LEGISLATIVE HEARING

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS

U.S. HOUSE OF REPRESENTATIVES

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STATEMENTS FOR THE RECORD

LEGISLATIVE HEARING

TUESDAY, MARCH 11, 2025

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

The subcommittee met, pursuant to notice, at 2:15 p.m., in room 360, Cannon House Office Building, Hon. Mariannette Miller-Meek [chairwoman of the subcommittee] presiding.

Present: Representatives Miller-Meek, Murphy, Hamadah, King-Hinds, Brownley, Cherfilus-McCormick, Dexter, Conaway, and Morrison.

Also present: Representatives Deluzio, Womack, Underwood, Garcia, and Bacon.

OPENING STATEMENT OF MARIANNETTE MILLER-MEEKS, CHAIRWOMAN

Ms. MILLER-MEEKS. The legislative hearing of the Subcommittee on Health will now come to order. I would like to welcome all members and witnesses for today's hearing. We look forward to a very productive discussion on some impactful veterans legislation.

Today we will discuss 12 bills, including bills which would enable the U.S. Department of Veterans Affairs (VA) to enter into innovative public-private partnerships, research cutting-edge hyperbaric oxygen therapy, and provide some long overdue oversight of the VA's budget management. Also on today's agenda are four bills I have had the pleasure of introducing.

Before I discuss my bills, I would like to thank our witnesses again for being here today. I would like to especially thank Dr. Andrew Kozminski, who is the medical director of the Hyperbaric Medicine at my beloved University of Iowa. I had the pleasure of touring Dr. Kozminski's office a few months ago and learned about the incredible healing properties that hyperbaric oxygen therapies can provide. Dr. Kozminski, welcome to my office and I would like to look forward to hearing your thoughts about Dr. Murphy's bill, the Veterans National Traumatic Brain Injury Treatment Act.

Now to my bills. First, the Supporting Prosthetics Opportunities an Recreational Therapy (SPORT) Act. The SPORT Act would make sure athletic prosthetics are defined as medically necessary for amputee veterans. Every year in my district, severely disabled veterans gather to play golf. I am not a golfer except for miniature golf, but it is amazing to see how many sports, even golf can improve veterans' mental and physical well-being. I think all veterans

should be able to enjoy the benefits and camaraderie sports provide, and my legislation would achieve just that.

I am also proud to introduce the No Wrong Door for Veterans Act. This bill would reauthorize VA's successful Fox grant Program. Fox grants enable community organizations to provide services to veterans, screen them for suicidal ideation, and connect them with the VA so they can receive the mental health support that meets their individual needs. My bill would ensure organizations who have been successful in our mission to expand mental health can receive additional funds by partnering with the VA to reach even more veterans. The Fox Grant Program is a great example of public-private partnerships working for the better. House Republicans will continue to push the needle and protect programs like this one.

Next, I am proud to lead the Providing Veterans Essential Medications Act. This bill would allow the VA to provide very high-cost medications to severely disabled veterans receiving care at State veterans homes. VA pays for these medications for all other veteran patients, but antiquated laws require VA to pay State veterans home a fixed per diem, limiting their ability to provide for veterans who desperately need these medications while residing at a veterans home. Unfortunately, these high-cost medications can cost as much as $1,000 per day, meaning State veterans homes are not able to house many of our most deserving veterans. My bill would fix this clear mistake and ensure veterans with complex needs are cared for.

Ironically, the last bill I would like to mention is the Standardizing Treatment and Referral Times (START) Act. Far too often our veterans receive community care referrals that are only valid for a fixed period of time, but due to provider shortages and bureaucratic delays, veterans might not even get in until halfway through the authorized time period. My START Act addresses this issue by ensuring that the validity of the referral begins only once a veteran has attended their initial appointment. It is pretty common sense.

It is a privilege to collaborate on crafting impactful legislation for our veterans and to address critical issues in the delivery of their healthcare.

I would now like to turn to Representative Brownley for any opening remarks she may have. Representative Brownley, you are now recognized.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Madam Chair.

At the outset, I have to say I find it a bit crazy that we are having a legislative hearing today rather than an oversight hearing. The Trump administration's executive orders, mass firings of VA employees, reckless contract terminations, and $1 spending limit on purchase cards are causing significant upheaval within the Veterans Health Administration (VHA). That we are here today proceeding to consider new legislation as if these changes are not already significantly impacting veterans access to care is absurd.

Our time today would be much better spent examining the administration's plan to gut VA's workforce by 80,000 employees before September. This would be in addition to the 2,400 or more VA

employees who have already been terminated. Committee Democrats have already heard a multitude of instances of these terminations negatively impacting patient care, despite Secretary Collins insisting that they are not. The terminations that have already occurred include positions like procurement professionals who play a critical role in purchasing prosthetics and medical devices veterans need. We are aware of numerous VA medical facilities where such terminations have occurred.

Supply chain staff who are responsible for equipping surgical suites with necessary supplies, the committee has heard from several supply chain professionals who were terminated from the VA facilities in Florida, Texas, Oklahoma, and in California. Human resources professionals who are necessary for filling clinical staff vacancies. While clinical staff have largely been exempted from the Trump administration's hiring freeze, VA cannot efficiently fill clinical positions without human resources professionals. Psychology technicians at the Cleveland Veterans Affairs Medical Center (VAMC), who perform neuropsychological tests for individuals with neurological conditions, like strokes, Traumatic Brain Injury (TBI), Post-Traumatic Stress Disorder (PTSD), and concussions. Staff that perform, manage, and analyze mammogram results at the Hampton VAMC. One veteran whose mammogram was canceled due to a staffing shortage at the Hampton VAMC just found out the earliest she could reschedule her appointment elsewhere is June, 4 months from now. These are just a few examples that the committee has heard about from across the Nation.

Unfortunately, none of the bills we are considering today will address the very real threat to VA healthcare access, quality, and safety that veterans are facing. In just the last few days, my Democratic colleagues and I have received tens of thousands of emails from veterans across the country asking that we do all we can to stop the VA workforce cuts and eliminations of crucial contracts. I certainly hope that our Republican colleagues are receiving the same messages.

Veterans do not support these cuts. I would encourage the witnesses and members here today to keep in mind that if we continue to see efforts to dismantle VA by firing hardworking employees, canceling vital research, terminating healthcare contracts, and eroding veterans' trust in VA, it will not matter what excellent legislation we put forth. There will not be employees or even an infrastructure left at VA to implement these bills, and veterans' care will suffer because of it.

I would hope the chair shares these same concerns and I understand that we must protect the many VA employees that provide critical care to our Nation's veterans. However, I understand that despite what I have laid out today, we are here to consider legislation today on this committee.

I am pleased today's agenda includes my VA Marriage and Family Therapist Equity Act. I am also glad that a bill I am coleading with my friend from Texas, Congresswoman Garcia, the Women Veterans Cancer Care Coordination Act, is on the agenda. I look forward to hearing from our witnesses on all of the bills on today's agenda.

With that, Madam Chair, I will yield back.

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

We have a full agenda today, so I will be holding everyone to 3 minutes per bill to ensure we can move in a timely manner.

This morning we are joined by several of our colleagues who will speak in support of their bills. We appreciate the dedication to serving our Nation's veterans. With that, I ask unanimous consent that all non-subcommittee members be waived on to speak on their bills from the dais. Hearing no objection, we will move forward.

I now recognize Representative Womack for 3 minutes.

STATEMENT OF STEVE WOMACK

Mr. WOMACK. I thank the chairwoman.

Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished members of this subcommittee thank you for considering my bill, H.R. 1107, Protecting Veteran Access to Telemedicine Services Act of 2025. I also want to express my sincere gratitude for allowing me to speak in support of this legislation.

This bill aims to guarantee that our Nation's veterans, whether in bustling cities or remote rural areas, have continuous access to the healthcare services they need and deserve. The Ryan Haight Online Pharmacy Consumer Protection Act, enacted in 2008, was designed to regulate the prescription of controlled substances via telemedicine in response to the rise of online pharmacies and the risk of misuse. While this law plays a crucial role in protecting public health, it has not been updated to reflect the realities of 2025, nor does it account for the fundamental differences between the VA and civilian online pharmacies.

During the COVID–19 pandemic, the Ryan Haight Act's in-person consultation requirement for prescribing controlled substances was temporarily waived. The Drug Enforcement (DEA) and U.S. Department of Health and Human Services (HHS) later extended these flexibilities through the end of this year. My bill, the Protecting Veteran Access to Telemedicine Services Act of 2025, would make this exemption permanent for the VA, allowing VA healthcare professionals to prescribe medically necessary controlled substances via telemedicine under specific conditions. This exemption has been a lifeline for our veterans. Without it, many will face severe restrictions in accessing vital healthcare.

For veterans in urban areas, letting this exemption expire would mean longer wait times for in-person appointments, further straining an already overburdened VA healthcare system. The impact is even greater for veterans in rural communities where geographic isolation and limited healthcare providers create significant barriers. The exemption has allowed them to receive care from VA specialists hundreds of miles away without the burden of costly and time-consuming travel.

Continuing this exemption is not just a matter of convenience, it is a necessity. It ensures that every veteran, no matter where they live, has equal access to the care they have earned and deserve. I am honored to speak in support of this legislation today. I urge my colleagues to act swiftly in passing the bill. Our veterans have sacrificed so much for all of us. It is our duty to ensure they receive

the care they need in a way that meets the demands of today's world.

Madam Chairwoman, thank you for the time and a yield back my balance.

Ms. MILLER-MEEKS. Thank you very much. Representative Womack.

The chair now recognizes Representative Garcia for 3 minutes.

STATEMENT OF SYLVIA GARCIA

Ms. GARCIA. Thank you, Madam Chair. Thank you to the ranking member for giving me a few minutes to talk about my bill, the Women Veterans Cancer Care Coordinator Act. I am pleased to lead this bill with Ranking Member Brownley to improve the breast and gynecological cancer care that the VA provides to our heroines.

Every day, more and more American women sign up to serve in these U.S. military. As women sign up, the women veteran community also grows. In Fiscal Year 2000, women veterans made up just about 4 percent of all the veteran population. Today, they rank at about 11.3 percent, over 2.1 million women veterans nationwide. However, as the women veteran community ages, breast and gynecological care rates in this population will also increase. The VA responded to this need by establishing the Breast and Gynecological Oncology System of Excellence in late 2020, a program that ensures women veterans are getting the appropriate cancer care they deserve.

The VA also partners with community care providers to treat these veterans when the VA does not have the means to provide care. Now, that sounds great, but the system that we set up for women is not entirely working as it should. Veterans must navigate multiple facilities alone and ensure that providers communicate with the VA. The lack of coordination between both the VA and these providers lead to treatment delays, miscommunication, and unnecessary stress. Without a well-coordinated care team, a lot can go wrong. No veteran fighting cancer should struggle with red tape. They should be focused on getting better.

My bill will effectively address these challenges by creating dedicated regional cancer care coordinators at the VA. These professionals would guide veterans through their treatment journey, improve communication between the VA and community care providers, track patient progress, and address the existing delays in their care. These coordinators would also provide veterans with emergency health information and mental health resources to support their well-being.

I firmly believe that a grateful nation shows its gratitude in the care and benefits we provide to our heroines. Supporting our veterans is one of the solemn promises we have made, and it is a promise we must keep.

Thank you again, Madam Chairwoman, and, of course, to Ranking Member Brownley for support on this issue. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Garcia.

The chair now recognizes representative Dr. Murphy for 3 minutes.

STATEMENT OF GREG MURPHY

Mr. MURPHY. Thank you, Madam Chair. Thank you, Ranking Member Brownley.

Delighted for the second time to introduce my bipartisan bill, H.R. 1336, the Veterans National Traumatic Brain Injury Treatment Act, being discussed here today. It is long overdue that we do something further for our veterans who suffer from PTSD and TBI. Sadly enough, we lose 17, up to 22 veterans a day due to suicide, many who are suffering from TBI and PTSD.

I am a big fan and have been for over 30 years of the treatments of hyperbaric oxygen therapy. We have used this in surgical wounds for wounds that will not heal. It has enjoyed great success amongst many different maladies. It has been my own experience now in exploring this issue for TBI and PTSD that this is not only a viable but a very, very successful intervention.

I am going to introduce into the record a meta analysis study from National Institutes of Health (NIH). This was done in January to March 2020, which is an exhaustive list of mostly randomized double-blind control studies which shows great objective improvement for those veterans who have suffered from TBI and PTSD, not only in cognitive function but mood disorder. I ask this be submitted for the record.

This organization now, HBOT4Heroes in North Carolina, has successfully treated over 200 veterans who suffer from TBI and PTSD. We had a witness here before the executive director, Mr. Ed Di Girolamo, who gave very compelling testimony at a roundtable concerning alternative therapy specifically for Hyperbaric Oxygen Therapy (HBOT). My bipartisan bill sets up a pilot program for 5 years at three veterans service networks. Costs are borne by donations, not to the taxpayer, but by donations. The veterans service organizations are supportive, multiple, and listed here. We also have expert witness from Dr. Andrew Kozminski, an M.D. from the great University of Iowa, I think somebody went there or knows there, who is a Hyperbaric Oxygen (HBO) medicine specialist.

I have thought this through and through. I believe it is sad that we get our veterans when they hit the wall, when there is literally nothing else that the VA can offer that we are not offering this therapy to them. It is a proven alternative and a successful alternative. I will say it again, and I have said this before, I believe it is medical malpractice that is not being offered to our veterans at this point in time.

I thank you for your support. I would ask that this committee at some point review this favorably, bring this to the floor so that we can get our veterans the care that they need.

Thank you Madam Chairman. I will yield back.

Ms. MILLER-MEEKS. The chair now recognizes Representative Deluzio for 3 minutes.

STATEMENT OF CHRIS DELUZIO

Mr. DELUZIO. Thank you, Chairman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee. It is great to be back with all of you and appreciate your flexibility working with me and my team on my bill, considering this impor-

tant measure to reduce veteran suicide, Saving Our Veterans Lives Act of 2025. It is H.R. 1987.

I am proud to say this has been a bipartisan effort from the start. Although they are not here, I commend Representatives Fitzpatrick, James, and Landsman, alongside Senators King and Sheehy, and a wide variety of organizations who have come together and worked with me and others on such an important issue of veteran suicide.

This bill will create a program at VA to provide and distribute gun lockboxes to veterans, including those who are not enrolled with the Veterans Health Administration. This aspect of the bill is very important. Cited in VA's 2024 National Veterans Suicide Prevention Annual Report, the rate of veteran suicide is about 17–1/2 per day, and the majority of those come, those terrible deaths, from veterans outside of VHA. We have got to do a better job at reaching these veterans and connecting them with resources that could make a difference in their lives, and this bill will help bridge that gap.

That said, I have read the VA's testimony. I know VA recommends some changes in the bill text. I welcome amendments and working with the subcommittee and its members to make this legislation stronger so we can save more of my fellow veterans' lives from the scourge of veteran suicide.

Madam Chairwoman, thank you for your time and engagement. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Deluzio.

The chair now recognizes Representative Underwood for 3 minutes.

STATEMENT OF LAUREN UNDERWOOD

Ms. UNDERWOOD. Thank you, Madam Chair. As a nurse, I am really proud to be here to testify before you today on one of the first bills that I introduced in Congress with my friend Senator Duckworth, the Copay Fairness for Veterans Act.

While I currently sit on the Appropriations Committee, I have the honor of serving on the House of Veterans' Affairs Committee in the 116th and 117th Congresses. Our veterans are heroes who have given so much to our country, and serving veterans and their families is one of the greatest privileges we have as Members of Congress. At a time where research shows us that veterans face worse health outcomes than the general public and have higher burden of chronic diseases, no veteran should go without the ready access to preventive healthcare services that can improve their healthcare and quality of life. That is why my legislation would eliminate, once and for all, all of the financial barriers that could prevent veterans from accessing basic care.

Under the Affordable Care Act (ACA), almost all private health insurance plans are required to provide coverage of preventive services without charging copays. However, while most civilians have been able to access preventive services without copays for nearly 15 years thanks to the ACA, this same guarantee does not exist for our veterans, at least who get their healthcare through the VA. Despite their sacrifices and commitment to our country,

veterans are still at risk of being charged out-of-pocket costs for services like cancer screenings, mammograms, diabetes care, and screenings for depression and anxiety. That is just unfair. Luckily, friends, we can fix it.

My Copay Fairness for Veterans Act rights this wrong by eliminating out-of-pocket costs for veterans seeking the preventive services that they need and deserve at the VA. My bill will ensure that veterans are not charged copays for basic essential care, such as screenings for cancer, depression, anxiety, diabetes, and other diseases; interventions to prevent and treat heart disease; maternal healthcare and breastfeeding support for new moms; help with alcohol and tobacco abuse; well woman visits; and other critical healthcare services for veterans and their families.

I am proud to say that this bill is endorsed by the Disabled American Veterans (DAV) and the Minority Veterans of America, among others. Our veterans have earned the best, and I urge my colleagues on both sides of the aisle to support this critically important legislation.

Thank you, Madam Chair, for including this bill in today's legislative hearing. Thank you to our witnesses for being here. I yield back.

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

As is our practice, we will forego a round of questioning for the members. For those off committee members, you may stay around to ask questions of the witnesses if you have time.

Our first panel is already at the table. Thank you. Joining us from the Department of Veterans Affairs is Dr. Thomas O'Toole, the VA's deputy assistant under secretary for Health and Clinical Services for Quality and Field Operations. He is accompanied by Dr. Antoinette Shappell, VA's deputy assistant undersecretary for Health and Patient Care Services, and Dr. Thomas Emmendorfer, VA's executive director of Pharmacy Benefits Managers. Also on our first panel, we have Dr. Jeffrey Gold, president of the University of Nebraska System. Welcome, Dr. Gold.

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

STATEMENT OF THOMAS O'TOOLE

Dr. O'TOOLE. Great. Thank you and good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee. Thank you for inviting us here today to present our views on several bills that will affect Department of Veterans Affairs' programs and services. Joining me today are Dr. Antoinette Shappell, deputy assistant undersecretary for Health for Patient Care Services, and Dr. Thomas Emmendorfer, executive director of Pharmacy Benefits Management.

I joined the VA 19 years ago, leaving a senior position at a large academic health center to work at the VA Hospital in Providence, Rhode Island. The surge in deployments needed for the Iraq War was underway. We were seeing more and more veterans returning from the war needing our help, and it is a decision I have never regretted. I have been incredibly proud to work in the VA. Our commitment to mission, the professionalism and dedication of my colleagues, and the excellence in care and quality that VA provides

to our Nation's veterans defines us as an agency. Much of this has come from the strong partnership, guidance, and oversight we receive from Congress, and the thoughtfulness and intent of the legislation being discussed today reflects that. While the Department views are provided in detail in written testimony, I would like to highlight several bills in my opening remarks.

The No Wrong Door for Veterans Act makes several amendments to the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. VA strongly supports the intent in some of the amendments the bill would make, particularly extending the program through Fiscal Year 2028 and requiring grantees to inform individuals about emergent suicide care. However, we do have concerns about some of the bill's amendments and look forward to working with the subcommittee to address those further. This bill aligns with the Department's priority of reaching veterans at risk for suicide.

VA also supports the Standardizing Treatment and Referrals Act, or START Act. This bill ensures that the referral period for care from a non-VA provider begins on the date of the first appointment. VA supports this bill. However, we would like the opportunity to work with the subcommittee to ensure the text is clear and does not result in any unintended consequences.

VA strongly supports, we all support efforts to reduce veteran suicide. However, in its current writing, we do not support the Saving Our Veterans Lives Act. As written, the bill is overly broad and the resources needed to implement would significantly exceed the authorized appropriation of $5 million per year.

VA supports with amendments the Women Veterans Cancer Care Coordination Act and the Veterans Supporting Prosthetics Opportunities and Recreation Therapy Act. VA supports H.R. 217, the Communities Helping Invest through Property and Improvement Needs (CHIP IN) for Veteran Acts, which would allow VA to modernize infrastructure more efficiently and cost effectively. VA supports efforts to ensure veteran State homes are adequately supported in covering the costs of care for veterans.

Though we do not support the Providing Veterans Essential Medications Act, we would appreciate the opportunity to discuss this bill and VA's concerns with the committee. VA supports the Copayment Fairness for Veterans Act with amendments and subject to appropriations.

Regarding the Veterans National TBI Treatment Act, this bill requires VA to implement a pilot program for hyperbaric oxygen therapy, or HBOT, for veterans with TBI or PTSD. VA does not support this bill due to the lack of scientific evidence supporting HBOT for these conditions and we have concerns about the proposed funding mechanism. VA does not support H.R. 658, qualifications for marriage and family therapists. We defer to the Comptroller General regarding H.R. 1823, directing VA and the Comptroller General to report on certain funding shortfalls in VA.

Finally, VA does not have views on H.R. 1107, Protecting Veteran Access to Telemedicine Services of 2025, and we will provide these views in a letter to the subcommittee after the hearing.

This concludes my statement. We appreciate the continued support and oversight of the committee. My colleagues and I are pre-

pared to respond to any questions you or other members of the subcommittee may have about the legislation before us. Thank you.

[THE PREPARED STATEMENT OF THOMAS O'TOOLE APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you, Dr. O'Toole.

The chair now recognizes Dr. Gold for 5 minutes.

STATEMENT OF JEFFREY GOLD

Dr. GOLD. Thank you and good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, and other members of the committee and Congressman Bacon. I am Dr. Jeff Gold and I have the distinct privilege of serving as the president of the University of Nebraska System, which has campuses in Lincoln, Omaha, and Kearney, as well as a top-ranked academic medical center in Omaha. We educate approximately 50,000 students, do approximately $700 million in peer-reviewed medical research. I myself am a recovering pediatric heart surgeon by training, but for the last 10 years, prior to my current position, I had the privilege of serving as the chancellor of the University of Nebraska Medical Center.

For many decades, UNMC, University of Nebraska Medical Center, has had a broad and deep relationship with civilian and military Federal departments focused on training, research, and quality clinical care. However, over the past decade there has been intense multi-departmental focus with key partnerships in civilian and military Chemical, Biological, Radiological, Nuclear, and High-yield Explosives (CBRNE) global health security challenges.

Thank you for the opportunity to testify today to support Congressman Bacon's H.R. 217, which seeks to make permanent the CHIP IN for Veterans Act. This bill supports our service members through innovative and productive approaches to develop and finance VA facilities through public-private partnerships.

In 2016, Congressman Brad Ashford of Nebraska and Senator Deb Fischer were instrumental in passing this new legislation creating a unique pilot program that allowed public-private partnerships with the VA. This opportunity led to remarkable improvement in care for local veterans in our community, including the construction of a new ambulatory center that today serves as a key resource for outpatient diagnostic, procedural, and interventional veterans care services in the Nebraska Western Iowa region. This project was funded through Federal dollars and private philanthropic support, and has been recognized nationally as a true pillar of success.

However, at this time, the University of Nebraska Medical Center, one key of the University of Nebraska system, has identified a significant need to replace several of our own aging academic facilities on the Omaha campus, and among these projects is a forthcoming $2.19 billion project known as "Project Health". This will serve as a state-of-the-art medical facility with unique training opportunities focused on meeting Nebraska's growing need for medical professionals. This project will also provide access to high-quality advanced medical care, a unique interprofessional multidisciplinary learning environment, and access to life-saving clinical trials for patients across the State and in the region. Project HEALTH is a collaboration of the State of Nebraska, the city of

Omaha, the University of Nebraska, the Academic Medical Center and, of course, extensive participation by Nebraska's philanthropic community.

Therefore, we have proposed that the much needed replacement local VA hospital now be repositioned on the UNMC campus to better meet the needs of veterans in Nebraska and Western Iowa. This would be constructed to replace the aging facility currently in use on the VA campus. This new freestanding facility would be branded, staffed, and operated by the VA with physical connectivity to Project Health for potentially shared diagnostic, interventional, laboratory, and support services. This would also provide proximity for university clinicians and learners from UNMC and also remain open to staffing and training for other public and private academic medical center professional staff.

Leveraging private construction and adjacent resources significantly creates more cost-effective facilities and opportunities for renovating and replacing the existing VA hospital that was opened in 1950. Our approach is not only cost-effective, but also ensures that veterans will receive the highest standard of care by utilizing private sector construction efficiencies and philanthropic support. We can significantly reduce construction timelines and costs, ensuring timely delivery of quality services to those that have served our country.

Our community has demonstrated the potential of highly successful public-private partnerships, the Veterans Health Care and the CHIP IN Act born in your committee. This is just one example of proven success. By effecting the proposed partnership in Omaha, we together can set the standard for future care for those that have worn the cloth of our Nation and protected our freedom.

I thank you for your time and look forward to your question.

[THE PREPARED STATEMENT OF JEFFREY GOLD APPEARS IN THE APPENDIX]

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

The chair now recognizes General Bacon for 3 minutes to speak on his bill H.R. 217.

STATEMENT OF DON BACON

Mr. BACON. Thank you, Madam Chair. I appreciate the opportunity to advocate on this bill in the subcommittee and the bill is H.R. 217, Communities Helping Invest through Property and Improvements Needed for Veterans Act, otherwise known as the CHIP IN for Veterans Act.

This bill will make the current pilot program a permanent site. Chairman Bost has been out to our district and seen the new facility. I appreciate that Chairwoman Miller-Meeks has been out there. I invite the ranking member and, frankly, anybody that wants to go to Omaha to see literally one of the most beautiful VA facilities in the country, and it was done through this bill that was temporary that we would like to make permanent.

I also want to thank President Gold for being here and Ms. Sue Morris, who helps manage the philanthropic operation here to make this possible.

The CHIP IN for Veterans Act enables communities to take the lead, contribute resources, and complete VA construction projects

on time and in a cost-efficient manner, benefiting taxpayers, the communities, and, most importantly, our veterans. The Ambulatory Care Center in Omaha, Nebraska, was the first public-private partnership project for the VA. Now, I would like to get your attention on this because this is what makes this so important. The VA had budgeted this for $135 million. That was going to be the cost. The community doing with State and local financing and philanthropic, plus Federal, was able to do this for $85 million. Right away we saved $50 million for the taxpayer.

It gets even better. Out of that $85 million, $35 million came from not Federal sources; philanthropic, State, and local. In other words, this cost went from $135 million for the VA down to approximately $50 million. This is why this bill is so important. We can do this all over the country where folks want to donate and contribute and where states, local governments want to help.

Since the doors opened in August 2020, the Ambulatory Care Center has provided—cares for 31,744 patients and over 261,000 visits. Now, we want to replace the inpatient facility now. We already have approximately $100 million outside of the VA ready to invest in this facility. It will be a great deal for the VA.

Look forward to working with the committee to enact this legislation and with the Department of VA and the philanthropic community to bring this to fruition. Another innovative facility for the benefit of veterans across the country.

I yield back.

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

As is my typical practice, I will reserve my time until all other members have had a chance to ask their questions.

I now recognize Ranking Member Brownley for 5 minutes for any questions she may have.

Ms. BROWNLEY. Thank you, Madam Chair.

Dr. O'Toole, I am disappointed that the VA is opposing my bill, the VA Marriage and Family Therapist Equity Act. You know, VA is an outlier among its peers, including TRICARE, in terms of requiring licensed marriage and family therapists to have graduated from a Commission on Accreditation for Marriage and Family Therapy (MFT) Education program in order to be promoted within the VA. MFTs are among the occupations for which VA has been developing national standards of practice for the last several years. Perhaps you can reconsider this standard as part of that effort if it is still underway under the new administration. Can you share any updates on the National Standards of Practice Initiative?

Dr. O'TOOLE. Thank you, Chair—thank you, Congresswoman. The national standards work is ongoing. The intent behind that effort is to ensure that there is minimized variance across states in terms of accreditation and licensure.

The VA is very supportive of position of marriage and family therapists. We see it as an integral part of the VA. Our primary concern with this is that there are currently no statutory requirements for supervisorial roles in any of our Title 38 positions and our concerns with State variances that currently exist and how those supervisorial roles are supported. We are very open and would be happy to work with the subcommittee further to, you

know, further advance this legislation in a way that would work or that our rules would work.

Ms. BROWNLEY. Thank you for that. I mean, I just believe that this kind of clinician is so critically important to the veteran community. You know, for a while, we did not even accept marriage and family therapists. Now we do. In order to keep them, they have to have a road of opportunity to be promoted. I just think it is so many other states, TRICARE, so forth, does not require this. It requires another accreditation and it works pretty well. Anyway, I hope that you will continue to consider it because I think it is really, really important.

Next question I had is I wanted to talk a little bit about the VA and its undertaking to expand access to lockboxes and other suicide prevention tools for veterans. You know, I think Mr. Deluzio's bill is a good one, and I think we need to strengthen those efforts. Can you sort of expand on the lockbox distribution program that you are already providing?

Dr. O'TOOLE. Thank you, Congresswoman. To begin, we very much share the concerns about the need and the essential capacity of we have to be there to reduce veteran suicides. I can speak personally to having had patients who have died by suicide. I think all of us know, sadly, individuals who have family members who have friends who have died by suicide. This is an emergency.

Currently, the VA does have a lockbox program that began last year. It is run jointly between our Office of Suicide Prevention and the Prosthetics Department to provide lockboxes for veterans identified as part of a clinical encounter and clinical screening who are determined to have risk for suicide, moderate to high risk; who have access to firearms or peripheral access to firearms, meaning a member of the family or household has access to firearms. In which case they are provided a lockbox, which is a proven method of trying to create space between the impulsivity of wanting to commit suicide and having access to a lethal means.

Our concern with this bill is that——

Ms. BROWNLEY. I am not asking about the bill. I am asking about the program and what you are doing.

I want to know, it is my understanding that under the current program, lockboxes have to be requested by their provider. How would a veteran or their provider know this program is available?

Dr. O'TOOLE. Thank you, ma'am. We have an extensive education experience both to the veteran as well as to the provider to promote this program to both groups to try to, you know, encourage its application and use.

Ms. BROWNLEY. Okay. We know it is a good program. You have already said that it is a good program. I just, you know, it seems to me that making sure that any veteran who wanted a lockbox should receive a lockbox because there are many veterans out there where we might not know their situation or their vulnerabilities. I think it is important to do that.

I guess what kind of—oh, I have run out of time. I yield back, Madam Chair.

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

The chair now recognizes Representative Hamadeh for 5 minutes.

Mr. HAMADEH. Thank you, Chairwoman.

As an Army intelligence officer who served overseas, I understand firsthand the obligation we have to the those who wore our uniform. Our veterans deserve more than gratitude. They deserve action. That is why I am proud to support several of the bills before us today that will directly improve healthcare access and quality of life for veterans all across Arizona and our country.

My first question is for Dr. O'Toole. The alleged budget shortfall within the VA raises serious concerns about your organization's financial planning and resource allocation. Do you believe the VA should undergo an annual forensic audit?

Dr. EMMENDORFER. Thank you, Congressman. First, I just wanted to say thank you for your service in the military as well as here with us today.

On this particular bill, we do defer to the Comptroller General.

Mr. HAMADEH. What is their recommendation?

Dr. EMMENDORFER. By deferring, we are deferring to the Comptroller General on the forensic audit.

Mr. HAMADEH. Do you believe that having a forensic audit would give confidence to veterans and the taxpayers that their money is being spent wisely?

Dr. EMMENDORFER. I do appreciate the question, Congressman, but we would defer to the Comptroller General.

Mr. HAMADEH. Dr. O'Toole, the Parker Gordon Fox Suicide Prevention Grant Program has helped expand access to mental healthcare for veterans. In what ways has the program been most effective and how can it be further improved to ensure veterans and crisis receive timely mental healthcare?

Dr. O'TOOLE. Thank you, Congressman. This act has been serving our veterans very well, and we support many of the amendments, several of the amendments that are in the bill. The grant program in particular, we have found very helpful and has been very supportive. Four of the amendments in particular we are supportive of, including the extending the duration of the pilot program because of its successes; requiring grantees to inform individuals about their ability to receive emergency suicide care, which we currently do, but I think codifying it is going to be a strength; ensuring that eligible entities have provided mental healthcare and support for veterans over the—excuse me, support services in the U.S. for the previous 2 years, we feel strengthens it. There is some technical corrections as well we support.

The concern we have with this bill is the $500,000 cap and the $10,000 per grantee additional payment, which we think would be difficult logistically to manage in the context of how Federal grants are currently managed with providers in that form.

Mr. HAMADEH. Thank you. Going off of Congressman Bacon's comments earlier, it is a very impressive facility from what I see and I would like to visit that, Congressman.

My first question—or third question is to Dr. Gold. What were the biggest advantages of using the public-private partnership for the Omaha center project and how can this model be replicated across the country?

Dr. GOLD. Thank you for asking, sir. Of course, thank you for your service.

There are so many different advantages. One was to, of course, save a lot of money. What would have cost the VA $136 million ended up costing $56 million out of the VA budget.

Second was this project was finished not only exactly on budget, but ahead of schedule, which does not always happen in large Federal construction projects. At least that has been my multidecade experience. It also was able to bring to bear the experience that our university had with being part of this small, but very effective 501(c)(3) corporation, in that we have built lots of different healthcare facilities, ambulatory care centers, ambulatory surgery centers, and many other inpatient and out patient health care facilities, women's health centers, imaging centers, et cetera. Being able to bring all that to bear with the architects, the engineers, and with the construction contractors allowed us to accelerate the planning for the process in partnership with the local VA and deliver it on time and on budget.

Mr. HAMADEH. A truly, truly impressive project.

Dr. GOLD. It is a beautiful facility, an award-winning facility.

Mr. HAMADEH. Right. On time and under budget. That is pretty rare for the Federal Government.

I yield back.

Mr. BACON. Like $85 million under budget.

Ms. MILLER-MEEKS. Thank you very much, Representative Hamadeh.

The chair now recognizes Representative Cherfilus-McCormick for 5 minutes.

Ms. CHERFILUS-MCCORMICK. Thank you so much. I would first like to say thank you to our panelists for testifying today. Thank you for your dedication and service.

Dr. O'Toole, Representative Garcia's Women Veterans Cancer Care Coordination Act identifies the difficulties veterans face in navigating transitions to and from community care. For instance, I have heard of cases where medical records from community providers took weeks to return, delaying crucial treatment and causing unnecessary stress for the veterans and their families. No veteran should navigate their battle with cancer alone.

Dr. O'Toole, do you have—Dr. O'Toole, do VA hospitals need dedicated community care coordinators, teams, to help veterans navigate and keep contractors accountable?

Dr. O'TOOLE. Thank you, Congresswoman. First, we agree with you absolutely that no veteran, no person, should have to navigate the management of cancer by themselves. We strongly support the role of care coordinators in helping them both navigate the care within the VA and navigating the care in the community.

Ms. CHERFILUS-MCCORMICK. What is the impact to the veteran's care when there is not a seamless through line between community care and the VA?

Dr. O'TOOLE. The biggest challenge, Congresswoman. I think, as we would all acknowledge, is the concern about care falling through the cracks, not being communicated well to different providers who were involved in that care for the veteran, not knowing what was going on with their care. These are things that nobody should have to experience in their care journey.

Ms. CHERFILUS-MCCORMICK. Dr. O'Toole, my second question, having a regional breast and gynecological care cancer care coordinator for each Veterans Integrated Service Network (VISN) has the potential to save many lives if Representative Garcia's bill were to become law. However, I have deep concerns that Department of Government Efficiency (DOGE) may work to stop this position from being in existence. Over the weekend, the New York Times uncovered a horrifying consequence of DOGE's indiscriminate workforce cuts. The VA hospital employees responsible for enrolling veterans with throat cancer in an NIH clinical trial was fired. As a result, the clinical trial was put on hold and veterans with cancer were left without access to potential life-saving medication.

Dr. Gold, should we exempt clinical trial coordinators and the coordinator position established by the Women Veterans Cancer Care Coordination Act from DOGE's indiscriminate firing?

Dr. GOLD. There is no question that access to clinical trials is life-saving, particularly in cancer, but also in end stage congestive heart failure, in neurodegenerative diseases, and so many others. Our veterans should be afforded the very best quality care that our Nation can provide, which means they need to have access to all of those trials. In order to do that, we must have qualified personnel to enroll and to perform those trials and to monitor them.

Ms. CHERFILUS-MCCORMICK. You would recommend expanding the exemption to other areas and other positions, also?

Dr. GOLD. Access to clinical trials is absolutely state-of-the-art care and needs to be available to all patients in our Nation.

Ms. CHERFILUS-MCCORMICK. Do you believe VA's plan to lay off 83,000 workers will help facilitate veterans access to cancer care?

Dr. GOLD. I know that the staffing of any medical center, large or small, is what makes it work. Buildings are beautiful, the coffee shops are important, but at the end of the day, it is the doctors, the nurses, the pharmacists, and the therapists that make it all work. I also know that you need a critical mass of that workforce to make it successful.

Ms. CHERFILUS-MCCORMICK. Is that a yes or a no?

Dr. GOLD. Do you mind repeating your question?

Ms. CHERFILUS-MCCORMICK. Do you believe that VA's plan to lay off 83,000 workers will help facilitate the VA's access to cancer care?

Dr. GOLD. Without understanding the details of which 83,000 workers will be laid off, it is difficult to give you a specific answer. Anything that materially reduces the workforce will materially reduce access to care and quality of care.

Ms. CHERFILUS-MCCORMICK. I will take that as a yes. Well, thank you.

I would like to know that the VA research has led to the best treatment in the world when it comes to prosthetics, spinal cord injuries, and TBI. In addition, VA researchers also brought use of the pacemaker, nicotine patches, and aspirin as a method to preventing heart attacks. Attacks on these healthcare researchers and the VA affects every veteran in America, not just the veterans who are presently receiving care.

Thank you so much for your time. I yield back.

Ms. MILLER-MEEKS. Thank you very much, Representative Cherfilus-McCormick.

The chair now recognizes Representative King-Hinds for 5 minutes.

Ms. KING-HINDS. Thank you, Madam Chair.

My question is to Dr. O'Toole. I come from the territories and I just wanted to get your thoughts. Given that the Parker Gordon Fox Suicide Prevention Grant Program is designed to reach veterans who may not necessarily be engaged with the VA, how is the program ensuring that the resources are effectively reaching veterans in remote or underserved areas, such as U.S. territories, like the Commonwealth of the Northern Mariana Islands (CNMI)?

Dr. O'TOOLE. Thank you, Congresswoman. That is obviously of great importance. I think the intent and design of the grantee process is critical to that, to ensuring and both also our monitoring of grantees to ensure that that is appropriately managed and distributed to every veteran no matter where they live.

Ms. KING-HINDS. Okay. Then, in addition to that question, what strategies are in place to support community-based organizations in these areas that may lack the infrastructure or capacity to apply for and manage these grants effectively so that we do meet the mission of certain serving our veterans, especially in underserved, remote areas?

Dr. O'TOOLE. Thank you, ma'am. I would have to take the specifics of that response on the record and defer to our subject matter experts in that program. It is something, though, we fully agree with in terms of its importance.

Ms. KING-HINDS. Thank you, I appreciate that. I yield my time, Madam Chair.

Ms. MILLER-MEEKS. Thank you very much, Representative King-Hinds.

The chair now recognizes Dr. Dexter for 5 minutes.

Ms. DEXTER. Thank you, Chairwoman Miller-Meeks, and thank you to our witnesses for being here today and for your service to our veterans.

Although I am very grateful for the opportunity to consider this legislation before us today, I have to state the obvious. We are proceeding with business as usual when nothing about what is happening in the world is business as usual. In a matter of hours, everyone on this dais will leave this room to vote on legislation put forth by my Republican colleagues to cut nearly $23 billion in advance funding to ensure we can care for our veterans exposed to toxic chemicals in the line of duty. If that were not bad enough, that vote comes just days after we found out that Trump's team will fire an additional 83,000 VA workers on top of the 2,400 they have already stripped of their jobs, and return us to the staffing levels we saw before implementation of the Sergeant First Class Heath Robinson Honoring our Promise to Address Comprehensive Toxics (PACT) Act, the biggest expansion of veterans' benefits in generations.

Make no mistake, these firings are as good as a cut for veterans. Without those dedicated workers, our veterans will absolutely have trouble accessing the care and benefits they have earned, waiting longer for their claims to be processed, or, worse, not being able to

access new benefits at all. Look, I built a track record at the State level for being able to reach across the aisle. I absolutely want to get things done. Several of the bills before us—and several of the bills before us are good policy, whether it is ensuring veterans have access to essential medicines regardless of where they are cared for, improving care coordination for women veterans, or advancing cost-effective gun safety measures. I have serious doubts about our ability to implement any of these policies if the VA does not have the staffing or the funding that it needs.

I spent much of my professional career practicing as a physician at Kaiser Permanente in Oregon and served first as a board member and then as chair of the board. I understand intimately the challenges of running a large medical system.

I simply have a—I have a simple question for you, I hope, Dr. O'Toole. First, would it make it easier or harder to implement a new initiative at the VA if it were uncertain that the VA would be provided with the funding required to do so?

Dr. O'TOOLE. Thank you, Congresswoman. I am, you know, trying to fully, I guess, understand the question. Obviously, any bill that comes through, it helps to have the authorizations associated with that bill to be able to implement it.

Ms. DEXTER. Okay, thank you. Would it make it easier or harder to implement a new initiative at the VA if there were no staff to do so?

Dr. O'TOOLE. Thank you, Congresswoman. Again, you know, I think in—I am not—I would have to take for the record specifics related to, you know, current issues related to staffing and the staffing proposals underway. I think, in general, though, I think your question is rather self obvious.

Ms. DEXTER. Thank you. Following up on my colleague's questions regarding care coordination, do you have objective reasons to believe that care coordination within the VAMC, especially around cancer care, is superior to care outside coordination with our community care systems?

Dr. O'TOOLE. I would need to defer to our subject matter experts who have spent, you know, many of them have spent their careers studying differences in quality between the VA and care outside the VA. I have been very proud to be a clinician in the VA system and very proud of the care that we provide and the outcomes we provide. You know, it is not to say we could never do better. We always can. I think the role of care coordination, particularly in complex care that involves multiple providers, it has been well proven to be an important element of that care.

Ms. DEXTER. I absolutely agree with you having had access to care coordinators throughout my practice as well on lung cancer treatment.

I am going to ask, Madam Chair, if we can submit some studies for the record looking at the comparison of outside versus inside care, one of which is titled, "VA Delivered or VA Purchased Care: Important Factors for Veterans Navigating Care Decisions."

Ms. MILLER-MEEKS. No objection.

Ms. DEXTER. Thank you.

I just urge my colleagues to keep in mind the importance of this legislation. I certainly appreciate the work that folks are doing, but

that we cannot expect better care when we gut the system that has to deliver it.

With that, I yield back, Madam Chair.

Ms. MILLER-MEEKS. Thank you very much, Dr. Dexter.

The chair now recognizes Dr. Conaway for 5 minutes.

Mr. CONAWAY. Thank you, Madam Chair, and thank you, thanks to our witnesses for presenting themselves to us today and offering information on the bills at hand.

