA, FDA) to develop and implement a plan for an observational study on the effects of cannabis products on the health outcomes of users of such products, including but not limited to covered Veterans. Enabling VA to coordinate with other agencies would result in unbiased data collection and the ability to focus on specific methods and dosages of those cannabis compounds that may be more beneficial to health outcomes. Further, the data that result from the collaborative, retrospective analysis would be robust and would likely allow VA to render a determination as to the advisability of proceeding with additional clinical trials.

VA also recommends that it be charged with determining the feasibility and advisability of establishing patient registries to support research to provide insight into how cannabis products are used and associated with medical outcomes. This would be methodologically sound and would buildupon existing efforts and research to inform conclusions based on the latest, evidence-based work. It would also support the goal of section 2(b) by ensuring that this work would support future efforts as well.

VA further recommends that, as it determines necessary, it be required to initiate additional scientifically peer-reviewed clinical trials to determine the safety and efficacy of cannabis-derived pharmaceutical products or cannabinoid pharmaceutical products. Section 2(c) of the bill recognizes that variations in dosages of cannabis and their effects on either chronic pain or PTSD could result in different outcomes due to variations in cannabinoids and variations in potencies that arise from different methods of administration (e.g., smoking, edible, transdermal). If VA conducted additional clinical trials, it could control for these variables to determine if specific methods of administration or specific dosages were more effective than others. VA also could carry out additional scientifically peer-reviewed clinical trials, as appropriate, to determine whether the reported benefits of the use of cannabis-derived pharmaceutical products or cannabinoid pharmaceutical products in the general population could be replicated in the population of covered Veterans.

We further recommend that any agency or Department of the Federal Government be exempt from the Paperwork Reduction Act in terms of the voluntary collection of information during the conduct of research engaged in or supported under this section. This would remove a potential barrier to collaborations with other Federal agencies, and this language would mirror the authority recently granted to VA through 38 U.S.C. § 7330D (as added by section 181 of the Joseph Maxwell Cleland and Robert Joseph Dole Memorial Veterans Benefits and Health Care Improvement Act of 2022 (Division U of P.L. 117–328)).

VA is already conducting clinical trials related to cannabis and would use existing criteria applicable to those studies for the purpose of assessing the feasibility of future clinical trials. VA has utilized the scientific peer review system and is currently supporting a clinical trial of CBD prescribed at a fixed dosage, not the entire plant, titled "Cannabidiol as an Adjunctive to Prolonged Exposure for the Treatment of PTSD" to treat PTSD where CBD is used as an add-on treatment to standard of care psychotherapy. This study was recently extended, until December 2024, and results will be available after the study's completion.

VA proposes clarifying that the eligibility or entitlement of a covered Veteran to any other benefit under law would not be affected by the Veteran's participation in any research or trial under this section. VA also recommends including a provision stating that nothing in this section would affect or modify other specific laws or authorities affecting other Federal agencies.

VA also proposes a new section 3 that would authorize to be appropriated additional funds to the Medical and Prosthetic Research account and the Information Technology Systems account for purposes of carrying out these provisions. Appropriated funds would remain available until expended. This would ensure that sufficient resources could be made available to support both research and necessary information technology projects to implement these requirements.

Finally, we note that Congress recently enacted the Medical Marijuana and Cannabidiol Research Expansion Act (P.L. 117–215), which established new provisions of law and amended various provisions in titles 21 and 42 of the United States Code regarding research on CBD and marijuana. While this law does not provide a needed authority to VA, given that VA already funds clinical trials that include medical uses of marijuana for conditions that impact Veterans, we do note that it may enable VA and other parties to conduct research on medical marijuana more easily. However, the Department of Justice and HHS have primary responsibility for implementing the provisions of this new Act, and until those Departments have issued guidance or regulations to implement these new authorities, it may be premature to begin new research under processes that may be outdated. The proposed amendments described above would provide these agencies time to issue guidance or regulations, and the coordination requirements in the proposed amendments would ensure VA's efforts are aligned with other Federal agencies. We also suggest that the Subcommittee solicit HHS for its views on this bill.

VA would be happy to provide specific amendments to the bill text and to discuss our recommendations further with the Committee.

H.R. 3644 Addressing Care Timelines (ACT) for Veterans Act

Section 2(a) of the bill would amend 38 U.S.C. § 1703(a)(3), which generally limits VA to furnishing care or services under VCCP to care or services authorized by the Secretary. The bill would amend this authority to provide that, in the case of emergency treatment furnished to a covered Veteran by an eligible entity or provider in the course of authorized care or services, VA could deem such emergency treatment to be authorized if the covered Veteran (or someone acting on the Veteran's behalf) or the eligible entity or provider submitted notice to VA in such form and containing such information as VA may determine appropriate. VA could not require such notification to be submitted earlier than 96 hours after the date on which such eligible entity or provider furnishes such emergency treatment to a covered Veteran. The term "emergency treatment" would have the same meaning given that term in 38 U.S.C. § 1725.

Section 2(b) of the bill would provide that these amendments would take effect on the date that is 1 year after the date of the enactment of this Act.

Position: VA does not support. VA currently authorizes emergency care furnished by an authorized entity or provider if VA is notified within 72 hours of the start of such care for covered veterans. VA has been reviewing the existing "72-hour rule" under 38 C.F.R. 17.4020(c) to determine whether changes are appropriate, including whether reliance on other statutory authorities (such as 38 U.S.C. §§ 1725 and 1728) might be more appropriate. VA would welcome the opportunity to discuss potentially broader reforms regarding eligibility for and administration of emergency care benefits to simplify the process for Veterans and VA.

The bill would generally expand VA's current 72-hour rule, which allows VA to authorize under the VCCP emergency care or services when VA is notified of such care within 72 hours of that care beginning. The bill, however, would extend this period to 96 hours, and it would potentially extend this even further. Current regulations provide that notice must be provided "within 72 hours of the beginning of such treatment," while the bill would refer to "after the date on which such health care provider furnishes such emergency treatment." In this context, the bill's language could mean that the 96-hour notice period would not begin until 12:01 a.m. of the date after care begins. VA is unclear whether this is the intent, but we recommend clarifying this language. If this is the intent and result, this would require systems and process changes to ensure accurate adjudication.

Additionally, we note that the phrase "in the course of care or services authorized under subparagraph (A)" could unintentionally narrow the scope of this text. As written, it would seem the authority to deem emergency treatment as authorized would only apply in situations where that emergency treatment was furnished during the delivery of other care or services. In other words, if a Veteran had been authorized by VA to see an orthopedist for a hip injury, and if during an appointment with the orthopedist, the Veteran had a heart attack that required emergency treatment, VA could deem that emergency treatment as covered. Currently, under VA's 72-hour rule, any emergency treatment, whether furnished "in the course of care or services authorized" by VA or not, that is furnished by an eligible entity or provider to a covered Veteran can be authorized within 72 hours of the emergency care or services being furnished. *See* 38 C.F.R. 17.4020(c)(2). In this context, if the bill is interpreted to override VA's discretionary authority under the 72-hour rule, the resulting benefit may be significantly narrower than VA's current authority.

Although section 2(b) of the bill would make the amendments effective 1 year from the date of the enactment of this Act, this could still present complications and

could be a difficult timeline to meet. VA would need to update its regulations to reflect this change (which would normally take more than 1 year to complete), making this timeline unrealistic. Separately, but related, VA would need different contractual terms than are currently in place to give effect to this change; that would either require a modification of current contracts or inclusion of these terms in future contracts. VA's efforts to develop the next generation of Community Care Network (CCN) contracts are already underway, so attempting to modify current contracts would likely not be feasible or advisable. If VA attempted to include this in the next generation contracts, this could delay the award of such contracts, and if these delays resulted in a gap between the expiration of the existing contracts and the award of the next contract, this gap could have significant consequences in terms of Veterans' access to community care.

We appreciate that this bill reflects and incorporated most of the technical assistance VA provided on an earlier draft of this bill. These changes improved the clarity of the bill in several ways from the prior draft.

H.R. 3649 Veterans National Traumatic Brain Injury Treatment Act

Section 2(a) of the bill would require VA to implement a pilot program to furnish hyperbaric oxygen therapy (HBOT) to Veterans with TBI or PTSD through health care providers who are not VA employees, Medicare providers, DoD, IHS, or federally qualified health centers.

Section 2(b) would require VA to select three Veterans Integrated Service Networks (VISN) in which to operate the pilot program.

Section 2(c) would establish in the general fund of the Treasury the VA HBOT Fund; the sole source of moneys for the Fund would be from donations received by VA for the express purposes of the Fund. Amounts in the Fund would be available without fiscal year limitation to pay for HBOT, and the Fund would terminate on the day that is 5 years after the date of the enactment of this Act (as established by section 2(d)).

Section 2(e) would define HBOT to mean hyperbaric oxygen therapy with a medical device either approved by the FDA or issued an investigational device exemption by the FDA.

Position: VA strongly opposes. VA, DoD, and others have conducted extensive research on the efficacy of HBOT on TBI, and the research has found no support for this as an effective treatment (particularly for mild TBI). In fact, there is a strong clinical basis that HBOT is not recommended for treating TBI. There is no evidence to support a sufficient basis for HBOT as a treatment for PTSD either. In this context, we are concerned that this bill could result in adverse health outcomes for participating Veterans; there is also little ability to monitor performance with definitive, evidence-based metrics. The bill also would result in significant burdens on Veterans in terms of the time commitment involved in treatment and potential personal liability for portions of treatment that are not covered by VA (such as travel or room and board, if applicable). Further, the resources associated with providing this treatment in terms of clinical and administrative time would mean fewer resources for evidence-based therapies for Veterans.

In 2017, VA initiated a clinical (non-research) program to evaluate the feasibility of referring Veterans diagnosed with PTSD (with or without a history of mild TBI) for HBOT treatment provided by DoD or community providers. This clinical program evaluation was designed to better understand the treatment protocol requirements and burdens on Veterans and VA in the context of PTSD treatment. The evaluation was not designed to examine or measure the efficacy of HBOT as a treatment for PTSD, TBI, or any other indication. VA proactively began the clinical program evaluation to understand the logistical and administrative requirements and barriers for providing this treatment for these indications, which are considered "off-label" because they have not been approved by FDA. VA's clinical program evaluation found that fewer than half of the Veterans referred completed the full course of HBOT treatment. Some Veterans were not interested in engaging or continuing treatment due to the treatment schedule (appointments are scheduled for 1–2 hours per day, 5 days a week, for 4–8 weeks) and the need to travel or because of the availability of evidence-based treatment alternatives. We anticipate that similar results could occur if this bill were enacted, in which case Veterans would be delayed in receiving evidence-based care to treat their conditions.

VA and DoD have developed evidence-based clinical practice guidelines (CPG) for both TBI and PTSD; the most recent update for the TBI CPGs was completed in June 2021, while the most recent update for the PTSD CPGs was completed in June 2023. The CPGs for PTSD found there is insufficient evidence to recommend for or against HBOT as a treatment for PTSD. The CPGs for TBI strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed

to mild TBI. Reviews of available research found no evidence of improved symptom severity and only a mixed effect on quality of life. When HBOT was compared to a sham intervention (effectively, a placebo treatment), HBOT actually was associated with decreased quality of life at long-term follow up at 2 and 3 years. In addition to the lack of patient improvement, the use of HBOT after mild TBI may have harmful impacts, including seizures. Emerging treatments are often marketed to patients struggling with chronic symptoms, and providers need to understand the potential negative impacts that referrals for unfounded treatments can have on the provider-patient relationship. The CPGs explain that when treatments do not work, it may lead to disappointment, damage to a patient's trust, an increase in the likelihood of the patient taking on a "sick role," and even harm to the patient. Given the evidence of harm in the literature and FDA's findings, the CPGs conclude that HBOT is not currently identified as a safe or effective treatment after mild TBI.

VA also has procedural concerns with this bill. Initially, the bill seems to establish a parallel program to VCCP for HBOT. Congress enacted VCCP to consolidate the various community care programs and to simplify eligibility by establishing a common set of criteria to determine when Veterans would qualify for community care. This bill appears to require VA to furnish this care exclusively through non-VA providers regardless of whether VA could furnish treatment for PTSD or TBI. The bill expressly excludes VA, Medicare, DoD, and IHS providers, as well as federally qualified health centers. Given this narrow range of potentially eligible entities, it is not clear that VA would have any means to verify the quality of those providers or the quality of services they would furnish under this bill. Additionally, this narrow scope of eligible providers could both limit Veterans' access to timely care and would very likely increase costs to VA as there would likely need to be a separate referral, scheduling, and follow-up process created for this authority. We recognize that there is a limited number of providers and HBOT treatment centers, but imposing additional restrictions would seem to make implementation more difficult and costly. Further, given that multiple treatments are often required and the limited number of providers, the likelihood that Veterans would need to travel to receive this care is high. This may be inconvenient and place a significant financial burden on patients.

The bill does not define which Veterans could receive care under this authority; it is unclear whether this is limited to enrolled Veterans or if another population would apply. Additionally, there are no criteria set forth in the bill to determine when HBOT would be offered to Veterans—whether this would be required to be a treatment of first resort or last resort, purely at the Veteran's election, or as otherwise clinically indicated. We emphasize that providers must determine that care is medically necessary and in the best interest of the patient to furnish it in accordance with current legal and ethical standards. We would infer these requirements would continue to apply if this legislation were to become law in the absence of specific language to this effect, but we recommend the bill include such requirements to reduce the potential for confusion. Given the CPGs described above strongly recommend against the use of HBOT for the treatment of patients with symptoms attributed to mild TBI, it is not clear that VA actually could refer such patients for treatment.

The funding mechanism proposed in this bill also raises significant questions and concerns. No other VA program operates under such parameters as proposed by this bill, so VA would need to develop new procedures and requirements to govern the use of an account like this. It is unclear whether there would be sufficient funds donated to VA to cover the costs of treatment. VA would need to wait until there were sufficient resources in the new HBOT Fund to support the delivery of care, which could delay VA's implementation of this (potentially by months or years). VA would need to develop new processes and procedures to determine who would manage these funds in VA and how the funding would be distributed. It is also unclear whether a new administrative office would be needed to handle the financial aspects that are unique to this arrangement. This could result in additional oversight costs that would divert funds from Veterans care.

In general, if Congress proposes to require VA to operate a new program, conventional appropriations measures would make it more feasible to carry out. This both ensures accountability for Congress (by ensuring Congress is responsible for funding these programs appropriately) and reliability for VA (by ensuring that there is a clear and dedicated resource pool for different programs).

The bill also lacks critical elements, such as a clear termination date—the bill only refers to the termination of the HBOT Fund, not the program authority in the first place, which would seemingly require VA to continue the program after the termination of the HBOT Fund (meaning within current appropriations accounts). In the absence of further clarity, VA would likely have challenges with implementing

this bill, and this could further increase administrative expenses that would divert funds from other evidence-based care.

H.R. 4424 Vietnam Veterans Liver Fluke Cancer Study Act

Section 2(a) of the bill would require VA, not later than 120 days after the date of the enactment of this Act, in consultation with the Director of the Centers for Disease Control and Prevention (CDC), to commence an epidemiological study on the prevalence of cholangiocarcinoma in covered Veterans of the Vietnam era. This study would need to use data from the VA Central Cancer Registry and the National Program of Cancer Registries. The study would have to identify the rate of incidence of cholangiocarcinoma in covered Veterans in the Vietnam era and in residents of the United States (U.S.) from the beginning of the Vietnam era to the date of the enactment of this Act. For each of these two groups, the study would have to identify the percentage of individuals with cholangiocarcinoma by various demographic characteristics, including age, gender, race, ethnicity, and the geographic location of the patient at the time of diagnosis.

Section 2(b) would require VA, within 1 year of completing this study, to submit to Congress a report that contains the results of the study and recommendations for administrative or legislative actions required to address issues identified in the study.

Section 2(c) would require VA to track the prevalence of cholangiocarcinoma in covered Veterans of the Vietnam era using the VA Central Cancer Registry and provide such information to Congress in periodic follow-up reports (as required by section 2(d)).

Section 2(e) would define the term "covered veterans of the Vietnam era" to mean Veterans who served in the Vietnam theater of operations during the Vietnam era.

Position: VA does not support. VA fully supports the need to conduct research to understand the health risks and conditions of Veterans who served in combat areas or were otherwise placed at higher risk due to their military service; however, the bill's requirements would not be as useful to VA as VA's current efforts. For nearly a century, VA research and development has been improving the lives of Veterans and all Americans through health care discovery and innovation. Congress' generous support of more than $900 million for VA research supports more than 7,000 active research projects designed to enhance the delivery of care for Veterans and others.

Cholangiocarcinoma is a rare cancer of the biliary tract, which is comprised of the gallbladder and bile ducts. Liver fluke infection is a type of parasitic infection that is prevalent in Southeast Asia and is acquired from the ingestion of raw or poorly cooked freshwater fish infected by this parasite. Liver fluke infection is a well-recognized risk factor for the development of cholangiocarcinoma. Liver flukes can survive in human bile ducts for decades and can cause a state of inflammation that can lead to cholangiocarcinoma, a cancer that is diagnosed far more commonly in countries like Thailand and Vietnam than in the U.S. Vietnam War Veterans have been concerned about exposure to liver flukes during deployment and subsequent development of cholangiocarcinoma.

Other risk factors for cholangiocarcinoma are biliary tract diseases such as primary sclerosing cholangitis (an autoimmune disease), chronic cholelithiasis (bile duct stones), cirrhosis (liver scarring from several causes), and infections such as Hepatitis B or C. An evaluation of VA health records in 2018 indicated that Vietnam Veterans who receive VA health care have similar or lower age-adjusted incidence rates of cholangiocarcinoma when compared with the U.S. population in most age categories (fewer than the U.S. rate of 1.6 cases/100,000 persons/year). VA does recommend that all Veterans who have not been tested for Hepatitis B or C in the past obtain those tests, as there is definitive treatment available to clear most Hepatitis B and C viral infections.

VA also has a current research study on rates and causes of mortality in Vietnam era Veterans. An analysis of deaths from 1979–2019 from cholangiocarcinoma is in final stages of preparation for submission to a peer-reviewed scientific journal. This analysis compares deaths from cholangiocarcinoma between all Veterans who served in the Southeast Asia theater of operations and all of those Veterans who served elsewhere in the world during the Vietnam War era. Because cholangiocarcinoma has a very high mortality rate, comparing death rates is an accurate way of counting cases and comparing incidence of this unfortunate cancer. VA's mortality study is very likely the most definitive way that the real incidence of cholangiocarcinoma can be measured because counting cases of Veterans who receive health care in VA does not include all Vietnam-era Veterans nor all diagnoses of cholangiocarcinoma as Veterans receive care outside VA. VA designed this study in collaboration with scientists from the Uniformed Services University of the Health Sciences. The VA

mortality study shows that there is no difference in mortality rates from cholangiocarcinoma among all Vietnam-War deployed Veterans compared to all Veterans who served elsewhere in the world during the era, except for Marines. Vietnam War-deployed Marines appear to have a higher rate of death from cholangiocarcinoma compared to non-deployed Marine Vietnam Veterans. The reasons for this cannot be definitively determined; data to compare risk factors (including exposure to undercooked fish and diagnoses of liver fluke infections) are not available. It is possible that Marine deployment locations or experiences resulted in greater exposure to liver fluke infections, but other risk factors could explain this outcome as well. These research results, once peer reviewed, will be communicated to Veterans and clinicians to be watchful for signs and symptoms of cholangiocarcinoma.

Given VA's observations with existing studies, the bill's requirements would not be as useful to the agency as VA's current efforts at this time. Any additional epidemiological study would face significant hurdles in counting cases because of the lack of available and comprehensive health care data (such as cancer diagnoses and risk factors) on the entire population of Vietnam-era Veterans over the years since the war, whereas VA has conducted this mortality study by compiling a roster of all Vietnam Veterans along with a data base of their death dates and causes. For example, reliable health care encounter data are available only from 2000 forward for both DoD and VA. Thus, there is at minimum a 25-year gap (1975 to 2000) where we would be unable to ascertain cholangiocarcinoma incidence. As noted earlier, given the high mortality of cholangiocarcinoma, using cholangiocarcinoma mortality as the primary outcome in the Vietnam-era Mortality Study provides the most robust epidemiologic assessment of this condition in Vietnam-era Veterans. We do not believe the bill would provide additional information that would justify the resources needed for implementation.

