

**H.R. 3636; H.R. 2972; H.R. 3036; H.R. 2798; H.R.
2645; H.R. 2681; H.R. 3224; H.R. 2982; H.R.
2752; H.R. 2628; H.R. 2816; H.R. 1527; H.R.
1163; H.R. 3798; H.R. 3867; H.R. 4096; DRAFT
BILL, TO ESTABLISH IN THE DEPARTMENT OF
VETERANS AFFAIRS THE OFFICE OF WOMEN'S
HEALTH, AND FOR OTHER PURPOSES**

HEARING

BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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Wednesday, September 11, 2019

COMMITTEE ON VETERANS' AFFAIRS,
U. S. HOUSE OF REPRESENTATIVES,
Washington, D.C.

The Subcommittees met, pursuant to notice, at 10:08 a.m., in Room 210, House Visitors Center, Hon. Julia Brownley [chairwoman of the Subcommittee on Health] presiding.

Present: Representatives Brownley, Lamb, Levin, Brindisi, Rose, Cisneros, Dunn, Radewagen, Barr, and Steube.

Also Present: Representatives Sablan, Underwood, and Bilirakis.

OPENING STATEMENT OF JULIA BROWNLEY, CHAIRWOMAN

Ms. BROWNLEY. Good morning, ladies and gentlemen. I call this legislative hearing to order. On this morning, we recognize the lives lost in the terrorist attacks that occurred on September 11. Since that time, upwards of 3 million servicemembers have been deployed on more than 5.4 million deployments. Seventeen percent of the servicemembers that have volunteered to defend this country in what has become the longest war in this Nation's history are women; they are mothers, daughters, sisters, soldiers, airmen, sailors and Marines, and those that were able to return home from the battlefield deserve the same access to timely, high-quality health care as their male counterparts. That is why during the 116th Congress the Health Subcommittee's key focus has been ensuring equitable access to high-quality health care for our Nation's heroes.

As chair of the Women Veterans Task Force, I am proud to lead 78 Members of Congress in identifying gaps and opportunities to achieve equity in access to health care benefits, economic opportunities, and other resources for women veterans. I am pleased that today's hearing includes 12 bills that will improve equity for the delivery of health care for women who have served in our Nation's Armed Forces.

Also, this month is Suicide Prevention Month, and it is critical that we address the gender-specific mental health needs of women veterans. Women veterans are nearly twice as likely to die by sui-

cide than women who have never served in the military. Experiencing military sexual trauma, isolation, and intimate partner violence increases the risk of suicide in women veterans.

Suicide is preventable and several of the bills presented at today's hearing provide additional resources to programs and services known to decrease the risk of suicide in women veterans. My bill, H.R. 2798, the Building Supportive Networks for Women Veterans Act, provides reintegration counseling for women veterans in retreat settings.

H.R. 3867, the Violence Against Women Veterans Act, introduced by Ms. Velazquez, improves programs and services for veterans who are survivors of intimate partner violence and sexual assault.

Mr. Brindisi's bill, H.R. 2972, improves resources for the women veterans call center and VA websites, so that women veterans can easily obtain information about accessing benefits and health care.

Research shows that these resources, and knowledge that those resources exist, significantly reduce the risk of suicide in women veterans.

Ranking Member Dunn, I understand from yesterday's Member Day that Mr. Bergman has also introduced a bill related to suicide prevention, and I would like to reiterate Chairman Takano's commitment to work alongside you and Ranking Member Roe to support VA's ability to connect veterans to the upwards of 45,000 community-based organizations that seek to serve them.

Women veterans are the fastest-growing demographic in the veteran population, and it is clear that VA facilities must be built, retrofitted, and staffed in accordance with that pace of growth.

H.R. 3636, the Caring for Women Veterans Act, introduced by Ms. Underwood; H.R. 3036, the Breaking Barriers for Women Veterans Act, introduced by Mr. Rose; H.R. 4096, the Improving Oversight of Women Veterans Care Act of 2019; and my bill, H.R. 3223, the Women Veterans Equal Access to Quality Care Act; all ensure that VA is providing sufficient staff, training, building, and retrofitting facilities, and maintaining an environment of care standards wherever women veterans receive taxpayer-funded care, whether at a VA facility or a community care provider.

It is imperative that we eliminate all cultural and physical barriers to women veteran's health care. Mr. Pappas' bill, H.R. 2681, ensures VA is equipped to provide women veterans with life-transforming prosthetics that are specifically for their needs.

Over the past decade, VA conducted two studies to identify barriers to care for women veterans. The most recent study, completely nearly 5 years ago, enabled VA to identify necessary changes to improve services for women veterans. More still must be done. And Mr. Cunningham's bill, H.R. 2982, renews the authorization for the barriers to care study to enable VA to best serve women veterans by 2030 and beyond.

In the last 20 years, we have seen a significant shift in the demographics of the veteran population. Not only is the women veteran's population growing rapidly, but women veterans are on average 15 years younger than male veterans and more likely to be of reproductive age. That is why members of the Women Veterans Task Force introduced three bills to improve reproductive health care access for women veterans.

My bill, H.R. 3798, Equal Access to Contraception for Veterans Act, eliminates co-payments for prescription contraceptives, so that women veterans have the same access to birth control as during their service.

For veterans who choose to become mothers, two bills will give veterans peace of mind in the earliest days of their newborn's lives. H.R. 2645, the Newborn Care Improvement Act, introduced by Ms. Lee, doubles the number of days of newborn health care coverage for children of veterans.

Mr. Allred's bill, H.R. 2752, the VA Newborn Emergency Treatment Act, further expands coverage for newborns when medically necessary and streamlines the billing process, so that veterans are not unnecessarily burdened with debt after the birth of a child.

In addition to today's legislation focused on women veterans, we are also considering a number of bipartisan measures that have been introduced by my Republican colleagues.

Last Congress, I was honored to join a number of Members of this Committee to cosponsor the Long-Term Care Veterans Choice Act, introduced by Congressman Clay Higgins. This measure is a first step towards right-sizing VA's long-term care options by offering veterans more opportunity to age at home.

As women are generally expected to live nearly 5 years longer than men, ensuring VA is prepared to care for its aging population is important to women veterans and the community at large.

In addition, the legislation introduced by Congresswoman Stefanik, H.R. 2816, the Vietnam Era Veterans Hepatitis C Testing Enhancement Act of 2019, would allow VA to partner with veterans service organizations to offer hepatitis C testing at outreach events is an important step towards ensuring VA is properly leveraging its existing partnerships to reach veterans where they are.

As chair of this Health Subcommittee, I am truly proud of the work we are doing here today; I am especially proud of the way we are doing it in a bipartisan manner.

In closing, I would like to thank our witnesses for appearing and I look forward to your testimony.

Ms. BROWNLEY. Before I recognize Dr. Dunn for his opening statement, I would like to note that I will not be asking Members to waive their opening statements today, as is tradition, so that the Members with legislation on today's agenda are afforded the opportunity to issue statements in support. While a few of the Members with legislation before us today are not Members of this Committee, please note that each has been given the opportunity to submit a statement for today's record, as well as the opportunity to deliver remarks in support of their legislation at yesterday's Member Day before the Full Committee.

With that, I would like to recognize Ranking Member Dunn for 5 minutes for any opening remarks he may wish to make.

OPENING STATEMENT OF NEAL P. DUNN, RANKING MEMBER

Mr. DUNN. Thank you, Chairwoman Brownley. After several weeks away from Washington, it is good to be back with you, working to serve our Nation's veterans.

Our agenda this morning is full, and I look forward to our discussion.

Before yielding, I do say, I would like to say I have three areas of regret and a little disappointment here, and that is this is the second legislative hearing that this Subcommittee has held in Congress and both of the agendas of those hearings were set entirely by the majority without any input from the minority, either Members or staff.

The witness list for this hearing did not include the Member panel, which you mentioned just a moment ago. Typically, Members who sponsor bills are invited to testify and contribute to our conversations about their bills.

I note that the Committee Members with bills up for consideration today, Committee Members with bills up today, have been allowed to sit on the dais and testify on their bills. And while most of the Democrat bills are sponsored by the majority Members, only one of the Republican bills chosen by the majority is sponsored by a Committee Member. Now, that is probably unintentional, but it creates a perception of imbalance.

By failing to provide the minority an opportunity to provide input about bills to be considered, and further failing to provide sponsors from both parties' equal opportunity to advocate for their legislation, I think it runs somewhat counter to the past practices of this Subcommittee. The VA and its Subcommittees have uniquely been very bipartisan, and I sincerely hope we will continue to conduct it that way.

Finally, had the minority been consulted in advance about the agenda, there is one bill that we would have asked to be included that has not been, that is H.R. 3495, the Improve Well-Being for Veterans Act, which you referenced in your opening statement. The Improve Act is bipartisan legislation, it is sponsored by Congressman Bergman and Congresswoman Houlahan. I note for the record that Congressman Bergman is also Lieutenant General Bergman, the highest-ranking officer and veteran ever to serve in Congress in the history of our Nation. It is supported by many veterans service organizations and by the VA, and, most importantly, it addresses what Chairman Takano has stated repeatedly is this Committee's single highest priority, preventing veteran suicide, by creating a grant program to support entities that provide and coordinate suicide prevention services for veterans and their families in their local communities.

The Improve Act alone would not solve the national suicide crisis that tragically takes the lives of 20 veterans a day, but it could certainly be part of that solution. It would save lives, and it is worthy of this Subcommittee's time and attention.

When staff was first informed of today's hearing, after the majority had already set the agenda and informed the VA of the hearing, our staff requested to add the Improve Act to the agenda, and that request by staff was denied. Letters were subsequently sent to Chairman Takano by Secretary Wilkie and followed by Ranking Member Roe requesting the Improve Act be included. Chairwoman Brownley, I certainly hope that your staff provided you copies of those letters and, to my knowledge, we have had no response on those.

September is National Suicide Prevention Month and Chairman Takano marked it on September 1st by calling for new solutions and fast actions. One concrete way for this Committee to follow that call would be debating the Improve Act without any unnecessary delay. I regret that we are not doing that.

But, with that, I look forward to today's hearing and I yield back. Thank you.

Ms. BROWNLEY. Thank you, Dr. Dunn. I appreciate it.

And just to follow up on your remarks with regards to Lieutenant General Bergman's bill, I assure you and the Committee that our staff and Chairman Takano are prepared to work through that bill to gain bipartisan support and, hopefully, that particular bill will come forward to us at another time. So I appreciate your comments there.

So now I would like to recognize Congressman Rose for 5 minutes for any opening remarks he may wish to make in support of his bill.

OPENING STATEMENT OF MAX ROSE

Mr. ROSE. Thank you, Chairwoman Brownley and Ranking Member Dunn, for having this forum to provide due attention to the pending legislation before us.

With respect to legislation impacting women veterans before us, let me just say it is beyond clear that the women who served alongside me in Afghanistan, who also served in Iraq and who have generally put on our Nation's uniform in defense of all that we hold dear, they deserve our support and national investment now more than ever.

When these heroes come home, they aren't necessarily greeted with a hero's welcome, although they are always thanked for their services. Instead, they face challenges severely disproportionate to their civilian and male counterparts, and it is unacceptable.

Studies have shown women veterans have higher rates of interpersonal trauma than male veterans, and this includes military sexual trauma. There is little doubt that this plays a role in higher instances of medical challenges than other groups. And, tragically, women who served have a rate of suicide that is nearly double than that of civilian women age 18 and over. It is Suicide Prevention Month and I want us to fully appreciate the scope of that. We cannot let this persist.

And let me just say that, if you thank a female veteran for their service when they come home, but nonetheless do not do anything about the fact that they receive inadequate health care at our VA institutions, then beyond that just being hypocritical in nature, saying thank you for your service is a disgraceful thing to be doing if we are not fixing this. Our female veterans deserve so much better.

That is why I am proud to have introduced H.R. 3036, a critical bipartisan piece of legislation to make sure facilities at the VA are as equipped as possible to serve a growing population of veterans. This bill would ensure funds to support the physical infrastructure of our VA hospitals and clinics for a woman veteran's care needs. It would require that there is at least one full-time or part-time woman's primary care provider within any given clinic or facility,

and would expand the woman veteran's health care mini-residency program, which further protects against staffing concerns being a barrier to access.

And, in addition to requiring the VA to produce relevant reports as care is provided, this bill would require the VA to establish a training module for community providers, because as we see time and again through these hearings, these issues do not end within the four walls of the VA.

After seeing the VA's testimony to this Subcommittee, I am heartened the VA supports the intent of many provisions within this bill and, while the VA is working on many of these goals, we must ensure that our women veterans do not fall through the cracks; that is not an option.

So, again, I urge all my colleagues to support this legislation. I thank many of those who have cosponsored. And, again, Madam Chairwoman, thank you again for the time.

[THE PREPARED STATEMENT OF CONGRESSMAN ROSE APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you. Mr. Bilirakis.

OPENING STATEMENT OF GUS M. BILIRAKIS

Mr. BILIRAKIS. Thank you, Madam Chair, I appreciate it. I would like to thank you again for—and the Ranking Member, of course—for allowing me to sit on this Subcommittee hearing and allowing me to speak on one of the bills being considered today, my legislation, which is H.R. 2628, the Vet Care Act.

Many of my veteran constituents have come to me over the years expressing their desire to add dental care to the VA's medical benefits package. As you know, Madam Chair, the VA currently on provides outpatient dental services to a limited number of the disabled veteran population who have 100 percent service-connected ratings, and then a couple other categories as well, POWs and, again, anything that happened on the battlefield as far as if it is service-connected regarding the mouth area. But, again, some may be eligible, some veterans may be eligible for the VA dental insurance program, which provides a discount, a low-cost insurance plan provided by insurers, but I believe we can do more to move this issue forward.

And I commend you, Madam Chair, for filing your bill as well and I am very supportive of your bill.

Many small studies suggest that regular dental care equates to lower overall health care costs and better health outcomes. One such study published in the American Journal of Preventive Medicine conducted by the University of Pennsylvania professor Dr. Marjorie Jeffcoat, found that regular periodontal checkups lead to reduced hospitalizations and overall medical cost savings and care for chronic conditions such as heart disease, cerebral vascular disease, including stroke and diabetes. And, again, I think there are more chronic diseases that are affected as well.

In light of these results, I worked directly with Dr. Jeffcoat and Dr. Zack Kalarickal, who is a constituent of mine from Wesley Chapel, Florida, we worked to develop the parameters and replicate this type of study at the VA by authorizing the Vet Care Act.

H.R. 2628, my bill, expands on this research to help determine the potential health benefits to veterans and potential cost savings to the VA associated with periodontal care. The Vet Care Act would require the VA to create a 4-year pilot program to provide dental services to 1500 veterans diagnosed with type 2 diabetes. Each treated veteran will receive appropriate periodontal evaluation and treatment on an annual basis during the pilot. Throughout and at the conclusion of the pilot, the overall health of the treated veterans will be recorded.

These results will be compared to veterans who did not receive treatment to determine if providing veterans with dental care equates to fewer complications of chronic ailments. If so, an analysis can be done to determine if the lower costs of the overall health care due to fewer chronic ailments saves the VA enough money to reallocate funds to provide more veterans with dental care. It makes sense, as far as I am concerned. The data recorded and collected by the VA would also be able to be distributed to the research community for further study.

Finally, at the end of the pilot program, the 4-year pilot program, veterans who participate in the program will receive administrative support and information from the VA on how they may continue to obtain dental services and treatments in the community for low to no cost, including information about enrolling in the VA DIP program.

Now, I want to thank the non-profits and the dental associations that offer care to our true heroes as well currently.

In this way, we can ensure that we are providing continuity of care for veterans in need of further treatment.