Mr. O'Toole, this question is, I think, directed at you. You are taking most of the incoming now, it seems. In the last Congress, the No Wrong Door Act was introduced to demonstrate improvements in veterans' mental health, a very critical issue. We are seeing, sadly, the number of suicides among that cohort going up. The updated version has changed that requirement that now grantees must show that funds are being used to assist a significant number of veterans. My concern is it went from showing that you have good outcomes to showing that you have, quote, unquote, "significant numbers of veterans" who are receiving assistance.

The question is, what does "significant" mean in that context? How do we measure it? When do people meet the bar?

Dr. O'TOOLE. Thank you, sir. That reflects similar concerns that we have to the construct of this bill. Absolutely, these pilot programs have made a difference and we are strong supporters of them. The bill as drafted and changing from the $750,000 grant amount to $500,000 with an additional $10,000 per individual served, we feel would create challenges and logistics to both how the grant would be administered, but also challenges to how we would be assessing performance of those grants.

We stand very much in support of this legislation and the intent of it. You know, I think we share the subcommittee's concerns and try to make sure we have the best bill going forward.

Mr. CONAWAY. I agree that the effort is more than worthwhile, the concerns that we are seeing among the veterans community and indeed mental health more broadly, and certainly would have a particular need and duty to provide that care to those who have given so much to our country.

Next, I want to address H.R. 1336, the Veterans National Traumatic Brain Injury Treatment Act. This bill aims to direct the Secretary of Veterans Affairs to establish a pilot program to provide hyperbaric oxygen therapy to veterans suffering from traumatic brain injuries or post-traumatic stress disorder. Indeed, we have seen studies in the traumatic brain injury space which suggests that the use of hyperbaric oxygen therapy would be really quite beneficial.

The VA conducted its own study and which showed, you know, great promise. Does the VA have any reservations regarding this pilot program and the potential impact of this therapy on veterans?

Dr. SHAPPELL. Thank you. Thank you for your question. VA shares your concerns. Mental health and suicide preventions are huge priorities for VA. We do not support this bill.

Our VA subject matter experts are continuously reviewing scientific literature and updating and publishing our clinical practice guidelines. Published results of the scientific rigorous research that has been done by VA and U.S. Department of Defense (DOD) re-

peatedly they have shown hyperbaric oxygen therapy has the same impact as a placebo.

Mr. CONAWAY. What is that? If you would speak into the mic, it would be very helpful.

Dr. SHAPPELL. Published studies——

Mr. CONAWAY. There you go.

Dr. SHAPPELL. Published results of the scientifically rigorous research that has been done by both VA and DOD has shown repeatedly that hyperbaric oxygen therapy has the same impact as placebo. There is no scientific basis to support the use of hyperbaric oxygen therapy for PTSD. There is strong scientific basis that hyperbaric oxygen therapy is not recommended for traumatic brain injury.

Mr. CONAWAY. We are looking at a study here on our desk that would suggest otherwise. It is an NIH study and certainly we do want to look at the preponderance of evidence across multiple studies. They are done, hopefully, according to the most rigorous standards. Therefore, if you do not like the hyperbaric oxygen as a treatment, could you suggest alternate therapies that—alternative therapies that we are perhaps not using now that ought to be deployed deal with these important conditions?

Dr. SHAPPELL. Thank you. As I mentioned, our subject matter experts are continuously reviewing scientific literature. I would be happy to provide you a review of other alternate therapies that we are currently considering.

Mr. CONAWAY. Great. Thank you, Madam Chair.

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

I now recognize General Bacon for 5 minutes for any questions you may have.

Mr. BACON. Thank you, Madam Chair, for the opportunity to be part of your subcommittee today. I would like to follow up with President Gold and some of his comments on the numbers because I think they are worthy of repeating.

What he said is that the VA—we saved the VA, or the Federal Government, approximately $80 million. What was going to cost the VA $135 million ended up costing the Federal Government $56 million. I think I got the numbers that you said right there.

President Gold, could you lay out what can we expect for the inpatient hospital, rough numbers? Like, what does the Federal Government or the VA think it is going to cost versus what we can probably build it at versus how much State and local philanthropic money we may get? We just want to show the benefit of this for our future facility.

Dr. GOLD. A great deal would depend upon how much shared services we are talking about. Certainly replacing inpatient med surg, critical care, and other bed space would be essentially at the standard construction rates for large, high-quality academic medical centers. However, a lot of the cost of construction in healthcare now really is not on the inpatient bed space, but it is in the extremely expensive equipment including diagnostics, procedural, and interventional space. Biplane fluoroscopy, for instance, some of the modern laparoscopic and endoscopic operating rooms, et cetera. Even in the ophthalmology world, the equipment has gotten incred-

ibly expensive with the operating microscopes interventional technology.

To the extent that some of that diagnostic and procedural space could be shared, some of the clinical and anatomic pathologies space, some of the imaging space, some of the—even some of the central sterile supply space that would need to be connected, shared parking, shared logistics, and infrastructure. Right now, the project is on the VA construction priority list, as, I believe, the number two priority for 2029 and, if I am correct, at $1.56 billion. I would estimate based on discussions with the local VA and VISN leadership, that we could probably save the Federal Government if we did this in a shared fashion and shared these types of resources, we estimate you could save a half a billion dollars to the taxpayers.

Mr. BACON. That is what I was waiting to hear.

Dr. GOLD. Well, it all depends on how much you saved due to shared very expensive space and equipment.

Mr. BACON. That is the savings right there. If I may ask our VA representatives, and I will defer to which one, could you talk about what this CHIP IN bill has done, what it means to you? I would love to get your perspective on this.

Dr. O'TOOLE. Thank you, Congressman. I think we are adding to the chorus, VA supports this bill. As you know, we were authorized as part of the pilot for up to five projects. Two have been undertaken, one completed in Omaha, as you have heard, and the hospital in Oklahoma is currently under construction. We do support this legislation.

Mr. BACON. With that, Madam Chair, I yield back.

Ms. MILLER-MEEKS. Thank you very much, General Bacon.

I now yield myself 5 minutes.

I am going to follow up on something Dr. Gold said, which is carrying the public-private partnership even beyond, i.e., sharing facilities, especially those expensive facilities, and sharing parking, and some people may be aghast at that. Dr. O'Toole, do not many VA hospitals, are not they staffed by people that have dual appointment between a medical center and a VA center?

Dr. O'TOOLE. Thank you, Congressman. Yes, actually we have a very deep academic partnership and footprint and particularly in our level 1A, 1B, and C facilities. I would note that 70 percent of doctors practicing in the United States all went through a veteran hospital as part of their training.

Ms. MILLER-MEEKS. As did I. Dr. Gold, the Omaha VA Ambulatory Care Center was completed a year ahead of schedule and over $40 million under budget thanks to the CHIP IN for Veterans pilot program. How did the VA's CHIP IN authorities foster such a successful public-private partnership?

Dr. GOLD. Thank you for the question. One of the biggest advantages that we shared was that we were able to plan this the way we would plan a commercial, large academic medical center clinic and then deliver it on a schedule that we would normally do it. Over my decade of leadership at the University of Nebraska Medical Center, we have done over a billion dollars of healthcare and academic construction and have never exceeded the budget and really never significantly exceeded the timeline, except minimally during the early months of the COVID–19 pandemic.

The construction standards are absolutely critical because of the penalties associated with going over budget and going over timeline. Anybody that has been involved with large academic medical centers understands that, that time is money for all of these types of projects. That type of precision was used through the 501(c)(3) and you will hear from Sue Morris in a little bit of how that actually worked. That type of precision was used in a very, very careful way to ensure we delivered this project.

Ms. MILLER-MEEKS. Thank you. It is one of the reasons we are hoping to make this permanent. For those who are interested, there is a pamphlet here that shows that clinic. It is quite outstanding.

Dr. O'Toole, the Parker Gordon Fox Suicide Prevention Grant has made tremendous progress in connecting veterans with timely mental healthcare in their communities. Why is it vital that we quit quickly reauthorize the program?

Dr. O'TOOLE. Excuse me while I catch up to my notes here on this. Thank you. Yes, we fully endorse the importance of this.

My understanding is that the concern is obviously being able to reauthorize it before the pilot project expires, which my understanding is September 30, 2028. We strongly endorse this legislation as an important armament in our effort to reduce veteran suicide. Thank Congress definitely for all of your work and support on this effort.

Ms. MILLER-MEEKS. Then again, Dr. O'Toole, the START Act would ensure community care referrals remain valid through the veterans standard episode of care. Would this help veterans receive all the care that the VA has determined necessary?

Dr. O'TOOLE. We think so, ma'am. I think this is an important element where this legislation will help the VA practice to its policy. Obviously, our intent is obviously ensuring that it is not just the episode of care or the first appointment, but rather the episode of care, which can be up to 1 year and renewable beyond that. More importantly, it is about helping the VA, I think, you know, shore up its practices to ensure that we are doing a better job of ensuring that that is actually what we are practicing, too.

Ms. MILLER-MEEKS. I think, Dr. Gold, you were asked a question that may be difficult for you to answer, was in letting people go and managing a very large healthcare facility. Let me just say that if you were given an increase in your budget by 126 million over a 4-year period, and over that same past 4 years, you had an increase in full-time employees of 60,000 and part-time employees for 23,000 and you were looking at 80,000 employees, exempting hiring of nurses and doctors, would you consider that gutting a program?

Dr. GOLD. It would depend on the role of those individuals employees. You know, having been a pediatric heart surgeon for over two decades of my life, it is not just the person that stands at the operating room or over the ether screen, but it is the person that mops the floors and stocks the supply cabinets and does so much else in our system.

Ms. MILLER-MEEKS. You would need to know——

Dr. GOLD. I would need to know.

Ms. MILLER-MEEKS [continuing]. what those positions are. Thank you so much. With that, I yield back.

I am going to ask if we would have our—on behalf of the subcommittee, I want to thank all of our witnesses for their testimony and joining us. You are now excused. We are going to wait a moment while the second panel comes to the witness table.

Welcome, everyone, and I thank you for your participation today.

On our second panel we have Ms. Sue Morris, president and CEO of Veterans Trust; Mr. Brian Dempsey, director of Government Affairs for Wounded Warrior Project; Dr. Andrew Kozminski, medical director of hyperbaric medicine for the University of Iowa Healthcare; Mr. Ed Harries, president of the National Association of State Veterans Homes; and Jon Retzer, deputy national legislative director for Health, Disabled American Veterans.

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

STATEMENT OF SUE MORRIS

Ms. MORRIS. Good afternoon, Chairman Miller-Meeks, Ranking Member Brownley, and members of the Health Subcommittee. My name is Sue Morris. I am the president of Veterans Trust, the nonprofit philanthropic entity that partnered with the Department of Veterans Affairs under the CHIP IN Act to construct VA's Ambulatory Care center in Omaha, Nebraska, serving Western Nebraska and Western Iowa.

Our nationally award-winning ambulatory care center project was completed and donated to Veterans Affairs in July 2020 as the first public-private partnership to be completed under the CHIP IN Act. The project received several national awards for healthcare design and construction. I am here today to speak in favor of taking the pilot program authorized under the CHIP IN Act and making it permanent, as H.R. 217 would do. Our project showed how VA, in partnership with the private sector, delivered a truly superb facility in a cost-effective and efficient manner.

What allowed the Omaha project to be successful? First, the project was owned by Veterans Trust during the development and construction phases and then donated to Veterans Affairs upon completion. While there was very close coordination and cooperation between Veterans Trust and VA officials at both the national and local levels, it was not a government construction project. This structure allowed Veterans Trust, whose leadership had a history of facilitating or over a billion dollars on local projects, to use local vendors and suppliers in its procurement of services and materials, leveraging demonstrated relationships for best pricing. We were able to tell our partners in design and construction that they will make money on the project, but not a lot of money, as this is a community project to serve our veterans.

Second was a strong commitment from Veterans Affairs' senior leadership. We met regularly at VA headquarters, including three meetings directly with the Secretary, to ensure project milestones were achieved. There was zero scope creep, which helped the project to be delivered on time and on budget.

One key factor in this regard was Veterans Affairs' willingness to review VA's normally applicable construction and physical security standards. We were able to come to agreement on which of those standards made sense, resulting in value engineered savings of $23 million. In the end we delivered the facility for a total of $86

million when it was originally budgeted at $135 million, saving the taxpayers $50 million. In addition, the private philanthropic contribution to the project was $30 million.

Based upon our experience and success with this effort, we recommend that H.R. 217 go further than simply making CHIP IN permanent to also consider other changes. In particular, we suggest the following. Add the option to construct facilities on land leased to VA, not just owned or donated real property. Add the ability to use the program for minor construction, not just major projects, and make clear that the act applies to more than just healthcare, but also to construction projects providing other types of facilities to veterans, such as housing and community centers.

In amending the act itself, we suggest the subcommittee and staff engage a small group of VA leadership and private sector representatives to recommend forward-looking best practices and new models for public-private partnerships. My team and board would be pleased to have been included in this effort.

In summary, we wholeheartedly support the effort to make CHIP IN a permanent tool to deliver state-of-the-art facilities. The act allows Veterans Affairs the ability to leverage advantages of private sector construction processes to deliver significant cost savings. We are tremendously proud of our role in helping lead in this effort to deliver a world class facility to our veterans and cost savings to our taxpayers.

I want to add one final point. As Dr. Gold mentioned, there is no doubt that a new inpatient facility to replace Omaha's aging VA hospital is sorely needed. Veterans Trust stands ready to partner with Veterans Affairs and the University of Nebraska Medical Center to assist in developing a new, state-of-the-art, inpatient facility that will better serve the veteran community.

I am happy to answer any questions that you might have. Thank you for including me today.

[THE PREPARED STATEMENT OF SUE MORRIS APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you.

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

STATEMENT OF BRIAN DEMPSEY

Mr. DEMPSEY. Chairwoman Miller-Meeks, Ranking Member Brownley, and distinguished Health Subcommittee members, thank you for inviting Wounded Warrior Project to testify on legislation intended to improve VA's ability to provide better access to care and ensure better health outcomes for our Nation's veterans.

Over 20 years ago, when the first wounded servicemembers returned from the battlefields of Iraq and Afghanistan, the founders of our organization made a promise: to be there for these warriors no matter what. In the years since, our organization has grown to provide more than a dozen programs and services to more than 227,000 veterans and servicemembers, and our reach continues to grow by the day. These programs and the relationships we have built with warriors along the way are what inform our advocacy before Congress. Today, I am pleased to speak on three bills from the agenda that we believe will have the biggest impact on those who serve.

First, we strongly support the Veterans Support Act. This bill would amend VA's legal definition of medical services to clarify that the agency's existing ability to provide artificial limbs includes the authority to provide adaptive prosthesis and terminal devices for sports and other recreational activities. If you are unfamiliar with what an adaptive prosthesis or terminal device is, think of the curved-shaped blades you might see on someone who has lost a lower limb or a waterproof fin that allows someone with an upper body prosthetic to swim in a pool. Now think about stress relief you may know from running, the community you found playing in a local softball league, or the body transformation you may have seen from lifting heavy weights. Participating in activities like these should be simple, but for veterans who use VA for prosthesis, it can be a challenge.

Under current law and stated as simply as possible, veterans often struggle to get this kind of prosthetic support if they are not actively pursuing a rehabilitation plan, even if they have completed one in the past and are very familiar with what they need to do what they want. These regulations focus on the clinical need for adaptive prosthetics, but disregard their potential to improve a veteran's quality of life. If a clinical need cannot be found, providers cannot offer the equipment.

The Veterans Support Act would help these veterans by effectively removing the requirement that they be enrolled in a VA rehabilitative program in order to receive the adaptive prosthetics for sports and recreation. The current population of post 9–11 veterans as young, young, mobile and energetic. We believe that VA should be building an ecosystem of care that encourages an active lifestyle and makes it easier to experience the profound health benefits, both mental and physical provided by sports and other recreational activities.

Second, we support efforts to renew the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant pilot program, including the No Wrong Door for Veterans Act. Our organization's approach to mental healthcare appreciates that no one organization and no single agency can fully meet all veterans' needs. Evidence-based mental health treatment absolutely works when available and when pursued, but the best results will be found by incorporating a public health approach focused on increasing resilience and psychological well-being. This kind of suicide prevention strategy embraces upstream prevention efforts, like helping with case management, peer support, work outreach, and establishing financial wellness, all of which are recognized as suicide prevention services through the Fox Grant Pilot program. Each year since the Fox Grant Pilot was launched, VA has discussed it as a key initiative for helping prevent suicide in its National Suicide Data Report.

Previous congressional oversight and legislative hearings have revealed that the pilot program is not perfect, but we appreciate efforts like the No Wrong Door Act that would continue to refine the pilot's operation and foster community collaboration in ways tailored to local needs. We hope that this legislation can be prioritized as a vehicle for bipartisan, bicameral action to renew this program in time and disperse grants in Fiscal Year 2025.

Third and finally, we support the Protecting Veteran Access to Telemedicine Services Act. This legislation would extend a COVID–19 era waiver from a law that requires patients to complete at least one in-person visit with a healthcare provider before that provider can prescribe them a controlled substance. If the waiver expires as planned in December 2025, rural veterans who do not live near VA or community healthcare facilities, who rely primarily on telehealth services, likely will be negatively impacted. Appointment coordination challenges and travel logistics may lead to interruptions in their care or lapses in prescriptions. The list of controlled substances contains not only pain medications, but also multiple mental health drugs that are important parts of treatment plans for many veterans dealing with mental health issues and for whom an in-person appointment may present additional challenges.

Members of the committee, it is my distinct honor to be here on behalf of Wounded Warrior Project to speak to the needs of our Nation's wounded warriors and their families. Thank you for letting us do our part to keep the promise. This concludes my testimony and I look forward to your questions.

[THE PREPARED STATEMENT OF BRIAN DEMPSEY APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Thank you.

Dr. Kozminski, you are now recognized for 5 minutes.

STATEMENT OF ANDREW KOZMINSKI

Dr. KOZMINSKI. Good afternoon, Chairwoman Dr. Miller-Meeks, Ranking Member Brownley, and members of the subcommittee. Thank you for inviting me to participate in this hearing to discuss H.R. 1336, the Veterans National Traumatic Brain Injury Treatment Act.

I am Dr. Andrew Kozminski, an emergency medicine physician with a specialization in undersea and hyperbaric medicine. I am the current medical director for Hyperbaric Medicine at University of Iowa Healthcare and medical director for the United Hospital Center (UHC) Wound Center.

This legislation aims to improve the health of our veterans, establishing a pilot program for the implementation of hyperbaric oxygen therapy for veterans with traumatic brain injury or post-traumatic stress disorder. As an emergency medicine physician, I have cared for numerous veterans suffering from TBIs and PTSD. With my experience in hyperbaric medicine, I think the implementation of hyperbaric oxygen for these ailments would be uncomplicated. Veterans already use this therapy through their VA insurance for currently approved HBO indications. Consequently, HBO, hyperbaric oxygen, has proven its safety after many decades of use by the medical community. For these reasons, this legislation has been potential to help improve the lives of our friends, families, and neighbors.

I want to comment on the potential for an increased likelihood of oxygen toxicity seizures in this patient population as 1 in 50 TBI patients develop post-traumatic epilepsy. However, an oxygen toxicity seizure is a complication that trained hyperbaric medicine professionals are well versed in how to manage and should be able to ensure continued patient safety throughout a treatment course.

Clinical trials, I will mention, even utilize a protective pressure of 1.5 Atmospheres Absolute (ATA), which should reduce the likelihood of this complication. However, this is an important reason to create a pilot program through the VA Health System, as this would provide a safe option for patients seeking treatment for what is currently an off-label indication. Without this program, desperate patients may find themselves at the mercy of popular health spas. Businesses that might not have adequately trained staff may use incorrect treatment profiles and at times pose serious risk to their patients or their clients.

The research that investigators in my field have completed on the utility of HBO for TBI and PTSD shows promise for improving health outcomes in these patient populations. For chronic TBI cases, HBO has been found to improve cellular metabolism, reduce cell death and oxidative stress, and enhance mitochondrial function. These mechanisms aim to promote neuronal repair and regeneration. The Brain Injury and Mechanism of Action, BIMA, trial published in 2016 demonstrated improved post-concussive symptoms, PTSD, cognitive processing speed, sleep quality, and balance function by 13 weeks after 40 60-minute HBO sessions at 1.5 ATA.

Unfortunately, these improvements did not persist beyond that 6-month follow up. In February 2025, however, just last month Dr. Lindell Weaver, a leader in my field, and his team published their most recent study a double-blind randomized trial of hyperbaric oxygen for persistent symptoms after brain injury. This study showed similar results to what was observed in the BIMA trial for both sham and HBO groups at 13 weeks, with the HBO treatment group maintaining the neuropsychiatric benefits at 6 months.

A second phase within the trial offered another 40 HBO sessions to all participants. Final follow up 3 months after the last of the second round of HBO treatments were given, patients who received 80 HBO treatments had greater neuropsychiatric improvement compared to their results after 40 sessions. Patients who received a maximum of 40 treatments also showed neuropsychiatric improvements compared to their baseline scores, but less improvement than their counterparts received 80 treatments.

In conclusion, I find the outcomes of these clinical trials seem promising. Establishing a pilot program for the VA to offer HBO therapy for veterans with TBIs and PTSD could help improve these patients' quality of life, provide access to safe healthcare environments in which to receive these treatments, and continue to build insight on how best to construct and administer treatment courses in the future. Thank you.

[THE PREPARED STATEMENT OF ANDREW KOZMINISKI APPEARS IN THE APPENDIX]

Ms. KING-HINDS. [Presiding.] Mr. Harries, you are recognized for 5 minutes.

STATEMENT OF ED HARRIES

Mr. HARRIES. Members of the subcommittee, as president of the National Association of State Veterans Homes, thank you for the opportunity to testify today and offer our strong support for the Providing Veterans Essential Medications Act. This legislation would remove an inequity in the law concerning high-cost medica-

tion for veterans that are preventing many of them from living in State veterans homes.

As you know, State veterans homes are not able to receive reimbursement from the VA for high-cost medications provided to seriously disabled veterans, even though private nursing homes that contract with the VA can. As a result, many State homes are losing hundreds of thousands of dollars every year that could be used to improve the lives of aging and disabled veterans.

For example, at the Iowa State Veterans Home they are caring for a 55-year-old service-connected Air Force veteran who suffers from Crohn's disease. Fortunately, a drug called Stelara can help control his symptoms. However, this medication costs about $20,000 a month, which is more than the full cost of care prevailing rate the VA pays the home. Despite the financial burden, the Iowa State Home decided to care for this veteran at a significant operating loss. However, that likely means that they will have to cut costs elsewhere, perhaps admitting fewer veterans, spouses, or Gold Star parents, or maybe cutting back on social, recreational, or other nonmedical services.

The same situation is occurring at State veterans homes across the country. At an Idaho State Veterans Home, a 63-year-old service-connected Army veteran is receiving a medication called Duopa for Parkinson's disease, which costs the home about $16,000 a month. The prevailing rate that Idaho receives for this veteran does not fully cover the cost of this one medication, let alone the cost of all the other care provided. Unfortunately, due to the financial strain from high-cost medications, some State homes can only afford to care for a limited number of such veterans who need these medications.

For example, a 76-year-old 100 percent service-connected Air Force veteran living in a VA contracted community nursing home in Idaho was taking a special medication called Promacta. The cost of that drug was $18,000 a month. The VA was providing this medication to the veteran's spouse, who took it to the private nursing home where they would administer it to him. Although the private nursing home was receiving a prevailing rate for the full cost of care, just like the State homes do, their contract included a provision for them to receive or be reimbursed for these high-cost medications. The veteran wanted to move into the State veterans home and his spouse asked if she could continue to pick up the medication and bring it to the home. The VA told her that by law they could not allow it, effectively denying this veteran the ability to live in State veterans home, which was his choice.

There are also cases where this inequity in the law is literally throwing away money that could be used to improve the care of veterans. In Wisconsin, a 76-year-old veteran who 100 percent service-connected veteran, a Marine sharpshooter, was admitted to the State veterans home while receiving chemotherapy medication free of charge through an Astellas Patient Assistance Program. After the veteran moved to the State veterans home, his wife brought the medication so that it could be administered to him. However, according to the VA's rules, they could not use the free medication. Instead, the facility itself incurred a cost of $12,000.

Wisconsin also had a service-connected army veteran living in one of their homes who was prescribed a chemotherapy drug by his VA oncologist, which was shipped directly from the VA pharmacy to the State home. When the medication arrived, the home contacted the VA, aware knew that it could not utilize the drug because they had not purchased it themselves under the program. When inquiring how to avoid wasting the $20,000 medication, the VA told them it could not be returned even though it was in its original sealed packaging and to dispose of it.

Madam Chairwoman, the Providing Veterans Essential Medication Act would require VA to furnish or reimburse State veterans homes for these high-cost medications, just like they are doing for the private homes. This would ensure that veterans could choose where they want to spend their twilight years without illogical statutes and regulations limiting their choices.

That concludes my statement and I will be pleased to answer any questions that you or the members of the subcommittee may have.

[THE PREPARED STATEMENT OF ED HARRIES APPEARS IN THE APPENDIX]

Ms. MILLER-MEEKS. Mr. Retzer, you are now recognized. Thank you.

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

STATEMENT OF JON RETZER

Mr. RETZER. Chairwoman Miller-Meeks, Ranking Member Brownley, and members of the subcommittee, thank you for inviting DAV to testify at today's legislative hearing. DAV is pleased to support the following bills.

The SPORT Act seeks to include adaptive prosthesis terminal devices for sports and other recreational activities and the medical services provided to eligible veterans of the VA. DAV has long recognized and continues to support the importance of adaptive sports through our involvement with the National Disabled Veterans Winter Sports and Golf Clinics, which helps veterans improve their physical and mental health by overcoming limitations and challenge their perceived disabilities.

The Saving Our Veterans Lives Act aims to tackle the devastating issue of veteran suicide by providing secure firearm storage. Firearms are involved in nearly 72 percent of veteran suicides and offering lockboxes creates time and space, reducing access to lethal means during moments of crisis, allowing veterans to reconsider their actions and seek help.

The Marriage and Family Therapist Qualification of Veterans Health Administration Act aims to ensure that veterans receive care for high qualified marriage and family therapists through effective supervision and improved therapeutic practices. Incorporating family and relationships into mental health treatment can result in more effective outcomes, reinforcing coping strategies and provide a sense of belonging and stability.

The Protecting Veterans Access to Telemedicine Service Act would ensure veterans can access controlled medications and consultations remotely, enabling convenience scheduling and thus improving treatment adherence and health outcomes. It breaks down

barriers, such as distance, mobility challenges, and transportation limitations, particularly for those in underserved areas.

The Women Veterans Cancer Care Coordination Act aims to ensure that women veterans diagnosed with breast and gynecological cancers receive seamless and tailored support through regional care coordinators. This would ensure veterans receive timely and appropriate care.

The START Act aims to streamline the referral process for veterans receiving community care, ensuring smoother transitions and reducing administrative barriers. By establishing a clear referral period, it would ensure better care coordination.

The Providing Veterans Essential Medication Act aims to address the financial burdens faced by safe veterans homes, ensuring veterans have access to high cost medications without added strain to the facilities. The bill guarantees continued high-quality care for veterans in long-term care, reflecting our commitment to their well-being.

The Copay Fairness for Veterans Act aims to eliminate copayments for medications and preventive health services provided by the VA. Removing financial barriers will encourage routine check-ups and screenings, leading to better overall health management and fewer emergency medical situations. We commend the thoughtful intent beyond the next two bills and encourage incorporating our recommendations to enhance their effectiveness.

The No Wrong Door for Veterans Act reauthorizing and extending the Staff Sergeant Gordon Fox Grant Program, providing ongoing support for community-based mental health services. To enhance its impact, DAV recommends reiterating the importance of the original requirements of baseline mental health screening, using validating tools, and measuring the effectiveness of suicide prevention services with pre and post evaluations.

Furthermore, funding criteria should focus on improvements in veterans' well-being rather than the number of participants served. Payment structure should be clearly defined to avoid overcompensation for minimal services. An annual renewal process is recommended until comprehensive data confirms the program's efficacy and identifies the most effective services in reducing suicide risk among veterans.

The Veterans National Traumatic Brain Injury Treatment Act aims to establish a pilot program to provide hyperbaric oxygen therapy for veterans whose PTSD and TBI symptoms have not responded to traditional therapies. While initial research shows promise, researchers suggest further rigorous studies are necessary to validate its efficacy and safety. DVA recommends amending the bill to prioritize research along treatment axis to ensure veterans receive care that is both effective and evidence based.

In conclusion, these legislative bills represent a comprehensive approach to addressing the urgent needs of our veterans to receive the services and healthcare that they have earned. This concludes my testimony on behalf of DAV and I am pleased to answer questions you subcommittee may have.

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

Ms. MILLER-MEEKS. Thank you very much.

Ranking Member Brownley, you are now recognized for 5 minutes.

Ms. BROWNLEY. Thank you, Madam Chair.

Mr. Retzer, thank you for your testimony and I certainly appreciate DAV's support of the VA Marriage and Family Therapists Equity Act as well as your support for the Women Veterans Cancer Care Coordination Act, which I am coleading with Representative Garcia. On the Cancer Care Coordination bill, can you sort of elaborate a little bit more? I know you did somewhat in your testimony, but can you elaborate a little bit more on why this legislation would be beneficial, especially in the light of previously enacted legislation, like the Making Advances in Mammography and Medical Options for Veterans (MAMMO) Act, which expanded veterans' access to high-quality breast imaging services, and the Service Act and the PACT Act, which expanded access to screening and made breast cancer a presumptive condition for veterans who were exposed to toxins during their military service?

Mr. RETZER. This bill is very important to us on a couple different facets. As in our written testimony, we outline the importance for our women veterans to get specialized care. The coordination of care is so important and the challenges that VA has with addressing women veterans' special needs, especially when we look at, for example, breast cancer prevention. We need to ensure that VA, being that their infrastructure is not built to sustain all women veterans care at every VA facility, we rely on partnerships and affiliates to be able to supply the technical and lab work requirements plus the clinical specialists that are out there to provide that care.

Another thing that we saw that was really meaningful in this bill with regards to the care coordinators is the impact it has with honoring our PACT Act. Now that we have found that male veterans who have been exposed to toxic exposures can also be, unfortunately, suffering from the same illness of breast cancer, we feel that this piece of legislation will open up the door to developing good care coordination not only for women veterans who suffer with breast cancer, but also for our male veterans who have been exposed to toxic exposures. We feel it is very important with the research and the clinical findings that they work with.

Ms. BROWNLEY. Thank you for that. Speaking of the PACT Act, I mean, I have to ask you with 83,000 folks being laid off or fired in the VA and significant cuts to the PACT Act, what impacts—I think it is 23 billion cuts to the PACT Act. What are the implications?

Mr. RETZER. What we are hoping for that the administration and VA and Congress itself work together in a bipartisan manner to ensure that these bills, and they are very thoughtful bills, continue to strengthen the VA system and that is the infrastructure, staffing, and technology.

Ms. BROWNLEY. Thank you. Dr. Kozminski, in your testimony you briefly discussed the importance of sufficient training and strict safety standards and the potential risks faced by patients who are seeking hyperbaric oxygen treatment for off-label indications, like TBI and PTSD, at health spas. You also mentioned the recent tragic explosion of a hyperbaric chamber at a facility in

Michigan, which killed a 5-year-old child. Dr. Murphy's legislation, H.R. 1336, does not seem to include any limitations or guardrails on which types of providers veterans with TBI or PTSD could receive treatment from under this proposed pilot program.

Do you think we should consider amending it to include safeguards such as ensuring that veterans would go to institutions that have been accredited by the Undersea and Hyperbaric Medical Society or another body? Would you recommend other safeguards? The bill literally is like two pages, maybe two and a half pages. It is just about funding and having the program and starting the program, but no safeguards whatsoever.

Dr. KOZMINSKI. Frankly, I mean, I do agree that it would be best to make sure that whatever treatment they receive, what our veterans receive, is done at an accredited facility. Amending the bill for that would be probably best for patient safety.

Ms. BROWNLEY. That is it?

Dr. KOZMINSKI. I am good.

Ms. BROWNLEY. Thank you. I will yield back.

Ms. MILLER-MEEKS. Thank you very much.

The chair now recognizes Representative King-Hinds for 5 minutes.

Ms. KING-HINDS. More along the lines of this traumatic brain injury treatment option. I guess this is a question for Dr. Retzer because it is a policy conversation. Right?

What additional research or oversight do you suggest or recommend is needed basically, that one we could actually explore this type of treatment, right, that a lot of folks support? How do we ensure balancing the safety of our veterans?

Mr. RETZER. I think as we see all the research that we see and what VA is doing and what NIH is doing, and also the Journal of Medicine, we are seeing all these factors that have progressed throughout the year, showing from a point of where there was an imbalance, where it was not positive, that age HBOT was reducing outcomes for traumatic brain injury and PTSD. As we started to move through the years, we started to see some progress and that is the promise that we are hearing, that we are wanting to see that more research. As a resolution-based organization, we support research, strongly support continuation of VA's research, and also the research partners and affiliates out there to ensure that they are looking at safe clinical practices, evidence-based methods to ensuring that we are providing alternative options of care for our veterans.

Ms. KING-HINDS. Okay. Thank you for that. This question is also for you. Given the importance of telemedicine in providing timely care to veterans, especially those who live in remote and underserved communities, like mine, the CNMI, what specific safeguards are being considered to ensure that prescriptions for controlled substances via telehealth are both safe and effective?

Mr. RETZER. Thank you for that question. With pharmaceutical care and trying to address the issues of mental health and suicide prevention along with substance use abuse, there is a responsibility on VA to ensure when they are providing patient care in direct environment or in the community care, that there are direct communication, clear communications on the treatment processes and

what medications are given so that the veterans themselves understand being informed what those interactions are and what the risk factors are and, at the same time, that VA and community are speaking directly with themselves.

For example, my time when I was stationed up in Alaska, very remote area, it is very difficult to find clinicians in every part of it. When you are dealing with the VA and community care and you look at their infrastructure up there, it is not built to communicate very directly or well. We hope that as we continue with the modernization of electronic health record modernization, that is something that will be worked very robustly into the system of the pharmaceutical safety measures and making sure that patient safety is paramount throughout the whole development.

Ms. KING-HINDS. All right, thank you. I yield my time

Ms. MILLER-MEEKS. Thank you. The chair now recognizes Dr. Morrison for 5 minutes.

Ms. MORRISON. Thank you, Madam Chair. It has been my distinct privilege to join in the work that this committee leads, ensuring that VA is meeting veterans diverse and evolving needs. As a physician myself, I have been part of teams that work together to help patients receive the highest quality of care and have witnessed firsthand the impact, positive impact of building comprehensive care coordination that enables effective communication and supports patients through their care. With the number of women veterans expected to continue growing, obviously we should be proactive in our efforts to coordinate care for one of the most pressing health issues women veterans face.

Mr. Retzer, you answered ranking member Brownley's question. I am going to direct it to you now, Mr. Dempsey, if I may, and thank you for being here today. We have highlighted that breast cancer is the most diagnosed cancer for women within VA and that we will likely see a rise in the volume of cancer care that veterans need. Can you expand a little bit on the importance of care coordination for improving health outcomes and women veterans overall VA experience?

Mr. DEMPSEY. Of course and thank you for the question. Thank you additionally for pointing out that breast cancer ranks as the second most common cancer among women in the U.S. and within VA, it is the most diagnosed cancer. I think for any veteran coming through the VA health system, in this case the increased volume of female patients that VA sees, it is important that patients feel supported with cancer care. In particular, where a lot of that care is received in the community, it is critically important to make sure that there is good coordination between the VA direct care system and those community providers. There is no gap in service, whether it be transfer of records back and forth, communication between the providers to make sure there is gaps in care. I think overall just creating a culture where veteran patients feel supported by their care providers.

Ms. MORRISON. Thank you. Appreciate that answer. I would also like to highlight another health issue that we have discussed that affects veterans at 1.5 times greater than nonveterans. Suicide rates among servicemembers have risen gradually over the decade, with veterans experiencing an alarmingly disproportionate rate of

suicide by firearm. As the wife of a veteran, I find this absolutely heartbreaking.

While we understand that mental health issues facing our veterans do not stem from a single cause, of course, it is important that we take any and every path to prevent these tragedies and empower veterans to address their mental health conditions. Safe firearm storage, education, and resources are integral to addressing the elevated risk veterans face for firearm suicide.

With firearms reported to be involved in up to 72 percent of veteran suicides, as you noted, Mr. Retzer, the evidence for continued support of intervention programs that promote potentially life-saving time delays is clear.

Mr. Retzer, in your testimony you do discuss time and space as critical components in preventing suicides. Why is approaching suicide prevention through safe firearm storage particularly impactful for veterans and their families?

Mr. RETZER. I can speak as a veteran who owns firearms and who suffers with mental health. It is very meaningful to have this conversation because it is a responsibility not just of the veterans, but to the clinicians and the families integrated to understand how to save the veteran and themselves. In our testimony we wrote about the community being safe, and that is the end goal is to make that community safe, but where it starts is that veteran is safe.

I have gone through the VA process of the clinical side, and I wish I was offered a lockbox. I was not. I met all the criteria that were actually testified, and I was not given an option for the lockbox. The good thing is that VA, throughout the process, has been doing and taking steps to ensuring that they offer these security measures to our veterans.

Ms. MORRISON. Thank you. The Saving Our Veterans Lives Act considered by the committee today includes an education element. How do you anticipate the educational component of the initiative will work with the resource component of the bill?

Mr. RETZER. That is a great question and education is always very important. That is something we, the veterans, have to also own for ourselves, for our responsibilities, something that we come from. We come from an environment of being educated on how to handle firearms in the military. Hopefully that VA will build upon that knowledge that we have and the way that we are taught those, so that it relates to us in a manner that is meaningful and it also has highlights the importance. Education, I think, is going to be very important because it is going to open up the dialog for us to talk about something that is not always easy to talk about.

Ms. MORRISON. Thank you, Mr. Retzer. The legislative efforts considered in today's hearing demonstrate critical steps toward delivering the quality care that VHA should continuously pursue. I sincerely believe that finding common ground on ways to improve VA is a goal that is shared by all of my colleagues that sit on this committee.

In recent weeks, there is been a lot of conversation about ramping up efficiency in our government. Every single one of the bills we have discussed today would require implementation actions that are the responsibility of VA employees. We cannot hope

to continue to deliver care to our veterans if we throw the folks responsible for its delivery into instability and uncertainty. We cannot wish for improved access to care if we allow the disruption of essential food functions in our VA hospitals and facilities. We cannot tell our servicemembers we value their well being if we permit critical contracts and research initiatives to be slashed.

I urge my colleagues, particularly those that have presented their bills before the committee today, to recognize the importance——

Ms. MILLER-MEEKS. Your time has expired. I am sorry. We have votes that are coming up——

Ms. MORRISON [continuing]. of supporting the workforce.

Thank you, Madam Chair. I yield back.

Ms. MILLER-MEEKS [continuing]. so please wrap-up your time.

The chair now recognizes Dr. Dexter for 5 minutes.

Ms. DEXTER. Thank you, Madam Chair. Again, thank you to our panelists for being here and for the work that you do with our veterans.

As I alluded to earlier, I spent my career in a comprehensive coordinated care system very similar to the VA, and so I appreciate the ability to really embrace our veterans within the system and deliver care. I know that these systems work for patients, as you have spoken to, and we have clear data that we will submit for the record showing that care outcomes and satisfaction for care received inside of the VA is superior to outside. We also want to make clear that our veterans have access to care and mitigate the need for our veterans to be able to access care and have that intervention at the moment of impulsivity and despair for our veterans at high risk for suicide is critical. Thank you for your support for the lockbox display policy. I think that is proven very high yield and critical.

It also is critical that our veterans have time to talk with a provider, be able to reach out when they are feeling most impulsive and desperate. I believe that is the intention with the No Wrong Door Act is to be able to help people at that moment. However, I am concerned about our requirement for in-person care delivery for mental healthcare and the fact that we are not going to allow telemedicine mental health any longer, that everyone is going to have to be in person because an established care provider is trusted and certainly preferable having worked in an emergency room to walking into an emergency room and expecting high-quality personalized care.

Despite the good intentions of the Wrong Door Act, it seems to run counter to the principles of a capitated inclusive body. I also have concerns about the reauthorization of a program for which we have collected good outcome data for only 4 percent of the participants.

I wonder, Mr. Retzer, if you would be willing to share your thoughts on when VA led interventions are looking to be most impactful for our high-risk suicide patients, do you feel like we have sufficient data to be confident that the No Wrong Door Act is actually saving lives more than further investing in VA comprehensive care and even telehealth mental healthcare?

Mr. RETZER. Thank you for that question. That is such an important issue that we have No Wrong Door Act really addresses alternative options where VA cannot do it by themselves. That is something that we are very realistic to. With having over 9 million veterans enrolled in the VA healthcare system and you have 2.7 million in the rural, we have to be able to provide that type of a resource. When the Compact Act came out and that was a great win for Congress and for American veterans to be able to get healthcare when they were in acute crisis, that is another tool. The No Wrong Door has the potential to do what we need to do to provide alternative resources and clinical support out in the community where veterans may not be enrolled in the healthcare system. I think that is the most Important thing is that we do not shut the door on this.

We continue to see what we can do with this. That is why we recommended our recommendations and testimony to be fiscally responsible, to make sure that it is not participants that are being gauged, and we are not a production of veterans going through the shop. We want quality care, the same kind of care that we get within the VA system and the wraparound services that were actually noted in the bill with regards to ensuring that they are going back to VA and being informed about how to utilize VA.

We see promise in there, but we are waiting for the report and we hope to see the final report and become public for us to be able to make a determination.

Ms. DEXTER. I absolutely share the intentions and the suppositions of the bill. I just am concerned about only 4 percent of output being really looked at for the outcomes. It is not a question, it is just I think that compelling data before we invest when we have so modest resources available to us is important.

What do you think Congress can be doing better to bolster interventions to help prevent suicide, which is at a critical crisis point for our veterans right now?

Mr. RETZER. Thank you for that question. I think like I said earlier, it is multifaceted. We have to look at every avenue directly within the VA healthcare system, making sure we have proper staffing. We have clinical psychologists, psychiatry shortages in staffing, but also to support them, we have to ensure that the VA staffing itself in general is on par.

For example, if we go to the phone call for the crisis line, someone has to be manning that line. If we go to the phone to call the public contact office, someone has to be there. If we go into a VA medical center, the facility has to be cleaned where we have our people who are custodians that they are working. All the employees that support their VA, it is very important that we look at it.

The other thing is we need more peer-to-peer. Our veterans who work within the VA system, they themselves know what the life is like and they have the experience to become peer-to-peer counselors or peer-to-peer to be able to mentor through us.

Ms. DEXTER. I recognize that I am over time, so thank you for your tolerance, Madam Chair. I thank you for your testimony.

Ms. MILLER-MEEKS. Thank you. The gentlewoman yields.

The chair now recognizes herself. I was going to recognize Dr. Conaway, but he slipped out. Thank you very much.

Ms. Morris, were there difficulties executing the construction of the VA clinic in Omaha, Nebraska, in coordination with the VA? If you could improve the CHIP IN authorities, what would you suggest if there, in fact, were difficulties?