Further, section 505 of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act of 2022 (P.L. 117–168) requires a review of cancer rates among Veterans. In implementing this requirement, VA has developed a bilateral agreement with State tumor cancer registries, which have accurate current data on cancer diagnoses and which could be leveraged to further the work this bill proposes to undertake. In this regard, VA is effectively already meeting the requirements of this bill. VA also suggest that the Subcommittee solicit HHS for its views on this bill.

H.R. 5247 Expedited Hiring for VA Trained Psychiatrists Act of 2023

H.R. 5247 would add a new section 7406A to title 38, United States Code, to allow VA to begin the process of appointing a psychiatrist *before* the psychiatrist completes a residency sponsored by or affiliated with VA, provided the individual meets the requirements in the VA qualification standards for psychiatrists. VA could appoint a psychiatrist under the proposed section 7406A(a) if the position remained unfilled for at least 35 days or more.

Position: VA does not support. VA does not support this bill because it is redundant given existing policy and authorities. VA currently has authority to begin the appointment process for psychiatrists prior to their completion of a residency contingent upon them meeting the qualification requirements by the time of appointment. VA focuses on expediting the hiring of both current and former trainees based on their qualifications.

H.R. 5530 VA Emergency Transportation Access Act

Section 2(a) of the bill would provide that VA may not change the rate of payment or reimbursement provided for the transportation of a Veteran or other eligible individual on a special mode of transportation, as in effect on January 1, 2023, unless such change would increase the rate of such payment or reimbursement or, before the effective date of such change, VA: (1) conducted a thorough review and analysis of the effects of the change on VA, industry, and Veterans; (2) developed a formal process to ensure any changes made to such rate would not reduce Veterans' access to care; and (3) ensured the new rate reflects, at a minimum, the actual cost of such transportation.

Section 2(b) would require VA, in carrying out any such review and developing any process, to consult with a committee made up of relevant industry experts, representatives from the Centers for Medicare and Medicaid Services (CMS), VA employees with subject matter expertise in various areas (transportation, access to care, integrated Veteran care, rural Veterans, Native American Veterans, and other matters determined appropriate), and representatives of VSOs.

Section 2(c) would require that, not later than 2 years before the effective date of any change made to the rate of payment or reimbursement for special mode

transportation that affects the payable rate under any contract, VA would have to establish a template and a standardized process for entering into and making changes to rates in effect under such contract, issue guidance about the use of such template and process within VA and across the industry associated with special mode transportation, and submit a report to Congress that includes a description of the template and process.

Section 2(d) would define the term "special mode of transportation" to mean an ambulance, ambulette, air ambulance, wheelchair van, or other mode of transportation specially designed to transport disabled persons. The term would not include a mode of transportation not specifically designed to transport disabled persons (such as buses, subways, taxis, trains, or airplanes) or a modified, privately owned vehicle with special adaptive equipment or that is capable of transporting disabled persons.

Position: VA does not support. In 2011, Congress authorized VA to pay to providers of transportation the lesser of the actual charges for transportation or the amount determined by CMS, unless VA has entered into a contract for that transportation with the provider.

In 2020, VA proposed to put in place the very change Congress had authorized. VA's publication of a proposed rule triggered a comment period, during which VA received five substantive comments. VA responded to these comments in a final rule, known as the Change in Rates Rule, which was published in the Federal Register on February 16, 2023. VA stated in the final rule that we would delay the effective date of the final rule by 1 year (to be February 16, 2024) to ensure that ambulance providers had adequate time to adjust to VA's new methodology for calculating ambulance rates (88 FR 10035). We further stated in the final rule that such adjustment could include ambulance providers entering negotiations with VA to contract for payment rates different than those under the CMS ambulance fee schedule, as contemplated in the final rule. Congress granted VA the discretion in 38 U.S.C. § 111(b)(3)(C) to use the CMS ambulance fee schedule as part of VA's methodology to calculate ambulance payments, ostensibly finding such schedule to be sufficient. VA cannot modify or increase the CMS ambulance fee schedule rates.

After publication of the final rule, however, VA received feedback from both internal and external stakeholders, including VA employees, ambulance providers, and industry experts, that more time was necessary for successful implementation of the rule. Specifically, the delay of the effective date was necessary to accommodate unforeseen difficulties in air ambulance broker contracting. These difficulties relate to air ambulance brokers requiring a contract or subcontract in place with all potential air ambulance providers that covers emergency, non-VA initiated trips. Based on this feedback and evaluation of the continued effort that would be required by air ambulance brokers to negotiate and enter into contracts before February 16, 2024, we delayed the effective date of the regulation by 1 year (to be February 16, 2025). VA understands the Committee is specifically concerned about the effect these proposed rules would have on unauthorized emergency transportation, and VA is exploring options to try to address this concern. We would welcome the opportunity to discuss this further with the Committee.

VA's regulations, as proposed for 38 C.F.R. § 70.30(a)(4), would allow VA to enter into a contract with a vendor of special mode transportation (including air ambulance transport), and the terms of that contract would govern the payment rates for such transport. Such contracts could provide for a different rate as agreed, in the event that VA determined it may be justified based on local considerations, such as for rural areas.

VA has other concerns with the bill beyond its apparent retreat from prior congressional intent. The bill is unclear in several critical respects. For example, the bill refers to a "rate" of payment throughout the text, but there is not a singular rate for transportation given the variability in geography, type of vehicle or conveyance (ambulance versus helicopter, for example), and type of service furnished. Other Federal agencies, particularly CMS, have established rates for ambulance services that reflect appropriate charges for such transportation, which do not reflect billed charges. VA's pending regulatory changes would give effect to the discretion Congress provided to VA to align its payment structures with these other Federal agencies (including CMS). By referring to special mode transportation of Veterans or other eligible individuals, this would also apply to health care programs for family members (such as the Civilian Health and Medical Program of VA (CHAMPVA) or the Children of Women Vietnam Veterans). VA currently pays for special mode transportation for eligible individuals under these programs consistent with the CMS ambulance fee schedule. It is unclear whether this was the intent of the bill.

Subsection (a)(2) would require VA to conduct thorough analyses of the proposed changes to rates for special mode transportation, but these would largely duplicate the requirements associated with a regulatory impact analysis, which VA already provided. In this context, these requirements would be duplicative and unnecessary.

Further, under subsection (a)(2)(B), VA would have to develop a formal process to ensure that any change made to such rate does not reduce the access to care for Veterans. It is unclear how VA would be able to determine whether any changes would affect access to care; access is influenced by many different variables, some of which are completely outside of VA's control (principally, the decision of private providers to offer services in the marketplace in the first instance). In this context, VA could likely never develop a process, formal or otherwise, that would ensure that rate changes do not reduce access to care.

We are also concerned about the language in subsection (a)(2)(C), which would direct VA to ensure that "the new rate reflects, at a minimum, the actual cost of such transportation." It is unclear what "the actual cost" is intended to mean, but we infer that the intent is to ensure that VA always pays, at a minimum, the billed charges for transportation. However, the billed charges do not reflect the "actual cost of such transportation," as billed charges also include profit margins and administrative expenses beyond the cost of the transportation. To the extent the bill is intended to require VA to pay billed charges, this would effectively allow private entities without a contract with VA to charge any amount, and VA would be obligated to pay this amount. This would seriously undermine VA's efforts to establish a contracted network of providers, which could increase both the predictability and accessibility of services while also providing cost assurances for the Government and taxpayers. Requiring VA, by statute, to pay no less than the billed charges would make budgeting and accountability impossible. It also raises questions about whether this would effectively allow private entities to determine Federal obligations of appropriated funds.

Subsection (b) of the bill would require VA to consult with various entities, including non-Governmental entities. The bill text appears to direct VA to establish a committee composed of relevant industry experts and representatives of VSOs, but this would seemingly require this to be a Federal Advisory Committee subject to the Federal Advisory Committee Act (FACA). There is no further discussion of this requirement or explicit authorization pursuant to FACA, and there is no express waiver of the need to comply with FACA. We recommend the drafters clarify the intent of this provision and whether this committee would be subject to FACA. We do not believe this provision is necessary as the consultation requirements would largely duplicate the public comment period that was previously available for VA's proposed regulations.

Subsection (c) of the bill would prohibit rate changes until a 2-year period elapsed from the time that a template and standardized process for entering into and making changes to rates and guidance about the template and process was issued with VA and across the industry. This would ultimately make entering into contracts at set rates more difficult, which appears antithetical to Congress' goal of ensuring accountability and predictability for the costs of these services. We are also concerned that the 2-year delay for the effective date of any change would result in VA paying greater costs for that entire period of time.

We understand the Committee's concerns regarding transportation access, and we would welcome the opportunity to discuss these in more detail.

H.R. 5794 VA Peer Review Neutrality Act

H.R. 5794 would add a new 38 U.S.C. § 7311B; the proposed subsection (a)(1) would require peer review committee members to withdraw from participation if the individual has direct involvement with the care under review, or the individual is unable to conduct an objective, impartial, accurate, and informed review. In addition, under the proposed subsection (a)(2), VA would have to conduct an additional review by a neutral peer review committee at another VA facility for quality management reviews conducted with respect to care provided by a peer review committee member. Under the proposed subsection (b)(1), individuals with knowledge of confidential quality assurance information regarding a matter under investigation could not serve as a factfinder or member of an administrative investigation board (AIB) examining such matter, nor disclose confidential quality assurance information to an AIB or factfinder. Under the proposed subsection (b)(2), VA would be required to ensure a member of an AIB or a factfinder does not: (1) have any personal interest or other bias concerning the investigation being conducted, (2) have direct involvement in matters being investigated, and (3) have a supervisory or personal relationship with the subject of the investigation. Any individuals with any of the

three identified relationships or personal interest or bias would have to inform the authority responsible for the investigation and recuse themselves.

Position: VA supports, if amended. VA supports the underlying premises in the bill, such as maintaining the integrity of peer reviews, protecting confidential quality assurance information, and ensuring investigations are free of bias and potential investigatory conflicts of interest that would compromise the integrity of the investigation. However, significant amendments to the bill's language would be needed to align these common interests for VA's support. The bill appears to overlook major components of existing statute and VA's existing processes for peer review, investigating patient care matters, protecting quality assurance information, and conducting impartial investigations.

VA has no concerns with the proposed section 7311B(a)(1), which is in line with current VA guidelines. Similarly, VA has no concerns with the proposed section 7311B(a)(2), which is also in line with current VA guidelines.

However, VA recommends that the proposed section 7311B(b)(1) be removed. VA has existing investigation formats for patient care concerns that comply with 38 U.S.C. § 5705, which deals with confidentiality of medical quality assurance records. Some investigations are confidential quality assurance reviews, but some are purposefully not covered by 38 U.S.C. § 5705, namely Focused Professional Practice Evaluations for Cause and Focused Clinical Care Reviews, fact findings, and AIBs. These reviews are critical for addressing concerns regarding substandard care that may be detrimental to Veterans because they are administrative investigations that provide a mechanism for information to be discovered, and in turn, utilized for administrative action if necessary. The non-disclosure element of the proposed provision extends provisions of 38 U.S.C. § 5705(b)(1), which already defines rules for release of information. VA agrees that employees who have knowledge of events being investigated because of their role in the quality review process cannot be a factfinder or member of an AIB. However, the vague language of the bill may preclude an employee from testifying or providing information obtained through the individual's role in an event or their appropriate peripheral involvement in an event. To ensure appropriate administrative action can be taken in response to misconduct, the discoverable investigatory processes must be able to collect information from all sources related to an event and not protected under 38 U.S.C. § 5705. VA can provide narrative examples of how these concerns could arise to the Committee upon request. If the proposed paragraph (b)(1) is not struck in its entirety, VA at least recommends removing the prohibition on disclosing information in at least some situations. Further, any clarifications should be included as an amendment to 38 U.S.C. § 5705, rather than as part of the proposed section 7311B, to avoid confusion and creating multiple statutes covering the same matter. VA can provide further technical assistance on this issue if needed.

VA also recommends amending the proposed section 7311B(b)(2). VA takes seriously the administrative investigation process and the impartiality of those conducting investigations. VA Directive 0700, Administrative Investigation Boards and Factfindings, and VA Handbook 0700, Administrative Investigation Boards and Factfindings, provide the framework for VA's general administrative investigations and include a specific requirement for those participating in fact findings and AIBs to undergo training. In 2021, VA updated these policies and training to emphasize the avoidance of potential investigatory conflicts of interest. VA policy requires that authorities responsible for investigations ensure that members of AIBs and factfinders are free from such conflicts. VA AIB members and factfinders are already required to be objective, impartial, and free from personal interests, bias, or involvement in the matter. AIB Members and factfinders also are already required to recuse themselves if they do not meet these standards.

VA supports the assurances that investigators do not have potential investigatory conflicts of interest or personal relationships impacting their objectivity regarding the incidents they are investigating. VA is concerned that moving these requirements from policy to statute will increase the likelihood and weight of employees challenging disciplinary actions by arguing that the underlying investigation violated the statute and constituted harmful procedural error. To mitigate this risk, VA recommends that the bill simply state that VA will ensure that its investigators are impartial and that VA must include appropriate measures in policy. This would allow VA to tailor and monitor the issue in light of the complexities and unique requirements of its administrative investigation structure.

Investigations within VA vary in severity and response, from every day information gathering where a supervisor asks an employee about minor infractions (e.g., being late to work) all the way to an AIB, which may investigate much more severe misconduct such as inappropriate conduct of a sexual nature or inappropriately striking a patient. Per VA policy, AIB members are not permitted to have a super-

visory relationship with the subject of the investigation. The same rule was intentionally not applied to factfindings, as they are intended to provide an investigative process for, among other things, first-line supervisors to address issues within their office of business unit. It is imperative that supervisors maintain their authority to conduct investigations, when appropriate. A first-line supervisor is the appropriate individual to inquire into the routine misconduct issues that surface every day within VA (e.g., tardiness, customer service complaints, observing suspected impairment, etc.). To ensure optimal operations, proposed subsection (b)(2)(B) would need to be amended to remove the provision disallowing this practice to allow routine exercises of supervisory authority. The bill could include further language clarifying that subordinates should not investigate an issue in which their supervisor has a significant interest (e.g., the supervisor is the subject of a related investigation). VA also supports adding explicit safeguards that preclude supervisors from completing an investigation when they are implicated in the misconduct under review. There would be no costs associated with this bill.

H.R. 6324 Fiscal Year 2024 Veterans Affairs Major Medical Facility Authorization Act

This bill would authorize major medical facility projects in American Lake, WA; Dallas, TX; El Paso, TX; Perry Point, MD; Portland, OR; Reno, NV; San Diego, CA; San Francisco, CA; San Juan, PR; St. Louis, MO; and West Haven, CT. It would authorize to be appropriated in Fiscal Year 2024, or the year in which funds are appropriated for VA's major construction account, $4,603,129,000 for these projects.

Position: VA supports, if amended. VA supports the authorization of the projects identified in this bill. VA has previously provided and is requesting an amendment regarding the authorization for the San Diego, CA project. VA recommends the bill also authorize "central utility plant upgrades" and the seismic retrofit of the existing spinal cord injury building 11 at the VA San Diego Healthcare System. VA can provide technical assistance on this language if needed.

H.R. 6373 Veterans Spinal Trauma Access to New Devices (STAND) Act

Section 2 of the bill would amend 38 U.S.C. § 1706 by adding a new subsection (d). The proposed subsection (d)(1) would require VA, in managing the provision of hospital care and medical services, to furnish (through direct provision of service, referral, or a VA telehealth program) a preventative health evaluation annually to any Veteran with an SCI/D who elects to undergo the evaluation. The proposed paragraph (2) would require that the evaluation include an assessment of any circumstance or condition the Veteran is experiencing that indicates a risk for any health complication related to the SCI/D, chronic pain and its management, dietary management and weight management, prosthetic equipment, and the provision of any assistive technology that could help maximize the independence and mobility of the Veteran.

Proposed paragraph (3) would require VA, in maintaining, prescribing, or amending any guidance, rules, or regulations issued by VA regarding the requirements in the new subsection (d), to consult with VA's SCI/D program managers, VA clinicians employed as specialists in SCI/D, and organizations named in or approved under 38 U.S.C. § 5902 (generally, organizations that prepare, present, and prosecute claims for VA benefits). Before issuing any guidance, rules, or regulations regarding the requirements set forth in this new subsection, VA would have to consult with manufacturers of assistive technologies and other entities relevant to the provision of assistive technologies if the guidance, rules, or regulations would directly affect such manufacturers or entities. VA would have to ensure, to the extent possible, that any Veteran known by VA to have an SCI/D receive information annually about the annual evaluation and the benefits to undergoing this evaluation.

Proposed paragraph (4) would require VA, within 1 year of the enactment of this Act and every 2 years thereafter, to submit to Congress a report on the number of Veterans who received medical care or hospital services from VA and used an assistive technology, received VA care or services and were assessed for the provision of an assistive technology, and received VA care or services and were prescribed an assistive technology. VA would also need to report the year-to-year change in the percent of Veterans with an SCI/D who received an evaluation described above.

Proposed paragraph (5) would require VA, in evaluating the performance metrics of a VISN for any year beginning after the date that is 1 year after the date of the enactment of this Act, to consider the provision of the preventative health evaluations described above.

Proposed paragraph (6) would define the term "assistive technology" to mean a powered medical device or electronic tool used to treat or alleviate symptoms or con-

ditions caused by an SCI/D, including a personal mobility device (including a powered exoskeleton device) and a speech-generating device.

Position: VA opposes. VA is committed to providing comprehensive, lifelong, innovative, and specialized care that is safe and evidence-based for Veterans with SCI/D. VA opposes this bill because it would reduce VA's ability to ensure the safety of Veterans and would compromise the integrity of the clinical decision-making process. It would also increase administrative costs to VA, burden clinicians' time, and ultimately result in reduced access to clinically appropriate care.

In particular, VA is opposed to proposed subsection (d)(3), which would require VA to consult with the manufacturers of assistive technologies "and other entities relevant to the provision of assistive technologies" if VA's guidance, rules, or regulations "would directly affect such manufacturers or entities." Mandatory consultation with such entities in the development of clinical guidance would introduce a conflict of interest that could easily compromise patient safety. This would not only set a concerning precedent, but it would contradict best practice for the development of clinical protocols in health care settings. Research indicates that increased stakeholder involvement in the development of clinical protocols or clinical practice guidelines can result in poor quality protocols that fail to ensure safety and do not meet the needs of clinicians in guiding best care for patients. The recommended course of action for the development of high-quality clinical protocols is to utilize research and subject matter experts from a range of settings and expertise. VA's assessment and procurement of assistive technologies is consistent with the standard practice of care for Veterans with SCI/D.

Additionally, the provisions in proposed subsection (d)(4), which would require detailed reports from VA, would consume clinicians' and administrators' time without apparent value; this additional burden would reduce the ability to see more Veterans in clinical appointments and to process requests for assistive technology and other devices, ultimately reducing Veterans' access to timely and appropriate care. VA's current data systems capture when assistive technology is procured, but the other data elements in the bill are not available. VA's systems are not able to capture instances where Veterans are evaluated, but not found suitable, for assistive technology, or Veterans who decline assistive technology.

VA is also concerned about the breadth of the definition of the term "assistive technology" in the bill. The term would mean a powered medical device or electrical tool used to treat or alleviate symptoms or conditions caused by an SCI/D, including a personal mobility device (including a powered exoskeleton device) and a speech generating device. Given the breadth of this term, the associated procedural requirements would apply in multiple instances; this would make practical implementation very difficult, if not impossible.

The provisions of this bill that would not result in these outcomes are unnecessary because VA is already meeting those requirements. For example, VA already provides annual evaluation for Veterans with SCI/D, and these requirements meet or exceed all elements of the bill in this regard. Furthermore, explicitly prioritizing powered assistive technology during annual evaluations diminishes the value all other aspects of the comprehensive medical and functional evaluation that is performed. While assistive technology is seen as a critical component of the evaluation, it is not weighted above other interventions or considerations in providing Veteran-centered care.