To conclude, if we are able to improve the VA health care system by providing preventive dental services that lead to fewer complications of chronic ailments, it not only shows that we are looking at the long-term outlook of our veterans' health, but it could also prove to be done in a cost-effective manner.

The Vet Care Act is a practical, commonsense way to demonstrate this approach for dental services, replicating already established research in the community.

Again, I thank the chair and I thank the Ranking Member for bringing this bill up for discussion at today's hearing, and I look forward to continuing the conversation further.

Thank you and I yield back, Madam Chair.

[THE PREPARED STATEMENT OF BILIRAKIS APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Bilirakis, and thank you for your work on this important measure, and I am hopeful that we will be able to find a path forward on this very, very important issue. So, thank you for bringing this bill forward.

Congressman Brindisi, you are now recognized for minutes to deliver any comments you may have in support of your bill, H.R. 2972.

OPENING STATEMENT OF ANTHONY BRINDISI

Mr. BRINDISI. Thank you, Chair Brownley and Ranking Member Dunn, for the opportunity to speak today about the importance of

improving VA services tailored to the needs of women veterans. I would also like to thank the Committee for their continued efforts this year to make VA more accessible and equitable for our women veterans, and for Chairwoman Brownley, for your leadership of the new Women Veterans Task Force, which I am proudly a member of.

Women veterans are the fastest-growing demographic in the veteran community. Women comprise nearly 10 percent of the veteran population and that figure is expected to rise to 18 percent over the next 20 years. As a result, the number of women veterans seeking care at the VA will certainly increase and VA needs to be ready. However, 75 percent of women veterans do not use VA health care, and face a number of inequalities in a system that simply hasn't adjusted quickly enough to meet their specific needs. That is why I introduced H.R. 2972, which directs the VA Secretary to improve VA's communications regarding services available to women veterans.

While VA has begun to offer text messaging as a way to connect the Women Veterans Call Center, and I commend VA for doing so, my bill would statutorily require VA to include a text messaging capability at the Women Veterans Call Center.

The Women Veterans Call Center is staffed by female VA employees who can provide and link women veterans to information regarding resources available to them, and requiring text message capabilities at the call center will make it even more accessible.

Additionally, this bill would make navigating VA websites easier by creating a central web page where women veterans can access various information regarding the extensive resources available to them within VA. This page would include the locations of each VA medical center and community-based outpatient center, as well as the name and contact information of each women's health coordinator, and contact information for staff from the Veterans Benefits Administration and the National Cemetery Administration.

This bill would build on efforts by the VA and this Committee to ensure all women veterans are aware of the hard-won resources and benefits available to them, and where to turn if they are struggling. I believe this bill is a positive step forward towards making VA more accessible to women veterans and I urge the Committee to support this legislation.

I want to thank Chairwoman Brownley, and I yield back the balance of my time.

[THE PREPARED STATEMENT OF CONGRESSMAN BRINDISI APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Mr. Brindisi.
[Audio malfunction in the hearing room.]

OPENING STATEMENT OF LAUREN UNDERWOOD

Ms. UNDERWOOD. Thank you, Chairwoman Brownley, for holding today's hearing, and thank you and Dr. Dunn for permitting me to join today's important panel. I appreciate you and Chairman Takano's willingness to focus on and fight for what our women veterans need.

Women veterans face a number of unique needs and challenges, from access to clinically appropriate services at VA facilities to mental health care. We need to act now to address their needs, because the number of women veterans is going to increase dramatically in the next decade.

I am proud to serve both on Chairwoman Brownley's Women Veterans Task Force and on the Servicewomen and Women Veterans Congressional Caucus, founded by my fellow freshman Congresswoman Houlahan.

So I am thrilled that the Committee is moving forward today on my legislation, H.R. 3636, the Caring for Our Women Veterans Act. My bill directs the Secretary of Veterans Affairs to submit an annual report to Congress on gender-specific care available at VA facilities. This includes locations where women veterans can access VA care; the numbers of women's health care centers and women's health providers like OB/GYNs; and recommendations for improving those facilities to better serve women veterans.

The bill will provide an informed and sustainable roadmap to providing high-quality, accessible care for women veterans.

I also want to highlight two critical health care issues for women veterans that I have been working on this year. The first is eliminating co-pays for contraceptives, breast cancer screenings, and other preventative health care services for veterans. Right now, civilians and active duty servicemembers don't have to pay these co-pays, but veterans do. That is unacceptable and we need to fix it.

Chairwoman Brownley has been a leader on this issue and I am looking forward to working with her to close this loophole and eliminate unfair health care costs for our veterans.

Lastly, I am proud to be introducing the ACE Veterans Act today with Congressman Conor Lamb. This bill allows women veterans to get a full year's supply of birth control at a time at the VA. My focus is always on data-driven, evidence-based policymaking, and so this bill builds off research showing that a full year contraception dispensing improves health outcomes for women and saves the VA money.

As this Committee moves forward on legislation to improve health care for women veterans, I am excited to work on these proposals and more.

Thank you again for holding today's hearing and to our witnesses for being here. I yield back.

[Audio malfunction in the hearing room.]

[THE PREPARED STATEMENT OF MS. UNDERWOOD APPEARS IN THE APPENDIX]

MS. BROWNLEY. —this Committee and a health care professional is really invaluable, so we really appreciate you being part of this and moving this important issue forward.

So are there any other Members that would like to deliver any opening statements this morning?

Hearing none, we will move on to two great panels before us today. I thank each of you for joining us today in what I hope to be a fruitful discussion on these 17 bills.

For our first panel, we have Dr. Teresa Boyd, Assistant Deputy Under Secretary for Health for Clinical Operations at the Depart-

ment of Veterans Affairs. Dr. Boyd is accompanied by Dr. Patricia Hayes, Chief Consultant, Office of Women's Health Services.

We are also joined by Dr. David Carroll, Executive Director for the Office of Mental Health and Suicide Prevention at the Department of Veterans Affairs.

I now recognize Dr. Boyd for 5 minutes for her opening comments.

STATEMENT OF TERESA BOYD, DO

Dr. BOYD. Thank you and good morning. Good morning, Ms. Chairman Brownley, Ranking Member Dunn, and Members of the Subcommittee. Thank you for inviting us here today to present our views on numerous bills, including those that address the critical needs of women veterans, as well as other important areas.

I also want to recognize the veterans service organizations represented on the next panel, as I have seen personally how much they contribute to our work on behalf of veterans and how dedicated they are in our common mission to serve veterans.

I do need to thank you for your patience, as the submission of my written testimony was delayed. Because I need to keep this statement brief, I cannot address all 17 bills in my oral statement, but they all touch on important topics. Of course, the written testimony covers all the bills in detail, and we are prepared to field questions on them today.

I would like to take a moment to briefly discuss a bill that is not on today's hearing. H.R. 3495, the Improve Well-Being for Veterans Act would help VA build partnerships with community groups, who can offer direct help to veterans, who are at risk of harming themselves. VA believes this legislation will assist us in reaching the 14 of the 20 veterans dying each day by suicide, who are not under VA care at the time of their death.

It would fulfill a critical legislative component of the administration's multi-faceted program to prevent veteran suicide, and we strongly urge its consideration. We appreciate that so many of the bills today are focused on meeting the special needs of our women veterans. That is a priority of the secretary, and a big focus of attention for VHA.

The VA supports the following bills, at the very least in principle, relating the care of women veterans. Although for some, we do believe there are important technical changes that should be made, or we need to ensure that the initiatives are adequately funded. We support H.R. 2645, which would increase the period that VA is authorized to care for a newborn child. And we also support in principle, H.R. 2752 regarding transportation of those newborns when medically necessary.

For the latter bill, however, there are some significant technical issues that would need to be worked through. H.R. 2798 concerns special retreat programs for women veterans returning from long deployments. VA is enthusiastic about these retreats. We have received very positive feedback from participants who have said they now realize that they are not alone, and that they have learned to trust themselves, and feel that they are important.

The response has been so positive, we would like to expand the scope of the bill for all veterans who are eligible for vet center serv-

ices, as long as we can secure adequate funding to do so. We support H.R. 3798, which aims to further improve veterans' access to contraceptives. Although we do have some technical points to offer on this bill.

There are other bills concerning women veterans on the agenda that we cannot offer our support today for the reasons explained in detail in my written statement, even though we are fully in line with the goals of the sponsors. In some instances, we believe they are duplicative of existing programs or initiatives, or are inconsistent with clinical practice. For example, on the key importance of making sure our clinical spaces are ideally configured for the needs of women veterans, the subject of H.R. 3036, many of the actions called for in that bill are already being undertaken. And for H.R. 2982, which requires a study of barriers that women veterans encounter in securing care from VA, we have in place an array of initiatives that recognize those barriers and aim to remedy them.

Regarding the draft bill that would establish the Office of Women's Health, we believe that the current placement of the Office of Women's Health Services is strategically aligned to interact with all other clinical programs at the national level that provides a conduit for coordination and collaboration where services are similar.

For H.R. 4086, we understand why the Committee wants to get a formal report on issues of concern to women veterans in the context of care with community providers. However, the data points required for the report would require the modification of contracts with community providers, which given the extent of care in the community would be disruptive. We would like to discuss how the Committee could exercise oversight in this area by other means.

H.R. 3867 is focused on an area of intensive nationwide concern for veterans and non-veterans alike. The issue of domestic violence and sexual assault. VA is totally in accord with the goal of coordinating in the fullest way possible all VA services across the board for victims of domestic violence and sexual assault.

There are other provisions, however, that may be duplicative of current programs and require technical changes. VA is very engaged in this issue, and we would welcome further discussion with the Committee. There are other bills on today's agenda that concern issues not directly tied to the special needs of women veterans, but which also touch on critical subjects. We support H.R. 1527, which would allow VA to pay for long-term care in what are known as our medical foster homes. This option is something we are enthusiastic about, as it will help reduce a barrier to the use of these homes.

For some veterans, a more homelike setting has great advantages over traditional nursing home care. We look forward to discussing some of the technical issues identified in our written testimony.

H.R. 2628 concerns dental care for veterans. We support the part of the bill regarding administrative support to those providing dental care to veterans, separate from VA's authority. Although we do have some technical comments. VA does not, however, support Section 3 for several reasons.

We are concerned the bill would create disparities in the overall application of dental eligibility by expanding access to these bene-

fits to veterans in participating locations, but not elsewhere. We also believe the bill is far too prescriptive in terms of its requirements, and that it is unnecessary because the dental literature already strongly supports the cost effectiveness of preventive dental care.

Before I conclude my statement, I know we all want to acknowledge the veterans and servicemembers who were inspired to serve our country in response to the attacks that occurred 18 years ago today on September 11th, 2001. We are eternally grateful to you and all veterans and servicemembers for the many sacrifices you and your families have made in order to preserve our freedom as a Nation.

Thank you, again, for inviting us here today. My colleagues and I are prepared to answer any questions you may have.

[THE PREPARED STATEMENT OF DR. TERESA BOYD APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Dr. Boyd. And I now recognize myself for 5 minutes for questions. And the first question that I wanted to ask is regarding Mr. Rose's bill, 3036. And in your written testimony, I understand with so many bills that you can't address each one in your opening comments today, and I understand that, but I did read your written testimony and I thank you for its thoroughness.

And you noted that the turnover for women's health providers is 20 percent. And during the task force, we have been traveling across the country, and having lots of visits, both myself and staff, making these visits. And we have really learned that the high rate of trauma within the women veteran community that is taking place can cause secondary trauma actually to the health care providers, because they are listening to so many traumatic stories.

And so staffing shortfalls have made it even more challenging for the providers because if there are less providers, they have more tragic stories to hear. And so I wanted to know really what the VA is learning—first, making sure that you are doing exit surveys of these providers who are leaving, and what you are learning from these exit surveys to help inform us in terms of how to hold on to our health care providers, particularly women health care providers and women health care providers who are serving our women veterans.

Dr. BOYD. That is a great question. And I do believe that next week, there will be another hearing with some subject matter experts with regards to our hiring and our work force. I will briefly state a few things and then let Dr. Hayes jump in. One thing that we have started to do, and we don't have enough data yet on it, but is to not wait until the exit—I mean, to continue to go ahead and do that, but let's get in the habit of asking folks, and learning why folks stay. Why our providers stay? What keeps them here?

With regards to burn out and exhaustion, workload, depersonalization, we pick that up more and more specifically now on our all employee survey as well. So in a nutshell, we have some tools that we are trying to connect the dots. But I do want to give Dr. Hayes a little bit of time, because she has specifics about the women's health providers.

Ms. HAYES. Good morning. You have pointed out some really critical issues for us about the overburdened numbers of women's health primary care providers. In fact, we have been doing a deep dive on their burnout and on their retention issues, talking to them, those sort of left having interviews. What we are finding are a number of factors.

One is that the population has grown so fast and we haven't gotten enough help, not enough providers in each site, and that is sort of a topic of a lot of other things. We have been talking about how to build that staff. One of the other factors is that they frequently don't have the appropriate nursing staff. So you can't take care of these women in a clinic without the nursing staff and the other staff, such as social work or pharmacy. So the staffing levels in the packed clinic is one of our targets. And then just the tremendous sense, as you were saying of the complexity of these patients with trauma histories, and also several—usually several physical comorbidities. These are very complex patients and it is too much. We need to reduce the panel sizes.

What we are doing is attacking all of these issues. The undersecretary and principal deputy have charged me with a women's health modernization called an IPT. We have been meeting approximately three times a week since June. We are looking at these in a very deep dive way and coming up with action plans for management that is coming back up to the leadership, we are hoping within the next month or so. So we are going to be informing the field where the problems are, what are the things we know, and try and deal with the issue of hiring more providers. But we will be getting into that a bit more in this hearing, I imagine, because the primary care provider recruitment issue is beyond women's health as well. It is a problem nationally.

Ms. BROWNLEY. Thank you, Dr. Hayes. And this Committee and myself will be very interested to see what your deep dive reveals, and what some of the solutions and policies moving forward are. So I appreciate that. Well, I only have a few seconds left, so I will end my questioning and hopefully can get back to it. And so I will now yield to Dr. Dunn for 5 minutes for questioning.

Mr. DUNN. Thank you, Chairwoman Brownley. This question is for Doctors Boyd and Carroll. Do you have formal views—it is regarding, by the way, the Improve Wellbeing for Veterans Act. That is 3495. Do you have formal views and cost estimates regarding the Improve Act for the VA, and would you—are you able to provide those? Either, both?

Mr. CARROLL. Good morning, sir. Yes, we do. I know we have prepared them. We will make sure that the department gets them to you if you have not received them.

Mr. DUNN. Yes. I appreciate that. Is it fair to say that you are supportive of that Act?

Mr. CARROLL. Yes.

Mr. DUNN. And, Dr. Boyd?

Dr. BOYD. Absolutely. We strongly support it.

Mr. DUNN. Do you think it could be funded out of existing appropriations without impacting the department's internal mental health or suicide prevention programs?

Mr. CARROLL. Yes, a similar proposal was included in the president's fiscal year 2020 appropriations budget. And so the plan was to fund it out of current appropriations without any impact or jeopardy to current programs.

Mr. DUNN. Thank you. You make me feel so much more comfortable. I appreciate that. Dr. Boyd, regarding H.R. 1163, do you know how many prospective hires each year are barred from VA employment due to non-compete agreements with other health care systems or private practices?

Dr. BOYD. I do not have that information.

Mr. DUNN. Is it something that is actually obtainable? I mean, do you think you—do you have a sense of it?

Dr. BOYD. I have anecdotal after being in the field and being a chief of staff. I think it is anecdotal and I am not really—I wouldn't put a lot of credence in it. There will be a hearing next week where there will be the workforce H.R. folks involved, and they may have more, but I doubt at this point that they do.