Ms. MORRIS. Really did not experience a lot of difficulties in construction. If you remember, probably the biggest challenge was the last 4 months. COVID hit March 2020, and we needed to finish up the project by the end of July in order to do the transfer in August. Our construction team and our design team worked diligently to be able to get that done on time, which is really kind of amazing that that was able to happen at that period.

Ms. MILLER-MEEKS. Were there certain waivers or exemptions that you sought from the VA in order to get construction done under budget and under time?

Ms. MORRIS. Well, certainly I referenced the construction manuals and the security manuals. Those were critical. We actually spent a 2-day time period in Omaha, Nebraska, where about 15, 20 VA employees came out. We went through those manuals with great precision and, at that point in time, we were able to have value engineering of about $23 million.

Ms. MILLER-MEEKS. Thank you. Dr. Kozminski, many aging veterans and those suffering from diabetes-related complications sadly receive amputations due to chronic limb ischemia. Could HBOT therapies be potential preventive treatment for our veterans suffering from those conditions?

Dr. KOZMINSKI. Just to clarify, so preventative in the sense of preventing those infections or preventing——

Ms. MILLER-MEEKS. Amputations.

Dr. KOZMINSKI. Yes. I do think that hyperbaric oxygen therapy has been a fairly well proven implementation for salvage therapy in those cases for sure.

Ms. MILLER-MEEKS. Thank you so much for coming in. Go Hogs.

Mr. Harries, I understand the difficulties your members are experiencing as a result of the VA's inability to reimburse for high-cost medications that the patient may have been on prior to coming to a facility. VA testified the status quo is okay. Do you agree?

Mr. HARRIES. No, we do not. The costs of these drugs that are coming in are climbing rapidly. The other thing that is happening, with the exposure to toxic chemicals that our veterans are having, we are having more and more cancer diagnoses. Some of these high-cost drugs, or a good portion of them, are related to chemotherapy.

Ms. MILLER-MEEKS. They, in fact, cover these drugs if the patient was at a different facility or at their home.

Mr. HARRIES. Correct. You know, looking at it from a cost perspective, the average institutional per diem is $262 for State veterans home, whereas with the community homes, it is $424. If you looked at balancing that out, it may be a net neutral event.

Ms. MILLER-MEEKS. Thank you. Mr. Dempsey, how could the SPORT Act assist post 9–11 veterans?

Mr. DEMPSEY. Thank you for the question. The SPORT Act would, I think, do a tremendous job of reforming the way that amputee veterans engage with the VA prosthetic department. Currently, with the limitation that adaptive and support-related pros-

thetics only be provided as part of a clinical program, expediting that process and getting these into a veteran's life is a great way to re-engage in the community, whether it just be participating in athletics, whether it be involved in community outings, golf, running, any number of activities I think a lot of people take for granted, but which could be greatly danced by better access to these prosthetics.

Ms. MILLER-MEEKS. Does it seem to you that the VA's current status and parameters are geared toward elderly veterans who perhaps have amputations from medical conditions, such as diabetes, rather than to our younger, much more active post 9–11 veterans?

Mr. DEMPSEY. Well, thank you for the question. To be honest, I do not know that I could speak to that. I would say that most of the voices that come to our post 9–11 serving generation are those who were injured in the early 2000's for whom, you know, getting adaptive prosthetics became part of their post-injury life very early. They have become familiar with how to use them, how they want them, and so ensuring that the process works a bit more smoothly for them is the priority here.

Ms. MILLER-MEEKS. Thank you. I yield my time.

Thank you to all of you. Thank you to our witnesses and for all your thoughtful input.

Ranking Member Brownley, I am going to ask if you have any closing remarks.

Ms. BROWNLEY. Thank you, Madam Chair. I just wanted to associate myself with Representatives Dexter and Morrison and their comments that they have made today. I will just repeat what I said in my opening remarks and that I find it a bit crazy that we are having a legislative hearing today rather than an oversight hearing while the Trump administration's careless executive orders, mass firings of VA employees, and reckless contract terminations are causing significant upheaval within the Veterans Health Administration. As I said earlier, none of these bills we are considering today will address the very real threat to VA healthcare, to VA access to healthcare, quality, and safety that our Nation's veterans are facing today.

Veterans do not support these proposed cuts, nor do they support cutting 83,000 employees within the VA. If we continue to see efforts to dismantle the VA by firing hardworking employees, canceling vital research, terminating healthcare contracts, and eroding veterans' trust in VA, it will not matter what excellent legislation we put forth. There will not be employees or even an infrastructure left at VA to implement these bills and veterans care will suffer because of it. We can do better than that.

I yield back.

Ms. MILLER-MEEKS. Thank you very much.

Perhaps it is because I am a physician and a 24-year military veteran, married to a 30-year military veteran, that I find it completely plausible that we as Members of Congress can actually make legislation, go through legislation, in addition to respond to things that are happening through other parts of the Federal Government as well.

Let me also say that I just need to address some misinformation I have heard here today. Whether it is intentional or unintentional,

there is a $6 billion increase to the Toxic Exposure Fund, not a decrease. Let me repeat that. The Toxic Exposure Fund in the Continuing Resolution that we may be voting on has a $6 billion increase.

Let me also say that over the past 4 years the VA's budget has increased $240 billion—or has increased from $243 billion to $369 billion, an over $126 billion increase, while nationally the level of veterans seeking care is level. Is level. Of that, in the past 4 years an increase of 60,000 full-time employees and 23,000 part-time employees.

Given my time in the military, I remember as an Operating Room (OR) nurse, I will not say what facility I was in, it was 1:30 in the afternoon. All of the staff, with the exception of three of us, and I can see Dr. Kozminski smiling because he knows what I am going to say, three of us were back putting together the instruments and putting up our instrument sets. Everybody else was in the break room. I would say to look at how we spend money in the Federal Government, so precisely what Ranking Member Brownley has said, so that we can continue to have the funds to deliver high-quality care to our veterans in a timely fashion, be it at the VA or in community care, is a priority for all of us. None of this dismantles or guts or defunds the VA or the Toxic Exposure Fund.

I want to thank our witnesses who have been here today. I appreciate your coming and testifying. I want to thank our veterans, most importantly who give us the opportunity to be here and to vote this afternoon. On behalf of the subcommittee, I want to thank you all again, the witnesses, members who are here today. I am looking forward to working with you to address the issues facing our veterans.

The complete written statement 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 include extraneous material. Hearing no objection, so ordered.

This hearing is now adjourned.

[Whereupon, at 4:20 p.m., the subcommittee was adjourned.]

A P P E N D I X

Prepared Statements of Witnesses

Prepared Statement of Thomas O'Toole

STATEMENT OF
THOMAS O'TOOLE
ACTING ASSISTANT UNDER SECRETARY FOR HEALTH FOR CLINICAL SERVICES
VETERANS HEALTH ADMINISTRATION
DEPARTMENT OF VETERANS AFFAIRS (VA)
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
U.S. HOUSE OF REPRESENTATIVES

March 11, 2025

Chairwoman Miller-Meeks, 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. I am accompanied by Dr. Antoinette Shappell, Deputy Assistant Under Secretary for Health for Patient Care Services, and Dr. Thomas Emmendorfer, Executive Director, Pharmacy Benefits Management.

VA does not have views H.R. XXXX, Protecting Veteran Access to Telemedicine Services Act. VA will provide these views to the Subcommittee in a letter after the hearing.

H.R. 217 CHIP IN for Veterans Act

Summary: Section 2(a) of the bill amends the Communities Helping Invest through Property and Improvements Needed (CHIP IN) for Veterans Act of 2016 (P.L. Law 114294) to make that authority permanent and removing the cap of donations under the program.

Position: **VA supports this bill.**

Views: VA supports this bill because it provides an additional method by which the needs of Veterans and VA may be served outside of the traditional procurement processes. VA has used authority given under the pilot to award two projects, an Ambulatory Care Center in Omaha, Nebraska (which began providing care to Veterans in late 2020), and a hospital currently in construction in Tulsa, Oklahoma. Making the pilot program permanent would provide an additional opportunity for VA to modernize and expand its infrastructure to provide world class health care to Veterans. Projects approved, funded, and constructed using this authority would typically provide faster speed to market at a lower cost than conventionally approved and funded projects. The CHIP IN for Veterans Act is another tool available to VA.

Currently, the CHIP IN for Veterans Act of 2016 is set to expire in 2026, and it sets a maximum of five projects that can be donated under the authority. Given the

success in the two projects to date, VA would take the lessons learned and best practices from those projects and apply them to future donations across the country.

Cost Estimate: There are no costs to VA associated with this bill.

H.R. 658 Qualifications for Marriage and Family Therapists

Summary: The bill would amend 38 U.S.C. § 7402(b)(10) to add a new subparagraph (B) that would state that, to be eligible to appointed to a marriage and family therapist (MFT) position and qualified to provide clinical supervision, a person would have to have the requirements currently set forth in law (which would be redesignated as subparagraph (A)) and be authorized to provide clinical supervision in the State where the person has been designated as an approved supervisor by the American Association for Marriage and Family Therapy.

Position: VA does not support this bill.

Views: In 38 U.S.C. § 7402, the basic qualification standards for various health care professionals. Currently, there are no statutory requirements for supervisory roles in any title 38 positions. Thus, VA has authority to establish qualification standards in VA policy for all levels of the position (for example entry level, full performance level, supervisory level, and so on.).

The current standards for MFTs were written by a group of subject matter experts (SME) in the MFT discipline. They considered whether the State designation would be appropriate or the supervisor designation from the American Association for Marriage and Family Therapy (AAMFT). The SMEs did not find the AAMFT Supervisor designation and a State credential to be equivalent due to significant variability across States.

After careful consideration, VA decided the AAMFT Supervisor designation is necessary to ensure individuals trained as MFTs are prepared to provide the best quality marriage and family therapy to the Nation's Veterans.

VA does not view the requirement to obtain an AAMFT Supervisor designation as a barrier. VA provides individuals in covered assignments who are AAMFT supervisor candidates 2 years from date of placement to obtain the AAMFT supervisor designation.

Under VA's initial MFT qualification standard, dated September 28, 2010, an individual qualifies if they graduate from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). Section 239 of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2017 (Division A of Public Law 114223), enacted September 29, 2016, provides for regionally accredited programs to qualify for MFT positions. VA revised the qualification standard April 18, 2018, to include regionally accredited programs. However, as February 24, 2025, there are only 234 MFTs currently onboard, compared to 901

Licensed Professional Mental Health Counselors (LPMHC). LPMHCs have more rigorous qualification standards (i.e., requirement to graduate from an accredited program).

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. XXXX Saving Our Veterans Lives Act

Summary: Section 2(a) would create a new 38 U.S.C. § 1720K that would require VA to carry out a program to provide to eligible Veterans, upon their request, covered items and information relating to the benefits of, and options for, secure firearm storage. The term "covered item" would mean a lock box that: is used for the secure storage of a firearm; is designed and marketed to deny unauthorized access to, or render inoperable, a firearm or ammunition; may be unlocked only by means of a key, combination, or other similar means; is in compliance with the applicable standard of American Society for Testing Materials; is manufactured in the United States; and is not eligible or intended for commercial or individual resale. The term "eligible Veteran" would mean a Veteran, as defined in 38 U.S.C. § 101, and an individual described in 38 U.S.C. § 1720I(b), which generally refers to former Service members with other-than-honorable discharges and who have other qualifying service. Section 2(b) would make a clerical amendment to reflect the amendment made by subsection (a).

Section 2(c) would require VA, in consultation with representatives of organizations and agencies that are subject to a memorandum of understanding with VA on preventing Veteran suicide and other such entities as VA determines appropriate, to develop an informational video on secure storage of firearms as a suicide prevention strategy and publish such informational video on a VA website. VA would also have to publish information to inform individuals who participate in the program under the proposed section 1720K that any lockbox furnished pursuant to such program is not eligible or intended for commercial or individual resale.

Section 2(d) would require VA to design and carry out a public education campaign to educate Veterans eligible for covered items under the proposed section 1720K to inform them of the availability of such covered items.

Section 2(e) would establish a rule of construction that nothing in this Act could be construed: to collect personally identifiable information of an individual who participates in the program under the proposed section 1720K for purposes of tracking firearm ownership; require any individual to register a firearm with VA; require mandatory firearm storage for any individual; prohibit any individual from purchasing, owning, or possessing a firearm under 18 U.S.C. § 922; discourage the lawful ownership of firearms; or create or maintain a list of individuals participating in the program.

Section 2(f) would authorize to be appropriated to VA $5 million for each of FY 2025 through 2035 to carry out this section.

Position: VA does not support this bill as drafted.

Views: VA strongly agrees with efforts to reduce Veteran suicide, which may include providing lock boxes to Veterans. However, the bill as drafted is too broad, and the resources needed to implement would significantly exceed the authorized appropriation of $5 million per year. We welcome the opportunity to meet with the Committee to pursue amendments that would address the concerns described below and align with VA's current program.

Late last year, VA established a lock box distribution program, where VA providers can place orders for lock boxes for enrolled Veterans. VA's program also includes education materials for Veterans and clinicians. VA clinical practice guidelines recommend the distribution of lock boxes as a risk mitigation strategy for Veterans at risk of suicide. Our current efforts are focused on Veterans with a risk of suicide, documented within the last 12 months, placing them at medium- to high-risk of suicide who have access to firearms; this access includes peripheral access, where a Veteran may not own a firearm, but may live in a home where someone else does. Through VA's current initiative, providers can place orders for lock boxes, track these orders, and ensure distribution.

The bill would require VA to develop education and training content, as well as a public education campaign, but VA is already working to increase awareness of firearm safety programs like the one described above. The bill is fairly prescriptive in terms of what material must be developed (an informational video), and how this would be developed. VA currently provides materials developed in collaboration with organizations like the National Shooting Sports Foundation (NSSF) and others, which we believe to be sufficient for our current needs. VA has not engaged in a broader public awareness campaign because VA cannot furnish lock boxes to persons other than enrolled Veterans with a documented clinical need. To avoid confusion, our communications are focused on enrolled Veterans and providers to ensure they can access available resources. Additionally, VA's mandatory suicide prevention training course, VA SAVE, includes information on accessing lock boxes through VA, and VA's collaboration with PsychArmor has supported updating this content and distributing it more widely.

VA has concerns about the scope of this bill, which would require VA to carry out the program to provide lock boxes to all Veterans, not just those enrolled in VA care, and not just those at risk of suicide. It would also include former Service members whose service does not qualify them as Veterans for purposes of title 38, United States Code. VA estimates that the lock boxes it distributes cost, on average, $150 each, so making these available to all 18 million Veterans in the United States, with no limitation on the number of lock boxes that could be obtained, could result in a significant drain on VA resources. Further, given the specific parameters that lock boxes must meet, this may increase the average cost per box even more. For example, VA does not currently provide fingerprint-enabled boxes, as the purpose of the lock boxes is to create time and space between suicidal ideation and action and a digitally accessible device would

frustrate that purpose. However, if VA were required to make these available under the program, the costs could also increase.

Given these concerns, we anticipate that the $5 million authorization limit would be reached well before the demand had been met, which would likely lead to frustration on the part of Veterans who may have greater need but who are unable to be among the first to receive a lock box under this program. We further note that the $5 million in authorization would also be applicable to the outreach and education efforts, which by themselves could easily eclipse the authorized limit.

Beyond these substantive concerns, VA has several technical comments on the bill. First, VA notes that there is already a section 1720K, as well as a section 1720L, in title 38, United States Code. As a result, the bill would need to amend this designation to avoid creating duplicate sections in the United States Code. Second, section 2(f) would authorize to be appropriated to VA $5 million for each fiscal year (FY) through FY 2035 "to carry out this section", but this creates some ambiguity as to the scope of that authorization, because section 2(a) would separately create a new section of the United States. Code (proposed section 1720K). If the intent is for this $5 million to be available to carry out the program under proposed section 1720K, we recommend the legislation clearly state that. In the absence of any amendment, VA would interpret the authorization to also include the program under the proposed section 1720K.

Cost Estimate: VA does not have a cost estimate for this bill at this time.

H.R. XXXX Women Veterans Cancer Care Coordination Act

Summary: Section 2(a) of the bill would require VA, not later than 1 year after enactment, to hire or designate a Regional Breast Cancer and Gynecologic Cancer Care Coordinator (coordinator) at each Veterans Integrated Services Network (VISN). Each coordinator would have to report directly to the Director of the Breast and Gynecologic Oncology System of Excellence (BGOSoE). Section 2(b) would state that Veterans would be eligible for care coordination provided by a coordinator if the Veteran is diagnosed with a breast or gynecologic cancer or has been identified as having a pre-cancerous breast or gynecologic condition and is eligible for health care under the Veterans Community Care Program (VCCP). Section 2(c) would require VA to establish regions for purposes of care coordination provided by coordinators; in establishing such regions, VA would have to assign all VA facilities to an appropriate region under the supervision of the BGOSoE Director and a designated coordinator and take into account existing VISNs and the specific needs of Veterans in each region, including Veterans living in rural communities. Section 2(d) would require that coordinators be responsible for carrying out six defined duties, as well as such other duties as may be determined appropriate by VA. Section 2(e) would require VA, not later than 3 years after enactment, to submit to Congress a report on health outcomes, an evaluation of what changes or additional resources are needed to further improve breast and gynecologic cancer care and coordination, and any other matters VA determines appropriate. Section 2(f) would define the term "community care provider" to mean a

health care provider described in 38 U.S.C. § 1703(c) that has entered into a contract or agreement to furnish care and services (other than care related to breast and gynecologic cancer) to Veterans under the VCCP. It would also define the term "breast and gynecologic cancer community care provider" to mean a breast or gynecologic cancer care provider descried in 38 U.S.C. § 1703(c) who has entered into a contract or agreement to furnish care or services related to breast or gynecologic cancer to Veterans under the VCCP. The term "breast cancer" would have the meaning given that term by the Director of the BGOSoE. The term "gynecologic cancer" would mean cervical cancer, ovarian cancer, uterine cancer, vaginal cancer, vulvar cancer, and gestation trophoblastic neoplasia. The term "non-Department facility" would have the meaning given that term in 38 U.S.C. § 1701.

Position: VA supports this bill, subject to amendments and the availability of appropriations.

Views: VA generally agrees that establishing a center and system like the BGOSoE would be advisable and beneficial if resources were not an issue, but there are other initiatives that VA would place as a greater priority in terms of patient outcomes than this proposed system. We recommend the bill be amended to support the current BGOSoE model, where this system hires cancer care coordinators, rather than the VISNs. By managing this program nationally, VA can maintain its current flexibility to respond to evolving needs locally, regionally, and nationally, and to ensure resources are devoted where they will have the greatest effect and benefit for Veterans. For example, the bill would require VA to hire or designate a coordinator in each VISN, even when we may not have sufficient patient populations to justify a full-time coordinator in each VISN. The organizational structure contemplated by this bill is inconsistent with current practice and operations. Also, the bill would require VA to establish regions for purposes of care coordination, but it is unclear if these regions are intended to duplicate, overlap, or represent subdivisions of existing VISNs. VA believes legislation that expands on our current efforts, and provides the necessary resources to support such expansion, would be beneficial to Veterans.

Many Veterans seeking breast or gynecologic cancer care from VA receive this care from community providers, and care coordination is a critical component to ensuring positive patient outcomes. Coordination can ensure Veterans are receiving timely, high-quality care, and are satisfied with their experience. VA has developed a care coordination navigator tool that we believe addresses many of the objectives of this bill. Our current efforts would not address everything this bill would require, but we are working to enhance our capabilities for these cancers and others as well. We would be happy to provide a demonstration to the Committee of our current efforts if that would be helpful.

We do have some concerns with the specific requirements in this bill. The requirement to make "regular contact with each Veteran based on the Veteran's specific medical needs when the Veteran receives care from a community care provider" could be burdensome on Veterans and VA staff; Veterans may be receiving care for services

completely unrelated to breast or gynecologic cancer care, but requiring coordinators to contact Veterans about this care could be overwhelming for Veterans and staff. Some of the information VA would be required to furnish, such as how to access emergency care, is already provided to enrolled Veterans.

VA also cautions that some of the reporting requirements in this bill may not be realistic or reliable, particularly given the potentially small populations involved. For example, it may not be possible to compare health outcomes of Veterans who received cancer care at a VA facility and those who received such care from a non-VA provider. We emphasize that, if enacted, VA could only report this information nationally, both to ensure data validity and integrity as well as to ensure patient confidentiality and privacy. Some of the data elements may not be able to be captured as written; for example, the patient safety requirements, particularly for non-VA care, would not be able to be gathered and verified. As noted earlier, VA would need appropriate staffing to ensure the data elements required in these reports could be collected and analyzed.

VA has some additional technical comments on this bill, particularly regarding the reporting requirements, and would be happy to work with the Committee to address them.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. XXXX No Wrong Door for Veterans Act

Summary: This draft bill would make 11 amendments to section 201 of the Commander John Scott Hannon Veterans Mental Health Care Improvement (Hannon) Act of 2019, P.L. 116-171, which authorized the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program (SPGP). First, it would change the requirement for the Secretary to consult with the Office of Mental Health and Suicide Prevention (OMHSP) in carrying out this program. The Secretary would instead be required to consult with the Assistant Under Secretary for Health (AUSH) for Clinical Services. Second, it would limit the amount of grant funds that could be awarded, reducing the amount from $750,000 to $500,000 per fiscal year, plus $10,000 per eligible individual who receives suicide prevention services provided or coordinated by the grantee. It would also limit the use of grant funds to provide that not more than 5% of a grant could be spent on food and non-alcoholic beverages in a fiscal year. Third, it would amend subsection (d)(2), which governs the use of preference in awarding grants, to provide that VA could not give preference to an eligible entity solely because the eligible entity previously received, or applied for, a grant under this section. Fourth, it would amend subsection (f), which governs requirements for application for grants, to add a new paragraph (3) that would require applications from entities that previously received grant funds to include evidence that the entity used such grant funds to serve a significant number of Veterans. Fifth, it would require the Secretary to provide to the appropriate personnel of each VA medical center (VAMC) within 100 miles of the primary location of a grantee a briefing, not less than once per calendar quarter, about the grant program to improve the coordination between a grantee and the VAMC personnel. VA could permit

a representative of a grantee to attend these briefings. Sixth, it would extend the authority to carry out this pilot program until September 30, 2028. Seventh, it would amend subsection (n), which requires VA to provide care to eligible individuals in certain situations, to state that grantees would have to notify eligible individuals receiving suicide prevention services that the eligible individual may receive emergent suicide care under 38 U.S.C. § 1720J. Grantees would also have to notify VA if the individual requests such emergent suicide care. Eighth, it would authorize the appropriation of $157,500,000 for FY 2026-2028. Ninth, it would amend subsection (q)(3), which defines the term "eligible entity" for purposes of this law, to require entities to have continuously provided mental health care or support services in the United States during the 2-year period before the date on which the entity applies for a grant. It would also include health care providers within subparagraph (A), which currently refers to incorporated private institutions or foundations that operate on a non-profit basis and that have a governing board that would be responsible for the operation of suicide prevention services. Tenth, it would make a technical change to the definition of emergency treatment. Finally, it would amend subsection (q)(11)(A)(ii), which defines suicide prevention services as including a baseline mental health screening for risk. The amendment would provide the baseline mental health screening for risk must use a protocol selected by VA. Section 2(k)(2) of the bill would provide a rule of construction that, in addition to the protocol selected by VA, VA may furnish another protocol to a grantee, and a grantee may use another protocol to screen for risk.

Position: VA supports the bill, subject to amendments and the availability of appropriations.

Views: VA supports four of the amendments this bill would make, specifically; (1) extending the duration of the pilot program through FY 2028; (2) requiring grantees to inform individuals, and VA when indicated, that they may receive emergent suicide care under 38 U.S.C. § 1720J (which is already occurring); (3) the additional requirement that eligible entities must have continuously provided mental health care or support services in the United States during the previous 2 years; and (4) the technical correction to the definition of emergency treatment (which would have no substantive effect on benefits for eligible individuals). VA continues to appreciate Congress's support of the SPGP, and we look forward to Congress reauthorizing the program; we also appreciate the opportunity to meet with the Committee to discuss the concerns we identify below.

VA has significant concerns with some of the changes this bill would make and seeks amendment to these provisions. The proposed cap of $500,000 per grantee per fiscal year (which we assume to be the intent, but the bill technically strikes the language making clear that the cap applies "per grantee per fiscal year"), plus an additional $10,000 per grantee per fiscal year for each eligible individual who receives suicide prevention services provided or coordinated by the grantee, does not align with the way Federal assistance through grants is operated by funders and recipients. Applicants propose the number of Veterans to be served and estimate their costs within their application. It would be incredibly difficult, if not impossible, to actually implement

this type of award schedule, as it would require significant reconciliation based on the actual versus projected number of eligible individuals served; further, any upward adjustments at the end of the year would likely have little effect in terms of further outreach or support. The mechanics, both for VA and for grantees, would likely prove incredibly onerous.

The required quarterly briefings to VAMCs would likely require resources disproportionate to the value that would be realized from sharing this information. VA currently provides information to facilities and staff to support coordination, and we believe these efforts are sufficient. Further, the specification of not more than 100 miles from the primary location of a grantee is less useful than the service area of the grantee.

VA is concerned about allowing grantees to use a different protocol for the baseline mental health screening for risk besides the protocol furnished by the Secretary. The current baseline mental health screening protocol is the collection of five screenings that assess mental health, well-being, financial stability, and social support. These inform the individual's treatment plan and referral needs; they also are vital to program evaluation because they are conducted both pre- and post-service delivery. To determine service and program effectiveness, it is essential that all grantees use the same protocol for this. The Columbia-Suicide Severity Rating Scale is currently a tool used by VA as one component of eligibility screening, in that it identifies individuals with suicidal thoughts and behaviors. If Congress's intent is simply to allow grantees to use a different protocol to determine the degree of risk for eligibility, we believe this needs to be clarified, though this could raise concerns with creating disparate approaches. VA has already established in regulations that both determining the degree of risk for eligibility and the baseline mental health screening protocol require the use of validated tools provided by VA and announced in each notice of funding opportunity. We believe this arrangement preserve's VA's flexibility to ensure the best results for Veterans. We are concerned that the rule of construction in section 2(k)(2) of the bill creates ambiguity, as it would provide that, "In addition to the protocol selected" by VA, VA "may furnish another protocol to a grantee", and "a grantee may use another protocol to screen for risk". The use of the phrase "another protocol" in both subparagraphs (A) and (B) could be read to mean that VA could establish one protocol and furnish another, and the grantee could use only one of these two options. Alternatively, subparagraph (B) could be read to mean that VA could establish one protocol, furnish another one, and the grantee could pick a completely different protocol on its own. For the reasons expressed above, we strongly recommend against this second reading, as it would make comparisons between grantees extremely difficult, if not impossible, and it could produce more confusion as to eligibility determinations as well.

Several of the amendments are unnecessary, including the change to require the Secretary to consult with the AUSH for Clinical Services instead of OMHSP (as the OMHSP reports to the AUSH for Clinical Services). OMHSP has separated into the two following offices: the Office of Mental Health and the Office of Suicide Prevention. We recommend the bill strike any reference to a sub-component of VA, as this would avoid further confusion that might arise from reorganization or renaming of existing offices.

The responsibility for implementation ultimately rests with the Secretary, so identifying further offices is neither necessary nor constructive. Also, VA does not view a limitation on the use of funds for food and non-alcoholic beverages as necessary within the pilot phase, where VA continues to gather data to inform the extent of this funding need and the justification for any such limitations. We do note that the limitation on non-alcoholic beverages implies there is no limitation on alcoholic beverages, which we do not believe would be appropriate. The amendment to require applications submitted by previous grantees include evidence that they served a significant number of Veterans is both vaguely defined and unnecessary as renewal applications and grantee performance reports already discuss this.

VA also recommends including additional amendments to section 201 of the Hannon Act in this bill. VA recommends removing the requirement to coordinate with the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide Task Force because this Task Force is no longer operational.

VA also recommends amending the definition of eligible individual in section 201(q)(4)(C)) as it relates to individuals eligible for readjustment counseling services. This amendment would account for a statutory change that was made to section 1712A just days after enactment of the Hannon Act that appears to have unintentionally changed eligibility conditions under the SPGP. As originally enacted, the Hannon Act established as eligible individuals those persons described in clauses (i) through (iv) of 38 U.S.C. § 1712A(a)(1)(C). The Hannon Act was enacted on October 17, 2020. On October 20, 2020, the Vet Center Eligibility Expansion Act (Public Law 116-176) was signed into law. This law created new clauses (iv) and (v) in section 1712A and redesignated the existing clauses (iv) and (v) to be clauses (vi) and (vii). As a result of this, for 3 days during October 2020, well before VA could implement the SPGP, individuals who received counseling under section 1712A before the date of enactment of the national Defense Authorization Act for Fiscal Year 2013 were eligible for the SPGP but are not currently eligible unless they meet another condition of eligibility under section 201(q)(4) of the Hannon Act. While we anticipate this would affect only a small number of individuals, we believe amending the Hannon Act to include this population would be fair to them and more consistent with Congressional intent. It is unclear if the other category of persons included by P.L. 116-176, namely individuals who participated in a drug interdiction operation as a member of the Coast Guard, were intended to be included in the definition of eligible individuals under the SPGP.

We would be happy to provide technical assistance to the Committee, including specific line edits, to address these recommendations.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. XXXX Providing Veterans Essential Medications Act

Summary: This bill would amend 38 U.S.C. § 1745(a)(3), which generally dictates terms of payment by VA to state homes for nursing home care provided to

certain Veterans. Specifically, this bill would create a new subparagraph (B) that would state, in addition to payment pursuant to a contract or agreement with each State home for nursing home care for eligible Veterans, VA would have to, at the election of a covered state home, reimburse a covered state home for a costly medication or furnish such costly medication to the covered state home. The term "costly medication" would be defined to mean a drug or medicine for which the average wholesale price for 1 month's supply, plus a 3% transaction fee, exceeds 8.5% of the payment under the contract or agreement by VA to a covered state home for care provided to the Veteran who receives the costly medication during a month. The term "covered State home" would mean a state home that, in the course of nursing home care provided pursuant to a contract or agreement, provides to a Veteran a costly medication.

Position: VA does not support.

Views: VA supports the intent to ensure state Veteran homes are adequately supported in covering the costs to care for Veterans. However, VA is concerned that several of the terms in this bill are ambiguous; several are too specific; and ultimately the bill could result in unintended or adverse consequences for Veterans. We would appreciate the opportunity to discuss this bill and VA's concerns with the Committee.

Initially, it is not clear that this bill is needed. Section 1745 already provides that each contract or agreement between VA and a State home is based on a methodology, developed by VA in consultation with State homes, to adequately reimburse the State home for the care provided by the State home under the contract or agreement. If the current methodology is inadequate, there are existing statutory means of updating it without further legislation. VA is not aware of existing data demonstrating that the existing prevailing rates paid to state homes by VA is insufficient for the patient population receiving care as it relates to high-cost medications.

Second, several of the bill's amendments could have significant unintended consequences to the operation of VA's programs due both to ambiguity in some terms and too much specificity for others. The proposed payment methodology is not aligned with how VA currently pays for and purchases medications. VA often obtains medications at significant discounts because of the size of the VA system, but the bill would not necessarily allow state homes to take advantage of VA's savings. For example, the bill would provide that VA would have to, "at the election of a covered State home", reimburse the covered state home for a costly medication or furnish such costly medication to the covered state home. However, this is unclear as to whether this is a one-time choice made by the state home, or if literally each costly medication administered to each Veteran is subject to this election. If VA were required to track each specific request for each medication for each Veteran, this could be extremely complicated to administer, track, and monitor. Further, if a state home elected that VA would furnish the costly medication, but VA had none in stock (or could not provide any in a reasonable and clinically appropriate time period for the Veteran), it is not clear what repercussions would follow. VA could be forced to maintain a surplus of costly medications to ensure that it could meet any demand from covered state homes, but

some of this medication could end up going to waste if it could not be used before it expired. VA has mechanisms in place to ensure it maintains a sufficient supply for its own needs, but it would likely have more difficulty and result in more cost if it needed to maintain inventory for state homes as well. The bill is also unclear as to the units that constitute a costly medication. For example, some medications may have a high up-front cost that might qualify, but could be used multiple times, such that the "average wholesale price" would fall below the threshold the bill would establish. Similarly, it is unclear what happens if a Veteran only needs a small dose of an otherwise expensive medication. The bill is unclear as to whether the state home could require VA to reimburse the entire cost of the medication or only the per unit cost of the medication. Depending on how this is implemented, VA could end up paying significantly more than its actual costs objectively should be. The "8.5 percent of the payment" language is also unclear, as it appears to reference the entire cost of the payment under each contract or agreement with a state home, which may cover multiple Veterans, or if the "8.5 percent of the payment" phrase is intended to only apply to a single Veteran.

VA is also concerned about several of the provisions in the bill that are too specific. In particular, VA is concerned about the "3 percent transaction fee" language in proposed subparagraph (C)(i). While this would technically only apply to the determination of which medications are considered "costly medications", this could be interpreted to require VA to include in its reimbursement this 3% fee, if the state home elected to be reimbursed, even if VA's transaction fees are actually much less. This would result in a windfall for state homes at the cost of other Veterans VA could serve. We recommend the bill clearly state that the amount that VA would reimburse would be separately established and that the 3% transaction fee would not be applicable to the reimbursement rate. In other words, the 3% transaction fee defines what would be reimbursable, not how much VA would reimburse.

The bill could also result in unintended or adverse consequences for Veterans. This section would require VA to assume additional liability for specific types of care for which the state homes are responsible. In doing so, this could remove incentives for State homes to provide certain medications that might be more clinically appropriate to Veterans because VA would not be financially responsible for them. By making VA responsible for additional payments for some medications but not others, this bill could incentivize the use of those medications over other, more effective or appropriate medications. VA also recommends against basing prices on the "average wholesale price", which is, in most circumstances, an arbitrary cost that does not reflect the actual purchase price of medications. The use of the average wholesale price would likely inflate actual costs as VA pays less than this price.

Cost Estimate: VA does not have a cost estimate for this bill but anticipates the costs could be significant.

H.R. XXXX Establishing the Period for Referrals for the Veterans Community Care Program

Summary: The draft bill would amend 38 U.S.C. § 1703(a)(2), which requires VA to coordinate the furnishing of care and services under the VCCP including coordination of several programmatic requirements. Specifically, the bill would include a new subparagraph (E), which would require VA to coordinate care by ensuring the period during which the referral of a covered Veteran, made by a VA health care provider to a non-VA provider, for care or services under the VCCP is valid and begins on the day that the covered Veteran has the first appointment with such non-VA provider.

Position: VA supports this bill, subject to amendments to clarify its intent and effect.

Views: VA supports the apparent intent of this legislation but recommends further changes for clarity. As written, the proposed subparagraph (E) is difficult to understand grammatically given the number of subordinate clauses used. It appears the intent is to ensure that a referral for care from a non-VA provider is valid beginning on the date of the first appointment with a non-VA provider. This intent would seem to be relevant given that eligible Veterans who elect to receive care through VCCP can elect to receive an episode of care from an eligible non-VA provider; VA has defined the term "episode of care" through regulation to mean "a necessary course of treatment, including follow-up appointments and ancillary and specialty services, which lasts no longer than 1 calendar year". See 38 C.F.R. § 17.4005. The bill, then, would presumably mean the period for an episode of care (which is up to 1 calendar year, but may be less in some situations) would begin on the date of the first appointment with a non-VA provider. VA supports this interpretation of the bill.

VA policy is currently consistent with the proposed text, but VA practice has been inconsistent in this regard. We are working to update training, documentation, and guidance to the field to ensure the date of the first appointment is the basis for the period of an authorized episode of care.

VA appreciates the opportunity to work with the Committee to ensure this bill text is clear and does not create any unintended consequences.

Cost Estimate: VA does not anticipate additional costs for this bill.

H.R. XXXX Veterans Supporting Prosthetics Opportunities and Recreational Therapy Act

Summary: This draft bill would amend 38 U.S.C. § 1701(6), which defines the term medical services for purposes of chapter 17 of title 38 of the United States Code to specify that artificial limbs include adaptive prostheses and terminal devices for sports and other recreational activities.

Position: VA supports this bill, subject to amendment.

Views: VA fully supports ensuring that eligible Veterans in need of adaptive recreation equipment, including adaptive prostheses and terminal devices for sports and other recreational activities, are able to access these items. VA has already included these items in its regulations at 38 C.F.R. § 17.3230(a)(1)(ii), which includes adaptive recreation equipment among the items and services VA will provide Veterans if VA determines that such items and services: (1) are needed to promote, preserve, or restore the health of the Veteran (under 38 C.F.R. § 17.38(b)); (2) serve as a direct and active component of the Veteran's medical treatment and rehabilitation; and (3) do not solely support the comfort or convenience of the Veteran. These regulations are VA's interpretation of sections 1701 and 1710 of title 38, United States Code, in this area. VA has defined adaptive recreation equipment at 38 C.F.R. § 17.3210 to mean an item that is designed to compensate for, or that by design compensates for, loss of physical, sensory, or cognitive function and is necessary for the Veteran to actively and regularly participate in a sport, recreation, or leisure activity to achieve the Veteran's rehabilitation goals as documented in the Veteran's medical record.

VA believes this language would be redundant given current regulations and practice. In addition, we express concern that enacting a bill of this type could result in confusion in this area. Such confusion could jeopardize or frustrate the delivery of benefits to Veterans because this language does not align exactly with VA's current regulations. This could lead to an inference that the bill is intended to create benefits different from VA's current regulations and could lead to litigation. We recommend Congress include the following rule of construction to address these concerns: "Nothing in this Act shall be construed to alter the scope of benefits the Secretary currently provides to eligible Veterans under section 17.3230 of title 38, Code of Federal Regulations, or successor regulations." We would be happy to work with the Committee on this language.

VA providers currently evaluate each patient's needs and prescribe such equipment as clinically appropriate. VA can also prescribe and furnish these items as prosthetic devices as well under current regulations. VA currently provides Veterans with artificial limbs specifically designed for numerous activities like running, swimming, and climbing. VA also provides Veterans with a broad array of adaptive equipment to participate in their preferred recreational activities. Examples include adaptive hand cycles; wheelchair basketball equipment; adaptive ski and hockey equipment; and customized adaptations to participate in activities from hunting to kayaking.

If any Members of the Committee are aware of issues or cases where Veterans have not received necessary equipment, we ask that you please let us know so we can assist.

Cost Estimate: This draft bill would result in no additional cost because it would result in no change in policy.

H.R. XXXX Veterans National Traumatic Brain Injury (TBI) Treatment Act

Summary: 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 posttraumatic stress disorder (PTSD) through health care providers who are not VA employees, Medicare providers, Department of Defense (DoD) providers, Indian Health Service (IHS) providers, or Federally-qualified health centers.

Section 2(b) would require VA to select three Veterans Integrated Services 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 monies for the fund would be from donations received by VA for the express purposes of the fund. The 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 Food and Drug Administration (FD)A or issued an investigational device exemption by the FDA.

Position: VA does not support.

Views: The bill 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.

Additionally, there is no scientific basis to support the clinical efficacy of HBOT as a treatment for PTSD, and there is a strong clinical basis that HBOT is not recommended for treating TBI. In this context, we are concerned that this bill could result in adverse health outcomes for participating Veterans and there is also little ability to monitor performance with definitive, evidence-based metrics.

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 to 2 hours per day, 5 days a week, for 4 to 8 weeks), the need to travel, or 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 a mild TBI. Published results of scientifically rigorous VA and DoD research on TBI have repeatedly shown that HBOT has the same impact as a placebo and no clinically relevant long-term effects[1,2,3,4,5,6]. In addition to the lack of patient improvement, the use of HBOT after a 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 increased 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

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[1] Walker WC, Franke LM, Cifu DX, Hart BB. Randomized, sham-controlled, feasibility trial of hyperbaric oxygen for service members with postconcussion syndrome: Cognitive and psychomotor outcomes 1 week postintervention. Neurorehabilitation & Neural Repair. 2014;28(5):420-432.
[2] Cifu DX, Walker WC, West SL, et al. Hyperbaric oxygen for blast-related postconcussion syndrome: Three-month outcomes. Annals of Neurology. 2014;75(2):277-286.
[3] Wolf G, Cifu D, Baugh L, Carne W, Profenna L. The effect of hyperbaric oxygen on symptoms after mild traumatic brain injury. J Neurotrauma. 2012;29(17):2606-2612.
[4] Miller RS, Weaver LK, Bahraini N, et al. Effects of hyperbaric oxygen on symptoms and quality of life among service members with persistent postconcussion symptoms: A randomized clinical trial. JAMA Internal Medicine. 2015;175(1):43-52.
[5] Weaver LK, Chhoeu A, Lindblad AS, Churchill S, Deru K, Wilson SH. Executive summary: The brain injury and mechanism of action of hyperbaric oxygen for persistent post-concussive symptoms after mTBI (BIMA) study. Undersea & Hyperbaric Medicine. 2016;43(5):485-489.
[6] Boussi-Gross R, Golan H, Fishlev G, et al. HBOT can improve post-concussion syndrome years after mild traumatic brain injury - randomized prospective trial. PLoS One. 2013;8(11):e79995.

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.

We strongly encourage that if Congress wants to create a new program, it should fund this through conventional appropriations measures, rather than relying on donated funds that are dependent on voluntary contributions from third parties. 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 has significant technical issues. For example, the bill lacks 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.

Cost Estimate: VA does not have a cost estimate for this bill.

H.R. XXXX Copay Fairness for Veterans Act

Summary: The Veterans Preventive Health Coverage Fairness Act would amend 38 U.S.C. §§ 1710 and 1722A(a)(3) to eliminate copayments by VA for hospital care, medical services and medications related to preventive health services. The proposed legislation would also amend 38 U.S.C. § 1701(9) to expand the definition of "preventive health services."

Position: VA supports this bill subject to amendments and the availability of additional appropriations to replace lost revenue from the elimination of these copayments.

Views: The proposed legislation does not appear to impact VA's authority to assess a copayment when an outpatient visit includes services beyond preventive health services or VA's authority to recover reasonable charges from a third-party under 38 U.S.C. § 1729. VA notes that under existing regulatory provisions at 38 C.F.R. § 17.108, outpatient visits solely consisting of preventive screening and immunizations and laboratory services, flat film radiology services and electrocardiograms are not subject to copayment requirements and, pursuant to existing 38 C.F.R. § 17.4600, an eligible Veteran who receives urgent care consisting solely of an immunization against influenza is not subject to a copayment.

VA has technical comments on some of the provisions in this legislation and would be happy to work with the Committee to address them.

Cost Estimate: VA does not have a cost estimate at this time.

H.R. XXXX Directing VA and the Comptroller General to Report on Certain Funding Shortfalls in VA

Summary: Section 1(a) of the bill would require the Comptroller General, within 30 days of enactment, to begin a review regarding the circumstances surrounding, and the causes of, the shortfall in funding of the Veterans Benefits Administration for FY 2024 and the expected shortfall in the funding of VHA in FY 2025. Within 30 days of completing the review, the Comptroller General would have to submit a written report to VA containing the results and findings of the review. Within 30 days of receiving this report, VA would have to submit the report to Congress.