To the extent the bill is concerned that Veterans do not have an opportunity to determine which assistive technologies would be best for them, VA providers work closely with Veterans to identify their needs and recommend the best solutions for them. When devices like exoskeletons are identified, VA allows Veterans to try these devices for up to 90 days to determine whether these are appropriate for them. Recent data indicate that nearly 40 percent of Veterans who use an exoskeleton during this trial period decide against using it beyond the trial period. This approach ensures Veterans receive the device or technology that best meets their functional needs while avoiding waste that could otherwise result if these technologies were furnished without personal experience. This reflects VA's commitment to both clinically appropriate care as well as accountable fiscal stewardship.

Additionally, it is critical to ensure that Veterans can safely use any devices they are prescribed. VA was an early adopter of exoskeleton technology, and powered exoskeletons have been provided to Veterans with SCI/D since 2015, shortly after the FDA first approved powered exoskeletons for home use. To provide guidance and ensure consistency in screening, evaluation, and training, VA developed a rigorous clinical protocol, which was shared with VA facilities in December 2015. This clinical protocol was updated in 2018, reflecting additional exoskeleton products that received FDA clearance for personal use in the community.

Further demonstrating VA's commitment to supporting exoskeletons and innovative technology, VA performed one of the largest national randomized, controlled multi-center exoskeleton research studies, investigating home/community use, efficacy, and safety of powered exoskeletons in Veterans with SCI/D. Powered exoskeletons can lead to assisted ambulation in individuals with SCI/D, yet they require careful evaluation of potential users, extensive training, inclusion of a companion for safe use, extensive clinician experience, and specific manufacturer training and expertise by staff for safe and effective use by individuals with SCI/D. Notably, the criteria for each device are largely based on FDA specifications. VA has taken an individualized approach to Veterans' exoskeleton training to minimize the burden on Veterans who are interested in and are evaluated for clinical appropriateness to utilize this technology.

After a Veteran is determined to be clinically appropriate for an exoskeleton device, training with the device can occur at a VA SCI/D Center or at a facility that provides equivalent certified exoskeleton training. Training typically requires 20–30 visits over a series of months to achieve proficiency with the device. Device issuance is considered when all critical skills are safely demonstrated by the Veteran and their companion(s). Clinical training and home trials must occur before a device can be purchased to ensure that the device meets the needs of the Veteran and is safe in the home environment.

Exoskeletons are complicated medical devices, and exoskeleton-trained clinicians must consider a number of factors when issuing this equipment. Factors include but are not limited to: level of spinal cord injury, height, weight, hip and leg length measures, joint range of motion (flexibility), skin integrity, spasticity, arm/hand strength, bone density, history of fractures, blood pressure, autonomic dysreflexia, cardiovascular health, cognition, environments of intended use, Veteran's goals for use of the device, vision, and the ability to develop the skill needed to operate this equipment. Due to the complexity of the devices, a large number of Veterans who are interested in exoskeletons are not appropriate for the use of these devices. Additionally, for safety reasons, the devices currently available in the U.S. require a companion to be present when an individual is utilizing this technology. Many individuals lack access to an appropriate companion to help with management of the device, which can weigh up to 51 lbs. Requiring the presence of a companion while utilizing the device can result in the perception of decreased independence to users who are fully independent when using a wheelchair. The involvement of a companion also prolongs the training period and requires a significant commitment from both the Veteran and companion.

Exoskeletons have been studied in a number of settings, and there are many potential benefits, such as standing, walking, cardiovascular response, spasticity management, weight loss, bowel function, and bone density. Evidence of adverse events, including fractures, falls, skin breakdown, autonomic dysreflexia, and soft tissue injuries have been reported across subjects, studies, and devices. Currently, there are no established CPGs regarding the use of exoskeletons. For each individual, it is still largely unknown if the benefits outweigh the risks and how to identify candidates who will most likely benefit from the technology. Therefore, VA has developed a clinical protocol that emphasizes patient preference and safety. Importantly, through safe, evidence-based services and devices, VA will continue its ongoing efforts to support Veterans with SCI/D in their goals of optimizing their health, functional mobility, and independence. Those efforts include the careful evaluation and when appropriate, provision of assistive technology devices including powered exoskeletons.

VA is focused on ensuring Veterans have access to and can use specialized technology to address their needs. A new Office of Advanced Manufacturing is focused on these efforts specifically in the context of assistive technology. VA is continually reviewing current clinical protocols to ensure Veterans can receive timely, high-quality, and evidence-based care and technology.

H.R. 7347 Reporting on Determination to Include Newly Approved or Licensed Psychedelic Drugs in the VA Formulary

This bill would add a new section 8125A to title 38, United States Code, that would require VA, not later than 180 days after a psychedelic drug is approved under 21 U.S.C. § 355 or licensed under 42 U.S.C. § 262, to submit to Congress a report regarding such drug that includes VA's determination whether to include the drug in VA's formulary and VA's justification for that determination.

Position: VA does not support. VA does not support this bill because it is unnecessary. VA already has processes in place where formulary decisions regarding inclusion or exclusion of a drug are released publicly. In this context, the bill would include additional administrative burden without any increase in transparency or

accountability. VA publicly lists changes to the formulary (see https://www.va.gov/formularyadvisor/), and any of the documents that VA reviewed and influenced VA's decision are publicly available (see https://www.pbm.va.gov/PBM/NationalFormulary.asp). We are also concerned about the precedent this could set; further reporting would only delay actions that would improve Veterans' access to new drugs and treatments. VA makes decisions regarding which drugs to include in the formulary in consideration of the best clinical outcomes of Veterans; if the FDA approves any psychedelic drugs, VA will review these drugs using the same process as any other drug or medication. If or when FDA approves any psychedelic medications, we anticipate such drugs would be prescribed in combination with evidence-based psychotherapy or other psychosocial support as directed in the FDA approval. In this context, the existence of a drug on VA's formulary would not necessarily guarantee Veterans access to these drugs, in VA or in non-VA facilities, if the related therapy or psychosocial support is not available at a given facility.

These concerns are hypothetical at this point, though, as no psychedelic drugs have been approved by FDA yet. VA is developing plans to respond in the event such drugs are approved. All drugs that are approved by the FDA are available to Veterans with clinical need, regardless of whether the drug is available on the formulary.

VA has supported and is supporting three main efforts to ensure that Veterans will have access to safe and effective treatments, including psychedelics, when approved. VA co-hosted a State-of-the-Art Conference in September 2023 to address two major objectives: first, to better understand the current state of scientific evidence and to identify a strategic framework to consider future psychedelic treatment research for select mental health conditions; and second, to determine the necessary next steps for potential VA system-wide clinical implementation for psychedelic compounds for potential future use. Additionally, VA issued a request for applications for proposals from its network of VA researchers (in collaboration with academic institutions) to study the use of certain psychedelic compounds in treating PTSD and depression. Finally, VA is establishing a workgroup to develop plans for potential future clinical deployment, provider training, evaluation, and further research. We would be pleased to brief the Committee in more detail on these efforts. Additionally, we request that the Subcommittee solicit HHS for its views on this bill.

Conclusion

This concludes my statement. We appreciate the Subcommittee's continued support of programs that serve the Nation's Veterans and look forward to working together to further enhance the delivery of benefits and services to Veterans and their families.

Prepared Statement of Jon Retzer

Chairwoman Miller-Meeks, Ranking Member Brownley and Members of the Subcommittee:

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

H.R. 3225, BUILD for Veterans Act
and
H.R. 6324, Fiscal Year 2024 VA Major Medical Facility Authorization Act

Over the past decade, the Department of Veterans Affairs (VA) Veterans Health Administration (VHA) has experienced significant growth and stress while implementing reforms to help ensure veterans receive timely access to quality health care. For the VA to remain the primary provider of care, the VA must tackle an aging infrastructure to improve its capacity.

The VA states that private sector health facilities have a median age of around 13 years. In contrast, VA facilities have a median age of nearly 60 years and suffer from a lack of resiliency and long-term sustainability. Facilities of this era, which were not designed to accommodate the technological and design innovations that support modern health care delivery, pose a challenge with renovation. For the VA to continue being the primary health care provider and care coordinator of choice for veterans, the VA must focus on improving its internal capacity by building and

modernizing facilities. Up to date and modern facilities will ensure that the VA can effectively meet the needs of both current and future veterans, offering a broad range of primary and specialized care options.

The Build, Utilize, Invest, Learn, and Deliver (BUILD) for Veterans Act, H.R. 3225, seeks to improve the management and performance of the VA's capital asset programs to better serve veterans, their families, caregivers, and survivors.

The BUILD Act would help provide the VA with a clear roadmap by identifying internal capacity needs and consistent funding for infrastructure needs, as well as strengthen the VA's capabilities to start and complete projects.

This bill would require the VA to develop plans to identify infrastructure needs and improve workforce hiring strategies. It would also examine capital asset budgeting strategies and identify potential reforms based on industry best practices. VA would also be required to forecast annual budget requirements over a 10-year period and lay out a concrete schedule to dispose of, or repurpose, unused buildings.

Furthermore, the bill mandates the VA Inspector General to assess and report on the management and performance of relevant VA capital asset projects, ensuring greater accountability. In addition, the Government Accountability Office would review and report on the VA's progress toward achieving the goals, metrics, and other plans specified in this bill.

We support H.R. 3225, in accordance with DAV Resolution No. 247, calling for modernization of the VA health care infrastructure to provide veterans with the quality care and benefits they deserve.

The Fiscal Year 2024 VA Major Medical Facility Authorization Act, H.R. 6324, would grant authorization for 11 major medical facility projects for the VA in Fiscal Year 2024, to include construction of new and renovation of existing medical specialty health care centers, parking facilities, clinical space expansions, replacement of community living centers, seismic retrofitting, and new research facilities.

Although DAV does not have a resolution calling for funding specific VA construction projects, DAV strongly supports increasing VA infrastructure funding to accelerate the expansion and the modernization of the VA health care system.

H.R. 3584, Veterans Care Act

and

H.R. 7347, to direct the Secretary of Veterans Affairs to report on whether the Secretary will include certain psychedelic drugs in the formulary of the VA.

DAV supports research to develop new, safe, and effective treatments and therapies for veterans, particularly when seeking relief from hard-to-treat injuries and illnesses. Our Nation's veterans deserve access to the most effective treatments and therapies available, including alternative options available under the law. It is important that Congress and VA support safe and effective innovations in delivering evidence-based treatments to improve veterans' health and quality of life.

The Veterans Care Act, H.R. 3584, would direct the VA to conduct and support research on the efficacy and safety of medicinal cannabis and promote medical research by VA on the use of medicinal cannabis to explore alternate means of treating veterans with post traumatic stress disorder (PTSD), chronic pain, and other illnesses and injuries. VA would be required to submit an implementation plan to Congress and report annually on its progress.

Many veterans are currently using cannabis, and it is important for medical research to continue exploring the safety and efficacy of cannabis usage for medical purposes. It is crucial for clinicians to be able to offer veterans with PTSD and chronic pain appropriate guidance on the potential impacts, harms, and benefits of cannabis use to provide comprehensive support.

Today there are 39 states and the District of Columbia that allow medical cannabis, with wide variations in how each regulates its production, distribution, and use. However, even in states where cannabis is legal, veterans may still be in violation of Federal laws due to its classification as a Schedule I drug by the Federal Government.

While VA policy encourages veterans to discuss their marijuana use with their VA health care providers, VA clinicians are not allowed to recommend or prescribe cannabis, and veterans who possess it while on VA grounds are violating Federal law.

We support H.R. 3584, in accordance with DAV Resolution No. 203, which calls for research into the medical efficacy of cannabis for service-connected disabled veterans.

H.R. 7347 directs the VA to make a determination on whether to add psychedelic drugs to the Department's formulary no later than 6 months after a psychedelic drug is approved by the Food and Drug Administration (FDA) or licensed for use by the Department of Health and Human Services (HHS).

At present, no psychedelic drugs are federally approved for prescription as medicine. The FDA has granted breakthrough status to two psychedelic compounds. When used in conjunction with existing psychotherapies, both Methylenedioxymethamphetamine (MDMA), and psilocybin, the active compound in psychedelic mushrooms, have shown to be safe and effective in treating PTSD and treatment-resistant depression, respectively.

Although psychedelics are tightly regulated as controlled substances under Federal law, research can still be conducted with proper regulatory approvals. These approvals must be obtained from the FDA and Drug Enforcement Administration. The promising yet preliminary research evidence points to the potential healing power of psychedelics.

In collaboration with academic institutions, the VA issued a request for applications for proposals from its network of researchers, which aims to study the use of certain psychedelic compounds in treating PTSD and depression. This is the first time since the 1960's that VA will study psychedelics.

VA's research involves studying psychedelic compounds, including MDMA and psilocybin use alongside psychotherapy for treating veterans with PTSD and depression. To properly inform veterans about the effects of psychedelics on conditions like PTSD and depression, ongoing medical research is vital to assess their safety and effectiveness.

DAV does not have a specific resolution on what drugs should be included in VA's formulary; however, we believe that once adequate clinical research has determined a new drug or therapy is both safe and effective, VA should consider whether to begin using it, particularly if there are no better alternatives.

This bill does not require VA to add psychedelics, but only requires a determination about adding them to VA's formulary after another Federal agency (FDA or HHS) has approved their use. We support this legislation, in accordance with DAV Resolution No. 535, which calls for increased medical research to develop new treatments for wounded and injured veterans.

H.R. 3303: Maternal Health for Veterans Act

The Maternal Health for Veterans Act, H.R. 3303, would provide additional support for VA programs coordinating maternity health care by authorizing $15 million per year for 5 years. It would also require the VA to report to Congress on its activities related to coordination of maternity health care, including data on outcomes and services provided by VA and non-VA providers, as well as make recommendations to improve the maternal health outcomes of veterans, particularly veterans from demographic groups with higher rates of maternal mortality, severe maternal morbidity, maternal health disparities, or adverse perinatal or childbirth outcomes.

This bill would strengthen VA oversight and expand VA funding for women veterans' maternity care. Currently, there are over 650,000 women veterans who receive health care services from the VA, and half of them are of childbearing age. Since 2014, there has been an almost 80 percent increase in the number of pregnancies among women receiving VA care.

Last month, DAV released our new report "*Women Veterans: The Journey to Mental Wellness*." Research findings note that hormonal shifts and changes women experience during pregnancy, birth, and post-pregnancy put women at higher risk for suicide. The report emphasized the need for strong support systems during and after pregnancy. Because most maternity care is provided through community partners, the VA has worked hard to create a supportive maternity experience for women veterans.

Previously set at 8 months, the cutoff date for post-partum care has been extended to 12 months for women veterans. This means that they now have access to maternity care coordinators from the start of their pregnancy until a year after giving birth. These coordinators assist veterans in navigating health care inside and outside of VA, connecting veterans with care after delivery, ensuring access to follow-up screenings, and more. This bill would help ensure that all new mothers will have the support and resources they need from VA.

We support H.R. 3303, as it aligns with DAV Resolution No. 027 calling for improved medical services and benefits for women veterans.

H.R. 3644, ACT for Veterans Act

H.R. 3644, the Addressing Care Timelines (ACT) for Veterans Act, would extend the time that veterans have to notify VA after receiving emergency care at non-VA medical facilities to ensure that the care is covered under VA's Veterans Community Care Program.

Currently, a veteran must contact the VA within 72 hours of receiving non-VA emergency care, otherwise VA may deny payment even if the veteran is eligible for treatment. The ACT for Veterans Act would provide an additional 24-hour period for veterans to inform the VA when receiving care at a non-VA facility.

The last thing veterans suffering medical emergencies should have to worry about is whether VA will deny coverage or refuse payment because of administrative barriers.

We support H.R. 3644, in accordance with DAV Resolution No. 205, which calls for the improvement of urgent and emergency care benefits for service-connected veterans.

H.R. 3649, Veterans National Traumatic Brain Injury Treatment Act

The Veterans National Traumatic Brain Injury Treatment Act, H.R. 3649, would establish a pilot program to offer Hyperbaric Oxygen Therapy (HBOT) to veterans who have Traumatic Brain Injury (TBI) or PTSD.

In clinical practice, HBOT has been employed and approved to treat different physical injuries, including non-healing wounds. When administered by a trained professional medical team, HBOT is deemed safe and any potential side effects are generally resolved without requiring additional treatment. In pre-clinical and clinical trials, it has been shown that HBOT can also enhance the clinical outcomes of veterans with treatment-resistant PTSD.

Military clinical trials, which focused on evaluating HBOT effects on post-concussion syndrome, a condition commonly accompanied by PTSD, demonstrated improvements in post-traumatic symptoms, potentially indicating a role in alleviating post-concussion symptoms.

Congress and VA have a responsibility to explore safe and effective alternative options for veterans who are not helped by VA's existing treatments and therapies for PTSD or TBI, which should include HBOT.

We support H.R. 3649, in line with DAV Resolution No. 013, which calls for well-designed studies to assess the effectiveness of hyperbaric oxygen therapy on treatment resistant TBI and PTSD. We would also recommend that the legislation include a provision requiring a report on the pilot program, which should include an assessment of the health outcomes from HBOT, as well as a recommendation on whether to extend the pilot program to all enrolled veterans.

H.R. 4424, Vietnam Veterans Liver Fluke Cancer Study Act

The Vietnam Veterans Liver Fluke Cancer Study Act, H.R. 4424, directs the VA to examine and document the occurrence of bile duct cancer in Vietnam veterans.

An aggressive disease, bile duct cancer (Cholangiocarcinoma) attacks the gallbladder, bile ducts, and liver, and it has been connected to infection by parasitic worms known as liver flukes. Vietnam veterans who consumed raw or undercooked fish during their service in Southeast Asia may have been at risk of infection due to common parasites in the region's fresh waters.

In a research study conducted by the VA at Northport, NY, it was discovered that one in four of the 50 Vietnam veterans tested had positive results for exposure to the liver fluke parasite.

According to the Cholangiocarcinoma Foundation, this type of cancer can develop over the course of 30 to 40 years while remaining asymptomatic. While there is no scientific consensus that consuming certain raw or undercooked fish causes liver cancer, the VA has granted some direct service connection claims for bile duct cancer, but it is not currently recognized as a presumptive illness for Vietnam veterans.

Given that many Vietnam veterans could have unknowingly been exposed to environmental conditions that resulted in bile duct cancer from their service in Southeast Asia, it is imperative that we make every effort to guarantee they receive the necessary care and benefits for their service-related injuries and illnesses.

We support H.R. 4424, in accordance with DAV Resolution No. 214, which calls for providing service connection for disabling conditions resulting from toxic and environmental exposure.

H.R. 5247, Expedited Hiring for VA Trained Psychiatrists Act of 2023

H.R. 5247, the Expedited Hiring for VA Trained Psychiatrists Act of 2023, aims to reduce wait times for veterans seeking mental health care by allowing the VA to establish a fast-track process for hiring psychiatrists.

This bill would allow the VA to directly hire psychiatrists who have completed residency at a VA facility, bypassing civil service or classification laws that can cause delays. Psychiatrists would still need to fulfill all educational requirements and obtain all necessary credentials to be hired.

The VA continues to struggle with recruiting and hiring mental health specialists, which hinders its ability to support the growing number of veterans seeking help. A 2023 VA Inspector General report (23–00659–186) revealed that 91 out of 139 VA facilities faced a severe shortage of psychologists, while 73 facilities had a severe shortage of psychiatrists.

The VA has stated that almost a third of veterans within its health care system suffer from PTSD. In 2021, there was an increase of 114 suicides from 2020, resulting in 6,392 veterans dying by suicide. These numbers, reflecting veterans' lives prematurely ended, are more than statistics, as they are still mourned by family members, loved ones, and the Nation. This bill could create a more efficient hiring process for psychiatrists trained by the VA, who are already culturally competent, to provide immediate clinical lifesaving services, including VA suicide prevention and lethal means safety counseling to veterans in need.

We support H.R. 5247, in accordance with DAV Resolution No. 250, which calls for effective recruitment, retention, and development of the VA health care system workforce.

H.R. 5530, VA Emergency Transportation Access Act

The VA Emergency Transportation Access Act, H.R. 5530, limits the VA's ability to change payment rates for transporting veterans and eligible individuals on specialized transportation modes.

The VA finalized a proposed rule change to cut its reimbursement rate for emergency air medical services earlier this year. By reducing the VA's reimbursement rate to the Medicare rate, which currently reimburses providers at less than 50 percent of transport costs puts the estimated 4.7 million veterans living in rural and underserved communities, who need reliable access to quality care, at even greater risk during emergencies, despite the existing barriers to health care they already face.