Mr. DUNN. Yeah. I would be interested to know that. Certainly in my private practice, we saw those non-competes crop up, even when I doctor was going into the VA, which I was sort of surprised that that—but people are people, right?

Do you know, has your office—General Counsel Office reviewed this piece of legislation, 1163, and do they have any concerns regarding the potential legal challenges that could arise as a result of this bill impacting existing non-compete agreements?

Dr. BOYD. Yes, sir. There may be an unintended consequence, especially for Section 2. It's possible that the former employer may actually litigate.

Mr. DUNN. Yes.

Dr. BOYD. And that is not something that we want. And back to your comment, if I just may. Really the VA is not in competition with private sector. And so—

Mr. DUNN. And I perceive that just like you do.

Dr. BOYD. Yes.

Mr. DUNN. But nonetheless, I see these non-compete agreements become stumbling blocks to treatment for veterans and employment of doctors. You have an answer? Your general counsel maybe has an answer.

Dr. BOYD. They do. Well, on that again, I can just go back to my own experience in the field. I come from the private sector. But then within the VA hiring physicians as a chief of staff. And most of the time, it was the former employer did not follow through on that non-compete, and that was just in my experience.

Mr. DUNN. All right. Let's, I guess, since I am picking on Dr. Boyd. Actually, I am enjoying your testimony. I am not picking on you. On 2816, the Hepatitis Testing Enhancement Act, first let me say 100,000 veterans cured of Hepatitis C. Never did I think I would see that in my lifetime. That is such good news. So congratulations. I know you have worked the number down to 25,000. Keep going. How does the VA intend to continue the screening, and the awareness on Hepatitis C?

Dr. BOYD. So it has been a multi-faceted approach. We are down to the more difficult veterans to bring in to test, and to not only test, but if they are positive, to actually treat. We are down to

those that are difficult to find, difficult to locate, maybe some of the homeless veterans as well. And so we continue. It is a multi-faceted, inter-disciplinary approach, not only with the homeless programs but with our primary care, women's—I mean, it is with all of our clinical.

We did send out a letter to all veterans that had not been screened within that cohort. And that letter is an order—

Mr. DUNN. There is 100 percent screening on time of separation from the military, am I correct?

Dr. BOYD. Now, that I am not sure. I would have to find out about that.

Mr. DUNN. I think that is one good way to start the screening. Although, you can get Hepatitis C as a veteran too.

Dr. BOYD. That is correct.

Mr. DUNN. Well, with that, we are out of time. I appreciate your comments.

Dr. BOYD. Sure.

Mr. DUNN. Thank you. And I yield back, Madam Chair.

Ms. BROWNLEY. Thank you, Dr. Dunn. Congressman Rose, you are now recognized for 5 minutes.

Mr. ROSE. Thank you, Madam Chairwoman. I wanted to first off give you all an invitation to just speak to the issue of frequency of deployments, as well as the time between deployments, and any effect that you have seen this have on the post-9/11 female veteran population, and any lessons that we could potentially learn as we as a Nation conduct warfare in years ahead.

Dr. BOYD. So I will pass that off to Dr. Carroll initially to see his input on that, and then of course, Dr. Hayes will have more specifics about the female deployments.

Mr. CARROLL. Thank you for your question, sir. We are very concerned about the impact of deployment on veterans. Male veterans, female veterans, anyone who is in a deployed situation. We know that deployment alone is not necessarily a risk factor. It depends upon what occurs during that deployment, the frequency of deployment. We have put into place special programs for units that we know had particularly difficult deployments. We are working with our partners to create reunion events for them and bring them back together.

We know that the power of peer support and veteran to veteran support is critically important. We are looking for ways to extend that beyond the military life cycle itself, and to the veteran experience, making sure that all providers are aware of the impact of deployment, in making sure the community providers are also educated about the risks that veterans may have if they are seeing a community provider instead of one of ours. Dr. Hayes?

Ms. HAYES. Thank you. I just want to bring up a couple of things, and I am very grateful to the veterans who have actually done a number of works published about this, as well as the Disabled American Veterans within their journey home, working on the issues for women veterans.

I think that there is a sense that for many women, they have had to come home and deal with the family and children issues, sort of postponing some of their own needs as they have dealt with this. And also, that is one issue, and the psychological family needs

it, family therapy, things like that that the vet centers can offer, but women sometimes postpone those needs, and then get a little bit lost to our systems. And some of the other challenges actually really are in the area of employment.

And women have more difficult times getting into the right kind of employment, and the levels of employment for any number of reasons. But these are areas that then are very impactful in their lives and concern us in the transition, and particularly about the issues of self-harm and the risk during the transition time.

Mr. ROSE. And then did you have anything else in that regard?

Dr. BOYD. Not at all. But it struck me when you asked the question, going back to Ms. Chairwoman Brownley's comment, the impact. I mean, it is just—it has kind of connected all the dots to me about the impact on our providers and our staff that meet these women veterans especially, whether at any point of care.

Mr. ROSE. So just lastly, I haven't heard much spoken about, and maybe I might have missed this, but care management programs and particularly efforts to meet patients, or future potential patients' veterans where they are, calls, text messages, knocking on their doors. This is the future of health care and it is particularly important for the veteran population because many of them are not seeking care. And they are certainly not seeking care at the VA, and sometimes we, based off our current systems, don't want them to.

So where do we stand on this and what do you think we should be doing?

Ms. HAYES. I think a really important part of this is the women veteran call center, which actually was set up to do outgoing calls to women veterans who don't use VA services, may not be connected and to inform veterans about eligibility, appointments, cemetery, BVA. And we have touched 1.6 million women through the outgoing call center.

The other part of the call center is obviously all of the incoming calls and we wanted to make sure that calls and texts were available. That is a primary triaging and information service that we find very valuable to women. The other is care management in terms of local care management. And we have expanded the number of women's care managers, particularly in the rural areas, and that is another part of our ongoing effort right now to beef up that program to hire more women's care managers to do exactly what you are talking about: hook up with the veterans when they are in our clinics or in our facilities.

Mr. ROSE. Is there any further improvements you think we should be making to the care management program? Is it adequately resourced right now?

Ms. HAYES. I think the resources are there within VA. I think we need to right size it so that we have the right kinds of services available.

Mr. ROSE. What would that look like?

Ms. HAYES. It means moving people. You know, making sure we have more care managers. It means even more devotion to this hiring of primary care providers, social workers, nurses. It is taking the resources we have and putting a greater focus on the women veteran program within our own system.

Mr. ROSE. Okay. Thank you.

Ms. BROWNLEY. Thank you, Mr. Rose. I now recognize Mr. Barr for 5 minutes.

Mr. BARR. Thank you, Madam Chairwoman. Thanks for holding this hearing. Thank you for our panel for discussing the legislative proposals before us. And first and foremost, let me echo the sentiments of those expressed today. In memory of those who sacrificed for our country, of course, the 3,000 Americans who lost their lives in the attacks in 9/11, also the thousands of servicemen and women who were inspired to defend our country in the aftermath of that great tragedy.

So many of these post-9/11 veterans now deserve and they have earned the support of this Congress and the Department of Veterans Affairs, and we appreciate all of your service in support of those heroes.

Dr. Boyd, let me ask you a little bit about this Long Term Care Veterans Choice Act, which I have been proud to co-sponsor. I want to thank, first of all, my colleague Representative Higgins, for introducing this legislation. And I like this bill because it gives our veterans who need long term care freedom and flexibility. They may not always want to go to a traditional institutional nursing home, and we think of the post-9/11 generation. These are young veterans, and especially if they are disabled, they don't want to go to what they consider a nursing home.

So this is a really good alternative, I think. Allowing those veterans to live in a more intimate setting, like a medical foster home makes sense for the well-being of the veteran and can be facilitated at a fraction of the cost.

And I noted, Dr. Boyd, your comment about the net savings estimate. So it is a win/win. Win for the taxpayer, win for the veteran, and I really think this is a great opportunity.

The Lexington VA in my own district is proud to have a medical foster home program, and a former medical director had this to say about the program. "The decision to leave the privacy and familiarity of your own home to live in a strange and unfamiliar environment is one of life's most difficult to make. Our program gives veterans a palatable middle option. Veterans live in the warmth and comfort of a medical foster home of their choice. And this is an encouraging option for our younger veterans injured in Iraq and Afghanistan who are too disabled to live alone, but they are too young to live in a nursing home.

Dr. Boyd, in your testimony, you state that only 200 of the 1,000 veterans living in MFHs currently would be eligible to be paid for by the VA under this program. Can you explain why that is?

Dr. BOYD. That is taking into account that their priority 1A veterans. But don't let this detour from this at all. We easily have capacity to accommodate up to the 900 average daily per year of veterans that would meet that criteria. This is a, as you said, a win/win. First of all, the quality and respecting the wishes and the preferences of our aging or our needy population. So it goes long in line.

I visited with Ms. Chairman Brownley in a field hearing once where we talked about the choose home initiatives and long term

care, and this coming up. And this is perfect. We strongly support this bill.

Mr. BARR. Thank you. And I noted your technical suggestions as well. You mentioned the one year timeline that the bill gives you to get all the contracts in place. Would this work like the MISSION Act's community care network? Opt in is region 2 in my area. They are going to take over for Tri-West, for example. Would they get the contract for Lexington—for the Lexington area if they are already operating in our region for community care? How will that work?

Dr. BOYD. So the medical foster home is a separate entity. I am not aware of this being part of our CCN, our community care.

Mr. BARR. Community care. Okay.

Dr. BOYD. No, these are within the community.

Mr. BARR. Okay.

Dr. BOYD. Yes.

Mr. BARR. So it would not—

Dr. BOYD. Not to use it with community—

Mr. BARR. Part of the VA, not in the community care network.

Dr. BOYD. That's correct.

Mr. BARR. Okay. MST really quickly. Can any of you all think of potential barriers to care that exist for MST survivors seeking care? And I want to ask that question in the context of the MISSION Act. Of course, eligibility criteria is whether or not it is in the veteran's best medical interest to qualify to seek care in the community.

If an MST survivor were more comfortable with a provider in the community than at the VA, how would they interact with the community care criteria?

Mr. CARROLL. We screen all veterans for military sexual trauma that come into VA care. So it is a priority of focus for us. In terms of— and they can receive care at VA at no cost, and we make sure that staff can refer people to our military sexual trauma coordinators across our facilities. And we would work with—if they are more comfortable in the community, we would want them to go to the most appropriate resource to take care of them.

Mr. BARR. Well, I appreciate that. I think the VA is improving rapidly in addressing MST. And I know there is legislation here today that we are considering that addresses that as well for the VA. But a number of my, especially female veterans who I represent, are very interested in accessing community care for that specific issue. So we appreciate that, and my time has expired, and I yield back.

Ms. BROWNLEY. Thank you, Mr. Barr. And I just want to say I concur with your support on Mr. Higgins' bill. I think it is a great bill and hopefully we can move that forward.

So, Mr. Cisneros, you are now recognized for 5 minutes.

Mr. CISNEROS. Thank you, Madam Chair. Thank you, everyone on the panel, for being here today. I want to address a couple things. Dr. Boyd, it has already been said, I think, like over 75 percent of women don't use the VA. It takes them almost three years before they are connected to VA, if they do. I mean, do you acknowledge that that is true?

Dr. BOYD. I would defer that overall to Dr. Hayes from her expertise.

Ms. HAYES. Yes, those are accurate statistics. There is a delay in seeking care. And what I would say, though, is we have gone up from—where only 11 percent of women used our care when I was first working on this, and now we are up to 25 percent, but we are still way below the percentage of men who use VA.

Mr. CISNEROS. Correct. We still have a long way to go.

Ms. HAYES. Right.

Mr. CISNEROS. I mean, it is good that there is improvement, but still a long way to go. We will acknowledge that. But, you know, on bills like 2982, where you oppose some research being done to find what are the barriers for women using VA care, and also in Section 4 of 3867. The VA doesn't—thinks that a task force that would help women expand—who will find out way expanding services are available to veterans at risk of pertaining to domestic violence, why that is necessary.

I mean, you both reference, or you reference in your opening statement that both with the one in 3867 that there was a study done or a task force created back in 2012 and 2013, and this doesn't need to be done again. And also in 2982, you talk about a study that was done in 2015, took down the barriers to find out what are the barriers that keep women from seeking care.

So if these studies have already been done, obviously, I mean, we both acknowledge, or everyone acknowledges that more needs to be done. Why would we not seek more data, more information? Why would we not want to do a task force that would provide us with the information to find out how women could find out more information, or really to seek in regard to domestic violence? Why won't the VA acknowledge that we need to find more data, and to do these studies, and to do these task force?

Dr. BOYD. Well, I will start with this. With regards to the Violence Against Women Veterans Act that you referenced; I will pass that off to Dr. Carroll in just a bit. But we have, and thanking Congress for the 17 million back in fiscal year 2018 and 2019, we have a very, very strong assistance program for the intimate partner violence assistance program.

We would suggest that that be the lead to take this forward. We already have that in place, and I would like—if it is okay, I would like Dr. Carroll just to give a little snippet about that as well.

Mr. CARROLL. It is an important area, and we know that intimate partner violence is also a risk factor for suicide, and so those two things, and being a woman, those—the combination of factors is a great concern for us. With the help of Congress, as Dr. Boyd mentioned, we did stand up the intimate partner violence assistance program. There is a point of contact at every facility.

We know that based upon evidence that if providers ask about this and veterans feel comfortable talking about it with their provider, that there is a significant chance, a significantly greater chance that they are going to get out of a dangerous situation and take action against that. And so I think we have many things in place already. We are very happy to move forward with it and to learn more from our experience, and to learn from women veterans as they participate in that.

Mr. CISNEROS. Your last task force was six years ago. There are still, obviously, barriers for women to seek out these services. Don't you think it is time to update and to kind of maybe get a new task force together to find out what can we do more to increase these numbers?

Ms. HAYES. If I could, we are sort of bifurcating two different topics. One is about domestic violence, interpersonal violence, and sexual assault. The other part is the survey that you have recommended. We do, again. Now, I want to show you. This is the 2015 survey. It is no small report. It didn't—we took this. We have made recommendations. We have initiated actions. We have those actions moving forward. We have them going on. In addition, we have continued to talk to veterans in a very critical way through something that is called the veteran experience journey.

We have been working individually with veterans in various parts of the country to have them describe what they need right now today, and those experiences are being acted on. So we have pain points for veterans, like getting into the system, finding out about their benefits, getting better relationships with their providers. Things that we would survey, but a survey just gives the answers across the country. It doesn't get us to the action.

We have gone more directly to veterans right now in real time, and then we have design factors that are making them happen. So we can explain more to you about what that is, but frankly, the amount of money that it takes to do a study like this, I have a sense that we are going to find the same answers that we know about right now from the veterans. They have difficulty with information, how to access, distance, understanding the MISSION Act, all of these things that we can work on today.

Mr. CISNEROS. Yeah. Well, my time has expired, and the size of the report doesn't really suggest that it is better, but maybe we need to start asking different questions so we can get these numbers up. We need to figure out how we can get women to start using the VA benefits and to really seek treatment at the VA that they are entitled to. And I am glad that you are up to 25 percent now, but that is still way below where it needs to be.

So thank you very much for your time.

Ms. BROWNLEY. Thank you, Mr. Cisneros.

Mr. Levin, you are just under the wire. You are now recognized for 5 minutes.

Mr. LEVIN. Thank you, Chair Brownley.

As a member of the Women Veterans Task Force I appreciate you holding this hearing on a number of bills addressing the women veterans' health care needs. It is critical that we tailor VA services to women veterans rather than asking them to just adjust to a male-centric system.