Position: **VA defers to the Comptroller General on this bill.**

Views: VA generally defers to the Comptroller General on this bill, but we note that the bill's requirement for the Comptroller General to submit a report to VA, and then for VA to submit the Comptroller General's report to Congress, is unusual. It would seem more direct for the Comptroller General to simply submit the report to Congress and to VA when complete.

Additionally, there is an ongoing assessment by the Comptroller General and VA's Office of Inspector General (OIG) of VHA's funding estimates. Under Public Law 118-82, Congress has already required VA to submit a report detailing corrections VA will make to improve forecasting, data quality, and budget assumptions relating to budget submissions for VBA funds; Congress also required VA to submit a report on the status of funds available for compensation and pensions and readjustment benefits, with updates every 90 days. This law also directed OIG to review the circumstances surrounding and the underlying causes of the announced shortfall for VBA for FY 2024 and VHA for FY 2025

Cost Estimate: VA does not have a cost estimate for this bill.

Conclusion

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

Prepared Statement of Jeffrey Gold

UNIVERSITY OF NEBRASKA

OFFICE OF THE PRESIDENT

March 11, 2025

The Honorable Mariannette Miller-Meeks
Subcommittee on Health
House Committee on Veterans' Affairs
364 Cannon House Office Building
Washington, D.C. 20003

Dear Members of the Subcommittee on Health:

On behalf of the University of Nebraska, I would like to extend my sincere gratitude for the opportunity to provide testimony on making permanent the CHIP-IN for Veterans Act. It is an honor to engage with the Committee on such a critical issue that has already demonstrated success in delivering high-quality healthcare facilities for our nation's veterans through innovative public-private partnerships.

As outlined in the attached materials, the University of Nebraska Medical Center (UNMC) and Nebraska Medicine have a longstanding history of collaboration with the Department of Veterans Affairs to provide exceptional care to those who have served our country. Building on the proven success of the CHIP-IN model, we believe there is an opportunity to further enhance healthcare delivery for veterans in Nebraska and Western Iowa through the construction of a new VA hospital adjacent to the forthcoming Project Health facilities on the UNMC campus.

This strategic co-location would result in significant cost savings, reduced construction timelines, and enhanced access to world-class care for our veterans. By leveraging private sector efficiencies and philanthropic support, this initiative aligns with the core principles of the CHIP-IN Act and exemplifies the power of public-private partnerships in modernizing veteran healthcare infrastructure.

We appreciate the Committee's leadership and commitment to improving healthcare for our nation's veterans. We encourage you to review the attached materials for further details on this proposal and look forward to continued discussions on how we can work together to make this vision a reality.

Thank you for your time and consideration.

Sincerely,

Jeffrey P. Gold, M.D.
President

Attachments

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OFFICE OF THE PRESIDENT

Testimony before the House Veterans' Affairs Committee
Subcommittee on Health
President Jeffrey P. Gold, M.D.
University of Nebraska System
Oral Testimony
March 11, 2025

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, Congressman Bacon, and members of the House Committee on Veterans' Affairs, Subcommittee on Health. I am Dr. Jeffrey Gold, and I have the distinct privilege of serving as the President of the University of Nebraska System which has campuses in Lincoln, Omaha, and Kearney, as well as a top ranked Academic Medical Center in Omaha. We educate approximately 50,000 students and do approximately $700 M in research. I am a physician and heart surgeon by training. For 10 years prior to my current position, I had the privilege of serving as the Chancellor of the University of Nebraska Medical Center (UNMC) and the Board Chair of Nebraska Medicine, a world-class, statewide medical care and research campus approximately one mile from the current VA facilities. For many decades, UNMC has had broad and deep relationships with civilian and military federal departments, focused on training, research and clinical care. Over the past decade, there has been intense multi departmental focus and key federal partnerships in the CBRNE global health security sector.

Thank you for the opportunity to testify today in support of Congressman Bacon's H.R. 217, co-sponsored by Congressmen Gottheimer and Wittman, which seeks to make permanent the *CHIP-IN for Veterans Act*. This bill supports our service members through innovative approaches to develop and finance VA facilities through public-private partnerships.

In 2016, a former colleague of yours, Congressman Brad Ashford of Nebraska, was instrumental in passing new legislation creating a pilot program that would allow for public-private partnerships with the VA. This opportunity led to a remarkable improvement in care for our local veterans' community, including construction of a new ambulatory center that today serves as the key resource for outpatient diagnostic, procedural and interventional veterans care services in local the Nebraska-Western Iowa region. This project, funded through a combination of federal dollars and private philanthropy, has been recognized nationally as a true pillar of success.

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Over the past years, the University of Nebraska Medical Center identified a significant need to replace several of our own aging academic medical center facilities on the Omaha campus. Among these improvements is a forthcoming $2.19 billion project, known as "Project Health," that will serve as a state-of-the art medical facility, with unique training opportunities focused on meeting Nebraska's growing need for medical professionals. This project will also provide access to high-quality advanced medical care, a unique interprofessional multidisciplinary learning environment and access to life saving clinical trials for patients across the state. Project Health is a collaboration with the state of Nebraska, the city of Omaha, the University of Nebraska, the academic Medical Center, and Nebraska's philanthropic community.

UNMC's history of successful partnership with the VA, combined with the forthcoming construction of Project Health facilities, present a unique opportunity for further collaboration to better serve our nation's veterans and a model for the future.

We have proposed that a new VA hospital, positioned on the UNMC campus to better meet the needs of veterans in Nebraska and Western Iowa, would be constructed to replace the aging structure currently in use. This new free-standing facility would be branded, staffed and operated by the VA with physical connectivity to Project Health for potentially shared diagnostic, interventional, laboratory and support services. This would also provide proximity for university clinicians and learners from UNMC, while remaining open to staffing and training of other private academic medical center professional staff.

This state-of-the-art facility, leveraging private construction and adjacent resources, would be significantly more cost-effective than renovating or replacing the existing VA hospital that was opened in 1950. In this scenario, both the new medical facility and adjacent academic, research, and clinical facilities, could potentially share state-of-the-art diagnostic and procedural equipment suites and leverage future generations of healthcare professionals and other strengths of the university.

This approach is not only cost-effective, but also ensures veterans receive the highest standard of care. By utilizing private sector efficiencies and philanthropic support, we can significantly reduce construction timelines and costs, ensuring timely delivery of quality services to those who have served our country.

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The permanent authorization of the CHIP-IN Act through H.R. 217 is essential to expanding these successful partnerships nationwide. Additionally, expanding CHIP-IN to allow minor construction projects and leased facilities could further enhance VA service delivery and flexibility in meeting veterans' needs.

Our community has demonstrated the potential of highly successful public-private partnerships in veteran healthcare, and the CHIP-IN Act, born in your committee, is one example of a proven success. By making this program permanent, we can empower other communities to replicate our achievements, providing long-overdue facility upgrades and improved access to care for veterans across the country. By effecting the proposed partnership in Omaha, we together can set the standard for the future of care for those who wore the cloth of our nation and protected our freedom.

Thank you for your time, and I look forward to your questions.

Enclosures: Background and Project Narrative, President Gold Bio, Ten (10) Photos

UNIVERSITY OF NEBRASKA

BACKGROUND & PROJECT NARRATIVE

The University of Nebraska System, founded in 1869, is the public land-grant system of the State of Nebraska and has served as such as the only public university system for the past 155 years. Serving just under 50,000 undergraduate, graduate and professional learners, with over 16,000 faculty and staff on a wide spectrum of rural and urban campuses, we continue to grow in size, quality and international reputation. In addition, we have the honor of housing a DOD University Affiliated Research Center (UARC), a USAF CSTARS training center, and the largest HHS/ASPR quarantine, isolation and biocontainment facility in the United States.

Varner Hall

In 1859, the same year as the founding of the university, Nebraska's only state Medical College was chartered in Omaha. It rapidly grew, and faculty and staff developed relationships with a wide spectrum of public and private hospitals, clinics and physician groups—including the VA—to better serve the community and educate the next generation of healthcare professionals. In 1968, the state Medical College formally became the University of Nebraska Medical Center (UNMC), which today contains seven colleges including medicine, nursing, pharmacy, dentistry and public health. Our graduate medical education programs enroll over 700 residents and fellows in 81 programs across our system.

Fred & Pamela Buffett Cancer Center

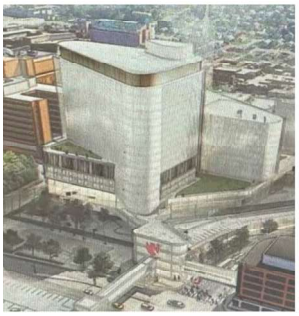
Nebraska Medicine, our long-time partner clinical delivery system, with physically connected facilities, shares many of the same campus locations, operates dozens of ambulatory care sites and inpatient facilities with our faculty, students, residents and staff. With well over one million outpatient visits, tens of thousands of surgical procedures, a world class NCI cancer center, cardiovascular center and more, UNMC enjoys longstanding patient quality, safety and experience ratings and rankings by Vizient, USNWR, Magnet and many others, as among the very best in the nation.

For more than 150 years our students, faculty and staff have strived to meet the medical needs of Nebraskans statewide, including our veterans—those who have worn the cloth of our nation and protected our freedom. Our relationships with the VA and other entities serving servicemen and women are broad and deep, many of which are bound in contractual relationships, joint appointments and clinical rotations. Even more are bound by dual professional families, camaraderie, friendship and community support. Together we have continued to work well and have continued to grow to serve our communities and, specifically, our veterans.

The past few decades saw many unsuccessful attempts to replace both the 75-year-old inpatient and outpatient facilities serving our veterans on their designated campus known as the Nebraska Western Iowa Veterans Administration Hospital. These attempts were unsuccessful for a variety of reasons, mostly related to an inability to secure appropriate funding in spite of the best efforts of our federal delegation and the communities that we collectively serve. However, a decade ago, we finally found success through an innovative leadership model that allowed creation of a public-private partnership through the institution of a not-for-profit 501-C3 corporate structure. The 501-C3, known as the Veterans Clinic Development Corporation, entered into a partnership with the Veterans Administration Central Office under the leadership of the Secretary of the VA to plan, build and then donate a large ambulatory care center to the VA on their campus. This project was completed in 2021 and in the years since has served a large majority of all outpatient diagnostic, procedural and interventional care.

Nebraska Western Iowa VA
Ambulatory Clinic & Surgicenter

This project has been recognized as a true pillar of success in that the funding through the federal taxpayer dollars, along with the funding through the private philanthropic community under the leadership of a small private not-for-profit corporation, served to turn this dream into a reality ahead of schedule and under budget. This success was only made possible through the creative energy of the leadership of the VA leadership, the local leadership here in Nebraska, and the wisdom and generosity of Omaha's private philanthropic community. A magical formula now known as the CHIP-IN was created by bipartisan action of Congress and signed into law in December of 2019.



UNMC Academic Medical Center - Phase 1

In recent years, the University of Nebraska Medical Center has identified a significant need to replace several of our own aging academic medical center facilities on our Omaha campus. While we have added over $1 billion in facilities to our medical center campuses over the past decade, a new project known as Project Health will produce what we believe to be one of the finest academic clinical centers of its type across all of the health professions in the nation. Appended to this document are architect renderings and descriptive briefings of the role and mission for this 1.36 million square foot $2.19 billion facility. Again, the capital stack for this amazing project represents a true public-private partnership with the state of Nebraska, the city of Omaha, the University of Nebraska Medical Center, and of course the generosity of private philanthropic community. Demolition and site preparation work has begun on the 7.7-acre site, and we anticipate contruction to begin this summer. A campus map of our primary Omaha site is included below outlining the location of this project and the interconnectivity to the remainder of the campus.

UNMC's history of successful partnership with the VA, combined with the forthcoming construction

of Project Health facilities, present a unique opportunity for further collaboration to better serve our nation's veterans and a model for the future.

A new VA hospital, positioned on the UNMC campus to better meet the needs of veterans in Nebraska and Western Iowa, would be constructed to replace the aging structure currently in use. This new free-standing facility would be branded, staffed and operated by the VA with physical connectivity to Project Health for potentially shared diagnostic, interventional, laboratory and support services. This would also provide proximity for university clinicians and learners from UNMC, while remaining open to staffing and training of other private academic medical center professional staff.

This state-of-the-art facility, leveraging private construction and adjacent resources, would be significantly more cost-effective than renovating or replacing the existing VA hospital that was opened in 1950. In this scenario, both the new medical facility and adjacent academic, research, and clinical facilities, could potentially share state-of-the-art diagnostic and procedural equipment suites and leverage future generations of healthcare professionals and other strengths of the university.

This approach is not only cost-effective, but also ensures veterans receive the highest standard of care. By utilizing private sector efficiencies and philanthropic support, we can significantly reduce construction timelines and costs, ensuring timely delivery of quality services to those who have served our country.

UNMC Prepared Campus
Academic Medical Center Site

As mentioned above, adequate land is currently available and could be transferred either by sale or lease if required to do so. The creation of a public-private partnership will markedly reduce the taxpayer cost of this new facility for our veterans that would literally be just feet away from the existing world-class ambulatory clinic. Co-location would also permit partnering to share important state of the are ancillary resources such as utilities, parking, central sterile supply and many others. The city of Omaha has already completed major roadway and utilities upgrades to support the scale of this combined project. An indirect benefit of this would be to free up sufficient space on the VA campus for other purposes which is desperately needed to better serve our veterans.

The call to action is to enter a public-private partnership with the University of Nebraska, Nebraska Medicine and/or the Veterans Development Corp to plan, build and operate a new inpatient facility on the UNMC Omaha campus to provide for generations to come of world-class care, develop the next generation of supporting multidisciplinary workforce, and connect transformational bioscience research to serve those who have served our nation.

ABOUT

PRESIDENT JEFFREY P. GOLD, M.D.

Jeffrey P. Gold, M.D., became the ninth president of the University of Nebraska System on July 1, 2024. He leads the four-campus system, which enrolls nearly 50,000 students and employs 16,000 faculty and staff. As president, he serves as chief spokesman and CEO for the system, which operates on a $3 billion annual budget and includes a Big Ten institution, an academic health sciences center, and key research institutes.

Previously, Dr. Gold was chancellor of the University of Nebraska Medical Center (UNMC) from 2014 to 2024 and chaired the Nebraska Medicine Health System board. He also served as Provost and Executive Vice President of the University of Nebraska System and concurrently as chancellor of the University of Nebraska at Omaha.

A nationally recognized leader in higher education and health care, Dr. Gold holds tenured faculty appointments in medicine and public health. He has authored over 200 peer-reviewed manuscripts, 40 books and chapters, and given more than 300 keynote presentations.

Dr. Gold earned his engineering degree from Cornell University and his M.D. from Weill Cornell College of Medicine, followed by surgical training at New York-Presbyterian Hospital, Memorial Sloan Kettering, and Harvard-affiliated hospitals. He is board-certified in surgery and thoracic surgery, specializing in cardiac procedures.

He serves on key economic development boards and has held leadership roles in over 100 national organizations. He has advised elected officials on education, research, and clinical care. Dr. Gold and his wife, a fellow physician, have two children and two grandchildren.

Figure 1. Nebraska Western Iowa VA Ambulatory Clinic & Surgicenter

Figure 2. Surgical suite in the Nebraska Western Iowa VA Ambulatory Clinic & Surgicenter

Figure 3. Exterior of the Negatively Pressurized Conex unit

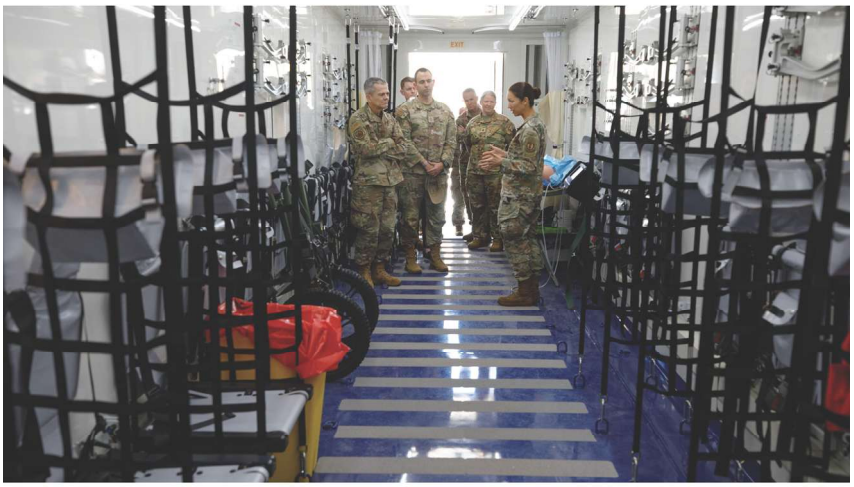


Figure 4. CSTARS personnel touring the Negatively Pressurized Conex unit as part of contract with the Department of Defense

Figure 5. Planned site for Project Health

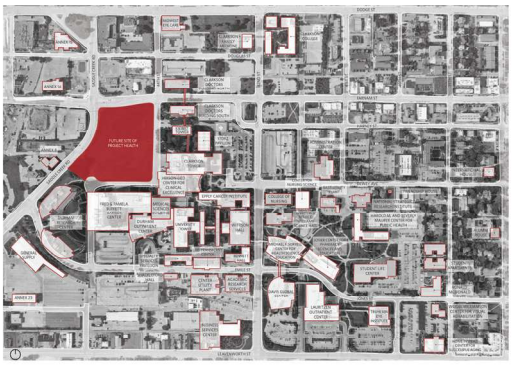


Figure 5. Planned construction on Project Health site

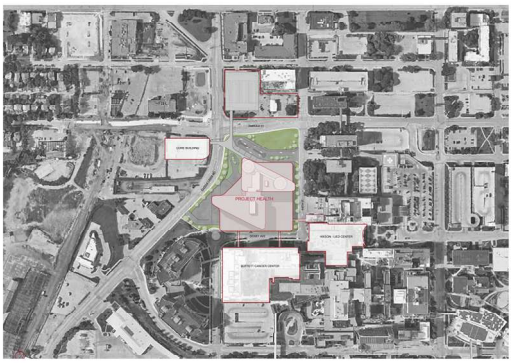


Figure 6. Omaha street map indicating close proximity of the UNMC and VA Campuses

Figure 8. Rendering of proposed Project Health facility

Figure 9. Rendering of proposed Project Health facility

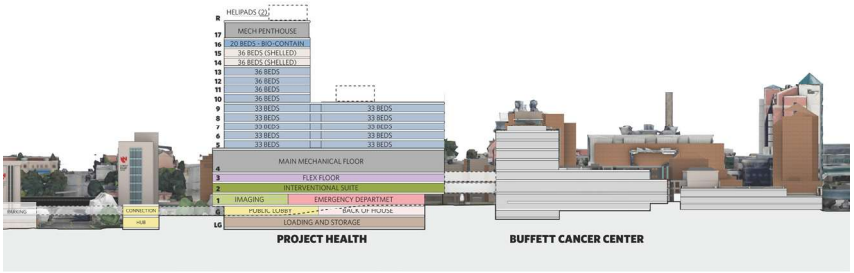


Figure 10. Stacking of proposed Project Health facility

Prepared Statement of Sue Morris

Good afternoon, Chairwoman Miller-Meeks, Ranking Member Brownley, Members of the Health Subcommittee.

My name is Sue Morris. I am the President of Veterans Trust, formerly known as Veterans Ambulatory Center Development Corporation, the nonprofit philanthropic entity that partnered with the Department of Veterans Affairs under the CHIP-IN Act to construct VA's ambulatory care center in Omaha, Nebraska, serving Western Iowa and Nebraska. I want to note first that our non-profit entity is led by Veterans. Our Chairman, John Henderson, is a retired Army Colonel and our Secretary, Mike Pallesen who is with me today, is a retired Navy Commander.

Our nationally award-winning Ambulatory Care Center project was completed and donated to Veterans Affairs in July 2020 as the first public-private partnership to be completed under the CHIP-In Act. The project received several national awards for health care design and construction.

I am here today to speak in favor of taking the pilot program authorized under the CHIP-In Act and making it permanent, as H.R. 217 would do. Our project showed how VA, in partnership with the private sector, can deliver a truly superb facility, in a cost-effective and efficient manner.

What allowed the Omaha project to be successful? First, the project was "owned" by Veterans Trust during the development and construction phases and donated to Veterans Affairs upon completion. While there was very close coordination and cooperation between Veterans Trust and VA officials at both the national and local levels, it was not a "government construction project". This structure allowed Veterans Trust, whose leadership had a history of facilitating $1 billion on local projects, to use local vendors and suppliers in its procurement of services and materials, leveraging demonstrated relationships for best pricing. We were able to tell our partners in design and construction that they will make money on the project, but not a lot of money, as this is a community project for the Veterans.

Second, was a strong commitment from Veterans Affairs senior leadership. We met regularly at VA's headquarters, including three meetings directly with the Secretary, to ensure project milestones were achieved. There was zero scope creep which helped the project to be delivered on-time and on-budget. One key factor in this regard was Veterans Affairs' willingness to review VA's normally applicable construction and physical security standards. We were able to come to agreement on which of those standards made sense, resulting in value engineered savings of over $23 million.

In the end, we delivered a facility for a total of $86 million when it was originally budgeted at $135 million, saving the taxpayers $50 million. The private philanthropic contribution to the project was $30 million.

Based upon our experience and success with this effort, we recommend that H.R. 217 go further than simply making CHIP-In permanent but to also consider other changes that will allow the public-private partnership structure to provide even greater opportunities to deliver best in class facilities to our Veterans while doing so in a way that saves taxpayer dollars. In particular, we suggest the following:

- Add the option to construct facilities on land leased to VA, not just owned or donated real property.
- Add the ability to use the program for minor construction, not just major projects.
- Make clear that the Act applies to more than just healthcare but also to construction projects providing other types of facilities to Veterans such as housing and community centers.

In addition to amending the Act itself, we suggest that the Subcommittee and staff engage a small group of VA leadership and private sector representatives to recommend forward-looking best practices and new models for public—private partnerships. My team and Board would be pleased to be included in this effort.

In summary, we wholeheartedly support the effort to make CHIP-In a permanent tool to deliver state-of-the-art facilities. The Act allows Veterans Affairs the ability to leverage the advantages of private sector construction processes to deliver significant cost-savings.

Thank you again for the opportunity to express our support for H.R. 217 and further expansion of the CHIP-In Act. We are tremendously proud of our role in helping lead in this nationally groundbreaking effort to deliver a world-class facility to our Veterans and cost-savings to taxpayers.

I want to add one final point. As Dr. Gold mentioned, there is no doubt that a new in-patient facility to replace Omaha's ageing VA hospital is sorely needed. Veterans Trust stands ready to partner with Veterans Affairs and the University of Ne-

braska Medical Center to assist in designing and constructing a new state-of-the-art facility that will better serve the Veteran community in Nebraska and Western Iowa while taking advantage of the public-private partnership model offered by the CHIP-In Act.

I am happy to answer any questions that you might have.

Prepared Statement of Brian Dempsey

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 life-changing programs and services to more than 227,000 registered post-9/11 warriors and 56,000 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.

Draft legislation: No Wrong Door for Veterans Act

Launched in 2022, the Department of Veterans' Affairs (VA) Staff Sergeant Parker Gordon Fox Suicide Prevention Grant ("Fox Grant") Program is a groundbreaking initiative that empowers community-based organizations to provide targeted mental health and crisis intervention services to veterans. The program was established through the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act* (P.L. 116–171 § 201) and facilitated VA's financial support to more than 80 organizations in Fiscal Year 2024 to provide or coordinate a range of suicide prevention programs for veterans and their families.[1] In each year since its implementation, the program has been discussed as a key initiative for helping prevent suicide in VA's national suicide data report.

The *No Wrong Door Act* is one of several legislative initiatives to renew the Fox Grant pilot program (see S. 2793; S. 5210 (118th Cong.)). This specific effort reflects the most comprehensive legislative effort to extend the current Fox Grant pilot and includes provisions to make clear that prior grant recipients shall not receive preference from VA for future grants; to require prior grantees to include evidence of services delivered to a "significant number" of veterans in applications for future Fox grants; to require that VA brief "appropriate personnel" of each VA medical center within 100 miles of a Fox grantee about the Fox grant program in an effort to improve coordination; to require Fox grantees to inform veterans receiving Fox grant services that they may receive emergent suicide care through VA; and to require Fox grantees to use a VA-selected screening protocol when using Fox grant funding to provide baseline mental health screening.

The changes outlined above would be welcomed; however, WWP encourages the Subcommittee to consider amendments that would lead to bipartisan, bicameral support to extend the Fox Grant program with enough time to allow for grants to continue to be dispersed to community-based grantees at the start of the next fiscal year. We would also encourage adoption of language from S. 793 focused on measures and metrics.

Draft legislation: Providing Veterans Essential Medications Act

State Veterans Homes (SVHs) – state-owned and—operated facilities that work in tandem with VA – play an important role in meeting the nursing home, domiciliary, and adult day health care needs of veterans across the country. While SVHs primarily serve an elderly population, the future long-term care needs of post-9/11 veterans can be mitigated by addressing critical priorities today. Part of that effort includes ensuring that veterans residing in SVHs receive the medical care they deserve, particularly access to life-saving and high-cost medications.

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[1] Press Release, U.S. Dep't of Vet. Aff., VA Awards $52.5 Million in Veteran Suicide Prevention Grants, Announces Key Updates in the Fight to End Veteran Suicide (Sep. 2023), https://news.va.gov/press-room/va-awards-veteran-suicide-prevention-grants/.

Under current law, VA provides per diem payments to SVHs for each eligible veteran receiving nursing home, domiciliary, or adult day health care.[2] For veterans with service-connected disabilities rated 50 percent or greater, the law requires VA to cover the cost of all medications administered by SVHs. However, if the veteran has service-connected disabilities rated 70 percent or greater, VA pays a higher "prevailing rate" to the SVH, but does not pay for any medications, even high-cost drugs that can cost upwards of $20,000 a month. These medications would otherwise be covered by VA when a veteran is not being cared for at an SVH. For example, existing law permits private nursing homes to receive VA reimbursement for high-cost medications.

The *Providing Veterans Essential Medications Act* seeks to amend 38 U.S.C.§ 1745(a)(3) to direct VA to either reimburse SVHs for the cost of expensive medications or directly provide these medications to the facilities. As defined in this bill, medications would be considered "costly" if their average wholesale price for a 1-month supply, plus a 3 percent transaction fee, exceeds 8.5 percent of VA's monthly payment to the SVH for the care of the veteran receiving the medication.

Wounded Warrior Project supports the Providing Veterans Essential Medications Act. By requiring VA to either reimburse or directly provide these essential medications, this legislation would help alleviate the financial strain on SVHs, ensuring they can continue to offer quality care without risk of budget constraints that limit veterans' access to necessary treatments.

Draft legislation: Veterans Supporting Prosthetics Opportunities and Recreational Therapy Act, or Veterans SPORT Act

The highest priority for amputees requiring prosthetics should be improved quality of life. In addition to enabling veterans to live more independently and complete activities of daily living, adaptive prosthetic devices and equipment can have positive and life-changing impacts on a warrior's life through exercise and recreation. WWP has witnessed this when assisting warriors through our Adaptive Sports and Soldier Ride programs. Adaptive sports equipment empowers warriors to engage in modified athletic opportunities designed for their individual abilities, resulting in profound improvements to physical and mental health.

VA's current definition of "medical services" includes "wheelchairs, artificial limbs, trusses, and similar appliances,"[3] but does not include adaptive prostheses or terminal devices. Although VA clinicians work with veterans to identify recreation activities and needed adaptive recreation equipment to support a veteran's rehabilitation goals, VA will not provide adaptive recreation equipment if the purpose of the equipment is to support the veteran's participation in an activity for personal enjoyment. Specifically, VA regulations only provide adaptive prosthetics and terminal devices for sports and other recreational activities for veterans if the device (1) is needed to promote, preserve or restore the health of the veteran; (2) serves as a direct and active component of the veteran's medical treatment and rehabilitation; and (3) does not solely support the comfort or convenience of the veteran.[4] These regulations focus on the clinical need for adaptive prosthetics but disregard their potential to improve veterans' quality of life.

If a veteran is interested in adaptive recreation equipment, VA regulations require that he or she must use it to support rehabilitation goals and, accordingly, must be enrolled in a VA rehabilitation program. The necessity to participate in such rehabilitation programs can be a deterrent for some veterans who may not be able to travel or devote the time required. These programs are also repetitive as they require that veterans be retrained to use replacement adaptive equipment for which veterans completed rehabilitation training in the past. For these reasons, some veterans may choose not to obtain or replace adaptive recreation equipment, hindering a veteran's ability to maintain an active and healthy lifestyle.

Wounded Warrior Project supports the *Veterans SPORT Act*, which would amend 38 U.S.C. § 1701 to add adaptive prostheses and terminal devices for sports and other recreational activities to VA's definition of "medical services." The current population of post-9/11 veterans is young, mobile, and energetic. WWP believes that VA should be building an ecosystem of care that is encouraging of such an active lifestyle. We recommend that VA authorize adaptive equipment for amputees without requiring that they be enrolled in a VA rehabilitative program for the profound benefits provided by sports and other recreational activities.

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[2] JARED SUSSMAN, CONG. RSCH. SERV., IF11656, STATE VETERANS HOMES (2020).
[3] 38 U.S.C. § 1701(6)(F)(i).
[4] 38 C.F.R. § 17.3230(a)(1).

Draft legislation: To direct the Secretary of Veterans Affairs and the Comptroller General of the United States to report on certain funding shortfalls in the Department of Veterans Affairs

In July 2024, VA notified Congress about a forecasted $2.8 billion shortfall that would prevent the agency from delivering VA benefits to veterans at the start of Fiscal Year 2025 (October 1, 2024). VA also reported a potential 2025 shortfall of approximately $12 billion for its health care system. Those estimates have since been adjusted, as the Veterans Benefits Administration (VBA) reported a $5.1 billion surplus from Fiscal Year 2024, and the Veterans Health Administration (VHA) more recently estimated its 2025 shortfall to be $6.6 billion.

Wounded Warrior Project is grateful for Congress's action to take precautionary steps when it passed the *Veterans Benefits Continuity and Accountability Supplemental Appropriations Act* (P.L. 118–82) to avoid any potential harm to veterans through VBA funding challenges. As a new budget cycle begins, we appreciate congressional commitment to ensure that VHA can meet its solemn obligation to deliver high-quality, timey care to veterans throughout 2025 and beyond.

H.R. 217: CHIP IN for Veterans Act

In 2016, the *Communities Helping Invest through Property and Improvements Needed (CHIP IN) for Veterans Act of 2016* (P.L. 114–294) became law. It authorized VA to carry out a 5-year pilot program to improve and expand its medical facilities by allowing private donors, local governments, and other organizations to contribute funding or property for VA construction projects. The bill was designed to address VA's backlog of construction needs – without solely relying on Federal funding – by leveraging community involvement to improve veterans' healthcare facilities more efficiently.

The VA Omaha Ambulatory Care Center was the first project completed under the *CHIP IN Act for Veterans Act of 2016*. The facility, which opened in 2020, was successfully built using $56 million in Federal funding and $30 million in private donations.[5] In 2021, the CHIP IN pilot program was extended for an additional 5 years through the *Department of Veterans Affairs Expiring Authorities Act of 2021* (P.L. 117–42). As of today, many VA construction projects continue to face delays and budget challenges. VA's Fiscal Year 2024 Budget in Brief estimates that between $106 billion and $129 billion will be needed over the next 10 years to maintain and enhance VA infrastructure.

The *CHIP IN for Veterans Act* would permanently authorize the program, allowing VA to accept private donations to help fund new construction and facility improvements. It would also remove the limit on the number of donations that VA may accept under the program. The *CHIP IN for Veterans Act* would expand the ability of local communities and organizations to invest in and directly support VA medical center projects to accelerate the development of VA infrastructure, make these projects more affordable, and increase transparency.

Wounded Warrior Project supports the *CHIP IN for Veterans Act*.

H.R. 1107: Protecting Veteran Access to Telemedicine Services Act of 2025

In 2008, the *Ryan Haight Online Pharmacy Consumer Protection Act* (P.L. 110–425) became law and required patients to complete at least one in-person visit with a health care provider before that provider could prescribe them a controlled substance. In consideration of the COVID–19 public health emergency, this requirement was temporarily suspended in March 2020. In November 2024, both the Drug Enforcement Agency (DEA) as well as the Department of Health and Human Services (HHS) agreed to continue this temporary suspension until December 31, 2025.[6] The *Protecting Veteran Access to Telemedicine Services Act of 2025* would make this exemption permanent for veterans and VA providers by authorizing the delivery, distribution, and dispensing of controlled substances to veterans from VA providers without requiring an in-person appointment.

If the current COVID-era extension expires, rural veterans who do not live near VA or community health care facilities – and who rely primarily on telehealth services – would likely be negatively impacted. Appointment coordination challenges and travel logistics may lead to interruptions in their care or lapses in prescriptions. The list of controlled substances contains not only pain medications, but also multiple

[5] Marc Thomas, U.S. Dep't of Vet. Aff., *Redefining Healthcare Spaces: The ACC Wins the AIA National Design Award* (Nov. 29, 2023), https://www.va.gov/nebraska-western-iowa-health-care/stories/redefining-healthcare-spaces-the-acc-wins-the-aia-national-design-award/.

[6] Third Temporary Extension of COVID–19 Telemedicine Flexibilities for Prescription of Controlled Medications, 89 Fed. Reg. 91,253 (Nov. 19, 2024) (codified at 21 C.F.R. pt. 1307).

mental health drugs that are important parts of treatment plans for many veterans dealing with mental health issues and for whom an in-person appointment may present additional challenges.

Many veterans who began treatment plans that included controlled substance prescriptions during the period of this exemption may not be aware of, or prepared for, the potential interruptions of their care plan. For instance, the *PACT Act* (P.L. 117–168), the most comprehensive authorization of VA benefits in recent history, became law in August 2022 while this exemption was in place. More than 1.5 million *PACT Act*-related claims have since been granted by VA,[7] meaning that none of those veterans have been subject to pre-exemption requirements. This dramatically increases the number of veterans who could have their current treatment plan impacted by the expiration of this exemption.

Wounded Warrior Project supports this bill in its current form; however, we recognize that laws surrounding in-person visits may be brought back to scale as we move further away from the COVID–19 public health emergency. In such a case, we would also support a modified version of this legislation that would authorize the renewal of controlled substance prescriptions written for veterans when the exemption was in place – and who are still seeing the same provider who issued the prescription – to help prevent unexpected disruptions of veteran treatment plans.

H.R. 1336: Veterans National Traumatic Brain Injury Treatment Act

The prevalence of PTSD and TBI among post-9/11 veterans remains alarmingly high. WWP's 2025 Warrior Survey[8] revealed that more than 3 in 4 responding warriors (76.5 percent) self-reported having PTSD and approximately half (52.3 percent) of those respondents screened positive for PTSD symptoms using the PCL–5 test.[9] Another 35.2 percent self-reported a TBI incurred during military service. As we continue to learn more about these invisible wounds and their prognosis, investments in research and treatment now and into the future must embrace innovation – and VA has an important role in leading those efforts.

Hyperbaric oxygen therapy treatments involve a patient entering a special chamber where they breathe pure oxygen in air pressure levels 1.5 to 3 times higher than average. This helps fill the blood with enough oxygen to repair brain tissue and restore normal body function. Currently this treatment is approved by the Food and Drug Administration (FDA) for treatment of inflammation in the body, and some doctors believe that both TBI and PTSD are the result of brain inflammation due to trauma. While some research recommends caution when administering HBOT treatment to individuals with PTSD, results are generally encouraging. [10]

The *Veterans National Traumatic Brain Injury Treatment Act* would establish a 5-year pilot program at VA 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. The effort would be implemented in three Veteran Integrated Service Networks (VISNs).

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*. If expanded to include reporting requirements on clinical outcomes and impact on health care access, we believe that this pilot has potential to contribute to the growing body of research and longitudinal studies on innovative treatments for TBI and PTSD.

Draft legislation: Saving Our Veterans Lives Act

Gun lockers, also known as firearm storage safes or cabinets, can play a significant role in reducing the risk of suicide by limiting access to firearms, particularly in moments of crisis. Increasing space and time between an individual and lethal means can create opportunities for interventions by another or through personally driven changes in thought. Many empirical studies have demonstrated that creating time and space between an individual and lethal means is effective in preventing

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[7] U.S. DEP'T OF VET. AFF., PACT ACT PERFORMANCE DASHBOARD (Feb. 21, 2025), https://department.va.gov/pactdata/interactive-dashboard/.

[8] To review WWP's Warrior Survey in more detail, please visit https://www.woundedwarriorproject.org/mission/warrior-survey.

[9] The PCL–5 is a validated tool used by VA that assesses symptoms over the past month.

[10] 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.

suicide, and although some individuals might seek other methods, many do not.[11] In such cases, the means chosen are often less lethal and are associated with fewer deaths than when more dangerous ones are available. In a veterans context, research like this helped drive the PREVENTS Task Force to recommend "increase[d] implementation of programs focused on lethal means safety (e.g., voluntary reduction of access to lethal means by individuals in crisis, free/inexpensive and easy/safe storage options)."[12]

The *Saving Our Veterans Lives Act* would create a new program to provide veterans with lock boxes intended for the secure storage of a firearm. It would authorize $5 million per year over a 10-year period for VA to carry out this program while also requiring an annual report that addresses topics including compliance with the new statute, outreach to veterans, obstacles with implementation, and how many lock boxes were distributed. The bill makes clear that VA would not be permitted to collect personally identifiable information on veterans who request a lockbox under the program, require mandatory storage, require firearm registration, or prohibit participating veterans from purchasing, owning, or possessing a firearm.

This effort would build upon existing efforts at VA to distribute free firearm cable locks to any veteran who requests one, as well as more limited availability of gun lockers. As our Nation continues to explore new investments and opportunities to end veteran suicide, WWP supports the *Saving Our Veterans Lives Act*.

Draft legislation: Women Veterans Cancer Care Coordination Act

Breast cancer ranks as the second most common cancer among women in the U.S., and within VA, it is the most diagnosed cancer for women.[13] The trend may continue as the recently passed *Dr. Kate Hendricks Thomas SERVICE Act* (P.L. 117–133) allows veterans who served in certain combat locations and periods to receive services to check their risk of breast cancer and get a screening mammogram if needed. And as the number of women veterans continues to increase[14], VA will likely see a rise in the number of female veterans needing cancer care in the coming years.

In its most recent annual budget submission to Congress[15], VA stated that its "policy requires that facilities have personnel assigned to breast and cervical cancer care coordination. To ensure accuracy, timeliness and reliability, VA tracks the provision of breast and cervical cancer screening and the availability of breast and cervical cancer care coordinators across the system." The submission further elaborated that "[t]he Breast and Gynecologic Cancer System of Excellence is providing state-of-the-art breast and gynecologic cancer care and care coordination across the system through VA's tele-oncology program."

The *Women Veterans Cancer Care Coordination Act* would build upon this foundation by requiring VA to appoint a Regional Breast Cancer and Gynecologic Cancer Care Coordinator in each Veterans Integrated Services Network (VISN). These coordinators will report directly to the Director of the Breast and Gynecologic Oncology System of Excellence. The bill sets eligibility standards for patients to receive care coordination through a Regional Coordinator and sets several responsibilities for those coordinators including ensuring seamless care coordination between VA clinicians and community care providers specializing in breast and gynecologic cancers and maintaining regular contact with veterans based on individual medical needs during community care treatments. Notably, the bill would also require VA to submit a report to Congress comparing health outcomes between veterans receiving cancer care at VA facilities and those treated by non-VA providers, evaluating necessary changes or resources to improve cancer care coordination, and addressing any other relevant matters.

Wounded Warrior Project is pleased to support the *Women Veterans Cancer Care Coordination Act*; however, we look forward to increased dialog among stakeholders to ensure that existing efforts at VA are enhanced and not duplicated.

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[11] *See*, e.g., Paul Yip et al., *Means Restriction for Suicide Prevention*, 379(9834) THE LANCET 2,393–99 (June 2012), *available at* https://www.thelancet.com/journals/lancet/article/PIIS0140–6736(12)60521–2/abstract.

[12] PREVENTS TASK FORCE, PREVENTS: THE PRESIDENT'S ROADMAP TO EMPOWER VETERANS AND END A NATIONAL TRAGEDY OF VETERAN SUICIDE (June 2020), *available at* https://www.va.gov/PREVENTS/docs/PRE–007-The-PREVENTS-Roadmap–1–2__508.pdf.

[13] *How Common is Breast Cancer?*, AM. CANCER SOC'Y, https://www.cancer.org/cancer/types/breast-cancer/about/how-common-is-breast-cancer.html (last visited Mar. 7, 2025).

[14] Katherine Schaeffer, *The Changing Face of America's Veteran Population*, PEW RESEARCH CTR. (Nov. 8, 2023), https://www.pewresearch.org/short-reads/2023/11/08/the-changing-face-of-americas-veteran-population/.

[15] U.S. DEP'T OF VET. AFF., Fiscal Year 2025 BUDGET SUBMISSION – MEDICAL PROGRAMS, VOL. 2 OF 5 at VHA–23.

Agenda items not addressed in this Statement for the Record

- Draft legislation: *Standardizing Treatment and Referral Times Act*
- Draft legislation: *Copay Fairness for Veterans Act*
- H.R. 658: *To amend title 38, United States Code, to establish qualifications for the appointment of a person as a marriage and family therapist, qualified to provide clinical supervision, in the Veterans Health Administration*

Concluding Remarks

Wounded Warrior Project once again extends our thanks to the Subcommittee on Health for its continued dedication to our Nation's veterans. Our commitment to keeping the promise by rebuilding the lives of warriors impacted by war and military service remains as strong as ever, and we are honored to contribute our voice to your discussion about pending legislation. 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 Andrew Kozminski

Testimony of
Andrew Kozminski, MD MSE
Clinical Assistant Professor of Emergency Medicine and Anesthesia
University of Iowa Health Care's (UIHC) Medical Director for Hyperbaric Medicine and the UIHC Wound Center
Before the House Committee on Veterans' Affairs, Subcommittee on Health
U.S. House of Representatives on "H.R. 1336, The Veterans National Traumatic Brain Injury Treatment Act (Rep. Murphy)"
March 11, 2025

Good afternoon, Chairwoman Dr. Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me to participate in this hearing to discuss H.R. 1336, The Veterans National Traumatic Brain Injury Treatment Act.

This piece of legislation aims to improve the health of our veterans. Establishing a pilot program for the use of hyperbaric oxygen (HBO) therapy for veterans with traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD) could help improve these patients' quality of life. Besides the potential clinical improvement, a VA pilot program would enable veterans to receive HBO in a safe environment. Furthermore, using this pilot program as a means to conduct more research for these indications could help to improve the delivery of care for not just veterans but for all civilians.