The VA's proposed reimbursement rate cut would also put additional strain on air medical bases, particularly in rural areas where there are high concentrations of veterans and a significant need for transportation to health care facilities.

For far too long, government reimbursement rates have been significantly lower than the true costs of providing service. If this trend continues and the VA lowers its reimbursement rate, air medical bases will be challenged, limiting emergency care access for rural veterans. Additionally, compounding this issue is the potential closure of approximately 600 rural hospitals, which would leave communities without local lifesaving care and long distances from the closest medical center.

We support H.R. 5530, in accordance with DAV Resolution No. 323, which calls for ensuring easy and equitable access to VA transportation benefits and services.

H.R. 6373, Veterans STAND Act

The Veterans Spinal Trauma Access to New Devices (STAND) Act, H.R. 6373, seeks to enhance health care for veterans with spinal cord injuries by mandating that VA offer them annual yearly preventative health evaluations and improve accessibility to assistive technologies that could help maximize the independence and mobility of the veteran.

The STAND Act is focused on improving access to and coverage of new and emerging technologies. For example, exoskeletons are wearable assistive technology devices that can empower certain individuals with spinal cord injury (SCI) to stand, walk, turn, and navigate stairs, which can enhance socialization, independence, and participation in community activities. According to the VA, there are around 42,000 veterans with SCIs, and the VA Spinal Cord Injuries/Disorders network provides care to over 27,000 individuals annually.

By offering yearly preventative health evaluation, assessments and making new assistive technologies accessible, VA can further improve the quality of life for veterans who meet the clinical eligibility criteria. Extensive clinical training and expertise are necessary to evaluate and assess veterans with SCI for the use of powered exoskeletons safely and effectively.

We support H.R. 6373, in accordance with DAV Resolution No. 286, which calls for improvement in the provision of comprehensive VA health care services to enrolled veterans. It is critical to ensure that SCI veterans have access to and coverage of these life-changing technologies.

H.R. 5794, VA Peer Review Neutrality Act

The VA Peer Review Neutrality Act, H.R. 5794, aims to eliminate conflicts of interest in the conduct of quality management and administrative investigations by the VHA.

For VA to ensure the quality of health care provided, it conducts a comprehensive monitoring and evaluation program. This program includes assessing significant deviations in mortality and morbidity for surgical procedures and evaluating deficiencies in overall health care quality. VHA employees may submit confidential reports on matters relating to quality of care in VHA facilities to the quality management officers for peer review.

Currently, the initial review involves one peer reviewer, followed by a broader peer review committee within the same facility that evaluates and discusses their assessment of the care provided by the facility.

The VA Peer Review Neutrality Act would require that local peer reviewers withdraw from cases involving conflicts of interest and would require that neutral assessments of initial peer reviews be conducted by a peer review committee from a different VHA facility.

To eliminate conflicts of interest, it is critical for the VHA to continue to review and update guidance, procedures and responsibilities at its medical centers while conducting quality management and administrative investigations.

We support H.R. 5794, in accordance with DAV Resolution No. 512, which calls for meaningful accountability measures, while ensuring due process for employees of the VA.

This concludes my testimony on behalf of DAV. I am pleased to answer questions you or members of the Subcommittee may have.

Prepared Statement of Roscoe Butler

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to present our views on pending legislation impacting the Department of Veterans Affairs (VA) that is before the subcommittee. No group of veterans understand the full scope of benefits and care provided by the VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). PVA provides comment on the following bills included in today's hearing.

H.R. 3225, the BUILD for Veterans Act

The Build for Veterans Act seeks to improve staffing to manage construction of VA assets and ensure that there are concrete plans to improve the planning, management, and budgeting of VA construction and capital asset programs. Currently, the VA has nearly $180 billion in backlogged infrastructure projects, and the backlog is growing every day. Also, it is important to note that this estimate is a snapshot in time and is based on current market conditions, a baseline capital portfolio, demographic data, and projected needs. The department's real needs are likely to be higher because its Strategic Capital Investment Planning list also does not include projects identified in the Asset and Infrastructure Review Commission needed to meet veterans' care needs.

In Fiscal Year (FY) 2025, the department is requesting a total of $2.8 billion for the entire infrastructure account. However, VA Capital Infrastructure's backlog of projects continues to grow faster than VA can address them. In addition to the lack of funding, neither VA's Office of Construction and Facilities Management nor the individual VA facilities have the staff to oversee the amount of work necessary to keep up with the growing backlog, much less decrease it. To overcome VA's infrastructure challenges, Congress must not only provide significantly increased funding to fully address these long-standing issues, but also enact comprehensive planning, budgeting, management, and oversight reforms to ensure more effective use of those funds.

Infrastructure is a top priority for PVA and we fully support this bill. VA's current number of long-term care beds for veterans with SCI/D is woefully inadequate for an aging veteran population with care needs not readily met in the community. As of January, only 169 of VA's 181 SCI/D Long-Term Care beds were actually available, and only one of VA's six specialized long-term care facilities lies west of

the Mississippi River. Until construction projects at the Dallas and San Diego VA Medical Centers are completed, only 12 long-term care beds are available for the thousands of SCI/D veterans that reside in this area of the country. VA desperately needs to increase its SCI/D Long-Term Care capacity. Among its many provisions, the BUILD Act directs the VA to report to Congress on the department's current and future anticipated long-term care needs and models of care for women veterans, veterans with SCI/D, traumatic brain injury, and other veteran populations with unique needs. It also requires VA to implement a more concrete schedule to eliminate or repurpose unused and vacant buildings, develop and execute a plan to hire construction personnel, examine infrastructure budgeting strategies and identify required reforms, and provide annual budget requirements over a 10-year period.

H.R. 3303, the Maternal Health for Veterans Act

More women are choosing VA healthcare than ever before with women veterans accounting for over 30 percent of the increase in enrolled veterans over the past 5 years. PVA supports this legislation which strengthens oversight of VA's maternity care coordination while authorizing new funding to make sure the department has what it needs to provide more women veterans with access to the maternal care they've earned through their service. Additionally, this legislation will require the VA to provide an annual report to Congress that would track maternal health outcomes as well as information pertaining to services provided by the Maternal Health coordinators. With a growing number of women veterans using the VA who are of child bearing age, the department needs to be prepared to fully support them. Congress must take its oversight seriously to ensure the health and welfare of women veterans and their families.

H.R. 3584, the Veterans Care Act

There is a growing body of evidence that cannabinoids are effective for treating conditions like chronic pain, chemotherapy induced nausea and vomiting, sleep disturbances related to obstructive sleep apnea, multiple sclerosis spasticity symptoms, and fibromyalgia. The Veterans Care Act directs the VA to conduct and support research on the efficacy and safety of certain forms of cannabis and cannabis delivery for veterans enrolled in the VA health care system and diagnosed with conditions such as chronic pain or post-traumatic stress disorder. PVA supports evidence-based alternative treatments, including research into the efficacy of medical cannabis. A series of clinical trials on the use of medicinal cannabis may help determine if it could provide any medical benefits for veterans.

H.R. 3644, the Act for Veterans Act

Veterans eligible for VA healthcare experiencing a medical emergency are allowed to seek medical attention immediately from the nearest emergency medical facility, even if it is not at a VA Medical Center. However, if they are suffering from an eligible condition that prevents them from physically contacting the VA within 72-hours, the VA may still deny payment. PVA supports the Act for Veterans Act which allows the VA to give veterans an additional 24-hour period, at a minimum, to notify the VA when receiving care at a non-VA facility. The additional time will allow for flexibility if a veteran needs additional time to recover from a severe medical condition or if they are experiencing other challenges.

H.R. 3649, the Veterans National Traumatic Brain Injury Treatment Act

Hyperbaric Oxygen Therapy (HBOT) is a well-established treatment for a variety of conditions including decompression illness, carbon monoxide poisoning, or compromised skin grafts and flaps. However, its safety and efficacy to treat Traumatic Brain Injury or Post Traumatic Stress Disorder is unclear. PVA has no objections to this legislation which seeks to establish a pilot program at the VA to furnish HBOT to veterans with these conditions.

H.R. 4424, the Vietnam Veterans Liver Fluke Cancer Study Act

PVA supports this bill which directs VA, with the assistance of the Centers for Disease Control, to determine the prevalence of cholangiocarcinoma (bile duct cancer) in Vietnam era veterans. Bile duct cancer is an aggressive disease that attacks the gallbladder, bile ducts, and liver and has been linked to infections by parasitic worms known as liver flukes, which are common in Asia. The study would identify the rate of incidence of cholangiocarcinoma in covered veterans of the Vietnam era and in residents of the United States, from the beginning of the Vietnam era to the date of enactment of this Act. It also requires the VA to track and report on the prevalence of cholangiocarcinoma using the VA Central Cancer Registry.

H.R. 5247, the Expedited Hiring for VA Trained Psychiatrists Act of 2023

PVA supports this legislation which authorizes the VA to appoint a psychiatrist who completes a residency at a Veterans Health Administration (VHA) facility to a VHA health care position immediately after such residency, without regard to civil service or classification laws, if (1) the psychiatrist meets the qualifications established in regulations prescribed for the position, and (2) the position has been unfilled for at least 35 days. The critical shortage of psychiatrists within the VA is well documented and extends wait times for veterans seeking this level of mental health care. Passage of this bill would help ensure some of them receive needed care sooner.

Many SCI/D Centers lack the direct support of a psychiatrist. This forces other members of the care team (psychologists, social workers, and other SCI/D staff) to submit an Intra Facility Consult—and in some cases, an Inter Facility Consult for all veterans with SCI/D requiring psychiatric care. The response time to these consults are lengthy, delaying essential psychiatric care and services for these veterans. The dedicated SCI/D psychologists provide crucial mental health services; however, many veterans require specialized services only a psychiatrist can deliver. The change authorized by this legislation may help alleviate shortages like these, enabling SCI/D veterans to receive the essential psychiatric care they need in a timely manner.

H.R. 5530, the VA Emergency Transportation Access Act

The VA Emergency Transportation Access Act would bar the VA from reducing rates of pay and reimbursement for special mode transportation providers, including ground and air ambulances, unless the department meets certain requirements that ensure rate changes will not reduce veterans' access to this essential service. Specifically, it requires the VA to conduct a thorough review of the impact a change in rates would have on veterans' access to care; consult industry experts, Centers for Medicare and Medicaid Services, appropriate VA subject matter experts, and veterans service organizations when conducting the review; and develop a formal process of updating the rates that protects or expands veterans' current access to emergency transportation. Most importantly, it ensures the new rates reflect the actual costs of transportation. Having access to VA's Special Mode of Transportation is the only way many veterans can safely get to their VA and authorized non-VA medical appointments. PVA supports this legislation, because it helps ensure changes in reimbursement rates do not adversely impact veterans.

H.R. 6324, the Fiscal Year 2024 VA Major Medical Facility Authorization Act

PVA wholeheartedly supports this bill which authorizes the VA to carry out 11 major medical facility projects during Fiscal Year 2024 and sets maximum spending amounts for each one of them. This includes more than $300 million to support the ongoing construction of a new SCI/D Acute and Long-Term Care Center and related facilities at the San Diego VA Medical Center.

In addition to meeting the acute care needs of veterans with SCI/Ds, the new facility would house 20 new, desperately needed long-term care beds. Currently, only 12 long-term care beds are available for the thousands of SCI/D veterans that reside in this area of the country, so completion of this project is extremely important to PVA members. We urge you to pass this important legislation as quickly as possible.

H.R. 6373, the Veterans STAND Act

Veterans with SCI/Ds rely heavily on the use of assistive technologies to increase their independence and enhance participation in work, their families, and communities. These range from a simple cane to complex systems that allow the veteran to stand and move at eye level. In recent years, the neuroscience and biomedical communities have made great strides in developing new technologies to help restore mobility for people with SCI/Ds. Many of the newest and more complex technologies are limited to those with specific physical and mental capabilities amongst other factors. Still, PVA wishes to ensure those who meet the appropriate clinical criteria are considered for emerging assistive technologies.

We support the STAND Act which would first ensure that veterans with SCI/Ds are offered an annual medical exam. These annual assessments are important because it allows the veterans physician to identify and treat health issues before they worsen; review any changes that have occurred over the last year; and identify risk factors that could lead to future health problems and offer expert advice on how to mitigate them. Some VA facilities do an excellent job reaching out to SCI/D veterans to offer them an annual assessment—*but not all*, so there is room for improvement in this area. Second, the bill directs the VA to ensure veterans are assessed for, and

briefed on the types of assistive technologies they may be eligible for during these annual evaluations. Advancements in technology could provide life-changing options for veterans with SCI/Ds, so it is extremely important that they are made aware of anything that could improve their mobility, functionality, or independence.

We would like to note that we do have a minor concern with the requirement under Section 2 (3)(B) for the VA to consult with the manufacturers of assistive technologies. Veterans are determined to be qualified candidates to use complex assistive technologies like exoskeletons based on clinical criteria. VA should work with industry, as appropriate, but we are concerned about such collaboration being required. Thus, the language should be modified as appropriate.

PVA would once again like to thank the subcommittee for the opportunity to discuss our views on some of the bills being considered today. We look forward to working with the subcommittee on this legislation and would be happy to answer any questions.

Information Required by Rule XI 2(g) of the House of Representatives

Pursuant to Rule XI 2(g) of the House of Representatives, the following information is provided regarding Federal grants and contracts.

Fiscal Year 2023

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events——Grant to support rehabilitation sports activities—$479,000.

Fiscal Year 2022

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events——Grant to support rehabilitation sports activities—$ 437,745.

Disclosure of Foreign Payments

Paralyzed Veterans of America is largely supported by donations from the general public. However, in some very rare cases we receive direct donations from foreign nationals. In addition, we receive funding from corporations and foundations which in some cases are U.S. subsidiaries of non-U.S. companies.

Prepared Statement of Brittany Elliot

Introduction

Madam Chairwoman Miller-Meeks, Ranking Member Brownley and distinguished members of the subcommittee.

My name is Brittany Elliott and I am a medically retired United States Marine Corps Veteran. I am honored to join you today to discuss the critical importance of H.R. 6373, the VA Spinal Trauma Access to New Devices Act, or the STAND Act. I am joined here today by my father, full-time caregiver and exoskeleton companion, Morgan Elliott.

Background

By way of background, I am a medically eligible Veteran in terms of VA healthcare and I am fully paralyzed from my chest down as a result of a head-on collision with a drunk driver on July 3, 2015.

As you can imagine, our journey to date has been a long one: One filled with great personal successes, but also great frustration and disappointment as it relates to the bureaucratic obstacles we have witnessed over the course of our VA journey.

I want to be clear: I am thankful that I, like many of my military brothers and sisters, have access to VA healthcare as it is indispensable to me and my family as a resource. Having said that, I am very concerned that many Spinal Cord Injury (SCI) Veterans like me continue to be effectively ignored when it comes to legitimately assessing their overall healthcare needs and the types of technologies that can assist them in regaining a sense of normalcy.

My story, is exactly mine, but many others with whom I routinely interact, share similar concerns and encounter many of the same obstacles while seeking care at the VA.

For the subcommittee's background, I was injured in 2015. After a month of intensive hospitalization, I was mistakenly sent home for a short period of time by my private sector providers. Due to ongoing and lasting issues, associated with the trauma, I was forced to return to the hospital, this time the Lt. Col. Luke Weathers, Jr. VA Medical Center in Memphis Tennessee, where I stayed for an additional five weeks of intensive treatment and rehabilitation. That time was followed by nearly three very tough years re-entering life in a wheelchair at my home outside of Nashville, Tennessee.

In late 2017 I was introduced, through social media and other means—NOT THE VA, to a device that I thought may have some utility for me if I were to ever regain the ability to stand and walk—The ReWalk personal powered exoskeleton. I approached my care providers at the Memphis VA and started pushing to gain access to the technology. After significant hesitation by my local providers, I was finally able to get them to agree to enroll me in VA's landmark study on the device, but that came at a significant cost to me and my family, especially my Dad as my full-time care-giver.

The VA Co-Op study was being undertaken at several VA facilities across the country, but not in Memphis. So, I was forced to travel, using my own limited resources, to the St. Louis, Missouri VA Medical Center at Jefferson Barracks. While there, I spent 3 weeks undergoing intensive training on the device (I might add this is normally an 8-week process, but I am a Marine, after all, and was able to power through the training at a faster pace) and successfully completed the trial. At which point, I was able to take the device home and start using it. I took it everywhere: Disney World, Sea World, Bush Gardens and multiple county fairs. It very quickly became an integral part of my new life and provided me opportunities otherwise unavailable to those in wheelchairs.

Unfortunately, the story doesn't end there. When I returned to my new home VA, the St. Louis VA in 2018, my provider (the VERY SAME PROVIDER who entered me into the trial) informed me that she would not support my continued use of the device AND TO THIS DAY has failed to provide any substantive rationale for that decision. As a result, the device was promptly returned to the VA and I was left in a chair and told "you should get used to it because that's all you can expect." Well, as a trained U.S. warfighter, THAT'S SIMPLY NOT GOOD ENOUGH, especially in light of all the training I had already successfully completed with the device and given how it had effectively changed my life over the course of its use.

For the next four (4) years, yes, that's right, four (4) years, I was engaged in a local and regional battle to regain access to the device that had already begun to change my life. Unfortunately, the VA bureaucracy is extremely strong and literally no one would stand up clinically and advocate on my behalf, even in light of my having successfully completed VA's own study on the device!

Finally, and thanks to a forward-thinking and supportive clinician at the Sonny Montgomery VA Medical Center in Jackson, MS, I was seen, re-evaluated over the course of weeks, AGAIN ON MY OWN DIME, and ultimately provided a new device which I still have today and use every day of my life. I am eternally grateful to this provider as his disposition was not one that lent itself to the institutional bureaucracy, but one that carefully considered the entirety of the evidence and the utility of this device for me—a young, vibrant, and motivated Marine.

I am confident this fight never needed to happen, but the system in many cases, it seems to me, is built to protect itself instead of the Veterans it serves.

While many of you saw me walk in here today, and while standing and walking are clearly critical elements of this device, it's what you don't see that may be the most life-changing for me. For instance:

- My bone density has returned to almost normal levels as a function of me standing and bearing weight that I would not be able to accomplish in a chair;
- My core strength has been improved and sustained allowing me to sit upright, which is not a given, considering my level of injury;
- While in a chair, I was having several urinary tract infections (UTIs) every month that were becoming increasingly difficult to combat with antibiotics and serious infections were causing serious challenges. Using this device, my UTIs have now decreased to around 2 per year—A DRAMATIC AND POTENTIALLY LIFE-SAVING REDUCTION;
- I have lost weight, which in a chair is nearly an impossibility due to the lack of mobility or activity overall; and
- My mental health has dramatically improved. When I stand, I get to look people in the eye, shake their hand properly and be addressed as a person, not simply

patted on the back and often overlooked altogether—this is HUGE for a Marine like me!

Even in light of the well-recognized health-related advantages to standing and being ambulatory, VA often relies on the fact that sufficient capacity in the various SCI centers and related "hubs" nationally, does not exist to do the extensive training associated with the device. At the same time, however, they seem equally unwilling to send Veterans into the community, through the existing and expanding Community Care Networks (CCN), for training by those who have already been professionally trained on the devices. It seems to me, you can't have it both ways... You either treat those who are clinically eligible, or follow the law and send them into the community. Unfortunately, this is rarely the case.

STAND Act

I am aware that we are here to discuss the STAND Act, but I wanted to ensure that my interest in this legislation was explicitly clear and I am confident my experience lends itself to this critical effort.

With regard to the bill, I am so grateful to General Bergman and his staff for his authoring, and I also want to personally thank Chairman Bost, Ranking Member of the subcommittee Brownley and Congresswoman Dingell for their willingness to co-lead this effort. My thanks as well to those who have agreed, and continue to agree, to co-sponsor the STAND Act.

Equally important, I am supremely thankful for the public support that has been provided by the Paralyzed Veterans of America (PVA), the Disabled American Veterans (DAV) and the Reserve Organization of America (ROA) and the Independence Through Enhancement of Medicare and Medicaid, or ITEM Coalition, a coalition of industry and non-profit organizations supporting assistive technologies, generally.