One of the ways we can do this is by training our providers at the VA and those we partner with in the community to better understand the unique needs of women veterans.

I want to thank my colleague, Mr. Rose, for introducing the Breaking Barriers for Women Veterans Act to work towards this important goal.

Dr. Boyd, I would like to ask you about your testimony on this bill. You mentioned that some clinics do not treat enough women

to justify a full-time women's health care provider and, instead, train existing providers to treat both men and women.

Who trains these providers and how does the training specifically address the needs of women veterans?

Dr. BOYD. Well, I will pass that on to Dr. Hayes. She can give you a much more fluid answer. We're very confident in that training. So, Dr. Hayes.

Dr. HAYES. We have an extensive training process. The basis, it starts with a women self-mini residency. The providers go for a week. They train with what is called standardized patients to do pelvic exams. They also learn about deployment issues, chronic pain, and they learn about contraception and abnormal pregnancies, everything that they need to have their skills updated on.

This year we trained over 700. We have trained over—it is our own staff that trains, and some of us have trained the trainer model, but it is our own highly proficient women's health providers that do the training.

Mr. LEVIN. Thank you, Dr. Hayes.

Dr. Boyd, you also stated that the \$1 million increase for the women veteran's health care mini residency program would be unnecessary, but also stated that past mini residencies have had waiting lists because demand exceeds capacity.

If this is the case, can you explain why the VA does not support a funding increase?

Dr. HAYES. If I may, this is a technical issue. In the bill we were unclear whether this \$1 million—first of all, whether that is a ceiling and would actually crimp our style. We have actually spent about \$1 million right now.

It is the staff capacity to go on and do more training that has left us with this problem of having people still on the waiting list. We have done a number of initiatives to work on that. One is our rural health initiative. We have started a new team and have people go out to the rural sites where our greatest need is and train them on site. So that is one of the things that we are doing.

But we have just sort of reached the max of what we can do right now, and that is why we have waiting lists. We could expand it. We think the VA has within its resources to do this. It is always great to get additional appropriations, but we were concerned that you not limit us to \$1 million—

Dr. BOYD. Right.

Mr. LEVIN. Okay.

Dr. HAYES [continued].—because we are already spending at that level.

Mr. LEVIN. So it sounds like there—

Dr. BOYD. That is right.

Mr. LEVIN [continued].—is an opportunity for some collaboration between yourselves and—

Dr. BOYD. That is correct.

Mr. LEVIN [continued].—staff to work out that language to clarify.

Dr. HAYES. I would welcome that. Thank you.

Mr. LEVIN. That is good.

Dr. BOYD. Uh-huh.

Mr. LEVIN. Dr. Boyd, I am glad also that another one of the bills we are reviewing today, the VA Hiring Enhancement Act, would provide additional tools to recruit staff.

I hear from many veterans in my district in Southern California that understaffing affects their ability to receive health care in a timely manner. And as you noted in your testimony, the provision allowing VA to recruit physicians before they complete their residencies only applies to those that enter a specialty field.

Could you explain why this authority is important in the recruitment of both primary and specialty care providers?

Dr. BOYD. So a couple of things. In addition to the hiring authority that we have, we can offer a job, if we have a slot available, to a training resident within any facility, within my facility, say. But they have to meet the requirements by the time of employment.

And that is part of what we want to do. We want to hire the ones that we train. They are there because they like the community. They are invested. And just to be clear as well, we have been afforded other hiring authorities and opportunities from congress as well. The education debt reduction is huge. That has been a huge success for us, as well as our retention and our incentives in relocation.

So we can hire ahead of time and that is the best thing to do. If you see a good candidate who is training, we want to hire them. So we already had that authority. We don't think that we—that, in fact, would be a duplicative authority for us.

And next week, I don't know if you were here earlier, but next week there will be a hearing and there will be specialists in that workforce area and HR area that we have been consulting with.

Mr. LEVIN. Thank you.

Dr. BOYD. You are welcome.

Mr. LEVIN. And I am out of time, but I want to again commend the chair for her great work on the women veteran's task force, and all of my colleagues on both sides of the aisle for all their excellent work in service to our veterans.

Thank you very much.

Ms. BROWNLEY. Thank you, Mr. Levin. And I don't see Mr. Steube. He was here earlier. And so I will just say before I excuse the panel that, Dr. Boyd, thank you for a pretty comprehensive written statement. I think that you have made some valid observations with some of these bills. There are some places where we may not agree completely, but I hope that over time we can work through these things and to see these bills through and sent to the president's desk for signature. So we will look forward to that work ahead of us.

And having said that, thank you for being here. And we will excuse you and we will move onto our second panel.

Dr. BOYD. Thank you very much.

[Pause]

Ms. BROWNLEY. Welcome to our second panel. Thank you for being here. We have Mr. Jeremy Butler, Chief Executive Officer for Iraq and Afghanistan Veterans of America. Next, we have Ms. Joy Ilem, National Legislative Director of Disabled American Veterans, and finally we are also joined by Mr. Roscoe Butler, Associate Leg-

islative Director for Paralyzed Veterans of America. Thank you, again, for being here.

And I now recognize Mr. Butler for 5 minutes.

STATEMENT OF JEREMY BUTLER

Mr. JEREMY BUTLER. Thank you, ma'am.

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee on behalf of IAVA, thank you for the opportunity to share our views on the pending legislation today.

I would like to take a moment to say that I also appreciate the opportunity to testify today on the anniversary of the September 11th attacks. It was obviously a tragic day in our country's history, but it was also a day that inspired many of IAVA's members to join the military. And it is an honor to be here with you all to work together to ensure that we are getting them the best care that our veterans deserve.

Support and recognition of women veterans is an incredibly part of IAVA's work. And as such, it is included in our 2019 big 6 priorities. We launched our groundbreaking, She Who Borne the Battle campaign in 2017, focused on recognizing the service of women veterans and closing gaps in care provided by VA.

IAVA chose to lead on this issue not only because it is important to the nearly 20 percent of our members who are women, but because it is important to our entire membership, and it will help ensure the future of America's health care and national security.

Two years ago IAVA worked with congressional allies to introduce the bipartisan Deborah Sampson Act in the House and the Senate. It called on the VA to modernize facilities to fit the needs of a changing veteran population. Increased newborn care, established new legal services for women veterans, eliminate barriers faced by women seeking care, and increased data tracking and reporting to ensure that women veterans get care on par with their male counterparts.

The Deborah Sampson Act was not passed last session, but IAVA recognized that some progress was made in support of women veterans with key provisions of that legislation passed or funded. With much more still to be done, though, IAVA strongly supports passage of all of the provisions of the Deborah Sampson Act. Many have been introduced by members of this Subcommittee and across congress, and IAVA emphatically supports the 6 Deborah Sampson Act bills being considered today: H.R. 2645; 2681; 2798; 2972; 3036; and 3636.

IAVA also supports the VA Newborn Emergency Treatment Act. Coupled with provisions in the Deborah Sampson Act, this will finally allow the VA to adequately care for veteran mothers and their babies.

To design precise policy solutions, we also need robust data collecting, sharing and analysis to know the extent to which women veterans are underserved. IAVA strongly supports 3 bills to address these shortcomings: The Improving Oversight of Women Veterans Care Act; The Women's Veteran Health Care Accountability Act; and Improving Benefits for Underserved Veterans Act.

For women veterans who choose to seek care at VA, finding quality providers who understand their needs can be difficult. Not sur-

prisingly, women veterans are more likely than their male counterparts to seek care in the community, meaning they are often seen by private care providers that may not understand military service and its health impacts.

Our 2019 member survey found that while 70 percent of respondents felt that VA clinicians understood the medical needs of veterans, only 44 percent felt that non-VA clinicians understood them. For these reasons IAVA supports the Women Veterans Equal Access to Quality Care Act and the draft legislation to establish the VA Office of Women's Health.

Since 2001 the number of women using VA services has tripled. As more military women make the transition to civilian life, it is paramount that DoD and VA are ready to support them. That includes ensuring proper reproductive care for women veterans and their spouses. Currently, women veterans do not have the same access to contraceptives as their civilian counterparts. That is unacceptable and it is why IAVA supports the Equal Access to Contraception for Veterans Act.

Ensuring that the VA is able to accommodate the millions of veterans who use it for access to medical care and benefits, it is paramount to ensuring the lasting success and health of the veteran population. About 48 percent of all veterans and about 55 percent of post-9/11 veterans are enrolled in VA care. Among our survey respondents, 81 percent are enrolled in VA health care, and the vast majority have sought care from VA in the last year.

The VA has made incredible strides in modernizing its operating systems, but VA also needs robust modern hiring practices in order to compete for talent to fill their overwhelming number of vacancies. To this end, IAVA supports the VA Hiring Enhancement Act.

Members of the Subcommittee, thank you for your commitment to ensuring women veterans receive care that is on par with their male counterparts. And thank you for the opportunity to share IAVA's views on these issues. I look forward to answering any questions you have.

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

Ms. BROWNLEY. Thank you, Mr. Butler. And I now recognize Ms. Ilem for 5 minutes.

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee.

DAV appreciates the opportunity to provide testimony on the 17 bills under consideration today. We thank the Subcommittee for its focus on improving VA health care services and programs for our Nation's women veterans.

Ensuring women have equal access to high quality, comprehensive primary care and the specialized services VA offers is a critical legislative priority for DAV. We are pleased that many of the bills that we are providing comments on today reflect recommendations made in DAV's 2018 report, Women Veterans, The Journey Ahead, and comport with DAV Resolution Number 020.

DAV offers our support for H.R. 2645 and H.R. 2752. These bills improve VA's maternity care package and ensure VA can secure appropriate contracts for VA sponsored community care for women veterans and their newborns.

H.R. 2681 requires VA to submit a report on the availability of prosthetic items for women veterans in VA.

While DAV supports the intent of this bill, under DAV Resolution Number 383, we ask the Subcommittee to consider broadening the scope of the study proposed to ensure the intent of the legislation is fully realized.

Specifically, we want to ensure that women veterans have access to high quality prosthetic items and prosthesis that meet their expectations in fit, function and appearance.

DAV is also pleased to support H.R. 2798, a bill that would establish a permanent counseling program in retreat settings. This pilot has shown consistent improvements in participants' ability to better manage PTSD symptoms and maintain learned coping strategies. It also garners high satisfaction rates among women who note peer interaction and networking is especially helpful for long-term recovery from post-deployment mental health challenges that many women veterans face.

DAV supports H.R. 2972, 2982 and H.R. 3036, bills which focus on improving web-based resources and outreach to women veterans, information about availability of women's health services throughout the VA system, correcting environment of care and staffing deficiencies for women's health, and eliminating barriers to care.

H.R. 3224 seeks to ensure women veterans have access to comprehensive gender specific care in all VA facilities, and calls for a study on using extended care hours to better serve veteran patients.

While DAV supports what we believe to be the overall intent of this bill, we do ask that the definition of gender specific services be added to the bill prior to its advancement. In our formal statement, we express concern that without that definition there could be an expectation that services such as obstetrics and newborn care, which are generally provided in the community, would be required in VA facilities.

H.R. 3636 and H.R. 4096 call for comprehensive reports that include data on the women veteran population using VA, models of care, access to care in the community, capital investment planning, environment of care standards, and staffing levels and provider training in women's health.

DAV believes the collection and summary of this data in one report can be helpful for future planning to better meet the needs of this growing population, and we are happy to provide our support for these bills as well.

DAV also supports H.R. 3798, a bill that would eliminate co-payments for contraceptive items and medication in accordance with DAV Resolution Number 365.

H.R. 3867 seeks to create a national task force to integrate VA programs with existing community resources to better serve veterans who have experienced sexual assault and domestic violence. DAV does not have a specific resolution calling for such a task force

or plan. However, we acknowledge the impact that these issues have on many veterans, and have no objection to a passage of this bill.

The final draft bill, women veterans bill being considered today would establish an office of women's health within the VA. This measure would provide the director of the office control over all aspects of women veterans' health care, including distribution of resources. DAV believes this change is warranted and necessary for VA to address many long-standing issues and the enhancement of the provision of care for women veterans using VA and, therefore, supports the bill's passage.

Finally, DAV supports the remaining bills on the agenda mentioned here today: H.R. 1163, the VA Hiring Enhancement Act; H.R. 1527, the Long-Term Care Veterans Choice Act; H.R. 2628, the Vets Care Center Act; and 2816, the Vietnam Era Veterans Hepatitis-C Enhancement Act.

Chairman Brownley, that completes my testimony and I am happy to answer any questions the Subcommittee may have.

[THE PREPARED STATEMENT OF JOY ILEM APPEARS IN THE APPENDIX]

Ms. BROWNLEY. Thank you, Ms. Ilem.
And I now recognize Mr. Butler for 5 minutes.

STATEMENT OF ROSCOE BUTLER

Mr. ROSCOE BUTLER. Thank you, Chairwoman Brownley.

Ms. BROWNLEY. Mr. Roscoe Butler.

[Laughter]

Mr. ROSCOE BUTLER. Thank you, Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee.

Paralyzed Veterans of America would like to thank you for the opportunity to submit our views on the important legislation pending before the Committee.

The bills being reviewed today address a number of challenges veterans are facing and will provide vital assistance to help them overcome the pain and suffering from domestic violence while improving oversight of women veterans' health care and breaking down barriers for women veterans.

For the sake of time, and since you have my full written statement, I would only discuss a few of the bills.

H.R. 1163. PVA encourages many efforts to bolster staffing levels at VA facilities, particularly within the spinal cord injury system of care which historically, data shows, is one of the most difficult areas to recruit and retain physicians and nursing staff.

We strongly support H.R. 1163, the VA Hiring Enhancement Act which seeks to release physicians from non-compete agreements for the purpose of serving at VA. Removing these barriers would help encourage more of the best and brightest doctors and nurse practitioners coming out of medical school to pursue a career in the VA.

H.R. 2982. PVA also supports H.R. 2982, which directs the Secretary of Veterans Affairs to conduct a study of the barriers for women veterans to health care from the Department of Veterans Affairs. A major concern for PVA members is the accessibility of facilities.

Here are a few recent examples of the barriers PVA members have experienced:

Women veterans having to sit in their wheelchairs outside a Model 3 women veterans' clinic because the facility did not have a system in place to alert staff that someone was waiting to gain access into the clinic;

Poorly designed facilities that limit VA's ability to provide medical care to people with severe or catastrophic disabilities and not having the appropriate diagnostic equipment on site to conduct mammography examinations on spinal cord injury women veterans.

Identifying these and other kinds of barriers that women veterans face is an important first step toward improving the care they receive from VA.

H.R. 3224. Without additional clarification, PVA cannot support H.R. 3224 as written. We are concerned that H.R. 3224 does not define the type of gender specific services VA is required to provide. VHA Directive 1330.01(02), Health Care Services for Women Veterans break down gender specific care into several categories: Primary care and specialty care. Paragraph j provides a list of gender specific specialty services that must be available in-house to the greatest extent possible.

Unless additional clarification is provided, VA could interpret Congress's intent with this legislation as a requirement to offer gender specific services in each VA medical center or community based outpatient clinic. There are a number of gender specific specialty services listed in VA's directive that VA medical centers and community based outpatient clinics are not capable of providing, particularly, when it comes to maternity and newborn care.

In order to improve the bill and earn our support, this legislation would have to include language clearly defining the kind of gender specific services VA would be required to provide.

Again, PVA appreciates this opportunity to express our views on some of the many important pieces of legislation being examined today, and I am available to answer any questions.

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

Ms. BROWNLEY. Thank you, Mr. Butler. And I want to thank all of the witnesses today for your testimony, and even more importantly thank you for your engagement on all of these very important bills.

So I will now recognize myself for 5 minutes for questioning.