Over the course of a lifetime, an average of 7% of veterans experience PTSD with the highest incidence at 29% for veterans deployed in Operations Iraqi Freedom and Enduring Freedom. As an emergency medicine physician, I have cared for numerous veterans suffering from TBIs and PTSD. With my experience in hyperbaric medicine, I think the implementation of HBO for these ailments would be uncomplicated. Veterans already use this therapy through their VA insurance for currently approved HBO indications. Thus, HBO has proven its safety after many decades of use by the medical community. For these reasons, this legislation has potential to help improve the lives of our friends, families, and neighbors.

I am Dr. Andrew Kozminski, an emergency medicine physician with a specialization in undersea & hyperbaric medicine. I am the current medical director for hyperbaric medicine at University of Iowa Health Care (UIHC) and medical director for the UIHC Wound Center.

One main function as the director of a hyperbaric medicine service is providing safe treatments for patients. The usual population for a hyperbaric medicine service includes patients with complicated chronic wounds, radiation injuries, and cases of acute soft tissue ischemia. Most patients receiving HBO across the country are in ambulatory, non-critical condition. However, many large healthcare systems are treating patients for emergency indications (i.e. decompression sickness, arterial gas embolism, central retinal artery occlusion, carbon monoxide poisoning, acute blood loss anemia) and patients who come from intensive care settings with life or limb-threatening conditions like necrotizing fasciitis, crush injuries, or impending compartment syndrome. At the University of Iowa, my team has treated the full spectrum of indications and for patients who are merely days-old to greater than 100 years of age. This range of patient demographics and conditions highlights HBO's relative safety when administered by trained hyperbaric medicine professionals at accredited healthcare facilities.

Since 2018, University of Iowa Health Care has participated and has been a top enrolling site in a phase II adaptive, multi-center, randomized clinical trial called Hyperbaric Oxygen Brain Injury Treatment Trial (HOBIT). This trial aims to determine

the optimal dose and frequency of hyperbaric oxygen that is most likely to improve outcomes for acute severe traumatic brain injury patients. As expected for those who incur a severe TBI, the mechanism of injury can damage any and all organ systems, which can make treating these cases riskier than an average HBO patient. However, despite these critical circumstances, skilled healthcare providers knowledgeable in the specific potential complications within a hyperbaric environment have been able to maintain a robust safety profile throughout the course of this trial. In comparison to treating these patients, caring for ambulatory, non-critically ill patients with chronic TBI or PTSD should be well within the capabilities of any accredited hospital system across the country with HBO capabilities.

The 14th Edition of the Undersea & Hyperbaric Medical Society's Indications Manual contains a summary of 34 publications, a mixture of case reports, retrospective reviews, prospective and randomized clinical trials from 1985 to 2018, that aimed to examine TBI and the potential role for HBO as a treatment. Adverse events, if reported, are listed in this summary. Neurologic oxygen toxicity and claustrophobia are two such adverse events that might be more prevalent in this sub-population compared to the general HBO patient population.

Oxygen toxicity seizures for the general population are a potential but rare complication of hyperbaric oxygen and is something I educate all of my patients on prior to beginning their treatment course. The Epilepsy Foundation reports 1 in 50 TBI cases result in post-traumatic epilepsy. This does not mean veterans with a TBI and concurrent epilepsy will be unable to receive HBO treatments. It is appropriate, however, to adjust treatment profiles to account for lower seizure thresholds in patients with known epilepsy or patients that experience an oxygen toxicity seizure during their treatment course. In any case, an oxygen toxicity seizure is a complication that trained hyperbaric medicine professionals are well-versed in how to manage and should be able to ensure continued patient safety throughout a treatment course.

I have also treated many patients with claustrophobia or hesitancy about receiving treatment in a confined space. Anecdotally, some patients find wearing an oxygen mask or hood to be bothersome. Within a patient population suffering from traumatic combat experiences, there will be some qualifying patients who refuse treatment because of the confined environment. Anxiolytic medications can be administered safely by trained professionals to help these patients receive HBO. In a worst-case scenario, a patient would need to be removed from a hyperbaric chamber mid-treatment. Aborting a treatment does not pose any increased risk of physical harm to a patient and would not keep them from continuing with other forms of therapy for their condition.

It is important to comment on the possibility of complications during an HBO treatment not only to provide a complete picture of the risks and benefits but to highlight the importance of trained hyperbaric medicine professionals being the ones to administer

this care for our veterans. As TBI and PTSD are not currently covered indications by insurance companies in the United States, there are desperate patients who seek HBO treatments at health clinics or "health spas" --businesses that claim to offer life-altering HBO treatments at low prices for off-label indications. In my experience, these "health spas" do not adhere to the same level of safety as hyperbaric services within a hospital system, nor might they even provide correct HBO doses or treatment profiles. Just this past January, a 5-year-old child was killed in Troy, Michigan at one of these businesses from an explosion. Reportedly, the mishap is still under investigation, but it was likely a result of insufficient training and/or lax safety measures. I do not want our veterans, or any person, to seek treatment for TBI or PTSD in health clinics that place patients in danger. Establishing a pilot program for veterans will enable them to get treatment at fully accredited institutions where they can be cared for by true medical professionals.

Unfortunately, current treatment options for TBI and PTSD leave a range of 15-50% of patients with persistent symptoms after standard intervention. The medical community strives to improve this outcome through more research and clinical trials. This legislation will help progress and add to this effort.

My participation in the ongoing HOBIT trial--testing the effect of HBO on acute, severe TBI—encompasses the extent of my personal experience in treating TBI or PTSD with HBO. As mentioned, these conditions are currently off-label and thus classified as experimental. I look to the lead investigators in my field and the research they have completed to derive my opinion on whether HBO has potential for providing relief for patients with chronic TBI and PTSD.

It is believed that HBO holds promise as a treatment for these conditions as it elevates oxygen tension in the blood and damaged tissues which helps promote neuroplasticity in the acute setting of injury. For chronic TBI cases, it has been found that HBO can improve cellular metabolism, reduce cell death and oxidative stress, and enhance mitochondrial function. These mechanisms aim to promote neuronal repair and regeneration. The Brain Injury and Mechanism of Action (BIMA) trial, published in 2016, demonstrated improved post-concussive symptoms, PTSD, cognitive processing speed, sleep quality and balance function by 13 weeks after 40, 60-minute HBO sessions at 1.5 ATA. Unfortunately, these improvements did not persist beyond 6 months. More studies have also shown clinical improvement in their HBO intervention groups while others have mixed results and would likely provide clearer answers with more patient recruitment and better long-term follow-up.

Most recently, Dr. Lindell Weaver, a leader in my field, and his team published their most recent study last month (February 2025), "A double-blind randomized trial of hyperbaric oxygen for persistent symptoms after brain injury." This study included both TBI and non-TBI brain injuries, making the findings more generalizable across patient populations. Participants were divided either into an HBO treatment group or a sham

group for the first phase of the trial. The treatment group received 40 HBO sessions at 1.5 ATA within 12 weeks. 13-week follow-up showed improvements in cognitive test scores, similar to what was seen in the BIMA trial, for both sham and HBO groups. These improvements were maintained at 6-months only for the HBO group. The second phase of the trial offered another 40 HBO sessions to all trial participants. At final follow-up, 3 months after the last treatments were given, patients who received 80 HBO treatments had greater neuropsychiatric improvement compared to their results after 40 sessions. The initial sham group, patients who received a maximum of 40 treatments, showed neuropsychiatric improvements similar to the treatment group in the first phase of the trial.

I find the outcomes of these trials to be promising. More work needs to be performed to better understand the potential long-term efficacy of HBO for TBI and PTSD. HBO dose and treatment frequency could also be further investigated, though 1.5 ATA is more neuroprotective in a population with higher incidence of seizures. For TBI and PTSD, HBO should still be performed in conjunction with frequent, specialized brain injury rehabilitation.

In conclusion, this piece of legislation aims to improve the health of our veterans. Establishing a pilot program for the VA to offer HBO therapy for veterans with TBIs and PTSD could help improve these patients' quality of life, provide access to safe health care environments in which to receive these treatments, and continue to build insight on how best to construct and administer treatment courses in the future.

References

Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder; Board on the Health of Select Populations; Institute of Medicine. Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations: Final Assessment. Washington (DC): National Academies Press (US); 2014 Jun 17. 2, Diagnosis, Course, and Prevalence of PTSD. Available from: https://www.ncbi.nlm.nih.gov/books/NBK224874/

Elaine Kiriakopoulos MD, et al. "Traumatic Brain Injury and Epilepsy." Epilepsy Foundation, www.epilepsy.com/causes/structural/traumatic-brain-injury-and-epilepsy. Accessed Mar. 2025.

Fann JR, Hart T, Schomer KG. Treatment for depression after traumatic brain injury: a systematic review. J Neurotrauma. 2009 Dec;26(12):2383-402. doi: 10.1089/neu.2009.1091. PMID: 19698070; PMCID: PMC2864457.

Skipper LD, Churchill S, Wilson SH, Deru K, Labutta RJ, Hart BB. Hyperbaric oxygen for persistent post-concussive symptoms: long-term follow-up. Undersea Hyperb Med. 2016 Aug-Sept;43(5):601-613. PMID: 28768076.

"Va.Gov: Veterans Affairs." How Common Is PTSD in Adults?, 13 Sept. 2018, www.ptsd.va.gov/understand/common/common_adults.asp#:~:text=About%205%20out%20of%20every,some%20point%20in%20their%20life.

"Va.Gov: Veterans Affairs." How Common Is PTSD in Veterans?, 24 July 2018, www.ptsd.va.gov/understand/common/common_veterans.asp.

Weaver LK, Chhoeu A, Lindblad AS, Churchill S, Deru K, Wilson SH. Executive summary: The Brain Injury and Mechanism of Action of Hyperbaric Oxygen for Persistent Post-Concussive Symptoms after Mild Traumatic Brain Injury (mTBI) (BIMA) Study. Undersea Hyperb Med. 2016 Aug-Sept;43(5):485-489. PMID: 28768068.

Weaver, L.K., Ziemnik, R., Deru, K. et al. A double-blind randomized trial of hyperbaric oxygen for persistent symptoms after brain injury. Sci Rep 15, 6885 (2025). https://doi.org/10.1038/s41598-025-86631-6

Weaver LK, Wilson SH, Lindblad AS, Churchill S, Deru K, Price RC, Williams CS, Orrison WW, Walker JM, Meehan A, Mirow S. Hyperbaric oxygen for post-concussive symptoms in United States military service members: a randomized clinical trial. Undersea Hyperb Med. 2018 Mar-Apr;45(2):129-156. PMID: 29734566.

Weaver, Lindell. "Hyperbaric Oxygen for Symptoms Following Mild Traumatic Brain Injury." UHMS Hyperbaric Medicine Indications Manual, 14th ed., Best Publishing, 2019, pp. 379–389.

Summary:

Good afternoon, Chairwoman Dr. Miller-Meeks, Ranking Member Brownley, and Members of the Subcommittee. Thank you for inviting me to participate in this hearing to discuss H.R. 1336, The Veterans National Traumatic Brain Injury Treatment Act.

I am Dr. Andrew Kozminski, an emergency medicine physician with a specialization in undersea & hyperbaric medicine. I am the current medical director for hyperbaric medicine at University of Iowa Health Care (UIHC) and medical director for the UIHC Wound Center.

This legislation aims to improve the health of our veterans. Establishing a pilot program for the implementation of hyperbaric oxygen (HBO) therapy for veterans with traumatic brain injury (TBI) or post-traumatic stress disorder (PTSD).

As an emergency medicine physician, I have cared for numerous veterans suffering from TBIs and PTSD. With my experience in hyperbaric medicine, I think the implementation of HBO for these ailments would be uncomplicated. Veterans already use this therapy through their VA insurance for currently approved HBO indications. Consequently, HBO has proven its safety after many decades of use by the medical community. For these reasons, this legislation has potential to help improve the lives of our friends, families, and neighbors.

I want to comment on the potential for an increased likelihood of oxygen toxicity seizures in this patient population as 1 in 50 TBI patients develop post-traumatic epilepsy. However, an oxygen toxicity seizure is a complication that trained hyperbaric medicine professionals are well-versed in how to manage and should be able to ensure continued patient safety throughout a treatment course. Clinical trials I will mention even utilize a protective pressure of 1.5 ATA, which should reduce the likelihood of this complication. However, this is an important reason to create a pilot program through the VA health system as this would provide a safe option for patients seeking treatment for what is currently an off-label indication. Without this program, desperate patients may find themselves at the mercy of popular "health spas"--businesses that might not have adequately trained staff, may use incorrect treatment profiles, and at times pose serious risk to their clients.

The research that investigators in my field have completed on the utility of HBO for TBI and PTSD shows promise for improving health outcomes in these patient populations. For chronic TBI cases, HBO has been found to improve cellular metabolism, reduce cell death and oxidative stress, and enhance mitochondrial function. These mechanisms aim to promote neuronal repair and regeneration. The Brain Injury and Mechanism of Action (BIMA) trial, published in 2016, demonstrated improved post-concussive symptoms, PTSD, cognitive processing speed, sleep quality and balance function by 13

weeks after 40, 60-minute HBO sessions at 1.5 ATA. Unfortunately, these improvements did not persist beyond the 6-month follow-up.

In February 2025, Dr. Lindell Weaver, a leader in my field, and his team published their most recent study, "A double-blind randomized trial of hyperbaric oxygen for persistent symptoms after brain injury." This study showed similar results to what was observed in the BIMA trial for both sham and HBO groups at 13 weeks, with the HBO treatment group maintaining the neuropsychiatric benefits at 6 months. A second phase within the trial offered another 40 HBO sessions to all participants. At final follow-up, 3 months after the last of the second round of HBO treatments were given, patients who received 80 HBO treatments had greater neuropsychiatric improvement compared to their results after 40 sessions. The patients who received a maximum of 40 treatments also showed neuropsychiatric improvements compared to their baseline scores but less improvement than their counterparts who received 80 treatments.

In conclusion, I find the outcomes of these clinical trials to be promising. Establishing a pilot program for the VA to offer HBO therapy for veterans with TBIs and PTSD could help improve these patients' quality of life, provide access to safe health care environments in which to receive these treatments, and continue to build insight on how best to construct and administer treatment courses in the future.

Prepared Statement of Ed Harries

NATIONAL ASSOCIATION OF STATE VETERANS HOMES

"Caring for America's Heroes"

Testimony of

ED HARRIES, PRESIDENT

NATIONAL ASSOCIATION OF STATE VETERANS HOMES (NASVH)

Before the

HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

MARCH 11, 2025

Chairwoman Miller-Meeks and Ranking Member Brownley:

As President of the National Association of State Veterans Homes (NASVH), thank you for the opportunity to testify today before the House Veterans' Affairs Subcommittee on Health to provide our comments on and strong support for the "Providing Veterans Essential Medications Act." This important legislation would remove an inequity in the law concerning high cost medications for veterans that has prevented many from living in State Veteran Homes (SVHs) during their twilight years.

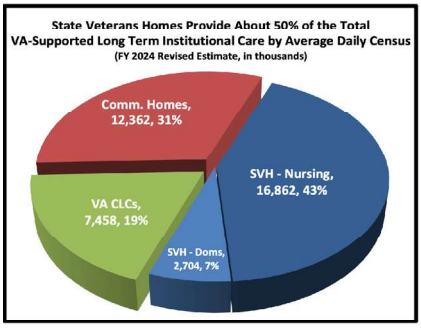
As you may know, NASVH is an all-volunteer organization dedicated to promoting and enhancing the quality of care and life for the veterans and families in our Homes through education, networking, and advocacy. In addition to my role with NASVH, I work full time as the Executive Director/CEO of the Tennessee State Veterans Homes, which includes five veterans' homes in Murfreesboro, Humboldt, Knoxville, Clarksville, and Cleveland.

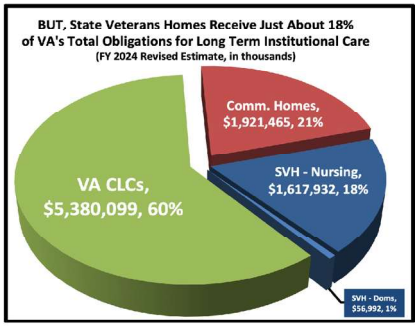
BACKGROUND OF THE STATE VETERANS HOME PROGRAM

Madame Chairwoman, the State Veterans Homes program is a partnership between the federal government and State governments that dates back to the post-Civil War period. Today there are 172 VA-recognized State Veterans Homes across the nation operating 166 skilled nursing care programs, 47 domiciliary care programs, and 3 adult day health care (ADHC) programs. NASVH is the only organization that represents their collective interests, and our membership is expected to continue growing as new Homes seek VA recognition.

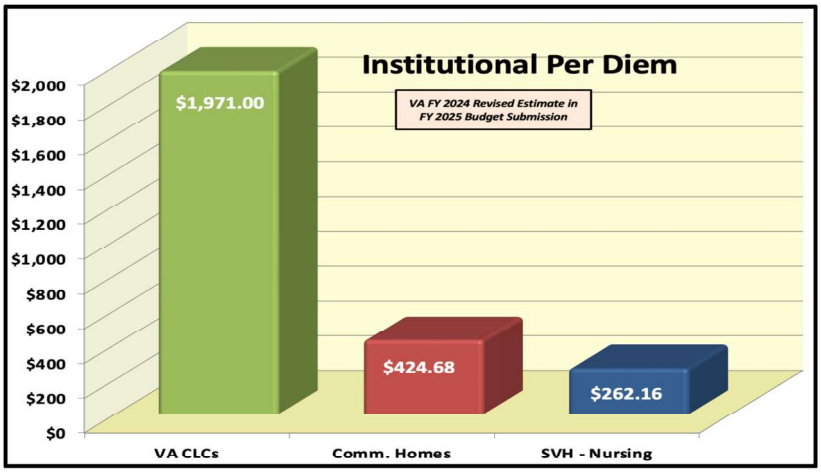
To help cover the cost of care for veterans in SVHs, VA provides per diem payments at different rates for skilled nursing care, domiciliary care, and ADHC. For veterans who have service-connected disabilities rated 70 percent or greater, VA has a statutory obligation to provide nursing home care and the law requires VA to reimburse SVHs – as well as private contract nursing homes – at higher "prevailing rates" intended to cover the full cost of caring for these severely disabled veterans.

Today, there are over 30,000 authorized State Home beds providing a mix of skilled nursing and domiciliary care, which accounts for **half** of all federally-supported institutional long-term care for our nation's veterans, according to VA's most recent FY 2025 budget submission. However, in providing this care, State Veterans IIomes only consumed about 18 percent of VA's total funding for veterans' long-term nursing home care. It's clear that the State Home program provides significant value to VA in meeting their obligations to the men and women who served.





Furthermore, according to VA's FY 2025 budget, the institutional per diem for SVH skilled nursing care is currently $262; by comparison, the rate for private sector community nursing homes is $424, about 60% higher, and the rate for VA's Community Living Centers (CLCs) is $1,971, about 750% higher. Although there are important differences among these programs that account for some of these cost differences, there's no question that SVH partnership plays a vital role by leveraging State matching fundings for the benefit of the veterans we all serve.



PROBLEMS CAUSED BY HIGH COST MEDICATIONS

As referenced above, SVHs can receive a basic per diem payment from VA for providing skilled nursing care to veterans that is currently equivalent to between 20-30 percent of the cost of caring for those veterans, depending on cost-of-living in the state. However, for seriously disabled veterans – those who have service-connected disabilities rated 70 percent or higher – VA provides a higher "prevailing rate" intended to cover the full cost of care for such veterans. While this would normally result in SVHs receiving high reimbursement under the prevailing rate program, many Homes are losing hundreds of thousands of dollars per year because of a misguided provision in the statute related to medications for veterans in SVHs.

Currently, VA is required to furnish drugs and medications for veterans residing in SVHs who are receiving the basic per diem if the veteran: 1) is rated 50 percent or greater; 2) needs the medication for a service-connected disability; 3) is receiving VA Aid and Attendance benefits; or 4) has been determined by VA to be catastrophically disabled. However, if the veteran is seriously disabled (70 percent service connected or greater) and the Home is receiving the prevailing rate for that veteran, VA will **not** furnish or reimburse the cost of any medications since a small portion of the prevailing rate is intended to cover the cost of medications. However, some veterans require extremely expensive medications that cost more than the entire prevailing rate paid to the State Home.

For example, the Iowa State Veterans Home is caring for a 55-year-old service connected Air Force veteran who suffers from Crohn's Disease. Fortunately, he is receiving a drug called Stelara, which is administered through IV infusion, to help control his symptoms. However, this medication costs about $5,000 a week, for a total cost of over $20,000 a month. Despite the financial burden, the Iowa State Home decided to care for this veteran at a significant operating loss per day, but that likely means the Home will have to cut costs somewhere else. They might have to admit fewer deserving veterans, their spouses, or Gold Star parents; or perhaps cut back on social, recreational, or other non-clinical services that contribute to their quality of life.

This same situation is occurring in State Veterans Homes across the country. At the Long Island State Veteran Home in New York, they are caring for an 85 year old Army veteran who is 100 percent service connected for his disabilities. He is a graduate of West Point and served as a Captain during the Vietnam War. This former Army Ranger, who received the Bronze Star, Silver Star & Purple Heart, was recently diagnosed with breast cancer and is on a high cost chemotherapy drug called Ibrance. The monthly cost for this drug is about $20,000 and the veteran will be on this medication for the foreseeable future.

The Long Island State Home also has a 79-year old Army Vietnam veteran and Purple Heart recipient rate 100 percent service connected, who was recently diagnosed with lymphoma. He was put on the drug Imbruvica at a cost of approximately $20,000 per month, and this is just one of the many medications he takes to treat his multiple chronic conditions. Unfortunately, due to the financial impact from these high cost medications, the State Home can only afford to care for a limited number of such veterans.

Recently A 78-year-old Army Vietnam veteran who was living in a private community nursing home applied for admission to the Long Island State Veterans Home's skilled nursing facility. The veteran has multiple myeloma and was prescribed a chemotherapy medication called

Revlimid, which cost almost $15,000 per month. The veteran was receiving the drug from VA at no cost to him or to the community nursing home, however if he were admitted to the State Veterans Home, VA would no longer pay for that drug. Due to the financial risk, the Home was forced to make the hard decision to turn down his request at this time. However, the Home looked to see whether the veteran could qualify for its medical model Adult Day Health Care (ADHC) program as an acceptable alternative to traditional nursing home care. If accepted into the ADHC program, the VA would continue to pay for the high-cost medication, and he would get the care he needs and wants. VA's irrational policy is penalizing veterans by limiting their choices of where and how to receive long term care services they are entitled to receive.

At the Bill Nichols State Veterans Home in Alexander City, Alabama they have been unable to admit and care for a 55-year-old Gulf War veteran who is 100% service connected and has a cerebral infarction and chronic myelogenous leukemia. He is currently prescribed the medication Asciminib which costs about $600 per day or $18,000 per month.

At the Idaho State Veterans Home in Pocatello, a 63-year-old, 100 percent service-connected Army veteran with Parkinson's disease was recently admitted. This veteran required Duopa, an IV medication administered via a pump 24 hours a day, 7 days per week, at a cost of over $500 per day or about $16,000 per month. Prior to admission, the VA covered the medication while the veteran was living at home. The State Home's in-house pharmacy was unable to obtain this medication through the VA Prime Vendor contract, and efforts to secure an outside pharmacy agreement were unsuccessful. As a result, the veteran was unfortunately discharged to return home to continue receiving the medication through VA coverage. As a result, the veteran decided to unfortunately discharge and return home to continue receiving the medication through VA coverage. If the Home had been able to obtain this medication, the prevailing rate Idaho receives would not have fully covered the cost of this single medication, in addition to the other care this veteran needed to be provided by the Home.

Unfortunately, the Idaho Veterans Home in Boise recently had to deny the admission of a 76-year-old, 100 percent service connected Air Force Veteran because of the financial strain of high cost medications. The veteran was living in a VA-contracted community nursing home and wished to be admitted to the Idaho facility. The veteran was taking a special medication (Promacta) for low blood platelet counts that cost approximately $18,000 per month. The VA was providing this medication to the veteran's spouse, who picked up this medication from the nearest VA medical center (VAMC) and took it to the VA-contracted private nursing home where they could administer the medication. Although the private nursing home was receiving a prevailing rate for the full cost of that veteran's care, their contract included a provision allowing them to receive or be reimbursed for such high cost medications. The veteran's spouse asked to continue to pick up the medication and bring it to the SVH, but current law prohibits this, effectively denying the veteran the choice to reside in a State Veterans Home.

There are also examples demonstrating of how this inequitable and unwise provision in the statute is literally throwing away money that could be used to improve the care of veterans. In Wisconsin, A 76-year-old, 100 percent service-connected veteran, a Marine sharpshooter, was admitted to a Wisconsin SVH while receiving the drug Enzalutamide (Xtandi), a chemotherapy medication that was being provided to him free of charge through an Astellas Patient Assistance Program (PAP). This program is used by many pharmaceutical companies to help people receive new and breakthrough medications that have exorbitant costs. The grant, which covers the full

cost of these drugs for eligible patients, was active for the veteran from June 2023 to August 2024.

When the veteran moved into the SVH he did not end his participation in the program and the medication continued to be shipped to his wife, who brought it to the SVH to be administered to the veteran. However, according to VA's rules, the SVH could not use this medication for the veteran, but instead had to purchase the same medication at a cost of about $12,000 per month, even though it was being provided for free to the veteran under the grant program.

Wisconsin also had another 100% service-connected Army veteran in one of their State Homes who during an oncology appointment was prescribed pirobrutinib chemotherapy by his provider. The drug was subsequently shipped directly from the VA pharmacy to the SVH where the veteran resided. When the medication arrived at the SVH, they contacted VA to return it since they were aware that under the prevailing rate program the SVH is responsible for all medications. However, they were told that VA would not accept any returns once the medication left their facility.

When inquiring about how to avoid wasting the $20,000 medication, VA advised that using it would be a violation of the law and could result in a citation. The VAMC confirmed the medication could not be returned, even though it was in the original sealed packaging. Instead, the Home was told to simply throw away the $20,000 medication.

PROVIDING VETERANS ESSENTIAL MEDICATIONS ACT

Madame Chairwoman, on behalf of NASVH and our members, I would like to thank you for drafting the Providing Veterans Essential Medications Act, legislation that would correct this inequity in the law. I'd also like to thank Representative Pappas for cosponsoring the legislation, as well as other members who are supporting the legislation.

If enacted, the bill would require VA to furnish or reimburse high cost medications for seriously disabled veterans residing in State Veterans Homes. The bill defines a high cost medication, or "costly medication", as one for which the average wholesale price for one month's supply, plus a 3 percent transaction fee, exceeds 8.5 percent of the SVH's total prevailing rate for that month. This definition is modeled on a provision that has been included in contracts between VA and private nursing homes receiving a full-cost-of-care prevailing rate for veterans rated 70 percent or greater. This legislation would provide equity between State Veterans Homes and private nursing homes caring for similar veterans.

The bill also includes language to allow a State Veteran Home the choice of whether to have VA furnish the high cost medication or receive reimbursement to purchase it directly. This provision recognizes that the SVH program allows each state to organize themselves in a manner appropriate to their state. Some State Homes may be better situated to purchase or to administer these drugs and the bill leaves that decision to each individual SVH.

NASVH strongly supports this legislation which would empower veterans who need high cost medications to receive necessary skilled nursing care in the facility of their choice. It would alleviate a financial burden placed on State Veterans Homes that has too often resulted in veterans effectively losing the option to choose a State Home over a private contract nursing

home that does not bear this financial burden. The legislation would provide equity between private contract nursing homes and State Veterans Homes when faced with seriously disabled veterans who rely in very expensive drugs and medications.

ISSUES RELATED TO HIGH COST MEDICATIONS

Madame Chairwoman, there are some issues related to this legislation that NASVH would like to bring to the attention of the Subcommittee. Public Law 117-328, enacted in December 2022, required VA to create a standardized process for State Homes to enter into sharing agreements with VA medical facilities providing medical services to veterans in SVHs. Unfortunately, VA's cursory implementation of this legislation did not resolve the problem. Since the Providing Veterans Essential Medications Act would allow State Homes the option to have VA provide them with high cost medications, a sharing agreement between the SVH and VA would be required. Unless VA fully commits to resolving this longstanding problem with sharing agreements, this provision of the legislation might be ineffective. NASVH believes additional congressional oversight or legislation will be required to end this problem and we would be pleased to work with the Subcommittee in this regard.

Another similar financial challenge for State Homes is VA's failure to cover the cost of specialty care for veterans in SVHs. Although VA is required by law to pay for specialty care, especially when the care is due to a service-connected condition, in practice VA is regularly refusing to cover the cost for veterans to receive certain specialized health care services, including psychiatric care.

For example, VA has interpreted mental health services to include psychiatric care services and has stated that there are no specified "specialty" mental health services that the VAMC may provide to eligible residents without a signed written sharing agreement with the SVH. Psychiatric services are outside the scope of primary care services provided in the SVHs and, therefore, should be considered and treated as specialty care, similar to cardiology and urology specialty care services. This interpretation is not right, and it is not oriented for the benefit of the veterans we care for. We would like to work with this Subcommittee to explore legislation to mandate that VA pay for all specialty care – including psychiatric care – for veterans residing in State Veterans Homes.

Finally, many State Veterans Homes face continuing and significant financial challenges, in part because they have never fully recovered from the severe impacts of the COVID pandemic. Every State Home had to significantly increase expenditures to prevent and contain COVID outbreaks. During that same time, occupancy levels in most SVHs declined significantly as new admissions were suspended, thereby reducing the amount of VA per diem support provided to them. Many Homes still have significant challenges in bringing their occupancy rates back up to normal levels, primarily due to national staffing shortages that impact all health care facilities. Many SVHs have had to reduce admission levels and even close bed wards due to these financial difficulties. It is in this context that the Providing Veterans Essential Medications Act can make a real difference to State Veterans Homes and the veterans they serve.

We would also note that VA is authorized to pay a basic per diem that covers up to 50% of the cost of a veteran's care, however the rate in recent years has fallen to the point that it is less than 30 percent of the actual cost on average, and as low as 20 percent in some states with higher

costs-of-living. NASVH would also welcome conversations with the Subcommittee about potential legislation that would set the basic per diem rate permanently at 50 percent of the daily cost of care.

CONCLUSION

Chairwoman Miller Meeks, State Veterans Homes can and must continue to play a leading role in meeting the long-term care needs of aging veterans. Over the past decade, VA has been placing greater focus and resources on home- and community-based services (HCBS) and NASVH strongly supports expanding these services to provide aging veterans a full spectrum of long term care options. However, the amount of nursing home care offered by VA today is woefully inadequate compared to the overall number of eligible veterans. Although the need for nursing home care may diminish as the veteran population declines in future years, it will never go away: there will always be significant numbers of veterans who lack adequate family support to allow them to age at home. Given the leading role that State Veterans Homes play in providing such care for aging, disabled veterans, it is imperative that Congress and VA continue to strongly support this program. Enactment of the Providing Veterans Essential Medications would be an important step towards strengthening State Veterans Homes and improving the lives of the veterans we serve.

NASVH looks forward to continuing to work with you and your colleagues to ensure that veterans can continue to choose where and how they spend their twilight years, without inequitable statutes or regulations limiting their long-term care options. That concludes my statement, and I would be pleased to answer any questions that you or Members of the Subcommittee may have.

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 is a congressionally chartered non-profit veterans service organization composed of nearly one million wartime service-disabled veterans. Our single purpose is to empower veterans to lead high-quality lives with respect and dignity.

It is crucial to provide timely, coordinated, and comprehensive health care tailored to meet the diverse needs of veterans. DAV is pleased to offer our views on the bills under consideration today by the Subcommittee. These bills address the necessity for timely access to medical services, infrastructure improvements, the removal of financial barriers, better understanding of health outcomes, the incorporation of adaptive sports prosthetics, hyperbaric oxygen therapy, secure firearm storage programs and effective care coordination.

H.R. 217, the Communities Helping Invest through Property and Improvements Needed or CHIP IN for Veterans Act

The CHIP IN for Veterans Act includes provisions that would make permanent a pilot program that authorized the Department of Veterans Affairs (VA) to accept donated facilities or donations to make facility infrastructure improvements. This legislation would eliminate the cap on the number of projects allowed in the pilot program and enhance the quality and availability of veteran services without additional Federal costs. For example, in Omaha, Nebraska, there was a project/donation for construction of an ambulatory care center and in Tulsa, Oklahoma a project/donation to construct an inpatient facility and parking garage to support the Muskogee Veterans Affairs Medical Center (VAMC). In 2021, VA received $120 million for a capital contribution to execute the Muskogee plan. These collaborations lead to improved access to care and services for veterans, while fostering community support and involvement.

We support the CHIP IN for Veterans Act in accordance with DAV Resolution No. 193, urging necessary infrastructure funding and exploring new funding models.

H.R. 658, to establish qualifications for the appointment of a person as a marriage and family therapist, qualified to provide clinical supervision, in the Veterans Health Administration

H.R. 658 seeks to establish qualifications for marriage and family therapists (MFTs) providing clinical supervision within the Veterans Health Administration (VHA). The bill aims to enhance mental health services for veterans and maintain consistent care across VHA facilities by ensuring that MFTs are highly qualified and recognized by reputable organizations like the American Association for Marriage and Family Therapy.

Veterans face numerous mental health challenges, including post-traumatic stress disorder (PTSD), depression, anxiety, substance use disorders, and traumatic brain injuries (TBI). Qualified MFTs can significantly improve mental health outcomes by providing effective supervision and promoting better therapeutic practices, potentially reducing the incidence of suicide among veterans. Including family and relationships in mental health treatment is crucial for the holistic well-being of veterans. Many veterans have found that involving their loved ones in therapy sessions helps create a better support system, and fosters improved understanding and communication. This approach can lead to more effective treatment, as the support from family members can reinforce coping strategies and provide a sense of belonging and stability.

We support this bill in accordance with DAV Resolution No. 224, which calls for program improvements, sufficient staffing, and enhanced resources for VA mental health services.

H.R. 1107, the Protecting Veteran Access to Telemedicine Services Act of 2025

The Protecting Veteran Access to Telemedicine Services Act is a crucial step toward ensuring that veterans receive the high-quality, accessible health care they earned. Many veterans face challenges in accessing timely and consistent medical care, particularly in rural and underserved areas. This legislation addresses these challenges by leveraging the power of telemedicine to provide controlled medications to veterans without the need for in-person medical visits.

Telemedicine bridges the gap for veterans living in remote locations, allowing them to receive necessary medications and consultations from home. This convenience is particularly beneficial for those with mobility issues or limited transportation options. Additionally, the flexibility of telemedicine allows veterans to schedule appointments that fit their busy lives, leading to better adherence to treatment plans and improved health outcomes. The bill would ensure that health care providers can maintain regular contact with patients, providing continuous care and preventing interruptions in treatment, which is vital for managing chronic conditions. Telemedicine is also a game-changer for mental health services, helping to reduce the stigma and barriers often associated with seeking help by providing therapy and support remotely. Finally, the bill includes robust guidelines and processes to ensure that the delivery and dispensing of controlled substances via telemedicine is safe and legal, maintains integrity of the health care system and patient safety while expanding access to care for veteran patients.

We support this bill in accordance with DAV Resolution No. 342, which urges the VA to enhance its national pain management program using patient-centered, interdisciplinary, and holistic approaches, ensuring timely medication delivery and humane alternatives to controlled substances. It also encourages the VA to regularly update its clinical guidance and policies to comply with Federal law and best practices for prescribing and dispensing controlled substances. By harnessing the power of telemedicine, we can provide veterans with the accessible, efficient, and high-quality care they deserve.

H.R. 1336, the Veterans National Traumatic Brain Injury Treatment Act

The Veterans National Traumatic Brain Injury Treatment Act would require the VA to establish a pilot program to provide hyperbaric oxygen therapy (HBOT) to veterans suffering from TBI or PTSD.

Veterans with TBI and PTSD face significant challenges, and traditional treatments have proven ineffective for some. Studies have shown that HBOT, which involves breathing pure oxygen in a pressurized chamber, can enhance the body's natural healing processes. This therapy, traditionally used for treating severe wounds that won't heal, has been found to promote the growth of new blood vessels, reduce inflammation, and improve oxygen delivery to injured tissues. One small clinical trial, published in the Journal of Clinical Psychiatry (JCP) in 2024, has also demonstrated improvements in PTSD symptoms and brain function among veterans undergoing HBOT.

However, despite these promising findings, more comprehensive research is necessary to fully understand the efficacy and safety of HBOT for patients with TBI and PTSD. According to the VA, the scientific evidence is currently mixed, and rigorous, larger-scale studies are recommended to validate the initial positive outcomes noted in the 2024 JCP study and to address any potential risks. A 2018 report by the VA's Evidence Synthesis Program found that large treatment benefits demonstrated in uncontrolled case series have not been easily replicated in well-controlled randomized controlled trials (RCTs). The report suggests that the potential benefits of HBOT may be subtle and require larger RCTs to demonstrate significant effects.

Currently, the VA offers HBOT as a treatment option for a small number of veterans with persistent PTSD symptoms that are resistant to standard treatments. This treatment is provided through partnerships with HBOT providers at select VA health care systems and medical centers. The VA is also conducting a multisite research study to examine the use of HBOT for patients diagnosed with PTSD.

While HBOT shows promise, we must remain committed to a comprehensive and evidence-based approach. By supporting further research and careful evaluation, we can better ensure that our veterans receive the best possible and most effective care for TBI and PTSD. We therefore recommend the Subcommittee include provisions in this bill to prioritize rigorous research alongside providing veterans access to HBOT. It is important to thoroughly validate and understand the efficacy and risks of this therapy as an alternative treatment option for PTSD and TBI before it is more broadly implemented.

H.R. 1644, the Copay Fairness for Veterans Act

The Copay Fairness for Veterans Act aims to eliminate copayments for medications and preventive health services provided by the VA. It would enhance access to these services by removing financial barriers that can discourage veterans from seeking essential care. Preventive services are critical for early detection and management of certain health issues, leading to improved health outcomes. The bill also includes provisions for women veterans to ensure they receive preventative care

services, screenings and contraceptives as outlined in the Health Resources and Services Administration Preventative Services Guidelines.

By removing financial barriers, the bill encourages routine check-ups, vaccinations and critical screenings, leading to better overall health management and fewer emergency medical situations. Many veterans, especially those on fixed incomes, struggle with copayments for health services and medication. By removing required copayments, the bill provides much-needed financial relief, ensuring that veterans can access the care they need without worrying about additional costs. Moreover, promoting preventive care can lead to long-term cost savings for both veterans and the health care system by reducing the need for more expensive treatments and hospitalizations. Preventive services with an "A" or "B" rating from the United States Preventive Services Task Force and immunizations recommended by the Advisory Committee on Immunization Practices are essential components of this approach.

We support this bill in accordance with DAV Resolution No. 246, which calls for legislation to eliminate or reduce VA and DOD health care out-of-pocket costs for service-connected disabled veterans to improve health care access, provide financial relief, enhance health equity and encourage routine care. This bill reflects our Nation's commitment to supporting our veterans and ensuring they receive the care they earned.

H.R. 1823, to direct the VA Secretary and the Comptroller General of the United States to report on certain funding shortfalls in the VA

This bill seeks to address funding shortfalls in the VA by directing the VA Secretary and the Comptroller General of the United States to conduct thorough reviews and report on funding shortfalls.

The bill specifically mandates a review by the Comptroller General to investigate the circumstances and causes of funding shortfalls in the Veterans Benefits Administration (VBA) for Fiscal Year 2024 and the VHA for Fiscal Year 2025. The review must include a comparison of monthly obligations and expenditures against the spending plan, an analysis of any transfers between accounts, an evaluation of reasons for significant diversions from the spending plan, an assessment of the accuracy of projections and estimates, and recommendations for remedial actions to improve accuracy and prevent future shortfalls. The Comptroller General would be required to submit a report to the VA Secretary, who will then submit the report to the specified congressional committees.

By identifying and addressing funding shortfalls, the bill aims to improve the financial management of the VBA and VHA and establish more efficient use of resources and better allocation of funds to critical services. The goal of the bill is to improve financial management, enhance accountability, establish preventive measures, and ensure more timely reporting of projected budget shortfalls. The bill also requires thorough reviews and reports aimed at increasing accountability within the VA and promoting more transparent and responsible budget management practices. The identification of remedial actions may help prevent future funding shortfalls, ensuring uninterrupted services for veterans.

We support this bill in accordance with DAV Resolutions Nos. 23 and 403, advocating for consistent VA funding, full implementation of existing laws, and protection of veterans' services and health care from budget caps.

H.R. 1860, the Women Veterans Cancer Care Coordination Act

The Women Veterans Cancer Care Coordination Act seeks to revolutionize cancer care for women veterans by establishing a comprehensive support system. The bill mandates the designation of Regional Breast and Gynecologic Cancer Care Coordinators within each Veteran Integrated Services Network (VISN). These coordinators would be tasked with ensuring seamless communication and coordination between VA clinicians and community cancer care providers.

Eligibility for care coordination would be extended to veterans diagnosed with breast or gynecologic cancer or those identified with precancerous conditions, provided they qualify for health care through the Veterans Community Care Program (VCCP). Additionally, the bill would require the establishment of regions for care coordination, to determine the specific needs of veterans in different areas, including rural communities. This regional approach aims to provide tailored support, ensuring that veterans receive timely and appropriate care regardless of their location.

The prescribed duties of the Regional Breast and Gynecologic Cancer Care Coordinators are multifaceted. They would facilitate the coordination of care between VA clinicians and community care providers, ensuring that veterans receive consistent and comprehensive treatment. They would be responsible for monitoring the services provided, tracking health outcomes, and maintaining data on cancer care. This

data—driven approach will help identify trends, measure effectiveness, and guide future improvements in care delivery.

A significant component of the bill is the requirement for the VA Secretary to submit a detailed report to Congress within 3 years of enactment. This report would compare health outcomes between veterans treated at VA facilities and those treated by community providers. It would assess the timeliness, safety, and quality of care, and identify any necessary changes or additional resources needed to enhance cancer care for women veterans. By establishing dedicated coordinators, focusing on data-driven care, and providing essential information and support, the bill strives to improve health outcomes and quality of life for these veterans and to ensure they receive coordinated, comprehensive, and compassionate care.

The bill would also help to ensure that male veterans who suffer from breast cancer due to toxic exposures receive the same specialized care as their female counterparts. The Honoring our PACT Act, signed into law in August 2022 (P.L. 117–168), expands and extends eligibility for VA health care for veterans with toxic exposures. This includes male veterans who have been diagnosed with breast cancer.

The VA has recognized the need to address the health effects of toxic exposures and has included male breast cancer in the list of conditions presumed to be caused by military service. Male veterans who have been exposed to toxic substances during their service and have developed breast cancer are eligible for the same benefits and specialized care as female veterans.

We support this bill in accordance with DAV Resolution 39, which calls for ensuring that the VA provides health care services and specialized programs, including gender-specific services, to eligible women veterans at the same degree and extent as services provided to male veterans. It also emphasizes improving women's health programs and finding innovative methods to address care barriers, ensuring women veterans receive quality treatment and specialized services.