In my view, the bill is critical for a few reasons, and I will relate them to my personal experience and to those with whom I routinely interact across the VA SCI spectrum:

- As you all know, the bill seeks to codify what VA is already supposed to be doing in the way of performing annual examinations—I can tell you with certainty, they are not. I have had 5 exams over the last eight (8) years and I had to push for several of those myself. So, the requirement for VA to proactively solicit participation in annual examinations from enrolled SCI Veterans is not only important as it relates to assistive technologies like mine, but to the overall health and well-being of this important population. It's VERY hard for me to hear VA claim to be the best at SCI care in the world, and at the same time know that many Veterans who need routine care simply are not getting it;
- Additionally, like me, I think it's imperative that VA assess the viability of assistive technologies for ALL Veterans with SCI as simply allowing them to stay in chairs, if they are clinically eligible for other devices, is just simply not good enough. The STAND Act mandates this type of assessment;
- One thing I've learned over my years of fighting the VA is that clinical behavior is very difficult to change. One way to accomplish change however, is to demand accountability for those responsible for making clinical decisions. This bill seeks to accomplish this by two means:
  - Make the VA reportable to Congress on their success against the metrics I mentioned; and
  - Hold VISN leadership accountable, through their annual performance evaluations for these same metrics;
  - Institutional change doesn't come easy, but it seems to comes easier if those in charge are held accountable and understand that some level of oversight is effectively in place.
- Finally, and I think this is important, VA failing to consult Veterans about the opportunities that exist for them is one thing, but their continued unwillingness to engage the manufacturers of these technologies when considering how the technologies can work for Veterans is disturbing. I know, based on my own experience, they will fall on their "objectivity sword" all day long, but the manufacturers and scientist who build these technologies possess the technical information that can truly assist in informing these types of important decisions for SCI Veterans.

Conclusion

Madam Chairwoman, Ranking Member Brownley and members of this subcommittee I am very thankful to you and all those who have supported this bill as

it can be truly life-changing for those like me, who have faithfully served their nation. But lack of system capacity, an unwillingness for VA leadership to allow Veterans to enter the community for training and just flat-out bureaucratic red-tape continue to hamper other Veterans' ability to gain access to these important technologies that are truly life-changing.

As I have already stated, ensuring others have access to technologies like mine is indeed my new mission in life and with your continued support I am confident more Veterans will be able to reclaim their lives and fulfill their ongoing obligations to family, community and country. I proudly stand, AND I MEAN STAND, in strong support of this bill as its importance can be truly immeasurable for those who are simply trying to rebuild their lives and who are seeking the VA's support to get them there. With your collective help this will be an easier path for others who are currently waiting and those who will inevitably follow.

I truly appreciate the opportunity to appear before you today and I am happy to respond to any question you may have.

Prepared Statement of Melissa Bryant

Subcommittee on Health
Legislative Hearing on Pending Legislation

Written Testimony Provided for the Open Session Legislative Hearing Covering H.R. 3584; H.R. 3644; H.R. 3649; H.R. 4424; H.R. 5530; H.R. 6324; H.R. 6373; H.R. 7347; H.R. 3225; H.R. 5794; H.R. 3303; and H.R. 5247

Testimony Submitted to:
Committee on Veterans' Affairs,
Subcommittee on Health
United States House of Representatives
118th Congress

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Chairwoman Miller-Meeks, Ranking Member Brownley, and Distinguished Members of the Subcommittee,

My name is Melissa Bryant, and I am honored to appear before you today on behalf of Minority Veterans of America (MVA) where I serve as Chair of the Board of Directors. As an organization dedicated to advocating for the unique needs of minority veterans, service members, and their families, we appreciate the opportunity to provide testimony and contribute the unique perspectives of those we serve to today's discussion. The focus of this testimony will be on H.R. 3303, the Maternal Health for Veterans Act.

About Minority Veterans of America

Founded in 2017 in Seattle, Washington, MVA is a non-partisan, nonprofit organization dedicated to creating belonging and advancing equity and justice for our nation's historically marginalized and underserved veterans: racial and ethnic, gender, sexual, religious and non-religious minorities. MVA works on behalf of more than 10.2 million minority veterans and is home to 3,300 members across 49 states, two territories, and three countries. Through our suite of programs, we directly serve thousands of veterans, service members, and their families each year.

Of MVA members, 52% identify as women, 7% are gender-diverse (including transgender, nonbinary, gender nonconforming, and gender-diverse veterans), 60% are of traditional reproductive ages of 18-45, and 30% are survivors of Military Sexual Trauma. We are grateful to be here today to represent their unique lived experiences and perspectives on the issue of maternal health for veterans.

Background on Veteran Maternal Health and VA Maternal Care Coordinator Program

Maternal health for veterans is a critical aspect of care that addresses the unique needs of veterans who are navigating pregnancy, childbirth, and postpartum care.[1] Within the Department of Veterans Affairs (VA) healthcare system, accessing comprehensive maternal health services presents challenges for veterans, particularly in light of the historical emphasis on male perspectives and priorities within VA healthcare. Veterans who use VA for care face obstacles in accessing timely and appropriate maternal care due to the limited availability of on-site obstetric services and poor care coordination between VA and community-based providers. As a result, pregnant and postpartum veterans must seek maternity care from non-VA providers, leading to issues surrounding fragmentation of care and challenges in accessing comprehensive maternal health services.

These challenges are compounded by the unique health issues veterans face, including physical and mental health conditions resulting from their service, which can impact their pregnancy and birth experiences. Veterans, especially those who have served in combat and that were exposed to toxins as a result, may experience unique health challenges related to their military service that can affect their maternal health outcomes. These challenges include physical injuries, such as traumatic brain injury or musculoskeletal injuries, as well as mental health conditions like post-traumatic stress (PTS) and depression. Additionally,

[1] While the term "maternal health" is commonly used to refer to health care related to pregnancy, childbirth, and the postpartum period, it is important to note that this terminology may not fully encompass the diverse landscape of individuals who can become pregnant, including transgender men and non-binary individuals. Therefore, discussions around maternal health should strive to be inclusive of all individuals who may experience pregnancy-related health needs. In this testimony, the term maternal health care will be used to represent prenatal, perinatal, and postpartum care, acknowledging the need for inclusive language that recognizes the diverse experiences and identities of individuals accessing reproductive health services.

exposure to environmental hazards and toxins during military deployments have been shown to have long-term health consequences that impact reproductive health and pregnancy.[2]

In response to the complexities of accessing maternal health care within the VA system, the Maternity Care Coordinator (MCC) program was established in 2012 to assist pregnant and postpartum veterans in navigating their prenatal, perinatal, and postpartum care and coordination. Recognizing the unique needs of pregnant veterans and the challenges they face in accessing comprehensive care, the MCC program serves as an important link between VA healthcare services and community-based maternity care providers. Through the MCC program, pregnant veterans can receive personalized support and assistance in coordinating their maternity care across different healthcare settings. MCCs work closely with veterans to ensure they have access to appropriate health care services throughout the perinatal and postpartum periods, addressing any barriers or challenges that may arise along the way. By providing guidance, advocacy, and coordination services, the MCC program aims to enhance the overall quality of care and improve maternal health outcomes for veterans.[3]

The specific responsibilities of VA Maternal Care Coordinators vary depending on the facility and the needs of the local veteran populations they serve. However, generally, MCCs are responsible for:

- **Coordinating Maternity Care Services**: MCCs help facilitate access to comprehensive maternity care services for eligible pregnant veterans. This includes coordinating appointments, referrals, and consultations with healthcare providers both within the VA system and in the community.
- **Providing Education and Support**: MCCs offer education and support to pregnant veterans regarding prenatal care, childbirth preparation, postpartum care, and newborn care. They may provide information about available resources, classes, and support groups.
- **Assessing Needs and Developing Care Plans**: MCCs assess the individual needs of pregnant veterans and develop personalized care plans to address those needs. This may involve collaborating with healthcare providers, social workers, and other professionals to ensure comprehensive and integrated care.
- **Advocacy**: MCCs are charged with advocating for pregnant veterans within the VA system to ensure they receive timely and appropriate care. They may address concerns or barriers to care and work to improve access to maternity services.
- **Monitoring Maternal Health Outcomes**: MCCs may track and monitor the health outcomes of pregnant veterans receiving care through the VA system. This includes tracking prenatal visits, screenings, and interventions to ensure the well-being of both the mother and the baby.
- **Collaboration and Networking**: MCCs collaborate with other healthcare providers, community organizations, and agencies involved in maternal and infant health to enhance the continuity and quality of care for pregnant veterans.[4]

VA's MCCs play an important role in supporting pregnant veterans throughout their maternity care journey, aiming to ensure they receive high-quality, patient-centered care that meets their unique needs.

Unique Maternal Health Challenges for Minority Veterans

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[2] Mancuso, A. C., Mengeling, M. A., Holcombe, A., & Ryan, G. L. (2022). Lifetime infertility and environmental, chemical, and hazardous exposures among female and male US veterans. *American Journal of Obstetrics and Gynecology*, *227*(5), 744.e1-744.e12. https://doi.org/10.1016/j.ajog.2022.07.002.

[3] CS, Rose D., Saechao, F., Shankar, M., Shaw, J., Vinekar, K. S., Yano, E. M., Christy, A. Y., & Johnson, A. M. (2023). *State of Reproductive Health Volume II: VA Reproductive Health Diagnoses and Organization of Care* (p. 31). Office of Women's Health, Veterans Health Administration, Department of Veterans Affairs.

[4] U.S. Department of Veterans Affairs. (2023, May 3). VA services for pregnant Veterans. *VA News and Information*.

Minority veterans face myriad unique maternal health challenges within the VA healthcare system, stemming from intersecting factors such as race, ethnicity, gender, sexual orientation, socioeconomic status, and geographic location. These challenges are rooted in systemic inequities, such as poverty, structural racism, implicit bias, and language and cultural barriers that impede access to essential prenatal, labor, delivery, and postpartum care. Moreover, minority veterans often contend with higher rates of underlying health conditions, including hypertension, diabetes, and mental health disorders, complicating their pregnancy and childbirth experiences and contributing to disparities in maternal health outcomes.[5]

The experiences of racial and ethnic minority veterans are profoundly influenced by unique identities, historical contexts, and the associated social determinants of health, all of which significantly impact access to and utilization of maternal health services within the VA healthcare system. Structural inequities, such as systemic racism and socioeconomic disparities, play a pivotal role in perpetuating disparities in maternal health outcomes among racial minority veterans. For instance, Black and African American, Native Hawaiian and Pacific Islander, American Indian and Alaska Native, and Hispanic women veterans face formidable challenges related to socioeconomic factors and are more likely to live in poverty than their white women and male counterparts.[6] These disparities can have deep impacts on pregnancy outcomes and lead to inadequate access to transportation, unstable housing situations, and financial constraints. Furthermore, racial minority veterans frequently confront stigma, discrimination, and cultural bias within the healthcare system, leading to mistrust and reluctance to engage with healthcare providers, further perpetuating disparities in maternal health experiences and outcomes for racial minority veterans.[7]

In a recent study titled, *VA Should Improve Its Monitoring of Severe Maternal Mortality Complications and Mental Health Screenings*, the Government Accountability Office found, "The severe maternal mortality rate was highest among Black veterans for each maternal health stage—that is, as of delivery (181.6 cases per 10,000 VA-paid delivery hospitalizations), postpartum (132.2 per 10,000 VA-paid delivery hospitalizations), and late postpartum (55.9 cases per 10,000 VA-paid delivery hospitalizations). Compared to the rates for White veterans as of delivery (134.2 per 10,000 VA-paid delivery hospitalizations) and postpartum (76.5 per 10,000 VA-paid delivery hospitalizations), the differences were pronounced."[8]

LGBTQ+ veterans – including transgender, nonbinary, gender diverse, and sexual minority individuals – face additional hurdles in accessing maternal health services within the VA system. These challenges include harassment and systemic discrimination in care settings,[9] which can result in delays in seeking and

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[5] CS, Rose D., Saechao, F., Shankar, M., Shaw, J., Vinekar, K. S., Yano, E. M., Christy, A. Y., & Johnson, A. M. (2023). *State of Reproductive Health Volume II: VA Reproductive Health Diagnoses and Organization of Care* (p. 43). Office of Women's Health, Veterans Health Administration, Department of Veterans Affairs.

[6] National Center for Veterans Analysis and Statistics. (2017). Profile of Veterans: 2017 (p. 22). Retrieved from https://www.va.gov/vetdata/docs/SpecialReports/Profile_of_Veterans_In_Poverty_2017.pdf

[7] MacDonald, S., Hausmann, L. R. M., Sileanu, F. E., Zhao, X., Mor, M. K., & Borrero, S. (2017). Associations Between Perceived Race-based Discrimination and Contraceptive Use Among Women Veterans in the ECUUN Study. *Medical care*, *55 Suppl 9 Suppl 2*(Suppl 9 2), S43–S49. https://doi.org/10.1097/MLR.0000000000000746

[8] U.S. Government Accountability Office. (2024). Veterans Health: VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings (GAO-24-106209). Retrieved from https://www.gao.gov/assets/d24106209.pdf. (Page 16)

[9] Shipherd, J. C., Darling, J. E., Klap, R. S., Rose, D., & Yano, E. M. (2018). Experiences in the Veterans Health Administration and Impact on Healthcare Utilization: Comparisons Between LGBT and Non-LGBT Women Veterans. *LGBT health*, *5*(5), 303–311. https://doi.org/10.1089/lgbt.2017.0179

receiving essential maternal healthcare.[10] Historic mistrust stemming from past discriminatory policies within the Department of Defense and VA healthcare systems can further compound delays or prolonged care-seeking behaviors, adversely impacting maternal health outcomes. Additionally, inequitable access to VA care, resulting from disparate discharge statuses such as those caused by discriminatory policies like "Don't Ask, Don't Tell" and the Military Trans Ban, further impedes access to comprehensive maternal care and support services, thereby exacerbating disparities in maternal health outcomes for LGBTQ+ veterans.

Intersectional challenges exacerbate the obstacles minority veterans face in accessing maternal health services within the VA healthcare system. Individuals who belong to multiple marginalized groups experience intersecting forms of discrimination and barriers that significantly impact their maternal health experiences and outcomes. These veterans are more likely to face a range of challenges, including socioeconomic disparities, cultural insensitivity, discrimination, and mistrust within the healthcare system, which can collectively hinder their ability to access timely and appropriate maternal care. Addressing these intersectional challenges requires a comprehensive approach that recognizes the intersectionality of factors such as race, ethnicity, gender, sexual orientation, and socioeconomic status, while emphasizing equity, inclusivity, and cultural competence in maternal health services for all minority veterans.

Successes of VA Maternal Care Coordinator Program

In the January 2023 Office of Women's Health State of Reproductive Health Report, VA outlined several key areas of success for the Maternal Care Coordinator Program which included[11]:

- **High Utilization Rate**: Between 60% to 75% of veterans who utilized VA maternity care reported engaging with an MCC during their pregnancy, underscoring the importance of MCCs in facilitating access to maternal care services within the VA system. Additionally, VA data indicates that in FY2020 there were 4,766 delivery hospitalizations among veterans who used VA maternity benefits to pay for their deliveries, an increase of approximately 85 percent from fiscal year 2011.[12]
- **Critical Role in Pregnancy Care**: Veterans perceive MCCs as indispensable in their pregnancy care journey, emphasizing their role in navigating and coordinating both VA and non-VA care, as well as addressing resource and billing issues.
- **Centralized Telehealth Program**: The implementation of a centralized VHA MCC telehealth program at the Veterans Integrated Services Network (VISN) level has been instrumental in leveraging resources and expertise to serve veterans across various geographic locations, including rural areas.
- **Enhanced Mental Health Support**: Collaboration between MCCs and mental health providers has led to improvements in perinatal mental health screening and care for pregnant and postpartum veterans. By integrating mental health services into maternal care coordination, MCCs contribute to addressing the holistic health needs of veterans during the perinatal period.

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[10] S, Rose D., Saechao, F., Shankar, M., Shaw, J., Vinekar, K. S., Yano, E. M., Christy, A. Y., & Johnson, A. M. (2023). *State of Reproductive Health Volume II: VA Reproductive Health Diagnoses and Organization of Care* (pp. 18-20). Office of Women's Health, Veterans Health Administration, Department of Veterans Affairs.

[11] CS, Rose D., Saechao, F., Shankar, M., Shaw, J., Vinekar, K. S., Yano, E. M., Christy, A. Y., & Johnson, A. M. (2023). *State of Reproductive Health Volume II: VA Reproductive Health Diagnoses and Organization of Care* (p. 31). Office of Women's Health, Veterans Health Administration, Department of Veterans Affairs.

[12] U.S. Government Accountability Office. (2024). Veterans Health: VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings (GAO-24-106209). Retrieved from https://www.gao.gov/assets/d24106209.pdf. (Page 3)

MCCs have served a pivotal role in enhancing access to comprehensive maternal care services, improving the care experience for pregnant and postpartum veterans, and addressing the unique healthcare needs of this population within the VA healthcare system.

Areas for Improvement for VA Maternal Care and Maternal Care Coordinator Program

While VA's Maternal Care Coordinator Program has made strides in supporting pregnant veterans, several areas for improvement remain.[13] These areas include:

- **Limited Access to Comprehensive Maternity Care**: One of the primary challenges is the limited availability of comprehensive maternity care services within the VA system. Many VA medical centers do not have obstetrics and gynecology (OB/GYN) departments or on-site maternity care providers, forcing pregnant veterans to seek care from community providers or face long travel distances to access VA facilities that offer maternity services. In a 2017 study, it was estimated that approximately 1 in 10 women veteran VA primary care patients lived in a gynecologist supply desert.[14]
- **Lack of Specialty Care Providers**: Even when maternity care is available within the VA system, there is often a shortage of specialty care providers, such as maternal-fetal medicine specialists or lactation consultants, leading to gaps in care and potential delays in accessing specialized services.[15]
- **Fragmented Care Coordination**: Coordination of care between VA providers and community-based providers can be fragmented for individual veterans, leading to challenges in communication, information sharing, care continuity, and issues relating to billing. This fragmentation can result in suboptimal care experiences for pregnant veterans and may contribute to disparities in health and financial outcomes.
- **Inadequate Screening and Risk Assessment**: Inconsistencies exist in screening protocols and risk assessment practices for maternal health conditions within the VA system. Failure to adequately identify and address maternal health risks, such as pre-existing medical conditions or pregnancy-related complications, can result in adverse outcomes for both the pregnant veteran and the baby. A recent GAO study revealed that due to issues related to a screening template that MCCs must use to document their results, VA's Office of Women's Health could not monitor the occurrence or results of mental health screenings conducted by MCCs.[16]

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[13] CS, Rose D., Saechao, F., Shankar, M., Shaw, J., Vinekar, K. S., Yano, E. M., Christy, A. Y., & Johnson, A. M. (2023). *State of Reproductive Health Volume II: VA Reproductive Health Diagnoses and Organization of Care* (p. 31). Office of Women's Health, Veterans Health Administration, Department of Veterans Affairs.

[14] Friedman, S., Shaw, J. G., Hamilton, A. B., Vinekar, K., Washington, D. L., Mattocks, K., Yano, E. M., Phibbs, C. S., Johnson, A. M., Saechao, F., Berg, E., & Frayne, S. M. (2022). Gynecologist Supply Deserts Across the VA and in the Community. *Journal of general internal medicine*, *37*(Suppl 3), 690–697. https://doi.org/10.1007/s11606-022-07591-5

[15] Inderstrodt, J., Stryczek, K. C., Vargas, S. E., Crawford, J. N., Hooker, T., Kroll-Desrosiers, A. R., Marteeny, V., Wallace, K. F., & Mattocks, K. (2024). Facilitators and Barriers to Breastfeeding Among Veterans Using Veterans Affairs Maternity Care Benefits. *Women's health issues : official publication of the Jacobs Institute of Women's Health*, S1049-3867(23)00216-5. Advance online publication. https://doi.org/10.1016/j.whi.2023.12.005

[16] U.S. Government Accountability Office. (2024). Veterans Health: VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings (GAO-24-106209). Retrieved from https://www.gao.gov/assets/d24106209.pdf. (Page 27)
The Office of Women's Health (OWH) additionally stated, "Such monitoring has been the responsibility of the VISNs and VA medical centers. Although OWH is responsible for VA's directive on maternity care and coordination, the

- **Limited Mental Health Support**: Pregnant veterans face unique mental health challenges, including perinatal mood and anxiety disorders (PMADs), but there is limited access to mental health services specifically tailored to pregnant and postpartum women within the VA system. Lack of tailored mental health support can negatively impact maternal well-being and birth outcomes.
- **Insufficient Data Collection and Analysis**: Gaps exist in data collection, analysis, and reporting related to maternal health outcomes among veterans. Without comprehensive data (aggregated and disaggregated), it is challenging for the VA to assess the effectiveness of its maternal health care programs, identify areas for improvement, and address disparities in care.[17]
- **Barriers to Care for Minority and Rural Veterans**: Minority veterans and those residing in rural areas face additional barriers to accessing maternity care within the VA system, including cultural and linguistic barriers, transportation challenges, and limited availability of providers. These barriers can exacerbate existing disparities in maternal health outcomes.[18]
- **Limited Support for Postpartum Care**: Postpartum care is a critical component of maternal health care, yet there are limited supports and resources available for postpartum care within the VA system. Improving postpartum care services and extending support beyond childbirth is essential for promoting maternal health and well-being.