And the first thing, the first question I wanted to ask really is to Ms. Ilem since you referenced this around my bill, the Office of Women's Health.

So, you know, what I am trying to get at here, basically with a bill, is, you know, when we are looking for equity and parity in terms of health services to women, you know, one quick thing one would look at is if women veterans make up 10 percent of the veteran population and then you look at the health care budget, roughly you should see, you know, 10 percent of the resources being spent on women's health. I mean, that makes sense.

Medical directors across the country have a lot of flexibility and authority in terms of how those resources are spent. And in some cases, they may spend way beyond 10 percent in their facility. In other cases, they won't.

So, you know, the intent here is to try to provide some accountability and some oversight with regards to how resources are being spent because reality, at the end of the day all of these issues that we are raising comes down to money to be able to provide the services, the staffing that we need to properly address veterans' needs, and in this case women veterans' needs.

So do you have any other ideas of how we go about that? Do you think this is headed in the—you mentioned that it was headed in the right direction, and I appreciate that, or if you had any other sort of ideas?

Ms. ILEM. I think this proposal would be key to really addressing what the congressional task force of women veterans is really seeking to do, which is to take care of these long-standing issues that have been around for some time. I mean, I can just remember testifying on these same, many of these same issues for, you know, more than a decade now.

I think the women's health services program office in VA has the direction, has the data, has much of what they need. They just need to be able to execute it. And I don't see that they really have that authority at the level of where that office is now.

I know in VA's testimony they indicate that, you know, they feel it is positioned appropriately for them to carry out, but we would respectfully disagree. I think this will be key. They have got a plan. They just need to execute it. And they have the support of the leadership in the secretary in VA to really address these problems and take care of the staffing issues, the deficiencies, the cultural issues that they want to address. They have noted all of these things and they have a provision of services that they want to provide.

So I hope that this will be—this bill will be considered and move forward because I see it is key in overall work that you and the Committee and the Subcommittee are trying to do.

Ms. BROWNLEY. Great. Thank you very much.

Do the Mr. Butlers have any comments?

[Laughter]

Mr. JEREMY BUTLER. I don't have anything to add.

Ms. BROWNLEY. Okay. Very good.

You know, and this question is really to anyone and all of you on the panel. You know, three of today's bills address improving reproductive health care access for women veterans. Can you add any additional services that the VA should be providing that would improve reproductive health for women?

Mr. JEREMY BUTLER. I am happy to jump in.

Yeah. I think a number of important issues are discussed in the legislation that is being discussed today. But beyond that, one of the recommendations that we have that IAVA has in our policy agenda is around expanding access to and funding for in vitro fertilization. I think IVF is another one of those areas where you have a disconnect between services available to active duty servicemembers and then what is available to veterans.

And this is an especially important question for our membership because we do have a younger cohort, many of whom have deferred parenthood perhaps until their time in service was over because those demands in service were so great. And so increasing these accesses to things around fertility and childcare is very important to our membership.

Ms. BROWNLEY. Thank you.

Mr. Butler.

Mr. ROSCOE BUTLER. I don't have anything additional to add, but I would like to bring to your attention the issue of mammography exams for women veterans in wheelchairs.

VA facilities, most VA facilities, while they may have a mammography machine to do the exam, they don't have the appropriate equipment. So most of the time women have to sit in their wheelchairs. If they are a large woman, it is difficult to raise.

There are certain equipment that they can purchase that will make it much easier for them to do their exams. And if they complete the exam without the woman getting out of the wheelchair, it is not going to be the appropriate type of examination that really should be done.

So I would ask that they really look at that and expand upon the type of equipment that they purchase and procure for women particularly who are in wheelchairs.

Thank you. Thank you for adding that and bringing that up. And I will say that you have an extraordinary representative who came to my office, a woman in a wheelchair talking about this issue, and she was quite persuasive.

So thank you very, very much.

And with that I recognize Dr. Dunn for 5 minutes.

Mr. DUNN. Thank you, Chairwoman Brownley.

I want to start with saying that we fully expect that some of the items that are coming through in these bills suggest like they have cost implications to the VA. And what we would like to do is secure, you know, the VSS, all of them, you being lead dogs as it were on the VSS, to work with us here in congress and with the VA specifically, that what we can do in our jurisdictions to get offsets for some of these costs because hopefully we can find some of the money right there.

You know, so please address that.

Mr. JEREMY BUTLER. I think we often caution about this discussion where the pay come from other veteran benefits. I don't necessarily have the answer as to where the money should come from, but what I can say is our membership is adamant that it should not come by reducing other benefits that go to veterans. We fought this battle just last year I think it was around the GI Bill, when there was an attempt to maybe make some cuts on the GI Bill payments to have money go to another veterans' benefit.

We always want to ensure that our veterans are getting the care that they deserve and the support they deserve and the benefits that they deserve, but we should not be cannibalizing one program to fund another one, especially when both of those programs are equally necessary and important.

Mr. ROSCOE BUTLER. PVA echoes Jeremy's concerns and would not support taking away funding from one program to support an-

other program. We have to find a common way to support all of the bills being presented today. And we, the PVA, supported all of the bills today with one exception.

So whatever the common ground that we can reach, but we echo Jeremy's concern.

Ms. ILEM. I think my colleagues have addressed our same concerns; that certainly we want to be able to work with the—with you and your staff on this agenda because we think it is so critical and so important.

But, you know, we do have those considerations in mind when it comes to taking away from one veteran to serve another veteran. And we want to make sure that services that are being provided to women veterans have—we have equal access to care which has been a problem—

Mr. DUNN. My thought was actually more about programs that are either no longer viable or they are replaced with newer programs, or there are some programs that overfunded. There is extra money sitting in some parts of the VA. And I think we can all identify efficiencies in offices. Certainly, I identified a lot of efficiencies in my offices over time.

Next question, Ms. Ilem, I read your testimony. I liked it. But there was one jarring, I kind of kept coming back to it. You said you thought that the—well, let me get the paragraph here. “We believe the VA health has different responsibilities than the health care industry in general.”

I have worked in both VA and, you know, civilian health care and active duty health care. What do you think is different about it? I mean, other than you have a unique population.

Ms. ILEM. Well, definitely I think in that reference for the—that was on Bill 1163 we were talking about the responsibility of VA to train, the training responsibility that they have had for training our Nation's clinicians. So—

Mr. DUNN. So training, you think that is the unique part of it, that they have to do training?

Ms. ILEM. Well, not just the training of clinicians, but that has been one of their major functions within the department.

Mr. DUNN. I remember.

[Laughter]

Ms. ILEM. Yes. You know, so many clinicians are trained through VA and they do have some additional responsibilities that, you know, we don't see so much in the general sector, and a very specialized mission and some very specialized programs.

So I think we were just trying to make the point that VA is a unique health care system in itself, you know.

Mr. DUNN. All right. So I thought I traveled pretty fluidly between the different programs and, you know, it is about taking care of people. Certainly, you know, I like taking care of military people especially, but that is why I did it for a long time. But I just—it kind of kept coming back like what is different, what is different. All right.

So the last thing is I want to ask you to help, again, as advocates for services in the VA for the Hepatitis-C program. We talked earlier with the first panel. You know, we have cured 100,000 veterans of Hepatitis-C. That is amazing. That is just amazing.

When I was practicing 20 percent of surgeons would terminate their career because they caught Hepatitis from a patient during surgery, you know, accidentally, needle pricks.

So this is a big, big deal. It is close to my heart. I want you to get the word out to the veterans.

Thank you very much.

Ms. BROWNLEY. Thank you, Dr. Dunn.

Mr. Lamb, you are recognized for 5 minutes.

Mr. LAMB. Thank you, Madam Chairwoman, and thank you for holding this important hearing and advancing all these bills. We have a lot of work to do in this area, and I think those of us who served in uniform more recently know that there is just absolutely no excuse for any veteran, man or woman, feeling that when they leave the service the VA services are not for them.

So I think we are starting to make a big impact on that now. But one of my concerns that we see across problems faced by the VA is difficulty in connecting with the people who we are intending these new services and reforms to reach.

And so I am sure you have addressed it a little bit already. I apologize for coming in late. But I just wanted to throw it open to any of the three of you about whether you can advise us on what we can do to better reach into the wider veteran population that is not enrolled in VA services or that are enrolled once and didn't like the experience and has never used it again, to advertise some of these new things that we are passing, to invite people back in.

And I guess kind of a subset of that, if you have had any experience with it already is what are the implications for community care. Obviously, community care has been expanded. A lot of new services and new patients will be eligible for all of that. Are you seeing excitement or interest in community care among women veterans, particularly those maybe who haven't used the VA much before? Anyone who can weigh in on that.

Ms. ISLAM. Sure. I would love to take the opportunity to talk about that.

While we support community care and we want women veterans who feel they need access to care in the community or may need because VA can't provide certain services, obviously we want that to happen. We think it is really critical, though, during this implementation phase of the MISSION Act that VA is really instrumental in being the coordinator of that care as those women veterans go to the community.

As you heard from the first panel today, so many women veterans have complex—the women who are being seen in VA have complex medical health histories and challenges. Their veteran experience is really important and VA can help train those providers that are going to be in their network to make sure if they are seeing a woman veteran, here are the things that we know about this women veteran population and to be sensitive about and the gender sensitivities and cultural sensitivities around military sexual trauma especially.

So I think that is going to be critical, and for VA to be a real partner because we know some women veterans have had a really negative experience in VA. But at VA we do want them to reach

out. So many changes have been made. Just over the past, you know, 10 years we have seen incredible changes.

I am a woman veteran. I use VA. I have for 20 plus years. I have seen those changes firsthand and I think they would really benefit for coming to VA, especially those who have service connected disabilities, obviously those who have catastrophic injuries, our OEF/OIF population, so key. You know, they have had several deployments and, you know, over time there is really so many benefits in VA with their specialized programs.

So I hope that VA will be able to do some additional outreach to those, come back, try the VA, we are there for you, and improve services.

Mr. LAMB. I think that is an excellent point.

Mr. Butler, did you want to—

Mr. JEREMY BUTLER. Yeah. I was just going to echo Joy's statements about MISSION Act and community care. And then just add maybe around your question on getting word out and everything. You know, I was in a similar case. When I transitioned off of active duty in 2005, I didn't really understand the VA. It wasn't really something that was talked about when you are on active duty. I think once you start to hear about it when you are out of active duty, you generally hear the more negative things rather than the positive things.

So I think as VA care continues to improve and there are more positive stories coming out, I think you're going to have a more understood idea in the veteran community that it is a positive place to go. But then there also just needs to be better interaction, I think, with the non-profit organizations, with community care organizations to understand how to access the VA.

I have been in this business for 4 years now and it still is incredibly complex to me to understand how one accesses the VA to begin with.

Mr. LAMB. No, it is, and that seems to be the most important hurdle. What I always hear, at least, is that once people finally get enrolled and are in and they know that they are in, at least in Western Pennsylvania they are happy. They think the VAs are great. But we have a hard time getting people over that initial obstacle.

So I think that is what we can all work on. And I think your groups play a really important role in that. So please continue to challenge us as to how we can support you to recruit new people and get better information to those that are there.

And with that, Madam Chairwoman, I yield back.

Ms. BROWNLEY. Thank you, Mr. Lamb.

Mr. Barr, you are recognized.

Mr. BARR. Thank you, again, Madam Chairwoman, for holding this hearing and thank you for considering legislation that supports and recognizes our women veterans and newborns and their kids, and looking at ways to eliminate barriers for women veterans to access the VA.

I would note, Chairwoman Brownley, that I was happy to support your bill, H.R. 840, earlier in this congress, the Veterans Access to Child Care Act. One of those barriers is needing to provide

women veterans with childcare so that they can have the time to go seek veterans care.

I would urge you and Chairman Takano to consider the VA Child Care Protection Act, which we offered as a motion to recommit and then we also offered it as an amendment in the last mark up to the Cisneros bill.

And then in July we introduced a separate bill because I think there was some commentary that it needed to be separate from the Cisneros bill, the VA Child Care Protection Act, to make sure that employees of the VA are not a threat to our children, so that that wouldn't be an additional barrier for women veterans seeking access to care.

And just to remind the Committee, we did send a letter on July 19th with 10 republican Members of this Committee to the Chairman asking for a hearing. We have not yet heard a response. I just bring that to your attention, Chairwoman Brownley, because we would like to work with you on that issue.

Mr. Butler, in your testimony you point out that while the VA provides care team support to the medical foster homes, it does not have the authority to pay for the costs of those medical foster homes. As a result, veterans must use personal or other funding sources should they choose this alternative rather than nursing homes.

And I appreciate your association, support and endorsement of the Long Term Care Veterans Choice Act to support more of your members having access to these MFHs.

Can you or any of the other colleagues on the panel describe what funding sources veterans do use to pay for this care and obviously the hardship that that creates?

Mr. JEREMY BUTLER. I can't necessarily speak specifically to that, but what I do know is that financial hardships are one of the main reasons that veterans come to our organization seeking support. And a lot of those financial hardship cases are underpinned by trying to pay for medical care that they need.

We have a rapid response referral program that veterans and family members can reach out and work with social service professionals that are employed by IAVA. And this is one of the most frequent things that they hear about. It is financial hardship, and then when they start to dig into what the cause of the financial hardship, it is paying for medical care.

So that is kind of a high level—

Mr. BARR. Yeah.

Mr. JEREMY BUTLER [continued].—answer to your question. It is not exactly specific.

Mr. BARR. Can you speak to the quality difference or the quality of life differences that veterans may experience, those who live in these medical foster homes versus traditional nursing homes? Any of your members of any organizations can speak to that.

Ms. ILEM. We just have heard that, and I think some members on the Committee today have mentioned, especially for younger veterans who maybe have experienced a TBI, can't live independently, but could really benefit from living in a medical foster home environment versus a long-term perhaps nursing home, one of the community living centers.

So I think it really adds to their dignity, to their quality of life, what they want to achieve even though they have undergone, you know, a serious injury or disability.

So I think the medical foster home is just an excellent program and I really hope that we can make sure there is no disincentive for any service disabled veteran to choose that access or that option.

Mr. ROSCOE BUTLER. And I would just add, it adds to their independence, being able to live outside of a nursing home facility. And then overall, as Ms. Ilem mentioned, their quality of life dramatically improves living in a medical foster home versus being in a—

Mr. BARR. Thank you, Mr. Butler.

Mr. ROSCOE BUTLER [continued].—community nursing home.

Mr. BARR. And, Ms. Ilem, one last question for you. With regard to your testimony on H.R. 3867, the Violence Against Women Veterans Act, I was interested in your testimony that there was a study that women are re-traumatized when they are attempting to obtain care in the VA, and that those occurrences are all too common.

Are we seeing the setup of nationwide community care under MISSION Act in a way that would get women veterans, or men veterans, who are uncomfortable in the VA because of re-trauma, being re-traumatized, are we seeing the MISSION Act give an alternative to those veterans who don't feel comfortable in a VA and want to choose community care to deal with MST?

Ms. ISLAM. Well, VAs recent harassment study, I think, is just really alarming for a lot of us. We know that some women veterans coming to VA reporting, you know, being harassed while seeking care, and that has been a disincentive for them to go. And these are generally probably the ones who most need that care.

So I think here in the community for some women veterans it may be the answer, but I hope that that is a temporary thing. I really hope VA, which they have talked about today, that they are addressing these issues full force, full on. Their culture has to change, making sure that every veteran feels welcome at VA. And obviously no veteran should be harassed, male or female, coming to VA.

And we don't want it to—we don't want that to remain. I mean, we know that is a problem, and I grant it to VA for actually bringing that research forward. And we have been hearing that for some time. And, you know, if that is prohibiting somebody from going, we want them to get care then. That might be something that they could consider in the community.