Draft Bill, the Saving Our Veterans Lives Act of 2025

The Saving Our Veterans Lives Act of 2025 aims to prevent veteran suicide by providing eligible veterans with secure firearm storage items upon request. The alarming rate of veteran suicide is a stark reminder of the urgent need for comprehensive measures to protect those who have sacrificed so much for our country. According to the VA 2024 National Veteran Suicide Prevention Annual Report, there were 6,407 suicides among veterans in 2022, with firearms being involved in 72 percent of these cases. Firearms are the primary method of suicide among veterans, and by providing secure storage options for firearms—such as a lockbox or safe, this Act aims to reduce access to lethal means during moments of crisis, potentially saving countless lives.

Creating time and space is a critical component of this Act's strategy to reduce veteran suicides. Providing veterans with secure firearm storage can create a critical time delay, allowing them to reconsider their actions and seek help during moments of crisis. This additional time can be a lifesaving interval, as it provides a window of opportunity for the veteran to reach out for support, contact the crisis hotline, or have a moment of reflection. The VA's 2024 suicide prevention report highlighted a reduction in suicide rates among veterans with VHA mental health diagnoses, underscoring the effectiveness of targeted suicide prevention efforts. By delaying access to firearms during a crisis period, the Act empowers veterans to make safer choices and access the help they need.

The Act includes an educational component that would help inform veterans about the benefits of secure firearm lock box storage with a goal of more responsible firearm handling and storage practices. The development of informational videos would help ensure that veterans receive the necessary guidance on secure storage as a suicide prevention strategy. Proper firearm storage not only protects veterans but also their families, reducing the risk of accidental discharges and unauthorized access by children or other household members. This program aims to promote a culture of safety within the veteran's community, fostering a secure environment for all.

We support this bill in accordance with DAV Resolution No. 224, which calls for mental health and suicide prevention program improvements to include suicide rate data collection and reporting, improved outreach for stigma reduction, sufficient mental health staffing, and enhanced resources for VA mental health programs.

Draft Bill, the No Wrong Door for Veterans Act

The No Wrong Door for Veterans Act would reauthorize and extend the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program through September 30,

2028, ensuring that community-based suicide prevention initiatives and mental health services will continue to be available to veterans.

By adjusting the grant amount and clarifying the criteria for eligible entities, the bill promotes equitable distribution of funds and aims to ensure that qualified organizations can provide high-quality mental health services to veterans. Moreover, the bill's emphasis on improved coordination and communication between grantees and VA medical centers is a significant enhancement. Quarterly briefings for local VA medical center personnel will help facilitate better collaboration and information sharing, hopefully leading to more efficient and effective delivery of mental health services. This improved coordination is crucial for creating a seamless support network for veterans in crisis.

Another critical provision in the legislation is the bill's requirement that grantees notify eligible individuals about emergent suicide care options and report requests for such care to the VA. Increased awareness and utilization of suicide prevention resources can lead to more timely intervention and potentially save lives. By requiring the use of screening protocols selected by the Secretary, the bill also ensures that veterans receive consistent and standardized care, further enhancing the quality of mental health services.

While the intent of extending the Fox Suicide Prevention Grant Program is commendable, DAV recommends strengthening the proposed legislation to ensure it meets its primary objective—reducing risk of suicide in this population. We recommend the bill reiterate the standard of baseline mental health screening that all grantees must provide or coordinate the provision of a baseline mental health screening to all eligible individuals they serve at the time those services begin. This mental health screening must be provided using a validated screening tool that assesses suicide risk and mental and behavioral health conditions. Applicants or partner organizations must measure the effectiveness of suicide prevention services provided to eligible individuals and their families using pre-and post-evaluations that employ validated measures of suicide risk and mood-related symptoms.

Additionally, funding criteria in the bill is associated with the number of participants served rather than prioritizing demonstrated improvements in veterans' well-being (i.e., reduction in suicide risk factors). We want to ensure that resources are directed to programs that achieve measurable outcomes. Finally, we suggest the payment structure be more clearly defined to prevent overcompensation for minimal services.

Given that the funding renewal for this initiative was supposed to be based on demonstrated improvements in veterans evaluation measures, we recommend a cautious, annual renewal process until comprehensive data confirms the program's overall efficacy and specifically, which services are most effective in reducing suicide risk in the veteran population. These changes are essential to maximize the program's potential and truly support at-risk veterans.

Draft Bill, the Providing Veterans Essential Medications Act

The Providing Veterans Essential Medications Act would amend title 38, United States Code, to ensure that veterans receiving nursing home care in State homes have access to necessary, yet costly, medications.

Under this bill, the VA Secretary is directed to either reimburse State homes for these high-cost medications or furnish them directly, at the election of the State home. The bill defines "costly medication" as any drug or medicine whose average wholesale price for a 1-month supply, plus a transaction fee, exceeds 8.5 percent of the payment made by the Secretary for the veteran's care. This amendment seeks to alleviate the financial burden on State homes and ensure that veterans continue to receive appropriate and comprehensive care without the added stress of high medication costs.

The cost of high-cost medications, such as revolutionary cancer drugs, can often exceed $1,000 a day. This bill will ensure that State homes are not financially strained by these costs. VA providing these types of medications also incentivizes more State homes to provide care for severely disabled veterans and increases the availability of high-quality long-term care services across the country. The PACT Act has led to an increase in veterans adjudicated as severely disabled due to toxic exposure. This rise will more likely than not necessitate State Veterans Homes to provide high-cost medications to more veterans. As the number of veterans requiring specialized and expensive medications grows, State Veterans Homes will face increased financial strain. It is essential to ensure that these homes receive adequate funding and support to meet the rising demand for care. This bill will help address the growing demand for high-cost medications in State homes and ensure that all veterans receive the health care they earned.

We support this bill in accordance with DAV Resolution No. 227, which calls on Congress and the VA to provide sufficient funding to support State Veterans Homes, including adequate per diem payments for skilled nursing care, domiciliary care and adult day health care, which properly support different levels of care within each program.

Draft Bill, to establish the period during which the referral of a veteran, made by a health care provider of the Department of Veterans Affairs, to a non-Department provider, for care under the VA Community Care Program, remains valid.

This bill seeks to streamline the referral process for community services, reduce administrative barriers, and improve access to care. The bill's primary objective is to establish the period during which a referral of a veteran, made by a health care provider of the VA, to a non-Department provider remains valid under the VCCP. The bill specifies that this period begins on the day the covered veteran has their first appointment with the non-Department provider. This provision would ensure veterans referred to non-Department providers have a clear referral validity period, facilitating smoother transitions.

We support this bill in accordance to DAV Resolution No. 18, which supports legislation that establishes clearly defined VA health care services for enrolled veterans.

Draft Bill, the Veterans Supporting Prosthetics Opportunities and Recreational Therapy or SPORT Act

The DAV has long recognized the importance of adaptive sports in the rehabilitation and well-being of veterans through our involvement with events like the National Disabled Veterans Winter Sports Clinic, and the National Disabled Veterans Golf Clinic. These recreational therapy programs help veterans improve their physical and mental health through sports and activities tailored to their abilities, while connecting them with other veterans and a community to help overcome limitations and challenge their perceived disabilities.

The Veterans SPORT Act seeks to include adaptive prostheses and terminal devices, for participation in sports and other recreational activities, in the medical services provided by VA to eligible veterans. Including adaptive sports devices is congruent with VA's holistic approach to veteran care, which includes the physical, psychological and social aspects of rehabilitation. This legislation aims to enhance the quality of life for our Nation's ill and injured veterans by providing them with the necessary adaptive devices to participate in various sports and recreational activities, which plays a vital role in their overall physical and mental well-being. These devices enable service-disabled veterans to engage in a wide range of activities, including Paralympic sports like track and field, swimming, and wheelchair basketball; archery with adaptive equipment; cycling with hand cycles and adaptive bicycles; skiing with adaptive equipment; hunting with specialized devices; rock climbing with modified safety equipment; skydiving with adaptive gear; golf with adaptive golf equipment; and various water sports like paddle boarding, kayaking, pedal boating, and canoeing.

We support this bill in accordance with DAV Resolution No. 429, which urges the VA to keep centralized funding for Prosthetics and Sensory Aids Service to provide high-quality prosthetic items and train veterans on their use and care. By supporting this bill, we honor the sacrifices of our most severely disabled veterans and promote their overall well-being by providing them with the necessary adaptive devices to once again engage in sports and recreational activities.

In closing, the proposed bills under consideration by the Subcommittee today represent a comprehensive and multifaceted approach to addressing the urgent needs of our veterans. By prioritizing timely access to care, effective care coordination, and comprehensive, individualized health care options, these bills aim to enhance the quality of life for our veterans, who have bravely served our Nation.

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

STATEMENTS FOR THE RECORD

Veterans Healthcare Policy Institute

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

On behalf of the Veterans Healthcare Policy Institute, we thank you for inviting us to submit a statement for the record for today's hearing on improving the health care and services for veterans. Many members of our organization are veterans or have family members who are veterans. Many of us have had long careers serving veterans, published papers on veterans' healthcare in peer-reviewed journals, or presented congressional testimony. In today's statement, we wish to convey our appreciation for your leadership and commitment to ensuring that veterans receive the highest level of health care within the Veterans Health Administration (VHA) and supplementary care in the private sector when it's both needed and authorized by the VHA.

While today's hearing considers 12 bills, we limit our comments to only one of them—The No Wrong Door for Veterans Act.

Background

The No Wrong Door for Veterans Act proposes to renew and modify the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. This pilot initiative allocated $174 million over 3 years to a diverse array of private and government community entities to supplement VA efforts, including veterans' associations, social service agencies, and tribal nations that partnered with the VHA at the local level.

Under the Fox Grant Program, 80 grantees receive up to $750,000 annually. Their primary role is to identify and engage veterans exhibiting one or more of 14 defined suicide risk factors. Once identified, these at-risk veterans and their families are provided with peer support, case management, benefits navigation assistance and/or other targeted services aimed at reducing suicide risk factors before they escalate into crises.

The Importance of the Fox Grant Program's Use of Outcome Measurement

The original Fox Grant law vastly improved the use of comprehensive outcome data to be able to discern which community programs effectively enhanced veterans' lives and reduced long-term suicide risk. As Congressman Jack Bergman, the bill's co-author, emphasized: "This bill would develop measurement tools to track the effectiveness of these community-level programs in order to address the suicide crisis and its impact on Veterans."

The law authorized the VA to establish and apply a comprehensive baseline mental health screening for outcome metrics. Five well-validated measures were identified for grantees to administer at the beginning and end of participants' involvement. These additional measures are crucial, given that the programs are not clinical and are expected to impact suicidality downstream. The VA was expected to analyze changes in these scores to direct renewal funding to the interventions that demonstrated improvement in these instrument scores.

Senator John Boozman (R-AR) hailed the Fox Grant Program for establishing "a common tool to measure the effectiveness of our programs and promote better information sharing, data collection, and continual feedback in order to identify what services are having the most impact."

Concerns with the No Wrong Door for Veterans Act

As the 3-year pilot comes up for reauthorization, the proposed "No Wrong Door for Veterans Act" contains several concerning elements that significantly undermine the Fox Grant program. Amendments are needed to remedy these shortcomings.

1. Eliminating Demonstrated Effectiveness as a Criterion for Continued Funding

The bill explicitly states that previously funded entities need only demonstrate "serving a significant number of veterans" to qualify for continued funding. That eliminates the core feature of the Fox Grant program to utilize participants' pre-post changes for decisions about continued funding. Grant recipients would only need to demonstrate throughput, not a track record of any successful improvements, leaving open the strong possibility that taxpayer funds would be misdirected into programs without proven effectiveness.

2. Ambiguous Language About Screening Requirements

As noted above, the original Fox program required grantees to screen for acute suicide risk and collect pre/post measurements of five psychosocial suicide risk factors.

The language in the No Wrong Door legislation is unclear whether both types of screening remain mandatory. At a HVAC hearing last December, testimony suggested the new bill might eliminate pre/post screening requirements. Without these crucial evaluation metrics, it will be challenging to accurately assess any program's success in addressing the issues surrounding veteran suicide prevention.

The bill also explicitly permits grantees to use their own protocols to screen for risk, undermining the ability to make apples-to-apples comparisons or aggregate data reporting, which require uniform protocols.

3. Insufficient Safeguards on Overpayment to Grantees

The bill provides $500,000 per grantee "plus $10,000 per eligible individual who receives suicide prevention services provided or coordinated by such grantee." This ambiguous wording could allow a grantee to be reimbursed $10,000 for nominal activities. For example, a grantee could be reimbursed for:

- Providing services to an individual that another funder is already fully covering
- Conducting a screening with no follow-up services
- Giving a pamphlet to an individual at an outreach event

There needs to be far more explicit definitions for what constitutes reimbursable "suicide prevention services provided or coordinated by such grantee."

4. Premature Extension of an Unproven Program

The bill calls for a 3-year extension through 2028 despite the lack of a proven track record. Yet, the Interim Report on the Fox Suicide Prevention Grant Program revealed extremely significant gaps:

- Of the 80 grantees, 55 failed to report any post-service outcome measurements
- The remaining 25 grantees had only 196 participants total who completed services and underwent some degree of pre/post measurement
- 27 percent of eligible participants did not complete even one instrument upon entering their program
- 23 percent of grantees served fewer than ten veterans/family members in their first year
- 80 percent of grantees had less than fifty participants

Thus, as of today, grantee effectiveness has been impossible to ascertain—either at the disaggregated grantee level or even at the Fox Grant program level—as required by law. The purpose of requiring both internal VA and external MITRE program evaluations of the pilot is to determine whether the Fox Grant program is effective for its intended purpose of reducing suicide risk factors. The program should not be extended carte blanche for three more years until its effectiveness is, as Bergman and Boozman intended, identified by data.

Recommendations:

1. **Tie funding to demonstrated effectiveness:** Add language specifying that reauthorizing an entity's funds is based on it serving a significant number of veterans and demonstrated improvements in participant outcomes on the mandated well-being measures.

2. **Strengthen outcome measurement requirements:** The Act must explicitly reinforce the requirement that Fox Grant recipients conduct pre-and post-intervention assessments across all relevant metrics. This ensures robust data collection that shows how veterans' scores on the five key measures improve after participating in each grantee's services. All grantees should use the identical measures.

3. **Clarify payment structure**: Tighten language to ensure that entities are paid $10,000 per enrollee only for a defined and substantial amount of provided services, not nominal interventions.

4. **Implement a 1-year renewal before blindly funding a long-term commitment:** Until there is concrete proof of the Fox Grant program's effectiveness, and until the congressionally mandated MITRE Corporation 18-month and 3-year evaluations show systematic success, renewal should proceed on a year-to-year basis rather than a multi-year extension.

While leveraging non-clinical community organizations is a crucial component of an effective upstream public health approach to suicide prevention, rigorous evaluation must be maintained to ensure these programs truly benefit veterans and represent good stewardship of taxpayer dollars.

We respectfully thank you for the opportunity to provide our perspectives on these essential matters. We look forward to working with the committee to ensure that veterans can receive timely, high-quality compassionate care in the VHA and the community now and in the future.

Prepared Statement of American Association for Marriage and Family Therapy and California Association of Marriage and Family Therapists

Dear Chairwoman Miller-Meeks and Ranking Member Brownley:

We are writing on behalf of the American Association for Marriage and Family Therapy ("AAMFT") and the California Association of Marriage and Family Therapists ("CAMFT"), organizations that represent the professional interests of more than 81,000 licensed marriage and family therapists ("MFTs") who provide individual, family, and group psychotherapy services throughout the United States. Thank you for providing AAMFT and CAMFT with an opportunity to comment in response to legislation considered on March 11, 2025 by the Committee on Veterans' Affairs Subcommittee on Health.

We are commenting in support of H.R. 658, legislation introduced by Ranking Member Julia Brownley to correct a problem that impacts care and treatment for Veterans. AAMFT and CAMFT would like to thank Ranking Member Brownley for sponsoring this legislation. H.R. 658 seeks to expand access to licensed MFTs for Veterans and their families by removing unnecessary guidelines and policies that currently restrict the promotion of many VA MFT employees to supervisory positions, resulting in barriers to a qualified mental health workforce and barriers to timely access to care. H.R 658 would allow MFTs in the VA who are authorized to provide clinical supervision under State law to be eligible to provide clinical supervision in the VA.

Background

In 2006, the Veterans Benefits, Health Care, and Information Technology Act of 2006 (P.L. 109–461) was signed into law. This legislation established MFTs as recognized professionals within the VA. The VA started hiring MFTs in 2010 after the adoption of the first qualification standard for MFTs.[1] In 2018, the VA issued its second and current qualification standard for MFTs.[2] This 2018 standard added a new requirement that all MFTs in the VA who are supervising or who want to serve at a supervisory or managerial level and above designation must first have obtained the AAMFT Approved Supervisor designation in order to supervise.[3] This requirement prevents well-trained and highly qualified MFTs who are serving in the VA at the GS–11 full performance level from advancing within the VA into a supervisory role. In addition, no such requirement exists in almost all other employment settings, and a similar requirement in the VA does not exist for psychologists, clinical social workers, or professional mental health counselors.

Currently, the VA requires that MFTs must hold the AAMFT Approved Supervisor designation to be promoted to supervisory positions. While AAMFT is proud of its high caliber supervisory designation, the AAMFT Approved Supervisor designation is not intended to be the only pathway for an MFT to become a clinical

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[1] VA Handbook 5005/41, Part II, Appendix G42

[2] VA Handbook 5005/101, Part II, Appendix G44

[3] The VA does allow MFTs to are working to obtain the AAMFT Approved Supervisor designation to serve as supervisors in the VA. These providers have 2 years from the date of placement to obtain the AAMFT Approved Supervisor designation.

supervisor in the VA or in other settings. The VA does not require that licensed professional mental health counselors ("LPMHCs"), licensed clinical social workers ("LCSWs") or other clinicians obtain a designation from a private organization in order to serve as a clinical supervisor in the VA.

The Current MFT Supervisor Requirement is an Unnecessary Barrier

The current MFT supervisor requirement is not necessary, and serves as a barrier for providers and Veterans. This requirement places MFTs at a disadvantage when it comes to the retention and promotion of MFTs within the VA. There are thousands of MFTs who are recognized as state-approved supervisors, yet they are not able to supervise within the VA because they do not have the AAMFT Approved Supervisor designation. We are aware of MFTs who have left VA employment because of this restriction, including MFTs that are Veterans themselves. We have heard that some hiring authorities within the VA are reluctant to hire MFTs for entry level positions due to the shortage of MFTs eligible to supervise in the VA, thus unnecessarily increasing workforce shortages and hampering Veteran's timely access to care.

The Current MFT Supervisor Requirement Does Not Align with State Requirements

The VA's current MFT supervisor requirement is not in alignment with State law. All 50 states and the District of Columbia license MFTs. States require that in order to become a licensed MFT, an applicant must hold a master's degree or doctoral degree in marriage and family therapy or a related field, have 2 years of clinical supervised experience, and pass a clinical exam. All states have requirements for MFTs who want to provide clinical supervision.

Based upon a review of the licensure laws governing MFTs in all 50 states and the District of Columbia, only two states—North Carolina and Tennessee—require that clinical supervisors providing supervision for MFT licensure must be AAMFT Approved Supervisors. In all 48 other states, a clinical supervisor of a candidate for licensure as an MFT does not need to be an AAMFT Approved Supervisor. Instead, these 48 states allow MFTs who have experience and/or training in supervision to obtain a State MFT supervisor designation or otherwise legally provide supervision to supervisees in those states. For example, under Texas law, a person can become a Texas MFT supervisor if have either successfully completed a 3-semester hour course in MFT supervision, completed a 40-hour continuing education course in clinical supervision, or completed a supervision course approved by AAMFT.[4]

In many states, the supervisor requirements for MFTs are identical to, or closely similar to, the State supervisor requirements for other mental health professionals. For example, in Iowa, the requirements to be an eligible supervisor for MFTs and LPMHCs are identical: hold an active license, have a minimum of 3 years of independent practice experience, complete at least a 6-hour continuing education course in supervisor or one graduate-level course in supervision, and knowledge of the law and ethics rules governing supervisees in Iowa.[5]

The VA's current additional MFT supervisor requirement does not align with the VA's own clinical supervisor requirements for other healthcare professionals. The VA generally recognizes clinical providers in the VA as eligible to supervise if State law allows them to supervise. For example, within the mental health professions, LPMHCs and LCSWs can provide clinical supervision if they are licensed to provide clinical supervision under State law or otherwise can legally provide supervision for licensure under State law.[6] Instead of following clinical supervisor requirements under State law, the VA MFT supervisor requirement is unique in requiring those applying for a supervisory position or having the ability to supervise trainees to obtain a supervision designation from a nongovernmental organization. Since the VA generally defers to State law pertaining to the minimum standards necessary to work in the VA, such as meeting a state's requirements for licensure in a recognized healthcare profession, the VA should allow MFTs who are authorized to provide clinical supervision under State law to be eligible to provide clinical supervision in the VA.

HR 658 Would Increase the Number of MFT Supervisors While Providing the Best Quality of Care to Veterans

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[4] 22 TX Admin Code § 801.143. In addition, all candidates for the MFT supervisor status in Texas must document the completion of 3,000 hours of MFT practice over a minimum of 3 years.

[5] Iowa Admin Code r. 481.891.7

[6] VA Handbook 5005/106, Part II, Appendix G43 (LPMHCs) & VA Handbook 5005/120, Part II, Appendix G39 (LCSWs)

HR 658 would expand access to licensed MFTs for Veterans and their families by removing unnecessary regulations that currently prohibit many MFTs employed by the VA from being promoted to supervisory positions. This legislation would significantly increase the number of current MFTs in the VA who would be eligible to provide clinical supervision. By increasing the pool of MFTs eligible to become clinical supervisors and be promoted within the VA, this bill would increase the retention of MFTs within the VA. Increasing the number of supervisors and improving retention of MFTs within the VA will also improve access to care in a timely manner for Veterans. H.R 658 protects Veterans by requiring that all MFT supervisors must be an AAMFT Approved Supervisor or authorized by a State to provide clinical supervisor. As with all clinical supervisors of any profession within the VA, under this bill, the VA would still retain the ability to manage VA employees, investigate supervisors, and take any action against employees who are not providing the best care for Veterans.

We would like to thank the Committee for the opportunity to submit comments in support of H.R. 658. AAMFT and CAMFT look forward to working with the Committee on this legislation.

Prepared Statement of Paralyzed Veterans of America

Chairman Bost, Ranking Member Takano, and members of the committee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to submit our views on some of the pending legislation impacting the Department of Veterans Affairs (VA) that is before the committee. No group of veterans understand the full scope of benefits and care provided by the VA better than PVA members—veterans who have incurred a spinal cord injury or disorder (SCI/D). We appreciate the opportunity to offer our observations on some of the bills being discussed during today's hearing.

H.R. 217, the Communities Helping Invest through Property and Improvements Needed or CHIP IN for Veterans Act

The Communities Helping Invest through Property and Improvements Needed for Veterans Act of 2016 (P.L. 114–294), often referred to as the "CHIP IN" Act, authorized the VA to carry out a pilot program under which it may accept up to five donations from nonfederal entities of existing facilities, land, or a facility to be constructed by the donor on real property of the VA. Increasing investment in VA's infrastructure, particularly facilities that support specialized health care services, is a crucial priority for veterans with SCI/D. PVA supports this bill, which would make the CHIP IN pilot program permanent, thus, increasing the availability of health care services to veterans.

H.R. 658, to establish qualifications for the appointment of a person as a marriage and family therapist, qualified to provide clinical supervision, in the Veterans Health Administration

PVA supports this legislation, which would establish qualifications for the appointment of a person as a marriage and family therapist, qualified to provide clinical supervision in the Veterans Health Administration (VHA). Veterans who have developed mental health issues often find it difficult to resume daily activities, which creates stress and anxiety. Well trained marriage and family therapists have helped thousands of veterans become productive citizens and improve their family relationships. Removing current restrictions that limit the growth potential for marriage and family therapists within the VA will increase retention of these professionals and improve access to the care they provide.

H.R. 1107, the Protecting Veteran Access to Telemedicine Services Act of 2025

PVA supports this legislation, which would permanently extend a pandemic-related exemption that allows VA health care providers to prescribe certain medications via telemedicine to their veteran patients. Specifically, it would authorize a covered health care professional to use telemedicine to deliver, distribute, or dispense to veterans certain controlled medications via telemedicine under specific conditions as determined under the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 301 et seq.). Veterans who live in rural communities often do not have easy access to a VA health care facility, and telemedicine is often the most convenient way to provide essential care. Using technology to increase access to care within VA is an

important way to provide care to better meet veterans' needs, ensuring they receive their medications without interruption.

H.R. 1336, 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. 1644, the Copay Fairness for Veterans Act

PVA supports this legislation, which would eliminate copayments for medications and preventive health services provided by the VA. While the VA charges copays to certain veterans for hospital and medical care, veterans should not be subject to copays for preventive services. These services are essential for management and early detection of health issues, that if left untreated, could lead to more serious illnesses or conditions. Ending copays for preventative care will also ensure parity for veterans with most other Americans who have no copays when accessing this type of care.

H.R. 1823, to direct the VA Secretary and the Comptroller General of the United States to report on certain funding shortfalls in the VA.

In July 2024, the Veterans Benefits Administration (VBA) projected a $2.88 billion budget shortfall for the remainder of Fiscal Year (FY) 2024 and VHA projected a $12 billion shortfall for Fiscal Year 2025. Toward the end of September 2024, Congress approved H.R. 9468, the Veterans Benefits Continuity and Accountability Supplemental Appropriations Act of 2024 (P.L. 118–82), which gave VBA an additional $2.9 billion to pay veterans' pension and disability benefits for Fiscal Year 2024.

On November 1, 2024, VBA revealed that it carried over approximately $5.1 billion from Fiscal Year 2024 to Fiscal Year 2025, meaning it did not need the additional funding approved by Congress. Also, at the end of November, the VA announced that it only needed $6.6 billion, not $12 billion, to cover existing shortfalls in the VHA budget for Fiscal Year 2025. The lack of clarity on what VA's true financial needs are has been a concern for all interested parties, and to date, sparse details have been provided about VA's inability to track and project its funding. PVA strongly supports this legislation, which requires the Comptroller General to investigate the circumstances surrounding the reported funding shortfalls for the VHA and VBA in Fiscal Year 2024 and Fiscal Year 2025.

Discussion Draft, to establish the period during which the referral of a veteran, made by a health care provider of the Department of Veterans Affairs, to a non-Department provider, for care or services under the Community Care Program of such Department, remains valid.

PVA supports this draft legislation, which would establish the valid time frame for a referral from a VA health care provider to a non-VA Community provider under the Community Care Program. As written, "valid time" begins the day a covered veteran has their first appointment with the community care provider. This would ensure veterans referred to community care providers meet all of VA's authorization requirements, allowing the provider to focus on delivering appropriate care to a veteran without delay.

Discussion Draft, the Providing Veterans Essential Medications Act

PVA supports this draft bill, which would ensure that veterans receiving nursing home care in State Veterans Homes have access to high-cost medications, as needed. Currently, the VA does not pay State homes for high-cost medications for veterans. This bill would require the VA Secretary to either reimburse State homes for costly medications or furnish them directly, which would eliminate financial burdens on these long-term care facilities and increase veterans' access to care.

Discussion Draft, The Veterans Supporting Prosthetics Opportunities and Recreational Therapy ("SPORT") Act.

PVA strongly supports this draft bill, which would provide VA coverage of prosthetic limbs that veterans with limb loss use to participate in sports and other recreational activities. Specifically, this bill would add "adaptive prostheses and terminal devices for sports and other recreational activities" to the statute governing which equipment and aids that the VA is allowed to grant veterans. Adaptive equipment is intended to promote and support holistic healthy lifestyles for amputees.

But occasionally, VA's own internal policies create unnecessary barriers for veterans with disabilities. For this reason, we highly recommend that VA provide these kinds of adaptive equipment for amputees without requiring that the veteran be enrolled in a VA rehabilitative program.

Discussion Draft, the Saving Our Veterans Lives Act

Firearms are the most common method of suicide in the US, with veterans representing slightly more than 69 percent of cases.[1] More than 70 percent of male veteran suicide deaths and 50 percent of female veteran suicide deaths are the result of firearms, and these rates greatly exceed those of non-veterans. Fifty-one percent of veterans report owning one or more personal firearms, and of those, over half report storing firearms that are loaded and/or unsecured. Many of the veterans who store their firearms loaded and unlocked don't even own a lockbox or safe. PVA supports this effort to make it easier for veterans to access secure firearm storage devices and raise awareness about the importance of lethal means safety to help prevent firearm suicide among veterans and their families.

Discussion Draft, the Women Veterans Cancer Care Coordination Act

The Women Veterans Cancer Care Coordination Act would require the VA to hire or designate a Regional Breast Cancer and Gynecologic Cancer Care Coordinator at each Veterans Integrated Services Network (VISN). While PVA supports the intent of this draft bill, some changes are needed to make it stronger. The National Women Veterans Oncology System of Excellence was established in 2020 to offer increased attention and collaborative treatment plans for women experiencing breast or gynecological cancers. Their work has led to improved early detection, coordinated treatment of cancers, and provided increased trust in VA among women veterans. However, the National Women Veterans Oncology System of Excellence is not protected in statute. PVA recommends adding a provision within the legislation that secures the National Women Veterans Oncology System of Excellence to ensure the great work VA is doing on behalf of women veterans living with cancer. Additionally, cancer care coordination is disparate across the system, and while PVA supports additional focus and attention on the needs of women veterans, we believe having someone within each VISN to focus on all cancers, regardless of gender, should be prioritized.

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

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 2025

Department of Veterans Affairs, Office of National Veterans Sports Programs & Special Events——Grant to support rehabilitation sports activities—$502,000.

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.

[1] Firearm suicide risk and prevention in service members—ScienceDirect

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 American Federation of Government Employees, AFL-CIO

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO

Eric Bunn Sr.
National Secretary-Treasurer

Dr. Everett B. Kelley
National President

Dr. Kendrick B. Roberson
NVP for Women & Fair Practices

March 10, 2025

Dear Chairman Miller-Meeks and Ranking Member Brownley:

The American Federation of Government Employees, AFL-CIO (AFGE) and its National Veterans Affairs Council (NVAC) appreciate the opportunity to provide comments on pending legislation. AFGE represents more than 800,000 federal and District of Columbia government employees, 310,000 of whom are proud, dedicated Department of Veterans Affairs (VA) employees.

Discussion Draft, "Standardizing Treatment and Referral Times Act of 2025"

AFGE opposes the discussion draft by Chairman Miller-Meeks, which would establish that the period during which the referral of a veteran to a private provider remains valid begins on the day of the first appointment. This proposal makes a referral to a private provider evergreen for as long as it takes a provider to provide an initial appointment. As such, it directly negates the point of the referral to the private provider in the first place, which was to make care available more quickly if care isn't available in VA within the drive times and wait times prescribed by Veterans Community Care Program access standards. This provision allows private providers to skirt timeliness requirements altogether by giving them an indefinite period in which they can provide services.

"No Wrong Door for Veterans Act"

AFGE opposes the elimination of the requirement that previous recipients of grants reapplying to the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program show evidence of efficacy. Under this legislation, previous grantees must only show that they have serviced a "significant" number of veterans when they reapply for grant funding. What purpose is served by providing grants to entities that cannot prove they have benefited veterans under their previous grant? This opens the door for charlatans to provide dubious care and put taxpayers on the hook for the costs.

AFGE looks forward to working with the House Veterans' Affairs Committee, Subcommittee on Health, to find better ways to improve the VA to make it work better for veterans.

Sincerely,

Daniel M Horowitz

Daniel Horowitz
Acting Director, Legislative Department

Prepared Statement of Trajector Medical

TRAJECTOR MEDICAL

March 12, 2025

Chairman Luttrell, Ranking Member McGarvey, and members of the Disability Assistance and Memorial Affairs Subcommittee:

This comment is submitted in response to this subcommittee's March 5, 2025, legislative hearing. For years, Congress has debated the complex and multifaceted topic of representation of claimants seeking Department of Veterans Affairs (VA) benefits. Unfortunately, the debate has been complicated by a misleading public relations campaign ("Claim Shark") driven by select Veterans Service Organizations (VSOs) and law firms that inaccurately proclaim that all service providers that are not VA-accredited are the same and operate illegally. These mischaracterizations have hampered honest dialogue, unfairly disparaged legally compliant service providers, and overshadowed the critical role of appropriately licensed and government-regulated professionals—including over one million licensed physicians, nurse practitioners, and registered nurses—who assist Veterans with their healthcare needs every day and play a critical role in the VA benefits landscape.

Congressman Pappas hit the bullseye during this Subcommittee's March 29, 2023, legislative hearing on the GUARD VA Benefits Act (and other proposals) when he stated:

> *"One of the consistent and false rumors regarding the Act is that somehow providers of third-party medical evidence might be swept into the net; and I understand the concern of some medical evidence providers, but I feel it's unwarranted. Could you clarify for the Subcommittee: has the provision of medical documentation to Veterans ever been considered to be part of the definitions of 'preparation, presentation, and prosecution'?"*

The VA witness, a senior staff attorney Christa Shriber, responded:

> *"We do not consider the submission of medical evidence to be part of preparation, presentation, and prosecution of a benefit claim. Medical evidence is…almost seen as expert testimony, versus a claims preparer or an attorney, agent, or VSO representative [who] is an advocate on the Veteran's behalf. They're two separate roles, and they both play an important part in our VA system. But they are separate and distinct."*

Unfortunately, the bills discussed on March 5, 2025, continue to miss the target because they fail to include simple language that clearly denotes the separate and distinct nature that divides legal advocacy from professional medical evidence services. As currently drafted, these bills remain fatally flawed due to their clear conflict with at least five separate well-established federal laws that countless Veterans, lawmakers, and VSOs have fought hard to get implemented over the past few years to protect Veterans' rights to have the VA appropriately consider all available private medical evidence in support of their disability claim.

Federal law guarantees a Veteran's right to submit private medical evidence, and the VA is required to consider private medical documentation:

- 38 U.S.C. § 5107(b) requires the VA to consider all "medical evidence of record," regardless of its source.
- 38 U.S.C. § 5125 requires the VA to accept medical reports from private healthcare professionals.
- 38 C.F.R. § 3.159(a)(1) defines "competent medical evidence" and emphasizes the training and expertise of healthcare providers in assessing its weight.
- 38 U.S.C. § 5101(d)(1)(A) mandates the VA to provide Disability Benefits Questionnaire forms on its public-facing website for use by private medical professionals.
- 38 U.S.C. § 5103A(b)(4)(A) encourages the submission of relevant private medical evidence.

A focus on essential policy nuances has been largely absent from this debate. The following points underscore the importance of this subcommittee's work. Your efforts are critical in shaping an informed, balanced, and Veteran-focused legislative proposal.

Introduction

Clearly presented medical evidence is the foundation of any successful legal claim for disabilities or injuries, whether it's a civil claim (e.g., personal injury claim) or government benefits claim (e.g., Social Security, Workers' Compensation, or Veterans Benefits). Not only is appropriate medical evidence needed by VA adjudicators,[1] but it also ensures that decisionmakers fully understand the cause, extent, and functional impact of a medical condition—greatly improving the probability of a timely and accurate outcome, thereby avoiding a costly appeals process and delays for the Veteran.

It is clear to both the VA and well-informed stakeholders that there is a significant difference between what is required to serve as a VA-accredited representative (i.e., individuals engaged in the preparation, presentation, and prosecution of VA benefits claims) in contrast to what is required by State Medical Boards and numerous 38 C.F.R. requirements (i.e., medical professionals engaged in the provision of a medical diagnosis and medical opinions).

Simply stated, when a Veteran combines competent representation or legal advocacy (which VA accreditation was designed to address) with thorough medical evidence services (which VA accreditation does not cover), their odds of receiving a timely, fair, and accurate decision increase. This formula applies in the VA benefits space just as it does in other disability or injury-related claims, such as a civil action related to a car accident. Even the most capable attorney cannot achieve a fair decision for a client injured in a car accident without medical evidence. Similarly, we have seen thousands of VA Rating Decision Letters deny service connection for Veterans due to the lack of medical evidence (such as no formal diagnosis or no nexus to active duty service).

Veterans enrolled in the VA healthcare system face massive additional challenges when trying to support their VA disability claims due to the ubiquitous policy implemented by VA leadership that prevents any assistance with completing Disability Benefits Questionnaires or providing

[1] Evidence Needed For Your Disability Claim | Veterans Affairs

medical opinions by the Veteran's VA treating medical providers who are generally considered the best source to assess the health conditions of their patients.

If the proposed bills fail to clarify that Veterans may continue to submit private medical evidence, millions of Veterans could be locked out of the ability to proactively build Fully Developed Claim packets and submit appropriate medical evidence for the claims they wish to pursue.

Medical Evidence and Legal Advocacy: Separate and Distinctly Different Essential Roles in VA Benefits

The process of evaluating VA disability claims relies on two interdependent components: medical evidence and legal advocacy (representation). While these elements work together to ensure thorough and accurate decisions, they serve separate and distinct functions and require different training and professional accreditation/licensure.

Medical Evidence: Establishing Clinical Facts

Medical evidence provides the factual foundation for any disability claim. It ensures that decisionmakers have objective, well-documented clinical information upon which to base their determinations.

The VA requires the following medical evidence to accurately administer a Veteran's claim for a disability benefit:

- Diagnosis of a medical disability OR documentation of symptoms consistent with a medical disability.
- A formal medical opinion by an appropriately qualified licensed medical professional opining on whether the root cause of the medical disability was caused or aggravated by military service.
- Establishment of the disability onset date.

- Evaluation of medical symptoms and markers to determine the functional impact and variable medical impairment level for disabilities that have multiple disability percentages available in 38 C.F.R.
- Assessment of the impact the Veteran's disability conditions have on their ability to maintain gainful employment.

NOTE: Only licensed medical professionals can legally diagnose medical conditions and provide formal medical opinions. VA-accredited representatives are strictly prohibited by law from doing so unless they hold appropriate licensure from their State Medical Board.

While medical professionals play a critical role in documenting medical conditions, they DO NOT:

- Complete VA benefit applications.
- File VA benefit applications.
- Act on behalf of Veterans pursuing VA benefits (i.e., no Power of Attorney).
- Represent Veterans before the VA.
- Present legal arguments of entitlement or engage in legal advocacy on the Veteran's behalf before the VA.
- Determine VA benefit eligibility.

Without thorough medical evidence, the VA may delay or deny a claim—not due to lack of merit, but due to insufficient documentation.

<u>Advocacy: Applying Medical Evidence to VA's Adjudication Process</u>

Legal representatives and claims preparers—such as VA-accredited attorneys, agents, and Veterans Service Officers—are responsible for helping Veterans navigate the complex VA claims process. Their roles include:

- Completing and preparing application forms for VA benefits.
- Filing or presenting applications for VA benefits or VA appeals and submitting legal arguments.
- Advocating or prosecuting benefit claims before VA, the Board of Veterans' Appeals, and the courts.
- Ensuring compliance with procedural requirements and deadlines.

However, legal representatives and claims preparers are not medical professionals and therefore DO NOT:

- Diagnose medical conditions.
- Provide independent medical assessments or medical opinions.
- Generate new medical evidence to appropriately document medical conditions that have been previously undiagnosed due to the Veteran's lack of historical engagement with healthcare providers.

Medical Evidence and Legal Advocacy Working Together

For a VA disability claim to be fully evaluated, both medical evidence and advocacy play mutually necessary but distinctly different roles:

- Medical professionals provide independent clinical assessments to ensure medical conditions are fully documented.
- Claims preparers and legal representatives apply that evidence within the VA system, ensuring proper adjudication under applicable regulations.

A strong claim submission or legal case requires both legal advocacy and medical evidence. Medical evidence alone does not constitute legal advocacy or claims preparation. Recognizing the distinction between these roles preserves the integrity of the VA disability benefits process, ensuring Veterans receive fair and accurate evaluations.

In contrast, the select few VSOs and accredited attorneys and agents leading the "Claim Shark" campaign have intentionally misrepresented Trajector Medical as illegal or unethical for charging a fee for its services; medical evidence services that VSOs claim they can provide for free. The architects of this campaign fail to mention that VA-accredited VSOs, attorneys, and agents are NOT legally qualified, appropriately licensed, or accredited to engage in the medical evidence services that Trajector Medical's healthcare professionals provide to its clients. Rather, VA-accredited VSOs, attorneys, and agents exist for the sole purpose of providing representation services to claimants before VA.[2] These VA-accredited parties lack the training, education, and licensure necessary to diagnose medical conditions or provide medical opinions on the causes of a disability condition. They are ill-equipped to provide what VA regulations require: a medical diagnosis and a favorable medical opinion to grant service connection for a disability condition.

If VSOs or other VA-accredited representatives diagnosed medical conditions or provided medical opinions, they would be violating every State Medical Board's licensure requirements and could be charged with practicing medicine without a license.

What Trajector Medical Does

The availability and importance of medical evidence services are not well known. Most Americans only become aware of these services after experiencing a denial of government benefits or a failed civil action due to insufficient medical evidence. Clients, including Veterans, often choose Trajector Medical because they learned through experience that their legal case is only as strong as the medical evidence that supports it.

Trajector Medical's services do not replace or duplicate the work of VA-accredited representatives because the company does not prepare (fill out VA claim forms), present (file VA claim forms), or prosecute (legally advocate) claims, nor does Trajector Medical ever act as a representative of a Veteran before the VA (stand in place of, act on behalf of, or use Power of

[2] Accreditation, Discipline, & Fees Program - Office of General Counsel

Attorney or Agency privileges for the Veteran). Instead, Trajector Medical ensures Veterans have complete, clinically sound, and well-documented medical evidence to support their VA applications.

What Trajector Medical's Medical Evidence Services Include

- Conducting live, one-on-one consultations with licensed medical professionals.
- Collecting medical symptoms from the Veteran's records and consultations.
- Reviewing medical history and records to document relevant health conditions.
- Mapping symptoms to conditions to ensure all relevant disabilities are adequately documented.
- Assessing severity or variable impairment level of potential disabilities.
- Assessing disability onset dates.
- Identifying the causal factors of disabilities using published medical research.
- Providing medical opinions on whether the Veteran's disability was aggravated or caused by military service, supported by the appropriate medical rationale.

Each Veteran client receives personalized medical evidence documentation designed to enable the confident and independent submission of their application for VA benefits.

What Trajector Medical Does NOT Do

Trajector Medical's service contract clearly communicates to clients that the company:

- Does not draft legal demand letters.
- Does not complete government benefits application forms.
- Does not file government benefits claims.
- Does not represent clients in court or before any government agency.
- Does not provide legal advocacy or engage in claims preparation services.

The Veteran's Legal Right to Medical Evidence

Operating within the legal and regulatory framework afforded by 38 U.S.C. §§ 5107(b), 5125, 5101(d)(1)(A), 5103A(b)(4)(A) and 38 C.F.R. § 3.159(a)(1), Trajector Medical supports the Veteran's right to obtain and submit medical evidence furnished by qualified providers; supplies medical documentation that satisfies VA evidence requirements; and ensures that decisionmakers consider the medical evidence most relevant to the disability the Veteran is claiming (a function that VA acknowledges "will help process [a] claim more quickly and accurately"[3]).