In addition to the above areas for improvement, challenges unique to minority veterans were outlined and included:

- **Persistent Racial Inequities**: Despite the availability of the MCC program, racial inequities persist among veterans accessing perinatal care and maternal mortality, highlighting the need for targeted interventions to address these disparities.[19] MCCs must be equipped with cultural competency and understanding to effectively intervene and address the social determinants of health that contribute to racial disparities in maternal outcomes.
- **Lack of Information Technology Tools**: MCCs face challenges due to inadequate information technology tools for tracking calls and workload.[20] Improved IT infrastructure is essential to enhance the efficiency and effectiveness of MCCs in coordinating maternal care services for veterans.
- **Insufficient Training for LGBTQ+ Support**: There is an urgent need for MCCs to receive specialized training and resources to effectively support LGBTQ+ veterans accessing maternal care services. Currently, many MCCs lack the necessary tools and training to ensure that the program is welcoming and inclusive for LGBTQ+ veterans.

Addressing these failures requires a multifaceted approach that prioritizes equity, cultural competency, and coordinated care. It will additionally require an investment in the resources, training, and support systems

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directive assigns the VISNs responsibility for ensuring its implementation generally. VA medical centers are responsible for supervising or monitoring MCCs, including their efforts to implement the directive requirement that pregnant and postpartum veterans be screened for mental health conditions through the Telephone Care Program."

[17] CS, Rose D., Saechao, F., Shankar, M., Shaw, J., Vinekar, K. S., Yano, E. M., Christy, A. Y., & Johnson, A. M. (2023). *State of Reproductive Health Volume II: VA Reproductive Health Diagnoses and Organization of Care* (p. 18-20). Office of Women's Health, Veterans Health Administration, Department of Veterans Affairs.

[18] Ibid, page 31.

[19] U.S. Government Accountability Office. (2024). Veterans Health: VA Should Improve Its Monitoring of Severe Maternal Complications and Mental Health Screenings (GAO-24-106209). Retrieved from https://www.gao.gov/assets/d24106209.pdf.

[20] CS, Rose D., Saechao, F., Shankar, M., Shaw, J., Vinekar, K. S., Yano, E. M., Christy, A. Y., & Johnson, A. M. (2023). *State of Reproductive Health Volume II: VA Reproductive Health Diagnoses and Organization of Care*. Office of Women's Health, Veterans Health Administration, Department of Veterans Affairs.

to empower MCCs to effectively address racial inequities, enhance technological capabilities, and provide inclusive care for LGBTQ+ veterans accessing maternal health services.

Analysis on H.R. 3303

H.R. 3303, the Maternal Health for Veterans Act, proposes several measures aimed at enhancing maternal care for veterans within the Department of Veterans Affairs (VA). H.R. 3303 would change or improve maternal care for veterans in the following ways:

- **Increased Funding for Maternity Health Care Coordination Programs**: The bill authorizes $15,000,000 annually for fiscal years 2024 through 2028 specifically designated for VA programs related to coordinating maternity health care. This increased funding would enable VA to expand and improve existing programs, allocate resources more effectively, and address gaps in care for pregnant and postpartum veterans.
- **Mandatory Reporting and Data Collection**: H.R. 3303 requires the Secretary of Veterans Affairs to submit annual reports to Congress that summarize activities related to maternity health care coordination programs within VA. This includes data on maternal health outcomes of veterans receiving care through either VA or non-VA providers.
- **Focus on Maternal Health Disparities**: The bill directs the Secretary of Veterans Affairs to provide recommendations for improving maternal health outcomes of veterans, with a particular focus on demographic groups experiencing elevated rates of maternal mortality, severe maternal morbidity, disparities, or adverse perinatal outcomes.
- **Support for Maternity Care Coordination Program**: H.R. 3303 supports VA programs related to the coordination of maternity health care, including the maternity care coordination program described in Veterans Health Administration Directive 1330.03.

H.R. 3303 would improve maternal care for veterans using VA by providing increased funding, mandating reporting and data collection, focusing on addressing disparities, supporting existing maternity care coordination programs, and ensuring supplemental funding to enhance resources for maternal health care initiatives.

Minority Veterans of America's Position

MVA supports Representative Underwood's H.R. 3303, recognizing the potential to significantly enhance maternity care coordination for veterans throughout pregnancy and one year postpartum within VA services. This legislation proposes an important comprehensive study focused on addressing the maternal health crisis among women and gender-diverse veterans, with specific attention to veterans with elevated rates of maternal morbidity, maternal health disparities, or other adverse perinatal or childbirth outcomes. Additionally, the bill will facilitate access to community resources and educational opportunities, improving maternal health outcomes among veterans.

Women veterans represent the fastest-growing demographic within the veteran community, comprising nearly two million individuals in the United States, with 40% of them between the ages of 18 and 44.[21] Alongside unique challenges such as Military Sexual Trauma (MST)-related PTSD and civilian life transition, veterans face alarming maternal mortality rates.[22]

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[21] Ibid.

[22] Quinn, D. A. (2024). *Examining Pre-Pregnancy Health and Maternal Outcomes among Women Veterans* (Project Number 1IK2HX003327-01A1). Veterans Health Administration. Preliminary findings at https://reporter.nih.gov/project-details/10314239#details.

Moreover, veterans encounter various barriers to accessing maternal health care, including geographic constraints, transportation issues, and resource inadequacies within local VA facilities. Tackling these challenges demands a comprehensive approach that recognizes the intersection of veterans' military experiences with their reproductive health needs while ensuring equitable access to quality maternal care services. Efforts to bolster the VA's capacity to deliver comprehensive maternal health services should prioritize the integration of obstetric and gynecological care within VA medical centers, increased funding for maternity care coordination programs, and the recruitment and training of providers proficient in addressing the unique needs of pregnant and postpartum veterans. Additionally, promoting awareness and education among veterans about available maternal health services and advocating for policies that support veterans' reproductive health needs are essential steps in ensuring equitable access to quality care for all veterans, regardless of their service-related challenges or backgrounds.

Recommendations

To improve H.R. 3303 and address the unique needs of minority veterans accessing maternal health services within the VA healthcare system, we recommend the following:

- **Enhance Cultural Competency Training**: Implement comprehensive cultural competency training programs for VA healthcare providers, including Maternal Care Coordinators (MCCs), to ensure that they are equipped to provide culturally informed and inclusive care to minority veterans. Training should focus on understanding the unique experiences and needs of minority veterans, including racial, ethnic, gender, and sexual minority groups.
- **Promote Diversity in Healthcare Workforce**: Increase recruitment and retention efforts to diversify the VA healthcare workforce, including OB/GYN specialists, MCCs, and mental health providers, to better reflect the diversity of the veteran population. A diverse healthcare workforce can improve patient-provider communication, trust, and overall quality of care for minority veterans accessing maternal health services.
- **Expand Access to Comprehensive Maternity Care**: Invest in expanding access to comprehensive maternity care services within the VA healthcare system, including obstetrics and gynecology (OB/GYN) departments, maternal-fetal medicine specialists, and lactation consultants. Ensure that in-house maternity care services are available at VA facilities serving higher minority veteran populations, particularly in underserved rural and urban areas.
- **Address Social Determinants of Health**: Develop initiatives to address social determinants of health that disproportionately impact minority veterans, such as poverty, housing instability, transportation barriers, and language barriers. Provide support services, resources, and referrals to address these social determinants and improve access to maternal health care.
- **Enhance Data Collection and Analysis**: H.R. 3303 should incorporate intersectional perspectives into data collection and reporting requirements to better understand disparities in maternal health outcomes among minority veterans. This includes collecting demographic data on race, ethnicity, gender identity, sexual orientation, and other intersecting identities to inform targeted interventions and policies.
- **Strengthen Community Partnerships**: Foster partnerships with community-based organizations and stakeholders serving minority veteran populations to enhance outreach, education, and support services related to maternal health care. Collaborate with community partners to develop culturally relevant and accessible resources and programs for minority veterans accessing maternal health services. Additionally, H.R. 3303 should allocate additional resources to support community-based outreach and education initiatives targeting minority veterans. This includes funding for grassroots organizations, community health centers, and other local stakeholders to provide culturally relevant and accessible maternal health education, support services, and resources.

- **Improving Language Access Services**: H.R. 3303 should prioritize improving language access services and addressing language barriers for minority veterans accessing maternal health care. This includes expanding language interpretation services, providing culturally and linguistically appropriate materials, and ensuring that language needs are adequately addressed in care delivery.
- **Expanded Access to Doulas and Culturally Competent Midwives**: Increasing access to doula care and culturally competent midwifery services can significantly reduce racial disparities and improve patient outcomes and experiences for LGBTQ+ veterans and families. Doulas and midwives who understand the unique needs and identities of minority veterans can provide tailored support throughout pregnancy, childbirth, and the postpartum period, ultimately enhancing the quality of care, reducing maternal mortality, and promoting positive birth experiences.

As the demographics of the veteran community continue to shift, the need for comprehensive reproductive health services through VA grows greater. Addressing maternal health disparities among veterans is paramount for future generations who will return from service to start families. Despite making strides through initiatives like the MCC program, significant challenges persist in ensuring equitable access to quality maternal care services for all veterans.

We urge Congress to prioritize the needs of pregnant veterans in advancing legislation aimed at improving maternal health care within the VA system. This includes supporting measures to enhance cultural competency training for VA providers, increasing representation of minority providers within the VA maternal health care workforce, improving language access services, and incorporating intersectional perspectives into data collection and reporting requirements.

MVA commends the efforts of Representative Underwood and others in introducing H.R. 3303 to further address maternal health disparities among veterans. We encourage Congress to strengthen this legislation by including provisions specifically targeting the unique needs of minority veterans accessing maternal health services within the VA healthcare system, and urge swift passage of H.R. 3303.

Once again, I thank you for the opportunity to submit written testimony and to provide verbal testimony during the Hearing. My team and I look forward to continuing to work with you and your offices, and to support your efforts in support of the minority veteran community. If we can ever be of further assistance, please feel free to contact our Director of Law & Policy, Peter Perkowski, via email, pperkowski@minorityvets.org.

/s/

Melissa Bryant
Chair, Board of Directors

Appendix - MVA Member Stories

"I gave birth during COVID and it was extremely scary and as stressful as anyone would imagine. I sell cars and was in constant contact with the public. In early February, I became sicker than is usual with pregnancy sickness and didn't know to check for COVID at the time. However, I was extremely sick for a week and a half but never fully recovered breathing wise. After the second quarantine, I had to bring my 5 year old home to home school due to breakouts at school. This put me on unpaid leave from work after my already unpaid medical leave and maternity leave. I'd been saving to buy a house but I've completely depleted those funds. I didn't qualify for unemployment because I wasn't furloughed, I was on medical and personal leave. My children's father hasn't been able to pay any child support and I'm now behind on every bill. I've even depleted my 401k. I've been trying with all that's in me to carry it all but postpartum depression makes everything so much heavier and the meds I'm prescribed aren't suggested while nursing but I can't afford baby formula. I'm fighting for myself and my family to not be homeless. Their father is the only family the kids have here and they are not involved with the children at all."

-Anonymous, Alabama

"I was a drilling reservist wrongfully discharged while I was pregnant. I applied for a 6 month leave of absence and submitted paperwork but was Administratively Separated and was ineligible for re-enlistment. Since my discharge, I have been struggling with housing and became homeless from July-October before finding housing with a friend. I hope to gain financial stability and find permanent housing for myself and my children."

-Lidesyan "Dez" Lincoln, Navy Reserves, Texas

"I've always been financially stable and been able to maintain that stability. I was a shift lead at Walgreens from October 2019 until October 2020. I loved my job but with a 4 month old there's no way I could have open availability. I worked my entire pregnancy all the way up until 2 weeks before I went into labor. I had my sweet girl Kinsley Marie in June , which is when I stopped working. Up until May her dad was still around. He left us while I was 8 months pregnant . We had planned to split the bills until I go into labor because then I would be out of work for a while. When he left I didn't know what I was going to do. He was sending money here and there but not nearly enough to cover the bills. I've fallen behind. I'm sorry this is all over the place but I have a teething 4 month old with no help. Also I decided to go back to work in September while I still was suffering from postpartum. Going to work actually was making me feel a little better but when her dad said he wasn't going to be able to keep her while I worked rocked my world . It's just set setback after setback . I'm facing eviction and about to get my car repoed. I just feel like I can't catch a break. I am looking for a job with a steady schedule."

-Anonymous, Mississippi

"I'm a 37 year old female that has been struggling with depression and anxiety. I was suffering severely from postpartum depression. I asked for help many times, but no one would listen. I failed a drug test and

my command sent me to the brig for 6 months. My mental health was never treated no matter how many tears I cried, or reached out to people."

-Anonymous, Pennsylvania

"I am a female Veteran who served active duty in the Navy for 4 years. Once separated, I became a government contractor in Washington DC. After the birth of my 2nd child, I experienced mild postpartum depression which led to my losing my job and ending the relationship with my children's father, becoming homeless, and engaging in an abusive relationship where my cycle of job loss and homelessness were perpetuated. Once becoming pregnant the abuse escalated and I left him and went to a homeless shelter for pregnant women with my 2 children. There I worked with the Veteran Affairs office in Richmond, Virginia and was able to secure housing for myself and children after the birth of my 3rd child. Now, a single mother of 3, I have secure housing with no support system to help. I have been diagnosed with depression and social anxiety.

Up until the past few weeks I have been unable to get treatment due to not having anyone to watch my children to go to therapy. I just recently put my youngest in childcare (it's been 2 weeks) which I can't afford but I honestly needed the break because my mental health was declining due to not having any breaks from my children and having the sole responsibility to care for them without any help. I'm currently doing the best I can to stay afloat, mentally and emotionally. Most days are extremely hard for me but I continue to push forward because giving up is not an option. Hard times don't last forever and the sun always rises again after a dark night."

-Khadija Smith, Navy, Virginia

"After returning from my deployment in 2010 I began dating my son's father. I became pregnant sooner than expected and things were great. Shortly into my pregnancy my son's father began cheating and verbally abusing me. My ex cheated and verbally/emotionally abused me for about 3 years until one night after returning from his mistresses house an argument became physical and I had to leave my home with my 3 year old son. I moved multiple cities away and started a new job. I have been a single mother since leaving my ex and trying to raise my mixed race son to be a better man and human being than his father. Currently I've started working at SFWMD and I'm just trying to do better for me and my son."

-Gracie Mangual, Army National Guard, Florida

Prepared Statement of TreatNOW

US House Committee on Veterans' Affairs Members,

EXECUTIVE SUMMARY: The TreatNOW Coalition supports H.R. 3649. We are dedicated to ending service member suicides (now over 146,000) through the use of Hyperbaric Oxygen Therapy (HBOT) and adjunct therapies. In over 150 Coalition clinics in the last 12 years, HBOT is proven to heal wounds of all types, especially including brain wounds caused by BLAST/TBI/PTSD/Concussion/Friendly fire. Over twenty-one clinical trials—including the US Government's own trials—demonstrate safety and effectiveness of using HBOT for mild Traumatic Brain Injury persistent post concussive syndrome. Ten State legislatures have already passed legislation mirroring H.R. 3649, and five have appropriated over $30 million to treat Veterans still suffering from ineffectively treated brain wounds. Over 31,000 patients with brain wounds, including over 12,500 active duty and Veteran service members have been restored to a Quality of Life denied them by lack of insured access to HBOT. **It is unfortunate that neither the VA nor DoD are practicing the standard of care as laid out in 1990 in the Textbook of Military Medicine**.[1] It is long past time that both the DoD and the VA insure HBOT coverage, beginning with immediate "informed consent" to all invisible brain wounded service members about the availability of HBOT. Federal funds should cover the use of public and private HBOT clinics to treat the brain wounded.

Our military has been exposed to blast force waves since the Civil War. The results: TBIs to our servicemen and woman. Labels came and went. In the Civil War, combat could lead to "soldier's heart" and "railway spine", [2] in World War I it was "Shell Shock;", in World War II it was "Battle Fatigue" or "War Neurosis;" in Korea it was "Combat Stress/Fatigue;" in Vietnam it was originally called "Post-Vietnam War Syndrome" which later migrated to PTSD, and now in the ensuing Gulf War Era and the preceding decades fighting terrorism, medicine has settled on TBI and or PTSD. A full 150 years of misdiagnosis of this same issue has deepened reliance on prescription drugs, leading in too many cases to drug and alcohol addictions, homelessness, unemployment, incarcerations, and suicides. Along the way, an array of varying drugs, and self-awareness education and calming protocols have done little to combat the **"invisible physical wounds"** to the brain.

The DoD has established a process and culture that punishes service members for their combat wounds versus treating the **"physical brain wound similar to a gunshot wound."** This has resulted in the current suicide (146,000+) and opioid (109,000) epidemics besieging our Veteran community. Over 255,000 Veterans have already succumbed to their invisible wounds because our government is unwilling to accept modern medical science. **The 255,000 combined deaths represent 41 percent of all the U.S. troops KIA since the beginning of WW I (623,718).** Hyperbaric Oxygen Therapy (HBOT) is proven safe and effective in treating and healing wounds of all types, including a portion of the 877,450+ brain wounds caused by 70,000+ IEDs, BLAST, 155mm Howitzers, dangerous close explosions, RPGs, and friendly fire. Twenty-one clinical IRB trials completed since 2007—including the US Government's own trials—demonstrate safety and efficacy of using HBOT for mild Traumatic Brain Injury persistent post concussive syndrome.

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[1] Conventional Warfare: Ballistic, Blast, and Burn Injuries, Textbook of Military Medicine Series on Combat Casualty Care, Part 1, Volume 5, 1990, Pages 311–316, Chart Page 313, Office of Surgeon General, Department of Army. See attached protocol.

[2] See, for example, U.S. Government Printing Office. The Medical and Surgical History of the War of the Rebellion, 1861–65. Part I, Volume II: Surgical History (1870). Prepared, under the direction of Joseph K. Barnes, Surgeon General United States Army, by George A. Otis, Assistant Surgeon, United States Army. Covers wounds and injuries of the head, face, neck, spine, and chest; and Howard H. Kaufman M.D., "Treatment of head injuries in the American Civil War," Journal of Neurosurgery, May 1993

Ten State Governors (OK, TX, IN, AZ, KY, FL, NC, WY, MD, VA) have enacted legislation and appropriated more than $30 million for treatments using HBOT. Why are individual states having to pay for effective medical treatment for invisible brain wounded Veterans? The DoD and the VA must insure HBOT coverage, beginning with immediate "informed consent" to all wounded service members about the availability of HBOT, and its use in public and private HBOT hospitals (1,156) and clinics (200+). Using independent scientific methods to collect and report on data aimed at more proof of the safety and effectiveness of HBOT is costing Veteran lives. The 3.75 million members of The American Legion, DAV, AMVETS, AFSA, and Vietnam Veterans of America, have endorsed their support for HBOT in the treatment of mild TBI/PTSD Veterans (see attached). Over a hundred TBI/PTSD Veteran video testimonials from the 12,500+ HBOT treated attest to the safe and effective results of HBOT treatment. See https://www.youtube.com/@treatnowdotorg/videos

The Army and Marines have sustained the majority of TBIs, 53 and 18 percent respectively, across all the service branches or 71 percent of the total because of their missions of boots on the ground. The Spec Ops groups have high TBI numbers but are in a smaller demographic population and largely go unreported for fear of punishment and or banishment from their military career. Clearly, the data reveals the current strategy and medical approach to mitigating TBIs—whether from blast overpressure force, IEDs, howitzer artillery rounds, rocket firing, etc.—has failed. The 2014 congressional testimony before the House Armed Services Committee by Marine Commandant Conway and Navy Chief of Naval Operations Admiral Roughead advocated HBOT be used to treat TBI/PTSD Veterans because in their words, "it can only help." What can we do? What is TreatNOW doing?