But we certainly don't want that to just be the only place—

Mr. BARR. Right.

Ms. ISLAM [continued].—they can go. We want it to be fixed within VA.

Mr. BARR. Absolutely.

Thank you. Thank you. And I yield back.

Ms. BROWNLEY. Thank you, Mr. Barr. You can never say I never gave you extra time.

[Laughter]

Ms. BROWNLEY. Mr. Bilirakis, you are recognized for 5 minutes.

Mr. BILIRAKIS. Thank you. Thank you, Madam Chair. I appreciate it very much.

Yeah. My questioning will be regarding H.R. 2628, the Vet Care Act, which I introduced.

The VA has expressed concerns—this is for the entire panel. We will start with, is it—well, whoever wants to go first. The VA has expressed concerns about apparent disparities created in H.R. 2628, the Vet Care Act, pilot programs, eligibility standards.

Given the logic of the VA, it seems to me that every pilot program VA has ever operated could also be viewed as creating disparities in care for veterans. Indeed, this argument could be applied across the board to all valid controlled clinical research done in science and in medicine. There will always be limitations and exclusions.

Considering the current eligibility criteria for dental care in the first place, can you explain why you agree that this pilot program is a reasonable way to take a first step into assessing the specific benefits of preventive dental medicine at VA such as the one in H.R. 2628? Whoever would like to go first, please.

Mr. ROSCOE BUTLER. I will try and address it.

But as we said in our written testimony, oral health has a major impact on their physical health, and gum disease is often associated with diabetes, heart disease and many other serious medical conditions.

So a large number of veterans who receive care from the VA are not getting the appropriate dental care needed, and which could later add to other complications of health complications.

Mr. BILIRAKIS. Thank you.

Anyone else, please?

Ms. ILEM. DAV has been a longtime advocate of dental care for all veterans, being within a comprehensive care package. As we know, anybody who has health insurance, I mean, dental insurance is an important part of that complete package of care. And we have long wanted to make sure that veterans have access to that.

So I think your bill is very reasonable in terms of a start to look at the conditions, as Mr. Butler indicated, that are prevalent in the veteran population and to kind of mirror the study as a first step of really offering that benefit.

Mr. BILIRAKIS. Anyone else?

Mr. JEREMY BUTLER. Just to agree. I never understood the disconnect between dental care and medical care. I think, you know, we all, I think, are in agreement here that it is the whole health that is the important part here and they should be seen as one thing. So we are very much in agreement.

Mr. BILIRAKIS. Thank you very much.

And I want to reemphasize that Dr. Jeffcoat from the University of Pennsylvania, who is the former dean of the dental school there, actually helped me craft this bill. She actually conducted the study and I worked with a dentist in my community as well, Dr. Zack Kalarickal, who is a good friend.

But let me go ahead and ask one more question. The VA has expressed some concerns that the pilot in the vet care program would lead to veteran dissatisfaction if the pilot disqualifies certain vet-

erans who receive examinations for dental care and are deemed to need surgery.

H.R. 2621, however, specifically authorizes the VA to provide administrative support to ensure those veterans can receive the treatment that they may need.

My thought is that the patient is better off than before because they have been alerted to a treatable problem having received a free examination compared to previously which must be seen as a significant benefit to the veteran with diabetes.

To the panel, do you think your members would be dissatisfied with the pilot program outlined in this bill, especially considering the end goal? And we know what the end goal is, and I appreciate the chairwoman working with me on this particular issue because we all want veterans who qualify for health care under the VA ultimately to get dental care.

So whoever would like to go first, please respond to that.

Ms. ISLAM. I think veterans would understand your explanation and, certainly sometimes just even having that first opportunity to really identify, I have a problem and there is an issue here, and hopefully the assistance to, you know, get that care, that they wouldn't be dissatisfied. They may want to make—you know, they would love to be able to have that access to a full treatment.

But I think it is a first good step and it is something. So certainly we would be supportive of that. And I think most veterans would agree with your logic.

Mr. BILIRAKIS. Thank you.

Mr. ROSCOE BUTLER. I agree with Ms. Ilem. And an informed veteran is a happy veteran to the most part. Knowing that they have a condition that they didn't know they had, and then what's the recourse for taking care of that condition then becomes the issue for the veteran if they can't get it in the VA. But not knowing you have a condition is of really not a good thing which could lead to other complications.

Mr. JEREMY BUTLER. Yeah. Agreed. I am still in the Navy Reserves and I have to get a dental checkup from a Navy dentist every couple of years. And it simply is to make sure that you have a proper level of dental care. If they find something wrong with you, the Navy, the Department of Defense isn't going to pay to cover it for you. They alert you that you need to go out and get that taken care of on the private side.

If that is the way we are handling our reservists, then I think veterans would understand that it is the same thing; that you are getting access to a determination that you need some support and then you can go from there. So I think they would be okay with it and understand it.

Mr. BILIRAKIS. Yeah. And under the legislation we authorize, after the pilot program, the caregiver, the dentist will refer them possibly to a non-profit or the insurance program. And that will be very helpful as well. But I think it is dangerous not to get the examination.

So thank you very much, Madam Chair. I appreciate it. I yield back. I guess I am over time. I apologize.

Ms. BROWNLEY. Yes. You, too, can never say—
[Laughter]

Ms. BROWNLEY [continued]. —that you have never had extra time on this Committee.

Well, this concludes our questioning. And, you know, before I close, I wanted to just thank the VA staff for saying through the second panel. That doesn't happen every time when the VA comes to our hearing. So we appreciate that very, very much.

And I just want to conclude with just a few remarks, and to say first that we have—I think this has been a good hearing. I am very excited about these proposed bills. But, first, we have a long way to go until we uphold the promise that we have made to our veterans, and this includes achieving equity for our women veterans.

And, second, the VA must plan ahead for rapid growth of the women's veteran population. And I think many of these bills sort of address that. And the bills discussed today gives VA the tools to identify gaps and opportunities to plan for that growth and allocate resources accordingly.

So, again, before I conclude I just want to reemphasize my hope for this Subcommittee and that we continue to work in a bipartisan manner. I look forward to continuing to work closely with Ranking Member Dunn as we have already done and will continue to do. And bipartisanship in this Committee, that is the only way we are going to get to good results for our veterans.

So I thank all of our witnesses for their expertise and my colleagues for their interest.

And with that, Dr. Dunn, would you like to make any closing comments?

Mr. DUNN. Thank you very much, Chairwoman Brownley. I just want to say thank you as well to both panels. I think, you know, it has been a good exchange. I think you see the interest level in veterans' affairs, you know, throughout the congress and the administration. It is reflected in the budget as well.

So I would—VA continues to be the single largest source of my constituent services' problems, I guess. The people come. They run afoul of the system. So anything we can do to help that system, you know, we are doing it on a one by one basis back home, but you guys could do the whole thing at once. So we appreciate everything that you do up here in helping us with that.

And I agree. Working with Ms. Brownley on a bipartisan basis, we should be able to get something accomplished. In the last session it was the single most productive Committee, I believe, wasn't it? Yeah. The VA Committee was the single most productive bill-wise Committee in the congress, in the last session of congress. Let's see if we can do that.

Thank you.

Ms. BROWNLEY. Hear. Hear.

So with that, all Members will have 5 legislative days to revise and extend their remarks, and include extraneous material.

Without objection, the Subcommittee stands adjourned.

[Whereupon, at 12:05 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Teresa Boyd, DO

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

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

H.R. 1163 VA HIRING ENHANCEMENT ACT

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

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

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

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

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

VA also recommends removing the language regarding an offer for an appointment on a contingent basis, subsection (b)(1)(B)(ii), since VA may currently provide job offers to physicians pending completion of residency training. There are no restrictions in statute or VA policy on making job offers contingent upon completing residency training and meeting other requirements for appointments as physicians within VHA. If this needs to be clarified in statute, VA suggests including the information in a new subsection (h) as follows: Section 7402 of title 38, U.S.C., is amended by adding at the end the following subsection (h): "(h) The Secretary may provide job offers to physicians pending completion of residency training programs and com-

pleting the requirements for appointments under subsection (b) by not later than 2 years after the date of the job offer.”

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

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

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

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

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

H.R. 2628 VET CARE Act of 2019

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

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

We believe the bill should be amended, however, to not limit the provision of administrative support to providers of dental care; we anticipate that in many cases, VA medical support assistants or providers would be offering administrative support directly to Veterans, advising them of the availability of pro bono or other services

from community providers furnishing care independently from VA. We would be happy to work with the Committee to provide the necessary amendments for this purpose. We also recommend a technical amendment to replace the “; and” with a period at the end of subsection (d)(2)(B), as that subparagraph is not followed by a subparagraph (C) and subsection (e), as redesignated, would not logically be connected to or qualify the rest of subsection (d)(2).

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

Section 3 would require VA to carry out a pilot program to provide outpatient dental services and treatment, and related dental appliances, to participating Veterans at no cost to these Veterans. The purpose of the pilot program would be to determine whether there is a correlation between Veterans receiving such services and treatment, and the Veterans suffering fewer complications of chronic ailments, thereby yielding a lower cost of care. To be eligible to participate in the pilot program, a Veteran would have to be: (1) enrolled in VA health care; (2) ineligible for dental care under section 1712; (3) not receiving regular periodontal care; (4) between 40 and 70 years of age; and (5) diagnosed with type 2 diabetes. Eligible Veterans would have to elect to apply for the program, and any eligible Veteran who applies for the pilot program would receive an initial periodontal evaluation, including vertical bitewing radiographs. If an eligible Veteran diagnosed with periodontal disease required surgery, the Veteran would be disqualified from participating in the pilot program. Subsection (c) would require VA to enroll at least 1,500 eligible Veterans for the pilot program, giving preference to Veterans with service-connected disabilities that increases in accordance with the Veterans’ disability ratings in a manner that ensures one-third of eligible Veterans enrolled in the pilot program have been diagnosed with no or mild periodontitis, and two-thirds of eligible Veterans enrolled in the pilot program have been diagnosed with moderate to severe periodontitis. VA would have to begin the pilot program within 180 days of the date of the enactment of this Act and carry out the pilot program for a 4-year period. VA would have to carry out the pilot program in five VA facilities, with one such facility in each of five Veterans Integrated Service Networks (VISN) the Secretary considers appropriate for the pilot program. Each facility would have to serve not more than one-fourth and not fewer than one-sixth of the Veterans enrolled in the pilot program, in approximately even proportions of Veterans categorized under subsection (c). VA would be required to make timely and appropriate periodontal therapy available to Veterans with moderate to severe periodontitis. Each eligible Veteran who elected to receive treatment would receive an annual dental evaluation, during which the periodontal health of the Veteran would be reassessed and recorded for purposes of determining the severity of the Veteran’s periodontitis. VA would have to collect and record data regarding the health of treated Veterans, including events, treatments, and outcomes; these data would have to be made available for analysis by qualified researchers. VA would have to provide standardized instructions to all physicians and dentists who work in facilities selected for the pilot program to ensure consistent evaluation and care for Veterans enrolled in the pilot program. VA would also have to provide each Veteran enrolled in the pilot program with an orientation and information before any care was provided under the pilot program, as well as an exit interview that includes information regarding how such Veterans may obtain dental services and treatment after the pilot program ends. VA would have to notify institutions of higher education that offer degrees in periodontology about the pilot program so that such institutions may engage in similar studies regarding private periodontal care for Veterans. VA would have to submit a report of findings to Congress within 18 months of the conclusion of the pilot program. Finally, VA would be required to administer the pilot program under such regulations as the Secretary would prescribe, including best practices regarding informed consent and study registration.

VA does not support section 3 of the bill. We are concerned the bill would create disparities in the overall application of dental eligibility under section 1712 by expanding access to these benefits to Veterans in participating locations but not elsewhere. We believe this could have the unintended consequence of Veteran dissatisfaction. We have serious concerns about the provision in the bill that would disqualify from treatment a Veteran who has been comprehensively examined and for whom surgery has been deemed necessary. This would be unethical and against VA’s core values and professional standards of care. Dis-enrolling Veterans who have advanced periodontal disease after examination could be a stressor on Veterans who believed VA had their best interests in mind in treating their conditions. Also, as a time-limited program, VA is concerned about how it would manage care authorized near the end of the pilot program, as some Veterans may actually be worse off if they received only a portion of a fuller episode of care.

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

Finally, we believe Section 3 of the bill is unnecessary because the dental literature already strongly supports the cost-effectiveness of preventive dental care. There is a large volume of scientific evidence supporting preventive dental care for individuals with conditions such as Type II diabetes to reduce the morbidity of tooth loss associated with periodontal disease. It is unclear how this proposed pilot program would further advance science and reduce overall health care costs. A controlled, well-defined, and sanctioned research project would be a more appropriate vehicle. The proposed legislation would not provide scientifically rigorous and valid findings because it does not adopt the structure and methodology of a controlled research project. The purpose of the legislation is to “determine” if there is a correlation based on treatment, but we do not believe VA could make such a determination given the parameters of the pilot program in the bill.

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

H.R. 2645 Newborn Care Improvement Act of 2019

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

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

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

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

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

VA provides comprehensive prosthetic and sensory aids and services that support and optimize the health and independence of all Veterans, regardless of gender. VA defines the term “prosthetic” as an item that replaces a missing or defective body part. For women Veterans, specifically, prosthetic items include: post-mastectomy

items; wigs for alopecia; long-acting reversible contraception (e.g., intrauterine devices); maternity support belts items; and vaginal dilators.

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

H.R. 2752 VA Newborn Emergency Treatment Act

H.R. 2752 would expand the scope of benefits for newborn children of women Veterans by authorizing VA to furnish transportation necessary to receive covered health care services. The bill also would allow VA to furnish more than 7 days of health care services to a newborn child and to provide transportation necessary to receive such services, if such care is based on medical necessity, including cases of readmission.

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

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

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

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

VA agrees that providing these retreats is beneficial to women Veterans; however, other Veteran and Servicemember cohorts could also benefit from this treatment modality. While VA appreciates the intent of this bill, we request that the bill language be amended to allow VA the ability to conduct these retreats for all Veteran or Servicemember cohorts eligible for Vet Center services and that appropriate resources be provided through the appropriations process. Examples include those who have experienced military sexual trauma, Veterans and their families, and families that experience the death of a loved one while on active duty. Also, rather than creating a separate biennial report, as would be required by the bill, VA recommends that this bill amend section 7309 to include a report on this program as part of the annual report to Congress on the activities of the Readjustment Counseling Service.

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

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

H.R. 2816 would require VA, not later than 180 days after the date of the enactment of this Act, to carry out a 1-year pilot program to make Hepatitis C testing available to covered Veterans at certain outreach events organized by Veterans Service Organizations (VSO). Covered Veterans would mean a person who served in the active military, naval, or air service between February 28, 1961, and May

7, 1975, and was discharged or released therefrom under conditions other than dishonorable, regardless of whether such person is enrolled in VA health care. VA would have to select five VISNs in which to carry out the pilot program, with two such networks predominantly serving rural areas and three predominantly serving urban areas. If at least 350,000 Veterans were tested for Hepatitis C by the termination of the pilot program, VA would be required to expand the program to all VISNs not later than 1 year after the date on which the pilot program ends. Not later than 180 days after the date on which the pilot program ends, VA would have to submit a report to Congress on the number of covered Veterans tested for Hepatitis C under the pilot program and a list of resources needed to expand the pilot program to all VISNs for the length of time necessary to test all covered Veterans for Hepatitis C. No additional funds would be authorized to carry out the requirements of this Act; VA would have to implement this authority using amounts otherwise authorized to be appropriated to VA for the express purpose of providing Hepatitis C-related care.