VA Accreditation Requirements Do Not Apply to Medical Evidence Services

As previously articulated, Trajector Medical is a medical evidence services provider, and neither the company nor its employees prepare, present, and prosecute Veterans' claims before the VA nor do they represent claimants before the VA.

During this subcommittee's March 29, 2023, hearing on this topic, it was confirmed that "the gathering and/or development of third-party medical evidence has long been excluded from the definitions of 'preparation, presentation, and prosecution.'" In other words, Trajector Medical does not engage in activities that are subject to VA accreditation and is not in violation of the VA's accreditation program requirements.

Finally, VA's Office of General Counsel has confirmed that if "services being provided to the Veteran or beneficiary…have significance beyond entitlement to VA benefits," they are not likely included within the "practice before VA" or the "preparation, presentation, and prosecution" of a claim requiring VA accreditation.[4] Trajector Medical's medical evidence services serve a purpose in non-VA forums and are valuable in other legal and medical contexts (e.g., Social Security disability, civil litigation, workers' compensation, insurance disputes, etc.), further supporting the fact that the company is outside the scope of VA accreditation.

[3] What VA means by evidence when processing claims - VA News
[4] Accreditation Frequently Asked Questions - Office of General Counsel

These Proposals Must Preserve the Veteran's Right to Medical Evidence

Another noteworthy exchange occurred during this subcommittee's March 29, 2023, legislative hearing when Congressman Pappas asked VA's counsel if anything in The GUARD Act would change [the "separate and distinct"] dynamic [of medical evidence providers and claims preparers]. The VA confirmed that nothing in the bill would change that dynamic. As such, Trajector Medical's understanding is that the GUARD VA Benefits Act does not apply to providers of medical evidence services.

However, as written, the bills discussed on March 5, 2025, do not clearly recognize the "separate and distinct" nature of medical evidence providers, nor do they clearly delineate between medical evidence services and representation or advocacy services.

For at least two reasons, it is crucial that this occurs:

(1) The VA's inadequate definitions of "prepare," "present," and "prosecute" allow for the interpretation that healthcare professionals engaging with Veteran patients are *assisting* in the preparation or presentation of a claim for VA benefits and are therefore operating outside of federal law. Absent clarification, this ambiguity could result in reluctance among healthcare professionals to assist Veteran patients in documenting their medical disability conditions due to a prohibition on compensation with respect to preparation and presentation. The criminal penalties that The GUARD Act seeks to reinstate would further contribute to this chilling effect.

(2) Congress would be advancing a proposal that contradicts multiple existing laws that codify the Veteran's right to medical evidence and guarantee that their evidence is heard, valued, and considered as part of a fair evaluation. Such action would also clearly conflict with the intent and scope of the VA's Fully Developed Claim program.

The discussion draft proposal's definition of "private medical professional" should also be clarified. Absent clarification, the current language risks adversely affecting the Veteran's statutory right to obtain and use—and VA's statutory requirement to accept—private medical evidence in support of VA disability claims.

We encourage you to review the Social Security Administration's (SSA) "All Evidence Rule" and evidence evaluation policy (which describes a shared duty of both the claimant and the SSA to develop and evaluate all evidence including medical consultations from the applicant's "own medical sources").[5] This existing framework helps the SSA identify the source of medical evidence and could provide guidance in ensuring Veterans' rights to submit private medical evidence are protected.

Conclusion

Trajector Medical is proud to provide licensed, independent medical evidence services to Veterans and non-Veterans alike. Within the VA context, Trajector Medical operates in full compliance with federal law. Our services are legally protected, are "separate and distinct" from the offerings of VA-accredited representatives, and fall outside the scope of VA accreditation requirements.

We welcome the opportunity to engage in constructive discussions with Members of this Subcommittee to ensure an informed and Veteran-centric approach to these legislative proposals.

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[5] 20 C.F.R. § 404.1512

Document for the Record Submitted by Greg Murphy

Celeste, Raymond

Subject: Hyperbaric oxygen therapy for mild traumatic brain injury persistent postconcussion syndrome: a randomized controlled trial - PMC

Importance: High

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Hyperbaric oxygen therapy for mild traumatic brain injury persistent postconcussion syndrome: a randomized controlled trial

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Abstract

Persistent postconcussion syndrome (PPCS) after mild traumatic brain injury (mTBI) is a significant public health and military problem for which there is limited treatment evidence. The aim of this study was to determine whether forty 150 kPa hyperbaric oxygen therapies (HBOTs) can improve symptoms and cognitive function in subjects with the PPCS of mTBI, using a randomized controlled crossover design with 2-month follow-up. Sixty-three civilian and military subjects with mTBI/PPCS were randomized to either 40 HBOTs at 150 kPa/60 minutes, once daily, 5 days per week in 8 weeks or an equivalent no-treatment control period. The Control Group was then crossed over to HBOT.

Subjects underwent symptom, neuropsychological, and psychological testing, before and after treatment or control with retesting 2 months after the 40th HBOT. Fifty subjects completed the protocol with primary outcome testing. HBOT subjects experienced significant improvements in Neurobehavioral Symptom Inventory, Memory Index, Automated Neuropsychological Assessment Metrics, Hamilton Depression Scale, Hamilton Anxiety Scale, Post-Traumatic Stress Disorder Checklist, Pittsburgh Sleep Quality Index, and Quality Of Life after Brain Injury compared to the Control Group. After crossing over to HBOT the Control Group experienced near-identical significant improvements. Further improvements were experienced by both groups during the 2-month follow-up period. These data indicate that 40 HBOTs at 150 kPa/60 minutes demonstrated statistically significant improvements in postconcussion and Post-Traumatic Stress Disorder symptoms, memory, cognitive functions, depression, anxiety, sleep, and quality of life in civilian and military subjects with mTBI/PPCS compared to controls. Improvements persisted at least 2 months after the 40th HBOT. The study was registered on ClinicalTrials.gov (NCT02089594) on March 18, 2014 and with the U.S. Food and Drug Administration under Investigational New Drug #113823. The Institutional Review Boards of the United States Army Medical Research and Materiel Command Office of Research Protections Human Research Protection Office and the Louisiana State University School of Medicine (approval No. 7381) approved the study on May 13, 2014 and December 20, 2013, respectively.

Keywords: chronic brain injury, hyperbaric oxygen therapy, neurobehavioral symptom inventory, neuropsychological testing, neurorehabilitation, persistent postconcussion syndrome, post-traumatic stress disorder, randomized controlled trial, symptoms, traumatic brain injury

INTRODUCTION

Mild traumatic brain injury (mTBI)/persistent postconcussion syndrome (PPCS) is a significant public health and military problem. In 2013 there were 2.8 million emergency department visits, hospitalizations, or deaths in the United States due to TBI,1 75% of which are estimated to be mild TBI.2 When non-hospital non-emergency department visits for head trauma are included there were an additional 1.16 million adult (18–64 years old)3 and 845,000 pediatric cases,4 comprising approximately 50% of all head trauma cases in the U.S. In total there appears to be at least 4.8 million TBI cases annually in the U.S., 4.1 million of which are mild TBI. This figure is further increased by military service

members and the elderly non-emergency department/hospital TBI subsets and is orders of magnitude higher worldwide.

Historically, only 15% of mild TBI patients are diagnosed with the PPCS,5 but more recent literature suggests a rate as high as 55%5 for mTBI with loss of consciousness. The longer the symptoms persist the higher the likelihood that they will become permanent. When symptoms persist longer than 3 years the syndrome appears to be permanent.6,7 In a military veteran population nearly 70% of patients entering the Veterans Administration system with a diagnosis of TBI were still receiving treatment 4 years later.7 Treatment has consisted of psychoeducational interventions, cognitive rehabilitation, psychotherapeutic approaches, integrated behavioral health interventions, and psychoactive medication administration. There is some evidence to support the use of cognitive rehabilitation approaches,8 limited evidence for the other three non-pharmacologic interventions,8 and very little evidence for psychoactive medications.9 This is a pharmacologic study which employed a well characterized biological wound-healing therapy, hyperbaric oxygen therapy (HBOT), to treat the chronic brain wounds of mTBI.10

HBOT is the use of increased atmospheric pressure and hyperoxia as drugs to treat disease pathophysiology11 through gene expression and suppression.12 Treatment effects are a function of dose and timing of intervention in the disease process.13 HBOT doses of 200–300 kPa have been applied to a limited 15 reimbursed acute central nervous system and acute or chronic extremity wound and infection diagnoses in the U.S.14,15 while a much larger list of diagnoses have been treated internationally.16,17,18 Lesser doses have been used mainly for chronic neurological conditions.13

HBOT has been applied to chronic TBI in animals and humans since 198919,20,21,22,23,24,25,26,27,28,29,30,31,32,33,34,35,36,37,38,39,40,41 with apparent conflicting results.25,27 Various researchers have attributed the different results in mTBI PPCS to mischaracterized sham groups/the effects of different doses of HBOT,11,12,24,42,43,44,45,46,47 design differences,48 (small sample size, dissimilar outcome measures/populations/sites/protocol adherence, non-equivalence of group, selection bias),29 ritual experience,28 and placebo/Hawthorne effects.49 Regardless, all of the studies performed at 150 kPa of oxygen in mTBI/PPCS have generated positive data.22,24,26,28,29,39,40 The purpose of this study was to use a randomly assigned Treatment Group versus Control Group design to demonstrate

efficacy and confirm or refute the previous experience using the 150 kPa oxygen dose of HBOT.

SUBJECTS AND METHODS

Full details of the Methods and Protocol are in **Additional file 1**.

Design

Subjects were randomly assigned to Treatment Group or Control Group; the Control Group then crossed over to receive HBOT following the control period (**Figure 1**). There was no sham control group in this study. Due to the bioactivity of oxygen and hydrostatic pressure,11,12,50 the two active components of an HBOT,11,12 the requirement of the absence of these two components for a true sham51 HBOT,11,12 and the absence of successful demonstration of a true sham HBOT in the history of clinical HBOT, a first-ever true sham HBOT control group was not attempted in this efficacy trial.

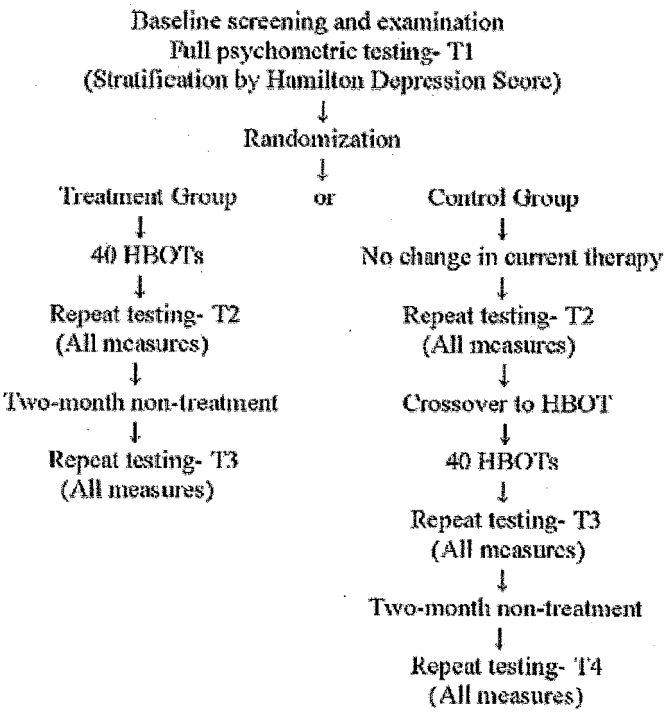

Figure 1

Study flow chart.

Note: HBOT: Hyperbaric oxygen therapy; T1–4: test points 1–4.

The outcome data was primarily generated by the study neuropsychologist who was blinded to group designation (single-blind). The study was registered on ClinicalTrials.gov (NCT02089594) on March 18, 2014 and with the U.S. Food and Drug Administration under Investigational New Drug #113823. The Institutional Review Boards of the United States Army Medical Research and Materiel Command Office of Research Protections Human Research Protection Office and the Louisiana State University School of Medicine (approval No. 7381) approved the study on May 13, 2014 and December 20, 2013, respectively. The writing and editing of the article were performed in accordance with the CONsolidated Standards Of Reporting Trials (CONSORT) Statement.

Subjects

Subjects were 18–65 year old adults who had experienced one or more blunt or blast mTBIs, as defined by the American Congress of Rehabilitation Medicine mTBI definition,52 that was at least 6 months old (3 months longer than the minimum time limit for definition of PPCS),53 occurred on or after September 11, 2001, resulted in the symptoms of the PPCS54 that developed within 4 weeks after the mTBI, and were continuously present through to enrollment. Subjects had to score at least 2255 on the Neurobehavioral Symptom Inventory (NSI)56 and complain of headache, a marker of symptomatic mTBI in both military57 and civilian populations58 with equal incidence in blast and blunt mTBI.59

Screening procedure and neuropsychological outcome testing

Subjects were screened with the NSI, Michigan Alcohol Screening Test,60 Drug Abuse Screening Test,61 Post-Traumatic Stress Disorder Check List-Military or Civilian (PCL-M or C 4: score less than 50),62 Ohio State TBI Identification Method63 structured interview, Clinician Administered PTSD Scale64 if the PCL was ≥ 50, semi-structured psychiatric evaluation, in-depth medical history by the principal investigator, and effort testing with complete neuropsychological outcome test battery [Test of Memory Malingering,65 Green Word Memory

Test,66 Wechsler Test of Adult Reading,67 Hamilton Depression Scale (HAM-D),68 Hamilton Anxiety Scale (HAM-A),69 Wechsler Adult Intelligence Scale (WAIS-IV)70 or Wechsler Abbreviated Scale of Intelligence,71 Wechsler Memory Scale,72 Rey Auditory Verbal Learning Test Delayed Recall (RAVLT),73 Benton Visual Retention Test (BVRT),74 Stroop Test,75 Controlled Oral Word Association Test,76 Category Fluency Test (Animals Test),77 Automated Neuropsychological Assessment Metrics (ANAM-4.1 A-1746T Core version),78 Pittsburgh Sleep Quality Index (PSQI),79 and Quality of Life after Brain Injury (QOLIBRI)].80 Subjects were then stratified by the HAM-D score and randomized to either the control (Control Group) or HBOT (Treatment Group) treatment using a block randomization scheme with random block sizes of four, six, or eight implemented in the R programming language.

Postconcussion symptoms were measured using the NSI. Cognitive functions were measured by five categorical variables constructed to reduce the data plus three additional measures (RAVLT-Delayed Recall, the ANAM-4.1, and Benton Visual Retention Test). The five categorical variables were: 1) Working Memory Index, 2) Memory Index, 3) Executive Function Index using T-scores,81 4) Information Processing Speed Index, and 5) General Intellectual Ability (See **Additional file 2** for index construction). The behavioral/emotional changes were measured using the HAM-D, HAM-A, PSQI, the QOLIBRI, and the PCL-C or PCL-M. The NSI and Working Memory Index were chosen as co-primary outcomes for the study82,83,84,85 and sample size determined by prior data in veterans24 and control group effects.86

Hyperbaric treatment

Forty treatments at 150 kPa for 60 minutes without air breaks were delivered consecutively in Class B Sechrist Industries (Anaheim, CA, USA) monoplace chambers (Model 2500 or 3200) once a day, 5 days per week.

Statistical analysis

The primary analysis compared the mean difference in the 14 outcome variables between the two treatment groups (Control and HBOT) from test point 1 to test point 2 using a general linear model and a two-sample *t*-test. Paired samples *t*-tests were used to assess changes within treatment groups from test point 1 to each subsequent time point for all 14 outcome variables. For categorical baseline variables chi-squared tests of homogeneity were used

to test for differences in proportions across categories among groups. Analyses were performed using SAS 9.4 (SAS, Cary, NC, USA).

RESULTS

Quantitative analysis of mild traumatic brain injury persistent postconcussion syndrome patients

Recruitment began on May 13, 2014, ended on September 29, 2017, and the last subject completed 2-month follow-up testing on March 5, 2018. Subject enrollment and testing numbers are in **Figure 2**. Only 12/13 in the Dropout Group were included in the demographic analysis (**Tables 1** and **2**) since one subject dropped out due to an employer problem, later re-enrolled, and was re-randomized to Control Group. That subject was counted in the Control Group for demographic analysis. Three of the thirteen Dropouts occurred pre-randomization due to an undisclosed post-enrollment discovered disqualifying neurological diagnosis, failed effort testing, and failed urine drug test. Eight of the ten remaining dropouts were in the Treatment Group and two in the Control Group. Four of the eight patients in Treatment Group Dropouts occurred before any treatment was delivered (one could not stay for immediate treatment, two could not obtain work releases for treatment, and one was diagnosed with cancer the day of randomization), one occurred after the third HBOT (financial problems) and one after the first HBOT (principal investigator missed the positive drug test). The other two Treatment Group Dropouts did not report for post-treatment testing. The remaining two Dropouts (Control Group) self-removed from the study due to substance abuse relapse/entry to an inpatient rehabilitation program and deterioration in symptoms upon returning to Canada post-randomization. Five subjects did not complete 40 HBOTs: four due to late fatigue (30, 34, 39, and 39 HBOTs) and one due to a pre-scheduled flight home (39 HBOTs). Thirty Clinician Administered PTSD Scales, based on a PCL over 50 during prescreening, were administered out of the 63 subjects who were enrolled in the study. None were found to have clinical PTSD at the time of enrollment.

Figure 2

CONsolidated Standards Of Reporting Trials (CONSORT) diagram.

Note: HBOT: hyperbaric oxygen therapy.

Table 1

Demographic variables: Analysis of group equivalence at baseline (test point 1) for the Treatment Group with HBOT first, Control Group, and Dropout Group

Demographic variables	Treatment Group (n = 23)	Control Group (n = 27)	Dropout Group (n = 12)	P-value
Age (yr)	42.7±10.7(22–58)	42.3±11.2(22–60)	42.3±10.8(27–59)	0.897
Years education	14.0±3.1(8–18)	15.6±1.95(10–20)	15.9±2.6(13–20)	0.030
Wechsler Test of Adult Reading Intelligence Quotient (Scaled Score)	108.7±9.2(88–122)	110.7±6.59(92–121)	114.5±5.37(100–122)	0.385
Number TBIs in lifetime	4.3±6.2(1–30)	3.6±3.22(1–15)	3.6±3.4(1–11)	0.646
Time index TBI to enrollment (d)	1598.1±1099 (194.0–1303.0)	1748.6±1471.7 (234.0–4460.0)	1767.3±868.8 (325.0–3568.0)	0.891
Time screen to enrollment (d)	84.5±71.4(16–320)	60.5±58.2(17–305)	51.1±17.7(12–74)	0.197
Test of Memory Malingering 2 (total correct)	49.4±1.5(45–50)	49.9±0.77(46–50)	50.0±0.0(50–50)	0.163
Word Memory Test Consistency (%)	92.6±7.5(77.5–100)	90.5±10.6(60–100)	90.6±6.0(80–100)	0.421
Word Memory Test Delay Recall (%)	95.2±5.9(80–100)	93.1±9.4(65–100)	93.5±7.94(75–100)	0.345
Word Memory Test Immed Memory (%)	94.7±6.6(77.5–100)	92.6±7.98(72.5–100)	93.8±4.2(85–100)	0.326
Sex (% female)	52.2%(12/23)	63%(17/27)	41.7%(5/12)	0.444
Race (% Caucasian)	95.7%(22/23)	88.9%(24/27)	91.7%(11/12)	0.411
Blast *vs.* Blunt (% Blunt)	87.0%(20/23)	92.6%(25/27)	83.3%(10/12)	0.325
Civil *vs.* Military (% Military)	17.4%(4/23)	18.5%(5/27)	33.3%(4/12)	0.918
Loss of consciousness (% yes)	73.9%(17/23)	66.7%(18/27)	83.3% (10/12)	0.551
Alcohol (% any use)	65.2%(15/23)	44.4%(12/27)	66.7%(8/12)	0.142
Clinician Administered Post-Traumatic Stress Disorder	47.8%(11/23)	40.75%(11/27)	66.7%(8/12)	0.615
Scale (% administered)				
Magnetic resonance imaging brain (% normal)	72.7%(16/23)	59.3%(16/27)	41.7%(5/12)	0.318
Tobacco (% no use)	73.9%(17/23)	77.8%(21/27)	66.7%(8/12)	0.75

Note: Data are expressed as the mean ± SD (range) in age, years education, Wechsler Test of Adult Reading Intelligence Quotient, number TBIs in lifetime, time index TBI to enrollment, time screen to enrollment, Test Of Memory

Malingering 2, Word Memory Test Consistency, Word Memory Test Delay Recall, and Word Memory Test Immed Memory, and percent in others. Data among all the three groups are analyzed by Tukey's test. *There are no significant differences among any of the 3 pairs of groups. Dropout Group: Subjects who dropped out of the study; TBI: traumatic brain injury; test point 1: baseline.

Table 2

Outcome variables: Analysis of group equivalence at baseline for the Treatment Group with hyperbaric oxygen therapy first, Control Group, and Dropout Group

Outcome variables	Treatment Group (n = 23)	Control Group (n = 27)	Dropout Group (n = 12)	P-value
Neurobehavioral Symptom Inventory (total score)	39.0±9.6	44.6±11.8	34.1±9.1	0.029*
	37 (24–58)	44 (21–67)	34 (22–48)	
Working Memory Index (SS)	103.5±12.2	104.6±14.4	109.2±10.9	0.466
	103 (78–127)	106 (79–131)	106.3 (89–128)	
Memory Index (SS)	101.7±14.3	102.9±14.3	97.8±11.1	0.574
	100 (75–127)	104 (72–107)	95.3 (79–124)	
Information Process Speed Index (SS)	94.0±14.5	95.4±15.0	98.3±13.3	0.709
	94 (62–117)	97 (65–122)	100 (71–122)	
Executive Function Index (T score)	45.3±8.8	48.1±7.1	47.3±7.9	0.461
	44 (30–60)	47 (37–64)	47 (36–59)	
Wechsler Adult Intelligence Scale Full Scale	105.6±12.3	106.4±10.6	106.9±10.3	0.942
Intelligence Quotient (SS)	108 (80–130)	106 (89–128)	107 (89–123)	
Automated Neuropsychological Assessment	−1.84±1.0	−1.6±1.3	−1.11±0.87	0.195
Metrics (composite score)	−1.72 (−4.2 to −0.2)	−1.3 (−3.9–0.6)	−1.2 (−2.7–0.2)	
Hamilton Depression Scale (total)	15.2±5.0	14.4±7.5	15.8±8.6	0.849
	16 (6–24)	15 (0–26)	15.5 (3–30)	
Hamilton Anxiety Scale (total)	16.5±7.9	15.8±7.3	17.5±10.4	0.835
	17 (2–35)	16 (4–31)	17 (0–32)	
Quality of Life after Brain Injury (composite score)	40.3±12.4	38.9±16.3	42.3±16.9	0.813

Outcome variables	Treatment Group (n = 23)	Control Group (n = 27)	Dropout Group (n = 12)	P-value
	40 (21–63)	38 (8–85)	40 (15–73)	
Pittsburgh Sleep Quality Index (composite score)	11.9±4.0	10.5±4.9	12.3±4.8	0.405
	12 (5–19)	11 (2–20)	12 (5–21)	
Benton Visual Retention Test (#correct)	7.3±1.5	7.0±1.9	7.2±1.5	0.812
	8 (4–10)	8 (3–10)	7.5 (3–9)	
Rey Auditory Verbal Learning Test Delay	47.8±14.0	47.1±14.6	41.3±9.3	0.365
Recall (T score)	50 (24–65)	47 (25–67)	42 (24–57)	
Post-Traumatic Stress Disorder Check List (total)	37.9±12.1	39.7±13.2	31.6±9.5	0.252
	37 (20–67)	37 (19–68)	32 (19–48)	

Note: Data are expressed as the mean ± SD, median (range). *Neurobehavioral Symptom Inventory was significantly different among the three groups. The Tukey's test showed that the Control and Dropout Groups were significantly different, but the Treatment and Control Groups were not. Dropout Group: Subjects who dropped out of the study; SS: scaled scores.

Demographics of the sample and dropout analysis

Analyses of group equivalence at baseline for demographic variables and outcome variables are presented for the Treatment, Control and Dropout Groups in **Tables 1** and **Table 2**. Tukey's Test87 analysis of the two significantly different variables (years of education and NSI) showed no significant difference between any two groups for years of education while the NSI was significantly different between the Control and Dropout Groups. The Dropout subjects had significantly lower symptom scores than the Control Group, but the two main study groups (Treatment and Control Groups) did not differ in PPCS complaints on the NSI.

Changes in the outcome after HBOT *vs.* control period

Figure 3 graphs the change in the two co-primary outcome variables (NSI and Working Memory Index) for the control (Control Group) *vs.* HBOT (Treatment Group) and the proportionate domain changes for NSI in the Treatment Group. The Treatment Group experienced a 26.3-point decrease in the NSI PPCS

symptom score compared to a 2.5-point decrease in the Control Group ($P < 0.0001$). The cognitive domain of the Treatment Group NSI registered the greatest relative improvement with a 19% relative decrease. The difference between the groups in working memory change was not significant. In total eight of the 14 outcome variables were significantly improved in the Treatment Group compared to control (Control Group): PPCS symptoms (NSI), Memory Index, overall cognitive efficiency (ANAM 4), depression (HAM-D), anxiety (HAM-A), quality of life (QOLIBRI), sleep quality (PSQI), and post-traumatic anxiety symptoms (PCL) (**Table 3**).

Figure 3

Change in the Neurobehavioral Symptom Inventory (NSI) and Working Memory Index for the Control Group *vs.* Treatment Group and the proportionate domain changes for NSI in the Treatment Group.

Note: (A) Change in primary outcome measures (post-HBOT minus pre-HBOT or post-control minus pre-control). $N = 23$ for Treatment Group and 27 for Control Group. (B) Treatment Group domain contributions to total NSI score pre- and post-HBOT. The components of the NSI are the somatic-vestibular (S-V), affective (A) and cognitive (Cog).

Table 3

Effect of pre-to-post-hyperbaric oxygen therapy change for Treatment Group versus pre-to-post control period for Control Group

Outcome variables	TP1 to TP2 mean change (TP2 minus TP1)		Mean difference	*P* of group difference
	Treatment Group ($n = 23$)	Control Group ($n = 27$)		
Neurobehavioral Symptom Inventory (total score)	39.0 to 12.7=–26.3	44.6 to 42.1=–2.5	–23.9±9.22(–29.2 to –18.6)	0.0001
Working Memory Index (SS)	103.5 to 111.0=+7.5	104.6 to 110.6=+6	1.5±6.5(–2.23–5.13)	0.431
Memory Index (SS)	101.7 to 113.3=+11.6	102.9 to 107.6=+4.7	6.92±8.6(2.01–11.83)	0.0067
Information Processing Speed Index (SS)	94.0 to 102.5=+8.5	95.4 to 100.7=+5.3	3.14±9.4(–2.25–8.54)	0.247

Outcome variables	TP1 to TP2 mean change (TP2 minus TP1)		Mean difference	*P* of group difference
	Treatment Group (*n* = 23)	Control Group (*n* = 27)		
Executive Function Index (T score)	45.3 to 47.0=+1.7	48.1 to 47.8=–0.3	1.97±5.8(–1.36–5.28)	0.2384
Wechsler Adult Intelligence Scale Full Scale Intelligence Quotient (SS)	105.6 to 112.2=+6.6	106.4 to 110.9=+4.5	1.13± 5.76(–1.16–5.41)	0.1993
Automated Neuropsychological Assessment Metrics (composite score)	–1.84 to –1.02=+0.82	–1.6 to –1.3=+0.3	0.51±0.64(0.15–0.88)	0.0069
Hamilton Depression Scale (total)	15.2 to 7.5=–7.7	14.4 to 12.8=–1.6	–5.99±6.85(–9.89 to –2.08)	0.0034
Hamilton Anxiety Scale (total)	16.5 to 9.3=–7.2	15.8 to 14.7=–1.1	–6.19±7.48(–10.5 to –1.92)	0.0054
Quality of Life after Brain Injury (composite score)	40.3 to 58.5=+18.2	38.9 to 40.9=+2.0	16.8±14.9(8.2–25.44)	0.0003
Pittsburgh Sleep Quality Index (composite score)	11.9 to 9.0=–2.9	10.5 to 10.9=+0.4	–3.31±3.64(–5.39 to –1.24)	0.0024
Benton Visual Retention Test (#correct)	7.3 to 7.3=0.0	7.0 to 7.3=+0.3	–0.22±1.72(–1.2–0.76)	0.6517
Rey Auditory Verbal Learning Test Delay Recall (T score)	47.8 to 52.3=+4.5	47.1 to 47.0=–0.1	4.6±11.9(–2.19–11.44)	0.1785
Post-Traumatic Stress Disorder Check List (total)	37.9 to 26.0=11.9	39.7 to 37.5=2.2	13.2±11.2(8.6–17.7)	0.0001

Note: Data in Mean difference column are mean change between Treatment Group and Control Group mean changes, and are analyzed using a two-sample *t*-test. SS: Scaled scores; TP1: test point 1 (baseline); TP2: test point 2.

Sequential changes for each group's 14 outcome variables at all test points are shown in **Tables 4** and **5**. The Treatment Group experienced significant improvements in 11 of 14 outcome tests after HBOT (**Table 4**) *vs.* 5 of 14 tests for the Control Group during the control period; the RAVLT showed a near significant improvement ($P = 0.0515$) while Executive Function was insignificantly changed in the Treatment Group. After HBOT the Control Group had a significant improvement in 13 out of 14 variables (**Table 5**) that were nearly identical in magnitude to the same Treatment Group test domain changes. Both groups showed minor changes in the RAVLT while neither group

demonstrated improvement in the Benton Visual Retention Test. After HBOT there were no significant differences in any outcome change between groups.

Table 4

Treatment Group change from pre-to-post-hyperbaric oxygen therapy and follow-up for outcome variables (postconcussion symptoms, cognitive, and emotional)

Outcome variables	Baseline (T1) (*n* = 23)	Post-HBOT (T2) (*n* = 23)	*P*-value (T1 vs. T2)	2-mon follow-up (T3) (*n* = 20)	*P*-value (T1 vs. T3
Neurobehavioral Symptom Inventory (total)§	39.0±9.6	12.7±10.6	0.0005	18.7±13.3	< 0.0001
	37 (24–58)	11 (0–44)		18.5 (1–47)	
Working Memory Index (SS)	103.5±12.2	111.0±8.8	< 0.0001	113.7±11.5	< 0.0001
	103 (78–127)	113 (95–127)		114 (90–138)	
Memory Index (SS)	101.7±14.3	113.3±11.6	< 0.0001	120±11.9	< 0.0001
	100 (75–127)	113 (89–135)		120 (93–140)	
Information Processing Speed Index (SS)	94.0±14.5	102.5±12.9	0.0001	104.2±14.7	0.0002
	94 (62–117)	102 (81–127)		102 (81–132)	
Executive Function Index (T score)	45.3±8.8	47.0±8.2	0.121	51.5±7.5	0.0001
	44 (30–60)	45 (33–61)	53 (36–66)		
Wechsler Adult Intelligence Scale Full	105.6±12.3	112.2±9.5	< 0.0001	117.2±11.7	< 0.0001
Scale Intelligence Quotient (SS)	108 (80–130)	114 (97–136)	117 (96–145)		
Automated Neuropsychological	−1.84±1.0	−1.02±0.8	< 0.0001	−1.1±1.4	< 0.001
Assessment Metrics (composite score)	−1.72 (−4.2 to −0.2)	−0.95 (−2.78–1.21)	−0.7 (−4.24–1.35)		
Hamilton Depression Scale (total)§	15.2±5.0	7.5±4.6	< 0.0001	6.3±5.3	< 0.0001
	16 (6–24)	6 (0–15)	5 (0–17)		
Hamilton Anxiety Scale (total)§	16.5±7.9	9.3±5.6	< 0.0001	7.1±6.7	< 0.0001
	17 (2–35)	10 (0–24)	5 (0–24)		
Quality Of Life after Brain Injury (composite score)	40.3±12.4	58.5±17.6	< 0.0001	62.1±16.0	< 0.0001

Outcome variables	Baseline (T1) (n = 23)	Post-HBOT (T2) (n = 23)	P-value (T1 vs. T2)	2-mon follow-up (T3) (n = 20)	P-value (T1 vs. T3
	40 (21–63)	63 (30–98)	12		
Pittsburgh Sleep Quality Index (composite score)§	11.9±4.0	9.0±3.8	0.0002	8.0±4.6	0.0006
	12 (5–19)	8 (3–15)	8 (2–16)		
Benton Visual Retention Test (#correct)	7.3±1.5	7.3±1.8	n.s.	7.6±1.8	n.s.
	8 (4–10)	7 (4–10)	8 (4–10)		
Rey Auditory Verbal Learning Test	47.8±14.0	52.3±8.8	0.0515	51.8±10.6	n.s.
Delay Recall (T score)	50 (24–65)	53 (32–67)	54 (28–67)		
Post-Traumatic Stress Disorder Check	37.9±12.1	26.0±8.3	< 0.0001	27.1± 11.7	0.0005
List (total) §	37 (20–67)	24 (16–45)	25 (3–51)		

Note: Data are expressed as Mean ± SD, median (range), and are analyzed by paired samples t-tests. Scores are reported in standard scores, T-score format, or Manual scoring. Increasing scores indicate improvement except those marked with §. n.s.: No significance; T1–3: test points 1–3.

Table 5

Control Group change from pre-to-post-control, -hyperbaric oxygen therapy, and follow-up for outcome variables (postconcussion symptoms, cognitive, and emotional)

Outcome variables	Baseline (T1) (n =27)	Post control (T2) (n =27)	P-value (T1 *vs.* T2)	Post-HBOT (T3) (n =27)	P-value (T2 *vs.* T3)	2-mon follow-up (T4) (n=23)	P-value (T2 *vs.* T4)
Neurobehavioral Symptom Inventory (total)§	44.6±11.8	42.1±10	n.s.	16.5±12.7	< 0.0001	19.8±14.3	< 0.0001
	44 (21–67)	41 (26–62)		14 (0–44)		18 (0–48)	
Working Memory Index (SS)	104.6±14.4	110.6±14.9	0.0001	115.2±15.1	0.001	118.6±15.	0.0001
	106 (79–131)	113 (82–140)		117 (84–140)		124 (86–147)	
Memory Index (SS)	102.9±14.3	107.6±13.0	0.006	118.3±14.5	< 0.0001	122.7±14.5	< 0.0001

Outcome variables	Baseline (T1) (*n* =27)	Post control (T2) (*n* =27)	*P*-value (T1 *vs.* T2)	Post-HBOT (T3) (*n* =27)	*P*-value (T2 *vs.* T3)	2-mon follow-up (T4) (*n*=23)	*P*-value (T2 *vs.* T4)
	104 (72–107)	108 (84–132)		120 (88–143)		126 (81–143)	
Information Processing Speed Index (SS)	95.4±15.0	100.7±17.1	0.004	107.4±15.0	0.004	109.9±16.8	0.002
	97 (65–122)	105 (71–132)		111 (74–127)		108 (74–146)	
Executive Function Index (T score)	48.1±7.1	47.8±6.8	n.s.	52.9±9.4	< 0.0001	51.5±10.2	0.01
	47 (37–64)	48 (37–61)		54 (37–73)		51 (37–78)	
Wechsler Adult Intelligence Scale Full	106.4±10.6	110.9±11.8	< 0.0001	117.0±11.5	< 0.0001	119.8±12.6	< 0.0001
Scale Intelligence Quotient (SS)	106 (89–128)	111 (92–136)		121 (94–139)		121 (94–139)	
Automated Neuropsychological	−1.6±1.3	−1.3±1.5	0.008	−0.7±1.1	< 0.0001	−0.8±1.4	0.03
Assessment Metrics (composite score)	−1.3 (−3.9–0.6)	−1.0 (−4.5–0.9)		−0.6 (−3.7–0.8)		−0.7 (−3.4–1.8)	
Hamilton Depression Scale (total)§	14.4±7.5	12.8±7.6	n.s.	6.6±6.6	0.0002	6.7±6.9	0.0002
	15 (0–26)	11 (2–27)		5 (0–23)		4 (0–22)	
Hamilton Anxiety Scale (total)§	15.8±7.3	14.7±7.3	n.s.	7.4±6.3	< 0.0001	8.5±8.0	0.0001
	16 (4–31)	15 (0–28)		5 (0–20)		6 (0–31)	
Quality of Life after Brain Injury (composite score)	38.9±16.3	40.9±14.8	n.s.	62.5±23.1	< 0.0001	62.0±21.3	< 0.0001
	38 (8–85)	40 (5–75)		68 (8–99)		63 (10–100)	
Pittsburgh Sleep Quality Index (composite score)§	10.5±4.9	10.9±4.2	n.s.	7.4±4.7	0.0001	7.9±5.4	0.0006
	11 (2–20)	12 (3–19)		7 (1–20)		7 (0–21)	
Benton Visual Retention Test (#correct)	7.0±1.9	7.3±2.3	n.s.	7.5±2.2	n.s.	7.7±1.5	n.s.
	8 (3–10)	7 (2–10)		8 (3–10)		8 (4–10)	
Rey Auditory Verbal Learning Test Delay	47.1±14.6	47.0±13.8	n.s.	52.0±11.8	0.02	52.5±12.2	0.01

Outcome variables	Baseline (T1) (*n* =27)	Post control (T2) (*n* =27)	*P*-value (T1 *vs.* T2)	Post-HBOT (T3) (*n* =27)	*P*-value (T2 *vs.* T3)	2-mon follow-up (T4) (*n*=23)	*P*-value (T2 *vs.* T4)
Recall (T score)	47 (25–67)	50 (23–67)		53 (24–67)		57 (25–67)	
Post-Traumatic Stress Disorder Check	39.7±13.2	37.5±10.6	n.s.	27.0±9.6	< 0.0001	25.6±9.2	< 0.0001
List (total)§	37 (19–68)	36 (18–60)		22 (17–50)		22 (16–55)	

Note: Data are expressed as Mean ± SD, median (range), and are analyzed by paired samples *t*-tests. Scores are reported in standard scores, T-score format, or test manual scoring. Increasing scores indicate improvement except those marked with §. T1–4: Test points 1–4.

Two months after the last HBOT the two groups maintained or experienced further improvement on most of the outcome variables. Working memory, memory index, information processing speed, executive function, full scale IQ, HAM-D and -A, QOL, and PSQI showed continued improvement for the Treatment Group. The Control Group also maintained their gains but did not have as much improvement. Executive Function and sleep quality were the only two variables that showed a significantly greater improvement for the Treatment Group compared to the Control Group. In sum, both groups showed significant and equal improvement on nearly all outcome variables after treatment by the conclusion of the study.

The percentage that each of the PPCS Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV TR) definition symptoms improved or worsened for both groups during the 8-week HBOT and control period are shown in **Table 6**. Treatment Group subjects experienced significant improvement in all eight of the PPCS definition symptoms; however, easy fatigability, headache, vertigo/dizziness, irritability, and anxiety/depression were the most responsive symptoms to HBOT. The Control Group experienced worsening on six of eight symptoms during the control period.

Table 6

Percentage of DSM-IV TR persistent postconcussion syndrome definition symptoms in both groups that improved or worsened during the first 8-week study period

DSM-IV TR Persistent Postconcussion Syndrome definition symptoms	% Improve		P-value	% Worse		P-value
	Control Group	Treatment Group		Control Group	Treatment Group	
Fatigue	11	87	< 0.0001	*19*	*9*	< 0.000
Sleep	19	59	0.01	*4*	0	0.015
Headache	8	83	< 0.0001	*33*	0	< 0.000
Dizziness/vertigo	9	82	< 0.0001	*13*	0	< 0.000
Irritability	12	89	< 0.0001	*19*	0	< 0.000
Anxiety/depression	8	86	< 0.0001	*28*	0	< 0.000
Personality change	0	60	< 0.0001	0	0	–
Apathy	10	61	0.0009	0	0	–

Note: Improved symptoms in normal font, worsened symptoms in italics. n = 27 for Control Group and n = 23 for Treatment Group. DSM-IV TR: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision.

Both groups completed the HBOT treatment periods in near-identical times: 57.0 ± 5.02 days for the Control Group, 56.5 ± 5.00 days for the Treatment Group (P = 0.7144). The planned 2-month follow-up testing occurred in 79 days for the Treatment Group and 80 days for the Control Group, over 11 weeks for both groups. Eighty-seven percent of subjects were able to complete 40 HBOTs in 8 weeks and 96% were able to complete at least 30 HBOTs. There was no significant difference between Treatment Group (HBOT) and Control Group (control period) in the numbers in each group who experienced either an increase or decrease in psychoactive medication usage; however, a trend favored a reduction in the Treatment Group (P = 0.0785). Both groups reduced psychoactive medication usage by 30–41% during HBOT, but the difference between groups was insignificant (P = 0.4492). There was no difference between civilian and military subjects in PPCS and PTSD symptom reduction after HBOT (P = 0.2320 NSI, P = 0.3818 PCL).

Trajectory of weekly NSI scores during HBOT treatment for both groups and during the control period for Control Group are plotted in **Figure 4** (data in

Additional Table 1) along with corresponding trajectories of extracted Immediate Postconcussion Assessment and Cognitive Testing (ImPACT) symptom scores for the 240 kPa oxygen and 130 kPa air groups from Wolf et al.25 The trajectories for the Control Group and Treatment Group during HBOT are near identical, but different from the Wolf et al.25 groups and the Control Group in the control period. Comparison of ours and the Wolf et al.25 symptom scores to symptom scores in all other studies of HBOT in mTBI/PPCS are shown in **Table 7**.

Figure 4

Symptom trajectories of total persistent postconcussion syndrome symptom scores during and post-treatment or control.

Note: NSI: Neurobehavioral Symptom Inventory; ImPACT: Immediate Post-Concussion Assessment and Cognitive Testing; COG: Control Group; TG: Treatment Group. ImPACT data were from Wolf et al.25

Additional Table 1

Total persistent postconcussion syndrome symptom scores this study and Wolf et al.25 during and post-treatment or control.