Through a national network of 150+ private HBOT treatment clinics and nonprofits across the country, the TreatNOW Coalition has treated and healed thousands of TBI Veterans and civilians alike. Hyperbaric Oxygen Therapy of Arizona, LLC (3,600 civilians/900 TBI Vets), Rocky Mountain Hyperbaric Institute, Colorado (1255/477), Extivita in North Carolina (3,500/3,150), The Patriot Clinics, Oklahoma (2,800/2,650), Tier 1 Therapy Centers, Virginia (800/572), America's Mighty Warriors, Arizona (600+ Navy SEALS) are examples of the network contributing to the estimated 12,500 TBI Veterans treated and healed to date.

We conservatively estimate over 877,450 TBI/PTSD PHYSICALLY brain wounded Veterans with an economic impact estimated at $118.1 billion annually, $4.7 trillion over 40-year lifespan. There is not a single FDA approved drug for TBIs, yet they are widely and routinely prescribed, along with a multitude of other off-label interventions. There were over 847 million opioid pills prescribed between 2006 to 2014 by the VA (DEA.gov) decimating our physical invisible brain wounded Veterans. From 2008 to 2020, VA mental health budget has tripled, totaling $86.1 billion. The medical research budget totals $7.7 billion during the same period without any change in the TBI/PTSD suicide rate. The VA estimated from 2020 to 2029 a $2.4 billion budget to treat TBI wounded Veterans.

Today, America continues to fail our veterans, contrary to Lincoln's promise, and the avowed Mission of the Veterans Administration. The failure is not for trying, it is for staying too long on afailed path to the exclusion of proven alternatives. Veterans continue to commit suicide at an epidemic rate. We need bold new action supported by medical data and demonstrated results which is exactly what we are offering. Dr Paul G. Harch's HBOT meta-analysis of 11 of the 21 clinical trials, and their positive results, highlights the safety and efficacy of HBOT for mTBI.

Some of you will have heard that HBOT is unproven in treating TBI. The gold standard of Hyperbaric medicine, the Undersea & Hyperbaric Medical Society (UHMS) last year revised its definition of hyperbaric medicine in line with current known laws of physics. This redefinition categorically proves that the Government studies, in line with the worldwide scientific evidence, demonstrate safety and efficacy of HBOT for TBI. The controversy was settled by scientific evidence in the last decade. HBOT has been a standard of care for TBI Israeli Veterans for over a decade; they "have the third lowest suicide rate amongst males compared to 27 countries worldwide"[3] How are they achieving these results?

Given the published scientific evidence, clinical results, continuing suicide rate, and the needless suffering of untreated brain wounds, it is past time to use HBOT for TBI as part of military medicine's tool bag. Dr George Wolf, the Principal Investigator of the first government study, has said **"Hyperbaric oxygen therapy for mild traumatic brain injury and PTSD should be considered a legitimate**

[3] State of Israel Ministry of Health Report, August 2020, https://www.health.gov.il/English/News__and__Events/Spokespersons__Messages/Pages/09082020__01.aspx

adjunct therapy..."[4] . We ask for your leadership in helping us migrate HBOT forward as a standard of care for our invisible wounded warriors as did the Israeli government. At a minimum, use **Emergency Use Authorization**, fund treatments in the ten states which have enacted HBOT legislation and help us help save the remaining 877,450 invisible wounded warriors from suicide and or opioid addiction.

Prepared Statement of Matt Cartwright

Thank you, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the House Veterans' Affairs Subcommittee on Health, for allowing me to submit a statement in support of critical legislation that would benefit our Nation's Veterans. I write today in support of my bipartisan bill, H.R. 5247, the Expedited Hiring for VA Trained Psychiatrists Act, which would increase access to mental health services for our Veterans—to whom we owe a great debt.

The Department of Veterans Affairs (VA) psychiatrists diagnose mental, emotional, and behavioral conditions, and provide treatment to our Nation's heroes after they've answered the call to uniformed service. Everyone knows the sobering statistic that the rate of suicide among veterans is almost 60 percent higher than that of civilians. Whether a Veteran is struggling with the aftereffects of military combat, adjusting to civilian life, or facing a mental illness such as PTSD, having access to a psychiatrist at a VA facility could make a world of difference in a Veteran's journey to mental health and well-being.

While the VA has prioritized hiring new medical staff at an unprecedented rate, it is still difficult to hire and retain psychiatrists at a level sufficient to meet the needs of our Veterans. The Government Accountability Office (GAO) has previously found that the VA does not have proper staff levels for its suicide prevention teams, and efforts to fill these vacancies have been significantly hampered by a long recruitment and hiring process. Furthermore, the GAO has repeatedly reported that demand for Veterans mental health services will only increase, exacerbating staffing shortages.

The practical impacts of understaffing include excessive wait times, lack of proper follow-up care, and Veterans' inability to schedule appointments in a timely manner. These unnecessary hurdles to accessible, reliable care and treatment can have terrible consequences.

The Expedited Hiring for VA Trained Psychiatrists Act would tackle the VA understaffing problem by codifying the VA Secretary's ability to hire psychiatrists who have completed their residency at a VA facility if a position has gone unfilled for at least thirty-five days.

Many aspiring psychiatrists do at least part of their residency in a VA facility. These trainees gain valuable experience working with Veterans and are already familiar with the issues specific to this community. By giving the Secretary the ability to directly convert psychiatric residents to full employment with the VA – pending satisfactory completion of both the residency and all credentialing requirements – Congress can help make the VA a more attractive place for these residents to begin their careers. By reducing the time it takes to fill critical psychiatrist positions, my bill would reduce the wait times for Veterans seeking to access mental health services.

Ensuring timely access to quality mental health care for all Veterans should be a priority for everyone, regardless of party. The Expedited Hiring for VA Trained Psychiatrists Act is commonsense, bipartisan legislation that would provide a fast track hiring process for qualified psychiatrists who train at VA facilities. I am grateful to my colleagues on both sides of the aisle for their support of this important legislation.

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee, I offer my sincere thanks for your consistent prioritization of the issue of Veteran mental health.

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[4] Traumatic Brain Injury and Hyperbaric Oxygen Therapy: Dawn of a New Day, APWCA 16th Annual National Clinical Conference, 7–9 September 2017

Prepared Statement of Wounded Warrior Project

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WOUNDED WARRIOR PROJECT
STATEMENT FOR THE RECORD

SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

LEGISLATIVE HEARING
ON

H.R. 3584, the *Veterans Care Act*; H.R. 3644, the *Act for Veterans Act*; H.R. 3649, the *Veterans National Traumatic Brain Injury Treatment Act*; H.R. 4424, the *Vietnam Veterans Liver Fluke Cancer Study Act*; H.R. 5530, the *VA Emergency Transportation Access Act*; H.R. 6324, the *FY24 VA Major Medical Facility Authorization Act*; H.R. 6373, the *Veterans STAND Act*; H.R. 7347, *To amend title 38, United States Code, to direct the Secretary of Veterans Affairs to report on whether the Secretary will include certain psychedelic drugs in the formulary of the Department of Veterans Affairs*; H.R. 3225, the *BUILD for Veterans Act*; H.R. 5794, the *VA Peer Review Neutrality Act*; H.R. 3303, the *Maternal Health for Veterans Act*; and H.R. 5247, the *Expedited Hiring for VA Trained Psychiatrists Act of 2023*.

March 21, 2024

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of the House Committee on Veterans' Affairs, Subcommittee on Health – thank you for the opportunity to submit Wounded Warrior Project's views on pending legislation.

Wounded Warrior Project (WWP) was founded to connect, serve, and empower our nation's wounded, ill, and injured veterans, Service members, and their families and caregivers. We are fulfilling this mission by providing more than 20 life-changing programs and services to more than 206,000 registered post-9/11 warriors and 51,000 of their family support members, continually engaging with those we serve, and capturing an informed assessment of the challenges this community faces. We are pleased to share that perspective for this hearing on pending legislation that would likely have a direct impact on many we serve.

H.R. 3584, the *Veterans Cannabis Analysis, Research, and Effectiveness (CARE) Act*

Chronic pain is a widespread issue among our warrior population and the veteran population at large. Our Annual Warrior Survey revealed that over 3 in 4 (75.8%) of WWP warriors self-report experiencing moderate or severe pain that interferes with their activities and

enjoyment of life.[1] Further, we know that chronic pain can have significant impacts on warrior's overall physical and mental health.

Warriors also have difficulty effectively managing their pain. While over 50% of WWP warriors report taking prescription pain medication to treat or manage their pain, most are not finding their pain management options effective. Over half who reported pain in the past three months say that they were "only a little effective" or "not at all effective" in managing their pain.

Similarly, post-traumatic stress disorder (PTSD) affects a majority of WWP warriors. Approximately 3 in 4 report experiencing PTSD and PTSD is associated with higher rates of suicidal thoughts among WWP warriors. With so many warriors experiencing PTSD and many facing significant barriers to accessing mental health care, finding additional modalities of treatment has the potential to save lives. And as veterans seek out alternative treatments for their mental or physical health needs, it is imperative that their decisions can be informed by quality research and transparent discussions with medical providers.

The *Veterans CARE Act* would direct the Secretary of the Department of Veterans Affairs (VA) to promote medical research into the safety and efficacy of medicinal cannabis usage on veterans diagnosed with PTSD, chronic pain, and other illnesses and injuries. The bill would also require reports to Congress on how they plan to conduct and support the research and implementation.

Wounded Warrior Project believes that choosing an alternative treatment is a personal decision that should be made between a warrior, his or her family, and his or her medical team. We also support warriors having access to evidence-based and evidence-informed therapies, as well as complementary and alternative therapies, that have proven to be effective in rehabilitation and recovery. As several early studies have shown promising results for veterans using cannabis to treat conditions like chronic pain [2], WWP supports continued research in this field and the passage of the *Veterans CARE Act*. As deliberation over this legislation continues, our support would extend to additional provisions that contemplate the legal ramifications (addressing protection or transparent communication) for patients, providers, and researchers who must consider other federal and state laws governing the use, possession, and transportation of cannabis, which remains a federally-classified Schedule I drug.

H.R. 3649, the *Veterans National Traumatic Brain Injury Treatment Act*

As noted above, PTSD continues to be one of the top reported service-connected challenges facing WWP warriors. Over 75% of warriors' self-report experiencing PTSD, a condition that often has an overall negative impact on an individual's daily activities and overall quality of life. Traumatic brain injury (TBI) is also extremely common among warriors and the broader post-9/11 veteran community. Inclusive of the 36.5% of WWP warriors who report experiencing a TBI in service, the Department of Defense reports that 492,167 Service members

[1] Figures associated with WWP warriors throughout this testimony are drawn from WWP's 2022 Annual Warrior Survey. A full copy of the report can be viewed at https://www.woundedwarriorproject.org/mission/annual-warrior-survey.
[2] *See, e.g.*, Marion McNabb et al., *Self-reported Medicinal Cannabis Use as an Alternative to Prescription and Over-the counter Medication Use Among US Military Veterans*, 45(6) CLINICAL THERAPEUTICS 562, 562-67 (2023).

were diagnosed with TBI between 2000 and 2023.[3] While TBIs can include a range of symptoms, warriors with a history of TBI generally report significantly lower overall physical and mental health in the present day.

The *Veterans National Traumatic Brain Injury Treatment Act* would establish a five-year pilot program at the Department of Veterans Affairs to supply hyperbaric oxygen therapy (HBOT) to veterans with traumatic brain injuries (TBI) or post-traumatic stress disorder (PTSD). The pilot program would be funded through a general fund of the Treasury, known as the "VA HBOT Fund" that is supplied solely by donations received for express purposes of the Fund.

Several recent studies have showed promising results in treating PTSD with HBOT. One trial found improved symptoms and functionality for veterans with treatment resistant PTSD that used HBOT.[4] Another review of pre-clinical and clinical trials found that HBOT can improve clinical outcomes of veterans with treatment resistant PTSD and found overall positive effects on PTSD symptoms.[5] Given these early signs of promise and frequent requests heard from warriors for access to HBOT, WWP supports the *Veterans National Traumatic Brain Injury Treatment Act*.

H.R. 5530, the *VA Emergency Transportation Access Act*

Among the critical health services that VA extends to enrolled patients is coverage of air ambulance services, and recent health care trends have highlighted the need for this service in rural areas. From 2010 to 2021, rural communities lost access to 136 rural hospitals[6] and residents in those areas with emergent needs (when time to treatment is critical) are more likely to be hours away from the most appropriate hospital or medical facility. Today, air ambulances and their crews are filling a critical gap by providing emergency transportation in those situations.

Unfortunately, the air ambulance industry has raised serious concerns about its ability to sustain and meet this demand because of low federal reimbursement rates. Currently, Medicare reimburses providers at less than 50 percent of the cost of transporting a patient, and Medicaid reimburses even less. In 2020, VA issued a proposed rule[7] to bring its reimbursement rates in line with the Centers for Medicare & Medicaid Services. In the time since, VA has proposed a final rule – consistent with its initial plan – to establish a new payment methodology for special modes of transportation available through the VA beneficiary travel and extended the effective date to February 16, 2025.[8]

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[3] DEF. HEALTH AGENCY, U.S. DEP'T OF DEF., *DoD TBI Worldwide Numbers*, https://health.mil/Military-Health-Topics/Centers-of-Excellence/Traumatic-Brain-Injury-Center-of-Excellence/DOD-TBI-Worldwide-Numbers (last visited Mar. 18, 2024).
[4] Keren Doenyas-Barak et al., *Hyperbaric Oxygen Therapy Improves Symptoms, Brain's Microstructure and Functionality in Veterans with Treatment Resistant Post-traumatic Stress Disorder: A Prospective, Randomized, Controlled Trial*, PLOS ONE (Feb. 2022), *available at* https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0264161.
[5] Keren Doenyas-Barak et al., *The Use of Hyperbaric Oxygen for Veterans with PTSD: Basic Physiology and Current Available Clinical Data*, FRONT NEUROSCI.(Oct. 2023), *available at* https://www.frontiersin.org/journals/neuroscience/articles/10.3389/fnins.2023.1259473/full..
[6] AMERICAN HOSP. ASS'N, RURAL HOSPITAL CLOSURES THREATEN ACCESS: SOLUTIONS TO PRESERVE CARE IN LOCAL COMMUNITIES (Sep. 2022), *available at* https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf.
[7] Changes in Rates VA Pays for Special Modes of Transportation, 85 Fed. Reg. 70,551 (Nov. 5, 2020) (to be codified at 38 C.F.R. pt. 70).
[8] Changes in Rates VA Pays for Special Modes of Transportation, 88 Fed. Reg. 90,120 (Dec. 29, 2023) (to be codified at 38 C.F.R. pt. 70).

While the House Report to the Consolidated Appropriations Act of 2024 (P.L. 118-42; H.Rept. 118-122) directs VA to "expeditiously contract with providers of special modes of transportation at fair and appropriate reimbursement rates to provide certainty about payments and ensure the availability of ambulance services," WWP supports the enhanced measures outlined by the *VA Emergency Transportation Access Act*. This bill would direct more specific action for VA to take before the agency can change the rate of payment or reimbursement for air ambulance services. Although we encourage expeditious consideration of this legislation, we appreciate Congress and VA actions to date to prioritize this issue and remain transparent with veteran service organizations and industry stakeholders.

H.R. 6373, the *Veterans Spinal Trauma Access to New Devices (STAND) Act*

Currently, there are an estimated 42,000 veterans living with chronic spinal cord injury (SCI) in this country and more than 11 percent of military personnel injured in Operation Iraqi Freedom and Operation Enduring Freedom have a SCI.[9] Among WWP warriors, 16.4% self-report living with a SCI as a result their service. Living with these injuries can have long-term effects on veterans physical and mental health and often have a serious impact on their quality of life.

The *Veterans STAND Act* would provide annual preventative health evaluations to veterans with a SCI to help increase access to prosthetic equipment and assistive technologies that could help maximize the independence and mobility of veteran. The bill would also require VA to conduct outreach to veterans, consult with assistive technology experts when developing or changing pertinent guidance, and report to Congress regarding the extent to which veterans are being prescribed and are using personal exoskeletons issued by VA.

As exoskeleton devices and other assistive technologies can be lifechanging for veterans with SCI, this bill will help to ensure that veterans living with these conditions have access to the best technology available to help improve their quality of life. WWP supports these efforts to expand access to assistive technologies and specifically the *Veterans STAND Act*.

H.R. 3303, the *Maternal Health Care for Veterans Act*

Maternal morbidity and mortality outcomes hold significant relevance for women veterans due to their unique healthcare needs and experiences, and severe maternal morbidity affects a significant number of women veterans.[10] VA notes that veterans using VA-covered maternity care are a high risk population and have elevated rates of pregnancy complications and adverse maternal and infant outcomes compared to the general population.[11] High rates of mental health problems, hypertension, obesity, and maternal conditions have been noted among

[9] Denise C Fyffe et al., *Spinal Cord Injury Veterans' Disability Benefits, Outcomes, and Health Care Utilization Patterns: Protocol for a Qualitative Study*, J. MED. INTERNET RESEARCH, RESEARCH PROTOC. (Oct. 2019), *available at* https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6800461/.
[10] Joan L. Combellick et al., *Severe Maternal Morbidity Among a Cohort of Post-9/11 Women Veterans*, 29(4) J. Womens Health 577, 755-84 (2020).
[11] U.S. DEP'T OF VET. AFFAIRS, *VA Pregnancy and Maternity Care Research* (Jan. 2023), https://www.hsrd.research.va.gov/centers/womens_health/Pregnancy-Maternity-Care-Research-Snapshot2023.pdf.

women veterans who experienced severe maternal morbidity events.[12] These and other factors can impact their reproductive health and increase their vulnerability to maternal morbidity complications during pregnancy and childbirth.

Fortunately, Congress recently codified VA's Maternity Care Coordination program with the *Protecting Moms Who Served Act* (P.L. 117-69) and provided $15 million in initial funding. This program manages the maternity care coordination position at VA, a multifaceted role that supports pregnant women veterans as a liaison between the patient, the non-VA provider, and the VA facility through monitoring the delivery and coordination of care and tracking outcomes of services related to maternity care. The *Maternal Health Care for Veterans Act* would reauthorize funding for the Maternity Care Coordination program at the same authorized funding level of $15 million per year for the next five fiscal years. The *Maternal Health Care for Veterans Act* also requires VA to provide an annual report to Congress through FY 2028 on its activities and use of funds relating to the coordination of maternity health care.

Wounded Warrior Project believes that women veterans should have equitable access to quality, gender specific health care through VA services, including for pregnancy and maternal health. With research suggesting that maternal morbidity and mortality rates are at increased risks for women veterans, there is an urgency to this issue to support the passage of the *Maternal Health Care for Veterans Act*.

H.R. 5247, the *Expedited Hiring for VA Trained Psychiatrists Act*

One of WWP's legislative priorities is to continue to support VA workforce improvements by supporting policies that allow VA to recruit and retain high-quality talent to improve veterans' experiences at VA and improve their health outcomes. Recently, we have seen strong hiring at VA, with both the Veterans Benefits Administration (VBA) and the Veterans Health Administration (VHA) employing at record levels, thus allowing them to deliver more critical benefits and services than ever before.[13] However, there are still critical areas with serious staffing shortages that urgently need to be addressed.