VA does not support this bill. Testing Vietnam Era Veterans and other Veterans at risk for chronic infection by the Hepatitis C virus (HCV), as well as Veterans who are not at increased risk but simply wish to be tested, remains a high priority for VA. The most recent HCV testing data for the general U.S. population show that as of 2016, only 14.1 percent of individuals born between 1945 and 1965 had been tested for HCV. By comparison, in 2016, 75.1 percent of Veterans in VA care had been tested for HCV.

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

- The VA laboratory would be using a rapid initial screening test that requires follow-up confirmatory testing for any positive results. There would not be any mechanism for logging, accessioning, and testing blood specimens for follow-up testing.
- Results from confirmatory testing are generally not available for several days. Again, because these individuals are not enrolled in VA care, there would not be a mechanism for contacting the Veteran to provide results.
- VA does not currently have authority to provide individualized follow-up assessments and counseling to individuals who test positive. This could create immediate and serious ethical conflicts for VA clinical staff. For example, if a Veteran who tests positive wants advice on informing his or her spouse, VA clinicians would have very limited (if any) ability to respond in detail.
- Performing the specified test requires oversight by a laboratory possessing a current, valid Clinical Laboratory Improvement Amendments (CLIA) certificate. It is not clear how willing VA laboratory directors would be to perform such testing outside of a VA facility because of legitimate concerns about jeopardizing the laboratory's CLIA certificate.

The automatic trigger provision in section 2(d) raises legal concerns as well. It states that if at least 350,000 Veterans are tested for Hepatitis C by the termination date, the Secretary shall expand the program to all VISNs not later than 1 year after the date on which the pilot program ends. However, this would create an uncertain legal authority for such expansion. By its terms, subsection (c) directs VA to act to expand the program not later than 1 year after the pilot program ends; however, subsection (a) would be VA's only authority to make Hepatitis C testing available to Veterans who were not enrolled in VA health care, and this authority is limited to the 1-year pilot program. Also, subsection (c) clearly provides that the program terminates 1 year after the program begins. Consequently, it does not appear the bill would provide VA an adequate statutory basis to furnish testing to Vet-

erans who were not enrolled in VA health care after completion of the pilot program. This subsection also has technical issues that create further ambiguity, namely its failure to use the term “covered Veteran” and its failure to specify whether the 350,000 Veterans tested must be tested under the pilot program (rather than generally). As of December 31, 2018, VA had screened 78.2 percent of the approximately 2.4 million Vietnam Era Veterans currently in VA health care, and across the system, there are approximately 527,000 Vietnam Era Veterans remaining to be tested.

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

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

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

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

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

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

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

at each VAMC a Web site specific to women Veterans that highlights the services available and provides information for a point of contact at the facility. In addition, VA offers two national Web sites that offer facility location information.

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

H.R. 2982 Women Veterans Health Care Accountability Act

H.R. 2982 would require VA to enter into a contract with a qualified independent entity or organization to conduct a comprehensive study of the barriers to the provision of comprehensive health care by VA encountered by women Veterans. In conducting this study, VA, through the contractor, would have to survey women Veterans who seek or receive care from VA, as well as women Veterans who do not seek or receive such care or services; administer the survey to a representative sample of women Veterans from each VISN; and ensure that the sample of women Veterans surveyed is of sufficient size for the study results to be statistically significant and a larger sample size than the National Survey of Women Veterans in FY 2007–2008. In conducting the study, VA would be required to build on the work of this survey from 2007–2008, as well as the Study of Barriers for Women Veterans to VA Health Care 2015. VA would be required to conduct research on the effects of the following on the women Veterans surveyed in the study: the perceived stigma associated with seeking mental health care services; the effect of driving distance or availability of other forms of transportation to the nearest medical facility on access to care; the availability of child care; the acceptability of integrated primary care, women's health clinics, or both; the comprehension of eligibility requirements for, and the scope of services available under, hospital care and medical services; the perception of personal safety and comfort in inpatient, outpatient, and behavioral health care facilities; the gender sensitivity of health care providers and staff to issues that particularly affect women; the effectiveness of outreach for health care services available to women Veterans; the location and operating hours of health care facilities that provide services to women Veterans; and such other significant barriers as VA considers appropriate. VA would be required to ensure that the head of the Center for Women Veterans and the Advisory Committee on Women Veterans reviews the results of the study, and that the head of each of these entities submits findings with respect to the study to the Under Secretary for Health. Not later than 30 months after the date of the enactment of this Act, VA would be required to submit to Congress a report on the study required by this bill. The report would have to include recommendations for such administrative and legislative actions as VA considers appropriate, including the findings of the Center for Women Veterans, the Advisory Committee on Women Veterans, and the Under Secretary for Health.

VA does not support this bill. VA conducted an extensive study of the barriers to health care for women Veterans in 2013 and released the results of the report to Congress in 2015. The scope of this proposed legislation is a study identical to that 2013 study. VA is already implementing initiatives that address the identified barriers.

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

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

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

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

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

H.R. 3036 Breaking Barriers for Women Veterans Act

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

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

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

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

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

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

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

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

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

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

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

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

VA agrees that the information required by section 6 would be useful but does not support this legislation because it is unnecessary. VA has self-reported data on the Women Veteran Program at each VAMC. The Women's Assessment Tool for Comprehensive Health (WATCH) is an annual report that assesses the Women's Health Program in VA medical facilities. The self-assessment enhances national and local strategic planning for the development of women's health programs. In addition, VA recently developed a women Veterans integrated project team (IPT) charged with focusing efforts on improving the experience of women Veterans by addressing capabilities impacting critical focus areas. The IPT is charged with transforming the culture and operation of VA by developing innovative solutions to create access to high quality health care with a respectful, safe, and welcoming environment for women Veterans by ending harassment and addressing capacity gaps, gender disparities, variation in women's health program implementation, and care coordination.

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

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

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

primary care services for women or more advanced services such as obstetrics and gynecology (for women) or urology (for men). We note that VA recently implemented two provisions of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018, the Veterans Community Care Program under section 1703 and the urgent care benefit under section 1725A, that expand access to timely care, particularly urgent or emergent conditions. These new initiatives may relieve some of the need for VA facilities to have extended hours of operation.

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

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

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

H.R. 3495 would require VA to provide financial assistance to eligible entities approved under this section through the award of grants to provide and coordinate the provision of services to Veterans and Veteran families to reduce the risk of suicide. VA would award a grant to each eligible entity whose application was approved by VA. VA could establish a maximum amount to be awarded under the grant, intervals of payment for the administration of the grant, and a requirement for the recipient of the grant to provide matching funds in a specified percentage. VA would ensure, to the extent practicable, that financial assistance is equitably distributed across geographic regions, including rural communities and Tribal land. VA also, to the extent practicable, would need to ensure that financial assistance is distributed to provide services in areas of the country that have experienced high rates or a high burden of Veteran suicide and to eligible entities that can assist Veterans at risk of suicide that are not currently receiving health care furnished by VA.

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

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

VA would be required to provide training and technical assistance to eligible entities under this section regarding the data that must be collected and shared with VA, the means of data collection and sharing, familiarization with and appropriate use of any tool to measure the effectiveness of the financial assistance VA provided,

and how to comply with VA's reporting requirements. VA would have to establish criteria for the selection of eligible entities that have submitted applications. In establishing these criteria, VA would have to consult with Veterans Service Organizations (VSO), national organizations representing potential community partners of eligible grant recipients, organizations with which VA has a current memoranda of agreement or understanding related to mental health or suicide prevention, State Departments of Veterans Affairs, national organizations representing members of the reserve components of the Armed Forces, Vet Centers, organizations with experience in creating measurement tools for purposes of determining programmatic effectiveness, and other organizations VA considers appropriate.

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

VA's authority to provide financial assistance would end on the date that is 3 years after the date on which the first grant is awarded. Not later than 18 months after the date on which the first grant is awarded, VA would have to submit a detailed report on the provision of financial assistance under this section. Not later than 3 years after the date on which the first grant is awarded, VA would have to submit to Congress a follow up on the interim report containing the same elements and a final report on the effectiveness of the financial assistance provided through this authority, an assessment of the increased capacity of VA to provide services to Veterans at risk of suicide and Veteran families as a result of this financial assistance, and the feasibility and advisability of extending or expanding the provision of financial assistance.

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

VA strongly supports this bill. VA's efforts to reduce the incidence of suicidal ideations and behavior (and suicide completions) among all Veterans could be complemented by partnering with community-based providers who are able to replicate VA's suicide prevention programs in the community and to connect with Veterans that are currently beyond VA's reach. This novel approach would assist VA in reaching more of the 14 of the 20 Veterans dying each day by suicide who are not under VA care at the time of their deaths; effective partnering with eligible grantees would be key to our being able to reduce, if not prevent, the number of these tragic occurrences. Additionally, the legislation aligns with VA's proposal submitted with the President's FY 2020 budget. This proposal has been identified as the Secretary's top

legislative priority and the legislation provides the necessary authorities clinicians believe will help the Department combat suicide among Veterans. Lastly, we note that the legislation is aligned with the President's strategic taskforce to combat suicides in the Nation. The taskforce will assist in planning and providing strategic guidance with our stakeholders allowing VA to operate and implement the grant program. The need for this legislation is evident and will enhance and increase the suicide prevention measures the Department is currently taking to combat and reduce suicides in the Nation.

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

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

H.R. 3636 Caring for Our Women Veterans Act

H.R. 3636 contains three substantive sections.

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

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

Section 3 of the bill would require VA to submit to Congress a report on the use by VA of general primary care clinics, separate but shared spaces, and women's health centers as models of providing health care to women Veterans. The first report would be required not later than 90 days after the date of the enactment of this Act, and VA would be required to submit annual reports thereafter. Each report would need to include the number of VA facilities that fall into each model described disaggregated by VISN and state; a description of the criteria VA used to determine which model is most appropriate for each VA facility; an assessment of how VA decides to make investments to upgrade facilities to the next higher-level model; a description of any plans VA has to upgrade facilities from the lowest-level model (general primary care clinics) to another model; an assessment of whether any facilities could be upgraded to the next higher-level model within planned investments under the strategic capital investment planning process (SCIP); an assessment of whether any facilities could be upgraded to the next higher-level model with minor modifications to existing plans under SCIP; and an assessment of whether VA has a goal for how many facilities should fall into each such model.

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

Section 4 would require VA to submit a report to Congress on VA staffing relating to the treatment of women. The first report would be required not later than 90 days after the date of the enactment of this Act, and VA would be required to submit annual reports thereafter. Each report would need to include the number of

women's health centers; the number of patient aligned care teams relating to women's health; the number of full- and part-time gynecologists; the number of designated women's health care providers; the number of health care providers who have completed a mini-residency for women's health during the previous year and the number that plan to participate in such a mini-residency in the following year; and the number of designated women's health care providers who have sufficient female patients to retain their competencies and proficiencies. Data for all of these would need to be disaggregated by VISN and state, except for the number of women's health care providers, which would be disaggregated by facility.

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

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

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

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

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

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

H.R. 3867 Violence Against Women Veterans Act

H.R. 3867 contains five substantive sections.

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

VA has no comments on this section.

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

and sexual assault, including safety concerns, legal protections, and the need for the provision of confidential services; (2) the eligibility of Veterans for VA benefits and services that are relevant to recovery from domestic violence and sexual assault, particularly emergency housing assistance, mental and other health care, and disability benefits; and (3) local community resources addressing domestic violence and sexual assault. Each coordinator would be required to assist domestic violence shelters and rape crisis centers in providing services to Veterans.

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

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

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

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

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

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

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

We do not believe this section is necessary, but we do not oppose it. VA recognizes the value of proceeding with data-driven decisions for program expansion. VA investigators are already conducting research in this area and have been doing screening, although such work has not surveyed spouses of Veterans. We would appreciate the opportunity to discuss this work with the Committee to determine if any additional action is needed. Research to gather metrics around the various elements to be addressed, including intimate partner violence use and experience for men and women Veterans, domestic violence experience, and types and prevalence of sexual assault inside and outside the context of intimate partner relationships is important, but there are many inherent challenges in conducting a Veteran-specific study on these sensitive issues. Such a project would require a well-funded research team to design and conduct the study, with specific costs contingent upon the scope, design, and length of the study.

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

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

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

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

VA does not support section 2. Many of the specific data points identified are not currently included in VA's contracts, agreements, or other arrangements for obtaining community care; as a result, VA would have to renegotiate or modify these contracts, agreements, and other arrangements, which could be costly and would impose additional administrative burdens. Some providers may choose to drop out of

network, rather than comply with these burdens, which would diminish Veterans' access to care. While VA does collect some of the data elements, other requirements, such as gender specific services (Mammography, obstetric care, and gynecological) are not specifically tracked or identifiable. Moreover, some Veterans eligible to receive community care choose to see providers who are farther away from their home; this could complicate any meaningful analysis of the reported data.

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

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

VA does not support this section as written. VA believes amendments could be made such that VA would not oppose it. Specifically, we recommend amending section 3(a)(1)(C) to clearly assign responsibility to the VAMC Director and VISN Director for EOC compliance. VA further recommends section 3(a)(1)(D) be amended to have the Directors of each medical facility report to the Under Secretary for Health, rather than to the Secretary. The Under Secretary for Health is directly responsible to the Secretary for VHA operations. VA does not support section 3(a)(2) and recommends its omission. Compliance with EOC standards should not be determinative of whether a facility otherwise furnishes high-quality care that would earn a five-star rating under the Strategic Analytics for Improvement and Learning Value Model. Regarding section 3(b) and the reporting requirement, we do not believe 180 days would be a sufficient amount of time to prepare this report. We recommend this be revised to provide VA 270 days.

Draft Bill Establishing the Office of Women's Health

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

VA would be required to implement each recommendation made by the Director with respect to modifying the VERA system; however, if the Secretary chose not to implement such a recommendation, the Secretary would be required to notify Congress within 30 days of such a determination and provide the reasoning for the determination and an alternative to such recommendation. The bill would also establish the standards of care for the provision of health care for women Veterans in VA to include a requirement for at least one designated women's health primary care provider at each VA medical center and CBOC, training for all personnel at each VA medical facility on preventing and addressing harassment at VA medical

facilities, and other requirements as determined by the Under Secretary for Health. The Director would have to provide to Congress an annual report on the actions taken by the Office, any identified deficiencies related to VA's provision of care to women Veterans and the standards of care established in this section, a description of the funding and personnel provided to the Office and whether additional funding or personnel are needed, and other information that would be of interest to Congress.

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

Conclusion

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

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

Prepared Statement of Jeremy Butler

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members worldwide, thank you for the opportunity to share our views, data, and experiences on the pending legislation today.

I took over as CEO of the organization in February following the transition of our Founder, Paul Rieckhoff, to our Board of Directors, and I have been proud to take the helm of this incredible organization.

I joined the Navy in 1999 and was commissioned as a Surface Warfare Officer. I served on active duty for 6 years to include deploying in 2003 on the USS Gary (FFG-51) in support of the initial invasion of Iraq. I transitioned into the Navy Reserve in 2006, and I continue to serve today.

Support and Recognition of Women Veterans

As the leading Veterans Empowerment Organization for the post-9/11 generation of veterans, IAVA has the distinct honor of representing the cohort of veterans with the largest female population. We are also very proud that, though women represent 11% of all veterans, our membership is roughly 20% female.

Support and Recognition of women veterans is an incredibly important part of our work; it is why it is included in our Big Six priorities for 2019, along with Combating Suicide, Defending Veterans Education Benefits, Reforming Government, Support for Injuries from Burn Pits and Toxic Exposures, and Support for Veteran Medicinal Cannabis Use.