	NSI COG Control	NSI COG HBOT 150 kPa	NSI TG HBOT 150 kPa	ImPACT Control 130 kPa air	ImPACT HBO 240 kPa
Pre	44.6	42.1	39.0	~38.5	~37.0
Post week 1		35.0	29.3	~44.5	~37.5
Post week 2		32.7	25.1	~36.0	~33.0
Post week 3		28.1	21.6	~37.0	~33.0
Post week 4		27.1	22.2	~35.0	~34.0
Post week 5		24.2	21.9	~31.0	~34.0
Post week 6		24.3	20.5	~29.5	~35.5
Post week 7		20.6	17.9		
Post week 8		17.0	13.5		
Post hyperbaric oxygen therapy or control	42.1	16.5	12.7		
Six week follow-up				~26.0	~32.5
Two monthfollow-up		19.8	18.7		

Note: NSI: Neurobehavioral Symptom Inventory; ImPACT: Immediate Post-concussion Assessment and Cognitive Testing; COG: Control Group; TG: Treatment Group. ImPACT data was approximated and abstracted from Figure 2 in Wolf et al.25

Table 7

RPCS Q, ImPACT, and NSI symptom outcomes in civilian and military studies of hyperbaric oxygen therapy in the persistent postconcussion syndrome of mild traumatic brain injury according to dose of hyperbaric therapy

Study	Year	No chamber treatment	120 kPa air	130 kPa air	150 kPa O_2	200 kPa/21 kPa O_2	200 kPa/150 kPa O_2	200 kPa O_2	240 kPa O_2
Harch et al.24	2017				–36%*				
Wolf et al.25	2012			–32%ª					–12%
Cifu et al.27	2013					+1%*	+4%*	–12%*	
Miller et al.28	2014	–2%*	–35%*		–37%*				
		+3%ϕ	–21%ϕ		–11%ϕ				
Weaver et al.29	2018		+21%*		–2%*				
			+13%ϕ		–10%ϕ				
Harch et al. (present study)	–	–5.6%ϕ			–52%ϕ				

Note: Negative numbers are improvement and positive numbers are worsening of symptoms. '*' represents Rivermead Post-Concussion Symptoms Questionnaire (RPCSQ); 'a' represents Immediate Post-Concussion Assessment and Cognitive Testing (ImPACT), and 'ϕ' represents Neurobehavioral Symptom Inventory (NSI).

Complications/side-effects

One Serious Adverse Event, a psychiatric deterioration/hospitalization which occurred 1 week after completion of HBOT was an annual Fall occurrence for a military subject that was deemed unrelated to HBOT. Two Unexpected Adverse Events/Unexpected Suspected Adverse Reactions occurred in two subjects who experienced fatigue with a reversal of improved symptoms late in the HBOT

protocol (39 and 34 HBOTs). This was attributed to oxidative stress/overdosing that resolved after 10 days and 4 weeks, respectively. All three events were reported to the Institutional Review Boards and U.S. Food and Drug Administration in Safety Reports. Mild reversible middle ear barotrauma during the prodrome of an upper respiratory infection occurred in one subject and perforation of a multiply previously perforated tympanic membrane (an expected and informed risk for this subject) in another subject during her first HBOT. She finished her HBOT course. Overall, there was an 8% (4/50 subjects) complication rate that was related to the HBOT.

DISCUSSION

This randomized clinical trial was undertaken to confirm22,24,26,28,29,39 or refute25,27 the efficacy of the 150 kPa oxygen dose of HBOT in mTBI PPCS. This study confirmed the efficacy of 150 kPa HBOT by demonstrating statistically and clinically significant, multi-domain improvements in patients with the PPCS of mTBI 4.6 years after their last TBI. This is the longest average delay to treatment of any of the mTBI/PPCS HBOT studies published.

Important findings in this study include significant improvements in postconcussion symptoms and seven other outcome variables [memory, cognition/speed of information processing (a computerized cognitive test battery, ANAM, developed and employed by the U.S. military for TBI), depression, anxiety, PTSD symptoms, sleep, and quality of life] in PPCS subjects treated with HBOT compared to a randomly assigned Control Group during the same period. The Control Group subsequently experienced the near identical and statistically indistinguishable improvements as the Treatment Group when they were crossed over and received HBOT. The improvement in PPCS symptoms (NSI) cannot be explained by test-retest improvements which have been shown to be minimal in a 30-day period or longer88 and less than the significant reliable change of eight points.88 Our subjects experienced a 26.3-point reduction in the NSI.

The NSI symptom improvement was mirrored in the improvements in DSM-IV TR PPCS definition54 symptoms. All eight DSM-IV TR PPCS symptoms were highly significantly improved in the Treatment Group compared to the Control Group while 13–38% of the Control Group demonstrated worsening of five of the eight symptoms during the control period. The only symptom that worsened for the Treatment Group was fatigue; 9% reported increased fatigue.

This may have been a sign of oxidative stress which appeared to be clinically significant in 4/50 subjects late in the protocol. This phenomenon was previously reported in a chronic brain injury HBOT study that employed higher doses or longer courses of HBOT89 and was possibly responsible for the "trend toward harm" in the 240 kPa oxygen group of Wolf et al.25 as reported by Scorza et al.90 The improvements in the NSI and DSM-IV TR PPCS definition symptoms are the dominant findings in this study. Since symptoms are the primary target of treatment in PPCS91 these findings have the greatest implications for patients with PPCS.

The results of the study are buttressed by multiple factors: 1) improvement in headache; 2) the use of a randomly assigned Control Group; 3) significant improvement in seven other outcome variables despite overall small sample size (n = 50) and smaller n of the Treatment Group compared to the Control Group (23 *vs.* 27); and 4) improvements post-HBOT with continued improvements in the nearly 3-month follow-up period that are generally contrary to the natural history of mTBI PPCS and uncharacteristic of placebo effects. The index inclusion criteria symptom for this study (headache) showed improvement in 83% of the Treatment Group, similar to 93% of military subjects with headache in another study on mTBI PPCS with PTSD.24 During the same period 33% of Control Group experienced worsening of headaches. This symptom has been identified as a primary symptom in TBI,57,58,59,91 the sole symptom distinguishing TBI/PPCS from PTSD,57 and is a surrogate marker for brain wounding in mTBI.10,92,93,94,95 The reduction in headache underscored that HBOT was treating TBI in this study and not just symptoms.91

The randomized controlled single-blinded design of the study was chosen to eliminate multiple causes of possible confounding and demonstrated that HBOT was responsible for the changes and improvements in symptoms, cognitive function, and emotional status as opposed to placebo effects or test-retest effects. This conclusion was supported by the data in Harch et al.23,24 where the magnitude of improvement was similar to our study, but the magnitude of those improvements was criticized because of the presence of PTSD and the lack of a treatment control.96 The present study excluded clinical PTSD, had a far lower PCL score (38.9 *vs.* 63.4 in Harch et al.24) and a treatment Control Group, yet the HBOT group in our study still showed significant cognitive and affective improvements compared to the Control Group. The conclusions of our study are further supported by the significant

functional imaging findings in both Harch et al.23,24 (military subjects) and Boussi-Gross et al.26 (civilian subjects) which were associated with significant improvement in symptoms, cognition, and emotional status similar to our study. Both studies demonstrated global improvements in brain blood flow and the Harch et al.24 study showed a normalization of pattern of blood flow that "could not be explained by placebo effects."23,24

Significant improvements occurred in the Treatment Group in the other seven outcome variables, including Memory Index and ANAM, compared to Control Group during the control period despite overall small sample size of the study (50 subjects) and disproportionately smaller sample size for the Treatment Group (23 vs. 27). In addition, the Treatment Group experienced non-significant increases in working memory, information processing speed, executive function, and Full Scale Intelligence Quotient (FSIQ) compared to the Control Group. The inability to achieve statistical significance for these 5 cognitive domains may be due to ineffectiveness of HBOT in these domains, test-retest effects, small sample size of the study and disproportionate smaller sample size in the Treatment Group than the Control Group, and the effects of 1.6 years of additional education in the Control Group on these cognitive domains.

The post-HBOT improvements in 11 and 13 outcomes seen in the Treatment Group and Control Group immediately after HBOT and continued improvements in memory, working memory, FSIQ, and processing speed in the nearly 3 months after HBOT (a possible tail-effect) are contrary to the natural history of mTBI PPCS, suggesting a cause and effect relationship of HBOT on improvement of PPCS deficits. The Treatment Group showed 58%, 76%, and 20% change score increases in Memory Index, FSIQ, and processing speed in the nearly 3-month follow-up period while the Control Group demonstrated 41%, 46%, and 37% increases, respectively. The natural history of PPCS as documented by the Veterans Administration,7 Defense and Veterans Brain Injury Center,97 and a civilian study6 showed a continued requirement for care or persistence of TBI symptoms for 4 years, 1 year, and 3 years, respectively. Post-HBOT further cognitive and affective improvements were demonstrated for symptoms in Harch et al.24 6 months after HBOT and in Wolf et al.25 6 weeks after treatment. They were not demonstrated in Weaver et al.29 for either symptoms or cognition where the 150 kPa HBOT group gains compared to the purported sham group were diminished by 3 months follow-up. The Weaver et al.29 results may be explained by the 70% of subjects with high risk

for sleep apnea98; cumulative effects of untreated sleep apnea may have eroded the improvements seen with HBOT in 3 months following HBOT. In addition, negative effects of testing at altitude in Colorado Springs (> 6000 feet, < 81 kPa) post-receiving HBOT at sealevel in two of three sites may have had a deleterious effect on performance similar to what was demonstrated in asymptomatic college students with remote mTBI with loss of consciousness99 and an animal model of HBOT in chronic mTBI.21 Pending medical boarding or disability status/compensation may have also influenced Weaver et al.'s29 results. The tail-effects observed in our study, Harch et al.24 and Wolf et al.25 are consistent with and possibly explained by HBOT's gene expression100,101,102,103,104 trophic changes105,106,107,108,109,110,111 that appear to be progressive.

The cognitive data reinforced a finding in Harch et al.,24 where subjects stated that they were abnormal/different from their premorbid level of function, yet most of their scores at time of randomization were in the normal range. After HBOT patients expressed that they felt more back to normal as in Harch et al.,24 were symptomatically and cognitively improved, and their scores were statistically and clinically improved. This indicated that they in fact were not at their "normal" level of function after their TBI even though their scores were in the "normal" range on standardized testing. Working memory was 96.3 and 104 pre-HBOT in Harch et al.24 and in this study and improved to 107.6 (+11.3 points) in Harch et al.24 and 113.7 (+10.2 points-Treatment Group) and 118.6 (+14 points-Control Group) in this study after HBOT. These "normal" WM scores suggest that reliance on a statistical deficit in memory compared to normals for the DSM-IV TR definition of PPCS may be insensitive when diagnosing PPCS. The common assumptions that mTBI does not affect IQ and that a "normal" FSIQ excludes mTBI cognitive deficits96,112,113 appear to be erroneous as well. In both Harch et al.24 and this study the pre-HBOT FSIQs were normal (98 in Harch et al.24 and 106 herein) and yet the subjects had mTBI and cognitive deficits. After HBOT the FSIQ improved 14.2 points in Harch et al.24 and 11.6 (Treatment Group) and 13.4 points (Control Group) in the current study, nearly a standard deviation.

Multiple researchers11,12,24,42,43,44,45,46 have pointed out that the differences in data and conclusions of all of the mTBI PPCS HBOT studies22,23,24,25,26,27,28,29,39,114,115 are best explained by different effects/outcomes of different doses of hyperoxia and/or hydrostatic pressure, including the most recent study by Weaver et al.29 The cluster of U.S.

Department of Defense-sponsored studies characterized different doses of hyperbaric therapy as sham controls. The sham groups, according to the definition of sham51 and the known bioactivity of hydrostatic pressure,50 were actually alternate doses of hyperbaric therapy.11,12,24 The mischaracterization of the low-pressure air doses as sham is supported by the headache data and the symptom trajectories during HBOT. Wolf et al.25 reported a significant ($P = 0.002$) 41% reduction in mean headache score on the ImPACT with the 130 kPa hyperbaric air group, but a non-significant 21% reduction in the 240 kPa oxygen group, while Cifu et al.27 reported no significant reduction in headache (Item 3) on the Rivermead post-concussion symptoms questionnaire with three different doses of HBOT and Harch et al.24 noted a 93% reduction and an 88% decrease in the current study. The other U.S. Department of Defense studies28,29 did not report headache. The trajectory symptom data in **Figure 4** shows different symptom trajectories for the NSI for the 150 kPa oxygen and Control Groups in the current study and the ImPACT 240 kPa oxygen and 130 kPa air doses in Wolf et al.25 All three trajectories are typical drug treatment response patterns that are distinctly different from placebo effect patterns identified in pharmaceutical studies.116 More importantly, the 240 kPa oxygen dose suggests a drug toxicity effect24 (improvement then loss of improvement with continued treatment) that was consistent with a "trend toward harm"90 in the isolated mTBI 240 kPa oxygen-treated group in Wolf et al.25 The differences in headache reduction and symptom trajectories in these studies suggest the differing effects of different doses of HBOT on PPCS11,12,24,26,42,43 and are inconsistent with placebo25,27,114,115 or ritual effects28 which would have demonstrated similar effects across all studies.

The finding from all of the HBOT-treated mTBI/PPCS studies is that two doses of hyperbaric therapy have shown benefit (150 kPa oxygen and 130 kPa air), three doses have shown no benefit (200 kPa pressure with three different doses of oxygen), one dose has shown equivocal results (120 kPa air), and one dose (240 kPa oxygen) is potentially harmful.90 Consistent with U.S. Food And Drug Administration Investigational New Drug evaluations this cluster of studies represents a dose-response evaluation of the dual components of HBOT, pressure and hyperoxia, in mTBI PPCS. The consistent finding is that all studies on HBOT in mTBI PPCS,22,24,26,28,29 including the current study, that have used the 150 kPa oxygen dose first pioneered in acute severe TBI,117 used in chronic TBI,19,20,30,31,32,33,34,35,36,37,38 and confirmed in an animal model of chronic mild TBI,21 have shown statistically significant

improvement in subjects. It is apparent that 40 treatments of 150 kPa oxygen for 60 minutes in an eight to ten-week period is a beneficial, valid, and durable treatment for mTBI PPCS. In addition, given the evidence for brain wounding in mTBI PPCS,10,92,93,95 HBOT's known effects on wound-healing14 and reparative/trophic effects in chronic animal mTBI21 and human mTBI PPCS,24,26,111 HBOT may be the first disease-modifying therapy91 for mTBI PPCS.

Limitations of the study

The crossover design is a minor limitation in that it precluded characterization of a post-control longitudinal comparison to the Treatment Group. Since the natural history of mTBI PPCS is well known to be permanent after a period of time, however, no spontaneous improvement post-control period would be expected. The absence of a non-crossover 2-month Control Group follow-up period does not weaken the conclusions of the study. A second limitation was lack of blinding of subjects to allocation. This was unavoidable since no true pressure control group methodology has been identified in hyperbaric therapy; however, the potential placebo effects of chamber experience and "ritual" have been seriously questioned.24 A third limitation is non-blinding of subjects to the principal investigator, the frequent interaction with the principal investigator during HBOT, and the non-blinded administration of the NSI by the hyperbaric technician at the treatment site. These factors likely contributed to the substantial treatment effect demonstrated for the NSI, but it does not explain the significant improvements in the other outcome instruments compared to the Control Group which were administered by the blinded neuropsychologist. A final limitation was the number of dropouts which necessitated increasing the sample size of the study.

Conclusions

A course of 40 daily, 5 days/week, 150 kPa 60-minute HBOT treatments delivered to civilian and military subjects with the persistent postconcussion syndrome of mild TBI an average of 4.6 years after last TBI resulted in significant improvements in postconcussion symptoms, cognitive variables (memory, cognition/speed of information processing), and behavioral/emotional problems (anxiety, depression, PTSD symptoms, sleep, and quality of life) compared to a randomly assigned Control Group. These improvements were duplicated in the Control Group after crossing over to

HBOT. In both groups most of the improvements were sustained and even improved for some tests nearly 3 months after the last HBOT, suggesting HBOT as a disease-modifying therapy for mTBI PPCS.

Additional files

Additional file 1: Full details of the Methods and Protocol.

Additional file 2: Construction of categorical variables to measure cognitive function.

Additional Table 1: Total persistent postconcussion syndrome symptom scores this study and Wolf et al.25 during and post-treatment or control.

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Footnotes

Conflicts of interest

Dr. Harch owns a small consulting company called Harch Hyperbarics, Inc. He also has a financial arrangement with the treatment facility which is the primary location of his medical practice. Part of the manuscript was presented at Hyperbaric Medicine International: HBOT 2019, The 13th Annual Hyperbaric Medicine Symposium in Charleston, SC, USA.

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Institutional review board statement

The study protocol was approved by the Institutional Review Boards of the United States Army Medical Research and Materiel Command Office of Research Protections Human Research Protection Office and the Louisiana State University School of Medicine (approval No. 7381) and registered on ClinicalTrials.gov (NCT02089594) on March 18, 2014.

Informed consent statement

The authors certify that they have obtained all appropriate patient consent forms. In the form the patients or their legal guardians have given their consent for patients images and other clinical information to be reported in the journal. The patients or their legal guardians understand that their names and initials will not be published.

Reporting statement

The writing and editing of the article were performed in accordance with the CONsolidated Standards Of Reporting Trials (CONSORT) Statement.

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Data sharing statement

Datasets analyzed during the current study are available from the corresponding author on reasonable request.

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REFERENCES

1. Taylor CA, Bell JM, Breiding MJ, Xu L. Traumatic brain injury-related emergency department visits, hospitalizations, and deaths - United States, 2007 and 2013. *MMWR Surveill Summ.* 2017;66:1–16. [PMC free article] [PubMed] [Google Scholar]
2. Centers for Disease Control and Prevention. *Report to Congress on mild traumatic brain injury in the United States: steps to prevent a serious public health problem. Vol 45. Centers for Disease Control and Prevention.* Atlanta, GA, USA: 2003. [Google Scholar]
3. Zogg CK, Haring RS, Xu L, et al. Patient Presentations in outpatient settings: epidemiology of adult head trauma treated outside of hospital emergency departments. *Epidemiology.* 2018;29:885–894. [PMC free article] [PubMed] [Google Scholar]
4. Zogg CK, Haring RS, Xu L, et al. The Epidemiology of pediatric head injury treated outside of hospital emergency departments. *Epidemiology.* 2018;29:269–279. [PMC free article] [PubMed] [Google Scholar]
5. McInnes K, Friesen CL, MacKenzie DE, Westwood DA, Boe SG. Mild traumatic brain injury (mTBI) and chronic cognitive impairment: A scoping review. *PLoS One.* 2017;12:e0174847. [PMC free article] [PubMed] [Google Scholar]
6. Hiploylee C, Dufort PA, Davis HS, et al. Longitudinal study of postconcussion syndrome: not everyone recovers. *J Neurotrauma.* 2017;34:1511–1523. [PMC free article] [PubMed] [Google Scholar]
8. Cooper DB, Bunner AE, Kennedy JE, et al. Treatment of persistent post-concussive symptoms after mild traumatic brain injury: a systematic review of cognitive rehabilitation and behavioral health interventions in military service members and veterans. *Brain Imaging Behav.* 2015;9:403–420. [PubMed] [Google Scholar]
9. Diaz-Arrastia R, Kochanek PM, Bergold P, et al. Pharmacotherapy of traumatic brain injury: state of the science and the road forward: report of the Department of Defense Neurotrauma Pharmacology Workgroup. *J Neurotrauma.* 2014;31:135–158. [PMC free article] [PubMed] [Google Scholar]

10. Wallace EJ, Mathias JL, Ward L. Diffusion tensor imaging changes following mild, moderate and severe adult traumatic brain injury: a meta-analysis. *Brain Imaging Behav.* 2018;12:1607–1621. [PubMed] [Google Scholar]
11. Harch PG. Hyperbaric oxygen therapy for post-concussion syndrome: contradictory conclusions from a study mischaracterized as sham-controlled. *J Neurotrauma.* 2013;30:1995–1999. [PMC free article] [PubMed] [Google Scholar]
13. Harch PG. *Textbook of Hyperbaric Medicine.* Cham: Springer International Publishing; 2017. HBO therapy in global cerebral ischemia/anoxia and coma; pp. 269–319. [Google Scholar]
14. Undersea and Hyperbaric Medical Society, Hyperbaric Oxygen Committee. *Hyperbaric Oxygen Therapy indications: The Hyperbaric Oxygen Therapy Committee Report.* Best Publishing Company; 2014. [Google Scholar]
16. Jain KK. Worldwide overview of hyperbaric medicine, Chapter 49. In: Jain KK, editor. *Textbook of Hyperbaric Medicine.* 6th ed. Cham: Springer; 2017. pp. 609–614. [Google Scholar]
17. Mathieu D, Marroni A, Kot J. Tenth European Consensus Conference on Hyperbaric Medicine: recommendations for accepted and non-accepted clinical indications and practice of hyperbaric oxygen treatment. *Diving Hyperb Med.* 2017;47:24–32. [PMC free article] [PubMed] [Google Scholar]
18. Takahashi H, Yagi H. Hyperbaric Medicine in Japan, Chapter 42. In: Jain KK, editor. *Textbook of Hyperbaric Medicine.* 5th ed. Gottingen, Germany: Hogrefe and Huber Publishers; 2009. pp. 495–498. [Google Scholar]
19. Harch PG. Hyperbaric oxygen therapy in the treatment of chronic traumatic brain injury: from Louisiana boxers to US veterans, an American Chronology. *Wound Care Hyperbaric Med.* 2010;1:26–34. [Google Scholar]
20. Harch P, Gottlieb S, Van Meter K, Staab P. HMPAO SPECT brain imaging and low pressure hbot in the diagnosis and treatment of chronic traumatic, ischemic, hypoxic and anoxic encephalopathies. *Undersea Hyperb Med.* 1994;21:S30. [Google Scholar]
21. Harch PG, Kriedt C, Van Meter KW, Sutherland RJ. Hyperbaric oxygen therapy improves spatial learning and memory in a rat model of chronic traumatic brain injury. *Brain Res.* 2007;1174:120–129. [PubMed] [Google Scholar]
22. Harch PG, Fogarty EF, Staab PK, Van Meter K. Low pressure hyperbaric oxygen therapy and SPECT brain imaging in the treatment of blast-induced chronic traumatic brain injury (post-concussion syndrome) and post traumatic stress disorder: a case report. *Cases J.* 2009;2:6538–6538. [PMC free article] [PubMed] [Google Scholar]

23. Harch PG, Andrews SR, Fogarty EF, et al. A phase I study of low-pressure hyperbaric oxygen therapy for blast-induced post-concussion syndrome and post-traumatic stress disorder. *J Neurotrauma.* 2012;29:168–185. [PubMed] [Google Scholar]
24. Harch PG, Andrews SR, Fogarty EF, Lucarini J, Van Meter KW. Case control study: hyperbaric oxygen treatment of mild traumatic brain injury persistent post-concussion syndrome and post-traumatic stress disorder. *Med Gas Res.* 2017;7:156–174. [PMC free article] [PubMed] [Google Scholar]
25. Wolf G, Cifu D, Baugh L, Carne W, Profenna L. The effect of hyperbaric oxygen on symptoms after mild traumatic brain injury. *J Neurotrauma.* 2012;29:2606–2612. [PubMed] [Google Scholar]
26. Boussi-Gross R, Golan H, Fishlev G, et al. Hyperbaric oxygen therapy can improve post concussion syndrome years after mild traumatic brain injury - randomized prospective trial. *PLoS One.* 2013;8:e79995. [PMC free article] [PubMed] [Google Scholar]
27. Cifu DX, Hart BB, West SL, Walker W, Carne W. The effect of hyperbaric oxygen on persistent postconcussion symptoms. *J Head Trauma Rehabil.* 2014;29:11–20. [PubMed] [Google Scholar]
28. Miller RS, Weaver LK, Bahraini N, et al. Effects of hyperbaric oxygen on symptoms and quality of life among service members with persistent postconcussion symptoms: a randomized clinical trial. *JAMA Intern Med.* 2015;175:43–52. [PubMed] [Google Scholar]
29. Weaver LK, Wilson SH, Lindblad AS, et al. Hyperbaric oxygen for post-concussive symptoms in United States military service members: a randomized clinical trial. *Undersea Hyperb Med.* 2018;45:129–156. [PubMed] [Google Scholar]
30. Harch PG, Van Meter KW, Neubauer RA, Gottlieb SF. Use of HMPAO SPECT for Assessment of Response to HBO in Ischemic/Hypoxic Encephalopathies, Appendix. In: Jain KK, editor. *Textbook of Hyperbaric Medicine.* 2nd ed. Seattle, WA, USA: Hogrefe and Huber Publishers; 1996. pp. 480–491. [Google Scholar]
31. Harch PG, Neubauer RA. Hyperbaric oxygen therapy in global cerebral ischemia/anoxia and coma, Chapter 18. In: Jain KK, editor. *Textbook of Hyperbaric Medicine.* 3rd Revised Edition. Seattle, WA, USA: Hogrefe and Huber Publishers; 1999. pp. 319–345. [Google Scholar]
32. Harch PG, Neubauer RA. Hyperbaric oxygen therapy in global cerebral ischemia/anoxia and coma, Chapter 18. In: Jain KK, editor. *Textbook of Hyperbaric Medicine.* 3rd Revised Edition. Seattle, WA, USA: Hogrefe and Huber Publishers; 2004. pp. 223–261. [Google Scholar]

33. Harch PG, Neubauer RA. Hyperbaric oxygen therapy in global cerebral ischemia/anoxia and coma, Chapter 19. In: Jain KK, editor. *Textbook of Hyperbaric Medicine.* 5th Revised Edition. Seattle, WA, USA: Hogrefe and Huber Publishers; 2009. pp. 235–274. [Google Scholar]
34. Harch PG, Neubauer RA, Uszler JM, James PB. Appendix: Diagnostic imaging and HBO therapy, Chapter 44. In: Jain KK, editor. *Textbook of Hyperbaric Medicine.* 5th Revised Edition. Seattle, WA, USA: Hogrefe and Huber Publishers; 2009. pp. 505–519. [Google Scholar]
35. Neubauer RA, Gottlieb SF, Pevsner NH. Hyperbaric oxygen for treatment of closed head injury. *South Med J.* 1994;87:933–936. [PubMed] [Google Scholar]
36. Golden ZL, Neubauer R, Golden CJ, Greene L, Marsh J, Mleko A. Improvement in cerebral metabolism in chronic brain injury after hyperbaric oxygen therapy. *Int J Neurosci.* 2002;112:119–131. [PubMed] [Google Scholar]
37. Golden Z, Golden CJ, Neubauer RA. Improving neuropsychological function after chronic brain injury with hyperbaric oxygen. *Disabil Rehabil.* 2006;28:1379–1386. [PubMed] [Google Scholar]
38. Churchill S, Weaver LK, Deru K, et al. A prospective trial of hyperbaric oxygen for chronic sequelae after brain injury (HYBOBI) *Undersea Hyperb Med.* 2013;40:165–193. [PubMed] [Google Scholar]
39. Wright JK, Zant E, Groom K, Schlegel RE, Gilliland K. Case report: Treatment of mild traumatic brain injury with hyperbaric oxygen. *Undersea Hyperb Med.* 2009;36:391–399. [PubMed] [Google Scholar]
40. Mozayeni BR, Duncan W, Zant E, Love TL, Beckman RL, Stoller KP. The National Brain Injury Rescue and Rehabilitation Study - a multicenter observational study of hyperbaric oxygen for mild traumatic brain injury with post-concussive symptoms. *Med Gas Res.* 2019;9:1–12. [PMC free article] [PubMed] [Google Scholar]
41. Shytle RD, Eve DJ, Kim SH, Spiegel A, Sanberg PR, Borlongan CV. Retrospective case series of traumatic brain injury and post-traumatic stress disorder treated with hyperbaric oxygen therapy. *Cell Transplant.* 2019;28:885–892. [PMC free article] [PubMed] [Google Scholar]
42. Figueroa XA, Wright JK. Hyperbaric oxygen: B-level evidence in mild traumatic brain injury clinical trials. *Neurology.* 2016;87:1400–1406. [PubMed] [Google Scholar]
43. Hadanny A, Efrati S. Treatment of persistent post-concussion syndrome due to mild traumatic brain injury: current status and future directions. *Expert Rev Neurother.* 2016;16:875–887. [PubMed] [Google Scholar]

44. Marois P, Mukherjee A, Ballaz L. Hyperbaric oxygen treatment for persistent postconcussion symptoms--a placebo effect. *JAMA Intern Med.* 2015;175:1239–1240. [PubMed] [Google Scholar]
45. Mychaskiw G, 2nd, Stephens PL. Hyperbaric oxygen, mild traumatic brain injury, and study design: an elusive target. *J Neurotrauma.* 2013;30:1681–1682. [PubMed] [Google Scholar]
46. Mychaskiw G. Known knowns, known unknowns and unknown unknowns: the science and the passion of HBO2 therapy and traumatic brain injury: an editorial perspective. *Undersea Hyperb Med.* 2013;40:371–372. [PubMed] [Google Scholar]
47. Hu Q, Manaenko A, Guo Z, Huang L, Tang J, Zhang JH. Hyperbaric oxygen therapy for post concussion symptoms: issues may affect the results. *Med Gas Res.* 2015;5:10. [PMC free article] [PubMed] [Google Scholar]
48. Weaver LK, Cifu D, Hart B, Wolf G, Miller S. Hyperbaric oxygen for post-concussion syndrome: design of Department of Defense clinical trials. *Undersea Hyperb Med.* 2012;39:807–814. [PubMed] [Google Scholar]
49. Mitchell SJ, Bennett MH. Unestablished indications for hyperbaric oxygen therapy. *Diving Hyperb Med.* 2014;44:228–234. [PubMed] [Google Scholar]
50. Macdonald AG, Fraser PJ. The transduction of very small hydrostatic pressures. *Comp Biochem Physiol A Mol Integr Physiol.* 1999;122:13–36. [PubMed] [Google Scholar]
52. Mild Traumatic Brain Injury Committee of the Head Injury Interdisciplinary Special Interest Group of the American Congress of Rehabilitation Medicine. Definition of mild traumatic brain injury. *J Head Trauma Rehabil.* 1993;8:86–87. [Google Scholar]
53. Bigler ED. Neuropsychology and clinical neuroscience of persistent post-concussive syndrome. *J Int Neuropsychol Soc.* 2008;14:1–22. [PubMed] [Google Scholar]
54. *Diagnostic and Statistical Manual of Mental Disorders.* 4th ed., text revised. Washington, D.C: American Psychiatric Association; 2000. [Google Scholar]
55. King PR, Donnelly KT, Donnelly JP, et al. Psychometric study of the neurobehavioral symptom inventory. *J Rehabil Res Dev.* 2012;49:879–888. [PubMed] [Google Scholar]
56. Cicerone KD, Kalmar K. Persistent postconcussion syndrome: the structure of subjective complaints after mild traumatic brain injury. *J Head Trauma Rehabil.* 1995;10:1–17. [Google Scholar]
57. Hoge CW, McGurk D, Thomas JL, Cox AL, Engel CC, Castro CA. Mild traumatic brain injury in U.S. Soldiers returning from Iraq. *N Engl J Med.* 2008;358:453–463. [PubMed] [Google Scholar]

58. Theeler B, Lucas S, Riechers RG, 2nd, Ruff RL. Post-traumatic headaches in civilians and military personnel: a comparative, clinical review. *Headache.* 2013;53:881–900. [PubMed] [Google Scholar]
59. Theeler BJ, Flynn FG, Erickson JC. Chronic daily headache in U.S. soldiers after concussion. *Headache.* 2012;52:732–738. [PubMed] [Google Scholar]
61. Gavin DR, Ross HE, Skinner HA. Diagnostic validity of the drug abuse screening test in the assessment of DSM-III drug disorders. *Br J Addict.* 1989;84:301–307. [PubMed] [Google Scholar]
63. Corrigan JD, Bogner J. Initial reliability and validity of the Ohio State University TBI Identification Method. *J Head Trauma Rehabil.* 2007;22:318–329. [PubMed] [Google Scholar]
64. Blake DD, Weathers FW, Nagy LM, et al. The development of a Clinician-Administered PTSD Scale. *J Traum Stress.* 1995;8:75–90. [PubMed] [Google Scholar]
65. Tombaugh TN. *Test of memory malingering: TOMM.* New York: Multi-Health Systems, Inc; 1996. [Google Scholar]
66. Lesak M, Howieson D, Loring D. *Neuropsychological Assessment.* 4th ed. New York: Oxford University Press; 2004. pp. 365–367,776. [Google Scholar]
67. Wechsler D. *Wechsler Test of Adult Reading (WTAR)-Manual.* San Antonio, TX, USA: The Psychological Corporation; 2001. [Google Scholar]
68. Hedlund JL, Vieweg BW. The Hamilton rating scale for depression: a comprehensive review. *J Operat Psychiatry.* 1979;10:149–165. [Google Scholar]
69. Hamilton M. The assessment of anxiety states by rating. *Br J Med Psychol.* 1959;32:50–55. [PubMed] [Google Scholar]
73. Lezak MD, Howieson DB, Loring DW. *Neuropsychological Assessment.* 4 ed. New York: Oxford University Press; 2004. pp. 422–429. [Google Scholar]
74. Sivan AB. *Benton Visual Retention Test.* 5th ed. San Antonio: The Psychological Corporation; 1992. [Google Scholar]
76. Spreen O, Strauss E. *A compendium of neuropsychological tests: Administration, norms and commentary.* 2nd ed. New York: Oxford University Press; 1998. [Google Scholar]
77. Lezak MD, Howieson DB, Loring DW. *Neuropsychological Assessment.* Fourth Edition. New York: Oxford University Press; 2004. pp. 520–521. [Google Scholar]
78. Vincent AS, Roebuck-Spencer TM, Cox-Fuenzalida LE, Block C, Scott JG, Kane R. Validation of ANAM for cognitive screening in a mixed clinical sample. *Appl Neuropsychol Adult.* 2018;25:366–375. [PubMed] [Google Scholar]

79. Buysse DJ, Reynolds CF, Monk TH, Berman SR, Kupfer DJ. The Pittsburgh sleep quality index: A new instrument for psychiatric practice and research. *Psychiatry Res.* 1989;28:193–213. [PubMed] [Google Scholar]
81. Heaton R, Miller SW, Taylor MJ, Grant-Isibor I. Lutz, FL, USA: Psychological Assessment Resources; 2004. Revised comprehensive norms for an expanded Halstead-Reitan Battery: Demographically adjusted neuropsychological norms for African American and Caucasian adults. [Google Scholar]
82. Soble JR, Silva MA, Vanderploeg RD, et al. Normative Data for the Neurobehavioral Symptom Inventory (NSI) and post-concussion symptom profiles among TBI, PTSD, and nonclinical samples. *Clin Neuropsychol.* 2014;28:614–632. [PubMed] [Google Scholar]
83. Wilde EA, Whiteneck GG, Bogner J, et al. Recommendations for the use of common outcome measures in traumatic brain injury research. *Arch Phys Med Rehabil.* 2010;91:1650–1660.e17. [PubMed] [Google Scholar]
84. Dretsch M, Bleiberg J, Williams K, et al. Three scoring approaches to the neurobehavioral symptom inventory for measuring clinical change in service members receiving intensive treatment for combat-related mTBI. *J Head Trauma Rehabil.* 2016;31:23–29. [PubMed] [Google Scholar]
86. Basso MR, Carona FD, Lowery N, Axelrod BN. Practice effects on the WAIS-III across 3- and 6-month intervals. *Clin Neuropsychol.* 2002;16:57–63. [PubMed] [Google Scholar]
87. Tukey JW. Comparing individual means in the analysis of variance. *Biometrics.* 1949;5:99–114. [PubMed] [Google Scholar]
88. Belanger HG, Lange RT, Bailie J, et al. Interpreting change on the neurobehavioral symptom inventory and the PTSD checklist in military personnel. *Clin Neuropsychol.* 2016;30:1063–1073. [PubMed] [Google Scholar]
89. Harch PG. The dosage of hyperbaric oxygen in chronic brain injury. In: Joiner JT, editor. *The Proceedings of the 2nd International Symposium on Hyperbaric Oxygenation for Cerebral palsy and the Brain-Injured Child.* Flagstaff, AZ, USA: Best Publishing Co; 2002. pp. 31–56. [Google Scholar]
90. Scorza K, McCarthy W, Miller R, Carne W, Wolf G. Orlando, FL, USA: Undersea and Hyperbaric Medical Society Annual Meeting; 2013. Hyperbaric oxygen effects on PTSD and mTBI symptoms: a subset analysis. [Google Scholar]
91. Polinder S, Cnossen MC, Real RGL, et al. A multidimensional approach to post-concussion symptoms in mild traumatic brain injury. *Front Neurol.* 2018;9:1113–1113. [PMC free article] [PubMed] [Google Scholar]
92. Kraus MF, Susmaras T, Caughlin BP, Walker CJ, Sweeney JA, Little DM. White matter integrity and cognition in chronic traumatic brain injury: a

diffusion tensor imaging study. *Brain.* 2007;130:2508–2519. [PubMed] [Google Scholar]
93. Lipton ML, Gulko E, Zimmerman ME, et al. Diffusion-tensor imaging implicates prefrontal axonal injury in executive function impairment following very mild traumatic brain injury. *Radiology.* 2009;252:816–824. [PubMed] [Google Scholar]
94. Roth TL, Nayak D, Atanasijevic T, Koretsky AP, Latour LL, McGavern DB. Transcranial amelioration of inflammation and cell death after brain injury. *Nature.* 2014;505:223–228. [PMC free article] [PubMed] [Google Scholar]
95. Korn A, Golan H, Melamed I, Pascual-Marqui R, Friedman A. Focal cortical dysfunction and blood-brain barrier disruption in patients with Postconcussion syndrome. *J Clin Neurophysiol.* 2005;22:1–9. [PubMed] [Google Scholar]
96. Wortzel HS, Arciniegas DB, Anderson CA, Vanderploeg RD, Brenner LA. A phase I study of low-pressure hyperbaric oxygen therapy for blast-induced post-concussion syndrome and post-traumatic stress disorder: a neuropsychiatric perspective. *J Neurotrauma.* 2012;29:2421–2430. [PubMed] [Google Scholar]
97. Ferdosi H, Schwab KA, Metti A, et al. Trajectory of postconcussive symptoms 12 months after deployment in soldiers with and without mild traumatic brain injury: warrior strong study. *Am J Epidemiol.* 2019;188:77–86. [PubMed] [Google Scholar]
98. Walker JM, Mulatya C, Hebert D, Wilson SH, Lindblad AS, Weaver LK. Sleep assessment in a randomized trial of hyperbaric oxygen in U.S. service members with post concussive mild traumatic brain injury compared to normal controls. *Sleep Med.* 2018;51:66–79. [PubMed] [Google Scholar]
99. Ewing R, McCarthy D, Gronwall D, Wrightson P. Persisting effects of minor head injury observable during hypoxic stress. *J Clin Exp Neuropsych.* 1980;2:147–155. [Google Scholar]
100. Siddiqui A, Davidson JD, Mustoe TA. Ischemic tissue oxygen capacitance after hyperbaric oxygen therapy: a new physiologic concept. *Plast Reconstr Surg.* 1997;99:148–155. [PubMed] [Google Scholar]
101. Godman CA, Chheda KP, Hightower LE, Perdrizet G, Shin DG, Giardina C. Hyperbaric oxygen induces a cytoprotective and angiogenic response in human microvascular endothelial cells. *Cell Stress Chaperones.* 2010;15:431–442. [PMC free article] [PubMed] [Google Scholar]
102. Chen Y, Nadi NS, Chavko M, Auker CR, McCarron RM. Microarray analysis of gene expression in rat cortical neurons exposed to hyperbaric air and oxygen. *Neurochem Res.* 2009;34:1047–1056. [PubMed] [Google Scholar]

103. Oh S, Lee E, Lee J, Lim Y, Kim J, Woo S. Comparison of the effects of 40% oxygen and two atmospheric absolute air pressure conditions on stress-induced premature senescence of normal human diploid fibroblasts. *Cell Stress Chaperones.* 2008;13:447–458. [PMC free article] [PubMed] [Google Scholar]
104. Kendall AC, Whatmore JL, Harries LW, Winyard PG, Eggleton P, Smerdon GR. Different oxygen treatment pressures alter inflammatory gene expression in human endothelial cells. *Undersea Hyperb Med.* 2013;40:115–123. [PubMed] [Google Scholar]
105. Marx RE, Johnson RP. Problem wounds in oral and maxillofacial surgery: the role of hyperbaric oxygen, Chapter 4. In: Davis JC, Hunt TK, editors. *Problem Wounds: The Role of Oxygen.* New York: Elsevier Science Publishing Co; 1988. pp. 65–123. [Google Scholar]
106. Brismar K, Lind F, Kratz G. Dose-dependent hyperbaric oxygen stimulation of human fibroblast proliferation. *Wound Repair Regen.* 1997;5:147–150. [PubMed] [Google Scholar]
107. Marx RE, Ehler WJ, Tayapongsak P, Pierce LW. Relationship of oxygen dose to angiogenesis induction in irradiated tissue. *Am J Surg.* 1990;160:519–524. [PubMed] [Google Scholar]
108. Manson PN, Im MJ, Myers RAM, Hoopes JE. Improved capillaries by hyperbaric-oxygen in skin flaps. *Surg Forum.* 1980;31:564–566. [Google Scholar]
109. Uhl E, Sirsjö A, Haapaniemi T, Nilsson G, Nylander G. Hyperbaric oxygen improves wound healing in normal and ischemic skin tissue. *Plast Reconstr Surg.* 1994;93:835–841. [PubMed] [Google Scholar]
110. Ueng SW, Lee SS, Lin SS, et al. Bone healing of tibial lengthening is enhanced by hyperbaric oxygen therapy: a study of bone mineral density and torsional strength on rabbits. *J Trauma.* 1998;44:676–681. [PubMed] [Google Scholar]
111. Tal S, Hadanny A, Sasson E, Suzin G, Efrati S. Hyperbaric oxygen therapy can induce angiogenesis and regeneration of nerve fibers in traumatic brain injury patients. *Front Hum Neurosci.* 2017;11:508. [PMC free article] [PubMed] [Google Scholar]
112. Belanger HG, Vanderploeg RD. The neuropsychological impact of sports-related concussion: a meta-analysis. *J Int Neuropsychol Soc.* 2005;11:345–357. [PubMed] [Google Scholar]
113. Belanger HG, Curtiss G, Demery JA, Lebowitz BK, Vanderploeg RD. Factors moderating neuropsychological outcomes following mild traumatic brain injury: a meta-analysis. *J Int Neuropsychol Soc.* 2005;11:215–227. [PubMed] [Google Scholar]

114. Walker WC, Franke LM, Cifu DX, Hart BB. Randomized, sham-controlled, feasibility trial of hyperbaric oxygen for service members with postconcussion syndrome: cognitive and psychomotor outcomes 1 week postintervention. *Neurorehab Neural Repair.* 2014;28:420–432. [PubMed] [Google Scholar]
115. Cifu DX, Walker WC, West SL, et al. Hyperbaric oxygen for blast-related postconcussion syndrome: three-month outcomes. *Ann Neurol.* 2014;75:277–286. [PubMed] [Google Scholar]
116. Quitkin FM. Placebos, drug effects, and study design: a clinician's guide. *Am J Psychiatry.* 1999;156:829–836. [PubMed] [Google Scholar]
117. Holbach KH, Caroli A, Wassmann H. Cerebral energy metabolism in patients with brain lesions of normo- and hyperbaric oxygen pressures. *J Neurol.* 1977;217:17–30. [PubMed] [Google Scholar]

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