Unfortunately, the mental health field is one of these areas, with both VA and the nation facing a shortage of mental health care providers. According to VA's Office of Inspector General, in Fiscal Year 2023, social work, psychology, and psychiatry remained among the most frequently reported occupations with severe shortages across VA nationwide.[14] Troublingly, 74 facilities reported severe shortages for social workers, 91 facilities reported severe shortages for psychologists, and 73 reported severe shortages for psychiatrists.[15]

The *Expedited Hiring for VA Trained Psychiatrists Act* would work to address this issue by speeding up the hiring process for psychiatrists who train at VA facilities. Specifically, the bill authorizes VA to hire psychiatrists who completed their residency at a VA facility –

[12] Ceshae C. Harding et al., *Maternal Chronic Hypertension in Women Veterans*, 59(4) HEALTH SERVS. RESEARCH (2024), *available at* https://onlinelibrary.wiley.com/doi/epdf/10.1111/1475-6773.14277.
[13] Press Release, U.S. Dep't of Vet. Affairs, VA Sets All-Time Records for Care and Benefits Delivered to Veterans in Fiscal Year 2023 (Nov. 6, 2023), *available at* https://news.va.gov/press-room/va-all-time-record-care-benefits-veterans-fy-2023/.
[14] OFF. OF INSP. GENERAL, U.S. DEP'T OF VET. AFFAIRS, OIG DETERMINATION OF VETERANS HEALTH ADMINISTRATION'S OCCUPATIONAL STAFFING SHORTAGES FISCAL YEAR 2023 6 (Aug. 2023).
[15] *Id.*

immediately after their residency is completed – without regard to civil service or classification laws. This will result in a shortened hiring process for a field that is critically needed at VA, allowing VA to fill positions more quickly and offering a further incentive to psychiatrists that may be interested in working at VA but are lured into private practices that may have less onerous bureaucratic hiring requirements. At least some veterans will benefit from continuity of care as residents are retained, and more stand to gain from the military cultural competence those providers developed over the course of their residency.

Wounded Warrior Project appreciates the attention to this critical issue as we work to improve access to quality mental health care for all veterans. We support the *Expedited Hiring for VA Trained Psychiatrists Act* and encourage continued investment in the VA workforce at large.

CONCLUSION

Wounded Warrior Project once again extends our thanks to the Subcommittee on Health for its continued dedication to our nation's veterans. We are honored to contribute our voice to your discussion about pending legislation, and we are proud to support many of the initiatives under consideration that would enhance veterans' access to care and support. As your partner in advocating for these and other critical issues, we stand ready to assist and look forward to our continued collaboration.

Prepared Statement of Association of Air Medical Services

Association of Air Medical Services
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Alexandria, VA 22314
703-836-8732

STATEMENT FOR THE RECORD
Association of Air Medical Services
For the: House Veterans' Affairs Committee, Subcommittee on Health
On Pending Legislation
March 21, 2024

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the Subcommittee, the Association of Air Medical Services (AAMS) fully supports H.R. 5530, the *VA Emergency Transportation Access Act*, which is set for a hearing on March 21, 2024. On February 16, 2023, the VA published a final rule that would establish a new payment methodology for ambulance services (AP89-Change in Rates VA Pays for Special Modes of Transportation) in which the Veterans Health Administration (VHA) would pay the lesser of the actual charge for ambulance transportation or the Medicare rate, unless the VA has entered into a contract for that transportation.

AAMS, alongside a coalition of other organizations, has shared with both Congress and VA the negative impact this rule will have on access to emergency ambulance services for Veterans and their communities, particularly those in rural and underserved areas. AAMS is grateful to VHA for delaying the effective date of this rule until February 16, 2025, while VHA considers a new contracting process for air ambulance services. However, AAMS remains concerned that VHA's contract proposal is both unworkable and insufficient to preserve the access to ambulance services currently available for our nation's Veterans and the communities in which they live. The most recent proposal will only allow for a contracted rate for emergency transports initiated by VHA for transports to and from a VA facility. However, air ambulance providers report that VHA-initiated emergency air ambulance transports represent a very small percentage (less than 5%) of Veteran transports, limiting the applicability or benefit of VHA's proposed contract process.

H.R. 5530 is essential in protecting access for Veterans, especially in rural and highly rural areas. H.R. 5530 will ensure that VHA does the appropriate economic analysis and review of effects of the rule change on Veteran access. Further, H.R. 5530 requires the VHA to work with the industry experts, CMS, and Veteran Service Organizations on a workable solution, and develops and implements a workable contracting process. These commonsense actions will prevent the drastic erosion in access to emergency air ambulance services that will occur after February 16, 2025, if the final rule for special modes of transport is implemented in its current form. AAMS remains committed to meaningful engagement with VHA to resolve this issue to ensure continued Veteran access to emergency services and critical care.

Based on air ambulance cost and reimbursement data collected and analyzed by a reputable third party[1], Medicare rates significantly undercompensate for air ambulance transports, covering just over half of the associated costs in 2017. Should VHA move its reimbursement for air ambulance transports to parity with the Ambulance Fee Schedule, air medical providers will not be able to cover the costs of operating air medical bases, which will lead to air ambulance base closures and a reduction of ground ambulance services. Such a reduction in services will reduce access to emergency air and ground ambulance services for our nation's Veterans, as well as their neighbors in the communities in which they live.

We are grateful to Chairman Bost and the robust bipartisan group of Representatives who have recognized the negative impact of this rule. We applaud the Chairman for introducing H.R. 5530 and we appreciate all Representatives who have joined as cosponsors.

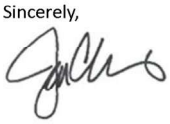
H.R. 5530 protects access to ambulance services by requiring the VA to engage with air ambulance providers, CMS, and VSOs and evaluate the effects on access to such services before proposing reductions in reimbursement to emergency transportation services. By requiring the VA to consult air and ground ambulance services and Veteran Service Organizations for stakeholder input, H.R. 5530 ensures that the VA considers all available information that is relevant to the effects of any reduction in reimbursement to emergency transportation services. Importantly, while H.R. 5530 does not prohibit the VA from making reductions in reimbursement, it includes a backstop ensuring that any reduction must still cover the basic costs of providing this lifesaving service and requires any change in rates to take place after careful consideration of cost data.

AAMS is joined in support of H.R. 5530 by the attached list of organizations. We urge all VA Committee members to support H.R. 5530 and move this bill towards passage by the House of Representatives.

Background information:

AAMS is the international trade association that represents over 93 percent of air ambulance providers in the U.S. Together, our more than 150 members operate over 1,000 helicopter air ambulances and 200 fixed-wing air ambulance services across the U.S. AAMS represents every emergency air ambulance care model, including aircraft based at hospitals, independent aircraft at bases in rural areas far from hospitals, and many hybrid variations.

Sincerely,



Jana Williams
President & CEO
Association of Air Medical Services

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[1] "Air Medical Services Cost Study Report"; March 24, 2017; Xcenda

Appendix 1—Supporting Organizations

- Association of Air Medical Services (AAMS)
- American Ambulance Association (AAA)
- Association of Critical Care Transport (ACCT)
- Wounded Warriors
- Jewish War Veterans
- American Legion
- Disabled American Veterans
- Paralyzed Veterans of America
- VFW
- International Association of Fire Chiefs (IAFC)
- International Association of Fire Fighters (IAFF)
- International College of Advanced Practice Paramedics (I-CAPP)
- National Association of Emergency Medical Technicians (NAEMT)
- Helicopter Association International (HAI)
- Arizona Association of Air Medical Services (AzAAMS)
- California Association of Air Medical Services (Cal-AAMS)
- Kentucky Air Medical Association (KAMA)
- Michigan Association of Air medical Providers (MAAP)
- Texas Association of Air Medical Services (TAAMS)
- Indiana Association of Air Medical Services (INAAMS)
- Northwest Association of Aeromedical Responders (NWAAR)
- Air Methods Corporation
- Global Medical Response
- PHI Health
- Life Flight Network
- Enterprise Rescue (Alabama)
- Airbus
- Leonardo
- Bell-Textron

Statement for the Record
Jewish War Veterans of the USA
H.R. 5530 Veterans Emergency Transportation Access Act of 2024
Before the House Veterans Affairs Committee
Subcommittee on Health
March 21, 2024

Presented by

Kenneth Greenberg
National Executive Director

Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the House Veterans' Affairs Subcommittee on Health, the Jewish War Veterans of the U.S.A. (JWV) strongly supports and calls for the enactment of H.R. 5530, *The Veterans Emergency Transportation Access Act*. JWV thanks Chairman Bost for introducing the bill on September 18, 2023.

H.R. 5530 is a commonsense bipartisan approach that, if passed, would require the Department of Veterans Affairs (VA) to conduct a rigorous review process and consult with stakeholders in a meaningful way before proceeding with any reimbursement changes. JWV encourages the Committee and Congress to pass H.R. 5530 to ensure veterans have access to lifesaving air and ground ambulance transport.

Background

VA Final Rule Cuts Emergency Medical Air Transportation Reimbursement Rates Putting Veterans at Risk

JWV has led the fight in the Veteran Service Organization (VSO) community on VA's proposed rule (RIN 2900-AP89, Change in Rates VA Pays for Special Modes of Transportation) that cuts the VA reimbursement rate for emergency air medical services to below the costs of the services themselves. As published, it would put more than 2.7 million rural veterans in our country who are enrolled in the VHA, and 4.8 million rural veterans overall, at risk of losing life-saving emergency air transportation.

When VA published the final rule on February 16, 2023, they made no changes but did delay the effective date to February 16, 2024. The final rule would cause emergency air medical bases around the country to shut their doors, halting services to veterans. On December 29, VA published in the Federal Register a delay in the effective date to February 16, 2025, due to tremendous pressure from Congress and the VSO community. JWV appreciates the delay but remains concerned about the continued misunderstanding by the VA of how many Veterans receive emergency air medical care to and from non-VA facilities.

JWV is pleased that the FY2024 MILCON/VA Appropriations Act included language confirming; *the Departments actions to postpone the final effective date for reimbursement rates for ground and air ambulance services. Before modifying these rates in accordance with the new timeline, the Department is directed to communicate directly with service providers to fully understand the impact of the proposed rule change on veterans. Further, the Department should identify staff dedicated to facilitating contracting with providers of these services at fair and appropriate reimbursement rates, to include providing technical assistance on the contracting process, and to provide support for entities who are beginning the contracting process for the first time. The agreement directs the Department to report back to the Committees on Appropriations of both Houses of Congress no later than 90 days after enactment of this Act on the feedback received from industry stakeholders and its plan for ensuring zero harm to veterans.*

JWV applauds Committee leadership for their support in getting this included in the Appropriations Act.

Passing H.R. 5530, *The Veterans Emergency Transportation Access Act*, will codify the FY 2024 MILCON/VA Appropriations Act requirements. JWV looks forward to working together to hold VA accountable and seek alternative workable solutions before the final rule becomes effective on February 16, 2025.

JWV thanks the subcommittee for the opportunity to submit this statement in support of H.R. 5530. JWV also appreciates the open dialogue available with the members of Subcommittee on Health as well as the support of the hard-working committee staff on both sides of the aisle.

About the Jewish War Veterans of the USA

The Jewish War Veterans of the U.S.A. (JWV) was founded in 1896 and was Congressionally chartered August 21, 1984. JWV advocates for all veterans regardless of their religion, heritage, or period of service. JWV is the longest serving Veterans Service Organization (VSO) in the country and celebrated its 128th anniversary on March 15, 2024. JWV's mission message is strong and clear: fighting for military and veterans benefits and services; advocating on their behalf with Congressional officials, Executive Branch departments and the White House; and continuing to combat antisemitism, bigotry and hate wherever and whenever it occurs.

Jewish War Veterans
of the United States of America

Founded in 1896

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JWV is A Jewish Voice for Veterans and a Veteran's Voice for Jews

Prepared Statement of Military-Veterans Advocacy

Military-Veterans Advocacy

Written Testimony/Statement in Support of HR 3649
Veterans National Traumatic Brain Injury Treatment Act

Submitted to the United States House Veterans Affairs Committee
Subcommittee and Health
March 21, 2024

Commander John B. Wells, USN (Ret)
Chairman

Introduction

Distinguished Chairwoman Marinnette Miller-Meeks and Ranking Member Julia Brownley and other members of the Committee, thank you for the opportunity to present the views of Military-Veterans Advocacy® (MVA™) on our legislative priorities.

The number of veterans personnel suffering from service-connected Traumatic Brain Injury (TBI) has ballooned, in part because of a realization that the disability exists as well as improved diagnostic capabilities has increased awareness. Unlike Post Traumatic Stress (PTS), which is a psychological injury, TBI represents physical damage to the brain. Unfortunately, the Department of Veterans Affairs has turned to numbing and often dangerous opioids for treatment. This problem is complicated by the lack of understanding of the physiological effects of TBI.

About Military-Veterans Advocacy®

Military-Veterans Advocacy Inc.® (MVA™) is a tax-exempt IRC 50l[c][3] organization based in Slidell, Louisiana that works for the benefit of the armed forces and military veterans. Through litigation, legislation, and education, MVA™ seeks to obtain benefits for those who are serving or have served in the military. In support of this, MVA™ provides support for various legislation at the State and Federal levels as well as engaging in targeted litigation to assist those who have served. We currently have over 1100 proud members. In 2022, our volunteer board of directors donated almost 9500 hours in support of veterans. MVA™ analyzes and supports/opposes legislation, assists Congressional staffs with the drafting of legislation and initiates rule making requests to the Department of Veterans Affairs. MVA™ also files suits under the Administrative Procedures Act to obtain judicial review of veterans' legislation and regulations as well as *amicus curiae* briefs in the Courts of Appeal and the Supreme Court of the United States. MVA™ is also certified as a Continuing Legal Education provider by the State of Louisiana to train attorneys in veterans' law.

MVA™ is composed of six sections: At-Risk Veterans, Blue Water Navy, Agent Orange Survivors of Guam, Veterans of Southeast Asia, Veterans of the Panama Canal Zone and Veterans of Okinawa. We are a member of the TEAMS Coalition, the Foundation for Veterans Outreach Programs and other working groups. MVA™ works closely with Veterans Service Organizations including the United States Submarine Veterans, Inc, the National Association of Atomic Veterans, Veterans Warriors, and other groups working to secure benefits for veterans.

Military-Veterans Advocacy's® Chairman, Commander John B. Wells USN (Ret.)

MVA™'s Chairman, Commander John B. Wells, USN (Retired) has long been viewed

as the technical expert on herbicide exposure. A 22-year veteran of the Navy, Commander Wells served as a Surface Warfare Officer on six different ships, with over ten years at sea. He possessed a mechanical engineering subspecialty, was qualified as a Navigator and for command at sea and served as the Chief Engineer on several Navy ships.

Since retirement, Commander Wells has become a practicing attorney with an emphasis on military and veteran's law. He is counsel on several pending cases concerning herbicide and other toxic exposures. Commander Wells was the attorney on the *Procopio v. Wilkie* 913 F. 3d 1371 (Fed. Cir. 2019) case that extended the presumption of herbicide exposure to the territorial sea of the Republic of Vietnam, which laid the groundwork for the Blue Water Navy Vietnam Veterans Act. He strongly supported, both in Congress and the courts, the extension of the herbicide presumption and to cover veterans in Thailand, Guam, American Samoa, and Johnston Island. He also initiated successful judicial review of the Appeals Modernization Act with a favorable outcome. *MVA v. Secretary of Veterans Affairs*, 7 F.4th (Fed. Cor. 2021). Since 2010 he has visited virtually every Congressional and Senatorial office to discuss the importance of enacting veterans' benefits legislation. With the onset of covid, Commander Wells has conducted virtual briefings for new Members of Congress and their staffs. His curriculum-vitae is attached.

HR 3649

Veterans National Traumatic Brain Injury Treatment Act

MVA™ has long supported the use of HBOT to treat Traumatic Brain Injury. There is an increasing body of evidence that show HBOT is an effective HR 3649 will direct the Secretary of Veterans Affairs to establish a pilot program to furnish hyperbaric oxygen therapy (HBOT) to a veteran who has a traumatic brain injury (TBI) and there are positive indications associated with this treatment. Our interviews with MVA™ members who served in combat or in Special Operations also point to an affirmative correlation between HBOT and TBI. We believe that HBOT could potentially allow for a more successful treatment pathway for these invisible wounds.

As the VA possesses this equipment for wound and burn treatment cost should be negligible. The HBOT process has been very successful in treating wounds, amputations and burns. TBI is just another wound – in this case to the brain. The brain is another organ susceptible to this type of treatment.

Granted some studies claim there is not sufficient evidence to confirm the effectiveness of HBOT for TBI. The VA, as they do with anything they do not want to do, embraced the "not sufficient evidence" argument. Additionally, many of the lukewarm studies have ties to "Big Pharma "who profit from the sale of the opioids.

Always mendacious, the VA decided to conduct a "pilot program" using HBOT to treat PTS. This is a program doomed to failure since PTS is a psychological injury - not a physical one. Accordingly HBOT will have little if aby effect on PTS. Whether the VA launched this program in a malicious attempt to taint HBOT or just does not understand the difference

between TBI and PTS is an open question. At best, MVA believes that the VA's rejection of this treatment protocol is negligent and constitutes malpractice. Our veterans deserve better..

Take the case of Sgt. Major Jim Kuiken, USMC (retired). Jim was involved in several explosive injuries and was diagnosed with TBI by private medical groups. The VA, despite Jim's 8 months of rehabilitation n in a military hospital and his purple heart termed his TBI not service connected. Jim sought assistance from a private non-profit who referred him for HBOT treatment. Despite receiving only 20 of the 60 prescribed treatments, Jim noted major improvements in his memory and other cognitive abilities.

HBOT calls for the application of 100% pure oxygen 11/2 atmospheric pressure. The treatment oxygenates the cells and regenerates them is the same way cells are regenerated to repair wounds and amputations. The question that must be raised is "Why not require a pilot program to use a proven treatment method to heal a wounded organ?" In other words, what harm can come of this? It is well settled that oxygen is good for the human body. Let's make this treatment available to our national heroes.

MVA™ urges the Subcommittee to favorably endorse HTR 3649.

Conclusion

On behalf of our membership, we would like to extend our thanks to the Chairwoman Ranking Members, and remaining Committee members for the opportunity to discuss our views.

Respectfully Submitted,

John B. Wells
Commander USN (retired)
Chairman

Prepared Statement of American Ambulance Association, International Association of Fire Chiefs and National Association of Emergency Medical Technicians

March 21, 2024

The Honorable Mariannette Miller-Meeks
Chairwoman
Committee on Veterans Affairs
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

The Honorable Julia Brownley
Ranking Member
Committee on Veterans Affairs
Subcommittee on Health
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Miller-Meeks and Ranking Member Brownley:

You have the full endorsement of our organizations in support of the VA Emergency Transportation Access Act (H.R. 5530). H.R. 5530 would protect access for veterans to essential 9-1-1 emergency and urgent interfacility ground ambulance services. Our organizations look forward to continuing to work with you to enact this bill into law.

Under the final rule entitled *Changes in Rates VA Pays for Special Modes of Transportation*, the Department of Veterans Affairs (VA) would reimburse for non-contracted ground ambulance services at the lesser of the actual charge or Medicare ambulance rates. As demonstrated by two Government Accountability Office reports and acknowledged by the Congress through legislating temporary add-on payments, Medicare rates are below the cost of providing ground ambulance services. Basing reimbursement on Medicare rates would deteriorate the ability of ground ambulance service organizations to provide critical and often lifesaving ground ambulance services to veterans and entire communities. We greatly appreciate the approach outlined in H.R. 5530 to protect ambulance access for veterans and establish a process to help ensure a more fair and equitable reimbursement rate.

The American Ambulance Association (AAA), International Association of Fire Chiefs (IAFC), and the National Association of Emergency Medical Technicians (NAEMT) represent the providers of vital emergency 9-1-1 and urgent interfacility ground ambulance services and the paramedics emergency medical technicians (EMTs) who deliver the direct medical care and transport for every community across the United States. Our paramedics, EMTs and firefighters are on the front lines of providing vital health care to our veterans.

We thank the Subcommittee for holding a hearing on the VA Emergency Transportation Access Act and highlighting ground ambulance service organizations, our paramedics, EMTs and firefighters and the veterans and communities we serve.

Please do not hesitate to continue to reach out to our organizations for our assistance in helping pass this important legislation.

Sincerely,

Randy Strozyk
President
American Ambulance Association

John S. Butler
President and Board Chair
International Association of Fire Chiefs

Susan Bailey
President
National Association of Emergency Medical Technicians