Over the past few years, we have fought to attain support for women veterans' issues. From health care access to reproductive health services to a seismic culture change within the veteran community, women veterans are now finally being elevated on Capitol Hill, inside the VA, and nationally. In 2017, IAVA launched our groundbreaking campaign, #SheWhoBorneTheBattle, focused on recognizing the service of women veterans and closing gaps in care provided to us by VA. Nevertheless, there is still a lot of work to be done.

IAVA made the bold choice to lead on an issue that was important to not just the nearly 20% of our members who are women, but to our entire membership and that will help ensure the future of America's health care and national security. We continue to fight hard for top-down culture change in VA for the more than 700,000 women who have served since 9/11, including 345,000 who have deployed to Iraq or Afghanistan in support of the most recent wars.

This is why in 2017, IAVA worked with Congressional allies on both sides of the aisle and in both chambers to introduce the Deborah Sampson Act. This bill called on the VA to modernize facilities to fit the needs of a changing veteran population, increasing newborn care, establishing new legal services for women veterans, and eliminating barriers faced by women who seek care at VA. This bill would have also increased data tracking and reporting to ensure that women veterans are getting care on par with their male counterparts.

Although the Deborah Sampson Act, the centerpiece of IAVA's She Who Borne The Battle campaign, was not passed in the 115th Congress, IAVA recognizes that some progress has been made in support of women veterans, with key provisions of that legislation passed or funded in the last two years. These hard-fought victories included funding to improve services for women veterans, such as research on and acquisition of prosthetics for female veterans, increased funds for gender-specific health care, women veterans' expanded access and use of VA benefits and services, improved access for mental health services, and for supportive services for low income veterans and families to address homelessness.

While we have seen greater awareness and progress toward improving services for women veterans, there is so much more we can do. Toward this goal, IAVA strongly supports passage of all of the provisions of the Deborah Sampson Act. Many of those provisions have been introduced by members of this Subcommittee and across Congress. To this end IAVA emphatically supports the six Deborah Sampson Act bills being considered today, H.R. 2645, H.R. 2681, H.R. 2798, H.R. 2972, H.R. 3036, and H.R. 3636. Collectively these bills would expand newborn care, ensure VA facilities have a women's health care provider and gender specific services for veterans, allow women to receive counseling in retreat settings, increase reporting on women who use VA services, and increase the availability of female prosthetics. IAVA thanks the Subcommittee for their commitment to ensuring women veterans receive care that is on par with their male counterparts.

In addition to the increase in newborn care under several Deborah Sampson Act provisions, IAVA supports another bill in front of the Subcommittee today, the VA Newborn Emergency Treatment Act (H.R. 2752). This legislation would allow VA to reimburse the cost of emergency transportation related to newborn care. Coupled with provisions in the Deborah Sampson Act this will finally allow VA to adequately care for veteran mothers and their babies.

Without quality data collection and analysis, there is no way to know the extent to which women veterans are underserved. To date, limited useful and timely data exists. To design precise policy solutions and to hold accountable every agency in the continuum of care, we need robust data collection, sharing, analysis, and publication. It is for these reasons that IAVA strongly supports three bills to address this issue, Improving Oversight of Women Veterans' Care Act (H.R. 4096), the Women Veterans Health Care Accountability Act (H.R. 2982), and Improving Benefits for Underserved Veterans Act (H.R. 4165). These bills will increase reporting and allow all of us to find and fill gaps in care for women veterans.

For women veterans who choose to seek care at VA, finding quality providers who understand the needs of women veterans can be difficult. While VA has made some progress improving female-specific care for women veterans, including expanding the services and care available within VA, there is still much progress needed. Women veterans are more likely than their male counterparts to seek care in the community, meaning they are often seen by private care providers that may or may not understand military service and its health impacts. IAVA's 2019 member survey underscores this as it found that while 70% of respondents felt that VA clinicians understand the medical needs of veterans, only 44% felt that non-VA clinicians understood them personally. For these reasons IAVA supports the Women Veterans Equal Access to Quality Care Act (H.R. 3224) to ensure women veterans have access to health care providers who are well qualified and with whom they feel comfortable and understood. In addition to the Draft Legislation to Establish the VA Office of Women's Health, in order to create a new office that will not only monitor VA's women-specific services, but create recommendations on how VA can improve their services to ensure that women veterans receive the health care that they have earned.

Since 2001, the number of women using VA services has tripled. As more military women make the transition to civilian life, it is paramount that DoD and VA are able and ready to support them. Part of that care means ensuring proper reproductive care and support for women veterans and their spouses. Currently, women veterans do not have the same access to contraceptives as their civilian counterparts. That is unacceptable. It is for these reasons that IAVA supports the Equal Access to Contraception for Veterans Act (H.R. 3798).

Modernize Government to Support Today's Veterans

According to a 2017 DoD report, more than 5,200 servicemembers, men and women, reported being sexually assaulted in 2017. Since only a fraction of sexual assaults are ever reported, this number is only the tip of the iceberg, and it is an increase of 10% from the previous year. Additionally, VA reports that about 29% of women veterans and 1% of male veterans report experiencing military sexual trauma (MST). The Violence Against Women Veterans Act (H.R. 3867) seeks to improve the services provided by VA for veterans who are victims of sexual assault and domestic violence by requiring an integration of those services with proven, existing community-based programs that serve domestic violence or sexual assault victims. In addition, this legislation would create a task force to review existing policies as well as develop a national program to address both domestic violence and sexual assault in the veteran community. IAVA insists on continuing efforts to help survivors of sexual assault and domestic violence come forward, so they can seek the care they need, bring the perpetrator to justice, and prevent future assaults by that perpetrator, and is supportive of this legislation.

Millions of veterans rely on VA for both health care and benefits. Ensuring that the system is able and agile enough to accommodate the millions of veterans who use its services is paramount to ensuring the lasting success and health of the veteran population. About 48% of all veterans and about 55% of post-9/11 veterans are enrolled in VA care. Among IAVA member survey respondents, 81% are enrolled in VA health care, and the vast majority have sought care from VA in the last year. Over the past few years, VA has made incredible strides in modernizing its operating systems both internally and externally. This needs to continue outside of just infrastructure, but also with their hiring practices. VA needs robust, modern hiring practices in order to compete for talent to fill their overwhelming number of vacancies. To this end, IAVA supports the VA Hiring Enhancement Act (H.R. 1163), which will allow VA to better compete with the private health care industry and update the hiring practices within VHA.

The Veteran Early Treatment for Chronic Ailment Resurgence through Examinations (VET CARE) Act (H.R. 2628) would create a pilot program to expand dental care to veterans that have certain chronic conditions. This type of care has been proven to increase overall health, and reduce health care costs. It is for these reasons that IAVA supports this legislation.

VHA's Medical Foster Home program (MFH), provides a non-institutional long-term care alternative for eligible veterans. However, while VA provides care team support to MFHs, it does not have the authority to pay for the cost of MFHs. As a result, veterans must use personal or other funding sources should they choose this alternative rather than nursing homes. The Long Term Care Veterans Choice Act (H.R. 1527) would change this and allow veterans to have more options when choosing their long-term care by authorizing VA to cover the cost of MFHs, during a three year period, up to 900 eligible veterans. IAVA supports the passage of this legislation.

The Vietnam Era Veterans Hepatitis C (HCV) Testing Enhancement Act (H.R. 2816) would provide for a pilot project to study the benefits of implementing enhanced eligibility for all Vietnam and Vietnam Era veterans access to existing Hepatitis C testing through VA. Many Vietnam Era veterans were unknowingly exposed to HCV during their service and may still go undiagnosed. Without treatment, HCV can lead to a multitude of long term health problems including liver cancer and other serious health problems. Many Vietnam era veterans that are not connected to VA are unable to receive free HCV testing, and for those reasons IAVA supports the expansion of free HCV testing for Vietnam era veterans.

Members of the Subcommittee, thank you again for the opportunity to share IAVA's views on these issues today. I look forward to answering any questions you may have and working with the Subcommittee in the future.

Prepared Statement of Joy J. Ilem

Chairwoman Brownley and Members of the Subcommittee:

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

H.R. 1163, the VA Hiring Enhancement Act

DAV believes the Veterans Health Administration's (VHA) employee vacancy number of over 43,000, which includes 39,500 health-related positions across all VHA medical facilities, is a problem that should be mitigated by Congress.¹ While VHA is experiencing challenges similar to the private health care industry that is facing a national shortage of health care professionals, we believe VHA has different responsibilities than the health care industry in general.

Title 38 of the United States Code mandates VA assist in the training of health professionals for its own needs and those of the nation. For over 70 years, in accordance with VA's 1946 Policy Memorandum No. 2, VA works in partnership with this country's medical and associated health profession schools to provide high quality health care to America's veterans and to train new health professionals to meet the patient care needs within VA and the nation. This partnership has grown into the most comprehensive academic health system partnership in history.

VHA conducts the largest education and training effort for health professionals in the United States. In 2018, nearly 121,000 medical trainees received some or all of their clinical training in VA. VA's physician education program is conducted in collaboration with 144 of the 152 Liaison Committee on Medical Education accredited medical schools and 34 Doctor of Osteopathic Medicine granting schools (AOA-accredited medical schools). In addition, more than 40 other health professions are represented by affiliations with over 1,800 unique colleges and universities. Among these institutions are Minority Serving Institutions including Hispanic Serving Institutions and Historically Black Colleges and Universities.

Congress should do all that it can to fully leverage this "upstream" access to the pipeline of health care professionals. DAV fully supports efforts to recruit, retain and develop a skilled VHA clinical workforce to meet the needs of veterans, which H.R. 1163, the VA Hiring Enhancement Act, is proposing to do.

This bill would allow VA, on a contingent basis, to begin both recruiting and hiring physicians up to two years before they complete their residency, as well as physicians who have completed their residencies leading to board certification. These contingent appointed physicians would be required to satisfy VHA's requirements to receive a permanent appointment.

In addition, an applicant for VA employment would be released from any "non-compete" agreements between that applicant and their previous employer. Employees appointed with this understanding would be required to serve out the length of their non-compete agreement within their VA position or serve in that position for at least one year (whichever is longer).

We applaud the goal of this legislation aimed at creating a larger applicant pool for qualified medical professionals to treat our service-disabled veterans without sacrificing the high quality of care VA provides. DAV Resolution No. 089 calls for effective recruitment, retention and development of the VA health care workforce. Because this measure attempts to reduce barriers for employment at VA for physicians, we are pleased to support the bill's passage.

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

Currently, subject to available appropriations, VA is required to provide nursing home care to enrolled veterans who are in need of nursing home care due to a service-connected disability or who are in need of nursing home care and have a service-connected disability rated at 70 percent or more.²

VA provides such institutional long-term service and support through VA owned and operated Community Living Centers (CLC), Community Nursing Homes (CNH) and State Veterans Homes (SVH) spending over \$6 billion in fiscal year 2018. In addition, VA spent over \$4 billion across these three settings for service-connected veterans with an average daily census of over 23,000.

H.R. 1527 would help VA better spend these funds and serve more veterans while providing high quality care in a setting service-connected veterans prefer—a Medical Foster Home (MFH). MFHs are a safe and proven alternative to nursing homes by which veterans with serious chronic disabling conditions requiring nursing home level of care are able to receive these services through VA's Home-Based Primary Care program, and the MFH attendant.

Veteran participation in the MFH program is voluntary and veteran residents report very high satisfaction ratings. Moreover, VA indicates it pays more than twice

¹ <https://catalog.data.gov/dataset/va-mission-act-section-505-data>

² 38 U.S.C. § 1710, 1710A

as much for the long-term nursing home care for many veterans than it would if VA was granted the proposed authority to pay for VA MFHs.³

Currently, the administrative costs for VA per veteran in the MFH program, including the cost of Home Based Primary Care, medications and supplies average less than \$65 per day. However, service-connected veterans who qualify for nursing home care fully paid for by the government, must pay the full cost for room, board, and personal assistance to live in a MFH. These veterans who would otherwise choose to reside in a Medical Foster Home but are unable to pay approximately \$1,500 to \$3,000 per month are not able to avail themselves of this benefit, so many are placed in nursing homes at a cost to VA of about \$7,000 a month.

This measure would address this inequity by giving VA a three-year authority to pay for a limited number of service-disabled veterans to reside in a VA-approved MFH and save taxpayers from having to shoulder the higher cost of nursing home care—a reasonable approach when providing VA new authority.

Chairwoman Brownley, as the veteran population continues to age, the need for more cost-effective long-term care services will continue to grow. Home-based community programs like MFHs will enable VA to meet the needs of aging service-connected veterans in a manner closer to independent living than institutionalized care. With the passage of this bill, service-disabled veterans would have the option of care that more closely aligns with their independence, protects their dignity and helps maintain their quality of life.

DAV is pleased to support H.R. 1527, the Long Term Care Veterans Choice Act, in accordance with DAV Resolution No. 372, which calls for legislation to improve the comprehensive program of long-term services and supports for service-connected disabled veterans regardless of their disability ratings.

H.R. 2628, the VET CARE Act of 2019

H.R. 2628, the Veterans Early Treatment for Chronic Ailment Resurgence through Examinations Act, or the “VET CARE Act of 2019, would establish a four-year pilot program for at least 1,500 veterans to receive dental care in one VA medical center within five different Veterans Integrated Service Networks (VISNs). The program would prioritize enrollment of service-disabled veterans and would enroll mostly veterans with moderate to severe periodontal conditions. The bill also requires VA to assess the health outcomes of veterans who participate in the program in order to explore the effect of periodontal care on chronic health care conditions. The bill further requires VA to work with appropriate dental schools to further investigate any potential such correlation.

The link between oral health and disability has been clearly established in medical literature. Patients who are medically compromised are more prone to oral disease, including periodontitis. If untreated, advanced periodontitis may lead to tooth loss and destroy tissue, bone and ligaments within the mouth. These outcomes can result in impaired functionality, productivity and quality of life for those with the condition.

We understand this bill seeks to replicate studies in the veteran patient population that is different than the civilian patient population in that veterans who use VA for health care are typically older and more likely to be diagnosed with several health conditions. Equally important, the prevalence of costly medical conditions in this veteran patient population is projected to increase.

DAV strongly supports this legislation in accordance with DAV Resolution No. 185, which calls on VA to offer comprehensive dental care to all service-connected veterans. We believe a pilot program such as this is a measured and reasonable way to assess the full costs and benefits associated with regular and preventive dental care for service-connected veterans and help policy makers in improving VA’s current arcane and limited eligibility criteria for dental care.

H.R. 2645, Newborn Care Improvement Act of 2019

This legislation seeks to improve the care VA provided to women veterans by extending VA’s authority to reimburse fees for newborn care from seven to 14 days. Women veterans using VA health care have high burdens of service-connected disabilities and many have delayed childbirth to accommodate their military careers. Both of these factors can affect women veterans’ pregnancies and put them at greater risk of adverse outcomes, including premature labor and delivery of low-birth weight newborns.

³VA Fiscal Year 2020 Budget Submission, Volume II—Medical Programs and Information Technology Programs, VHA–269.

According to VA, younger women in childbearing years who use VA are particularly likely to be service-connected—noting that in fiscal year 2015, almost three-quarters (73%) of its younger women veterans (18–44 years old) had service-connected disabilities.⁴ Additionally, pregnant veterans with mental health conditions and injuries affecting their ability to procreate are liable to experience problematic pregnancies, including problems with labor and delivery that may threaten the life of the veteran and her newborn. VA must continue using its comprehensive maternity health coordination protocol and provide additional time for veterans and their newborns to recover from birth problems that are often related to their service-connected conditions.

DAV is pleased to support H.R. 2645 based on recommendations in our 2018 publication, *Women Veterans: The Journey Ahead*, which calls for legislative remedies to extend authority to reimburse care for newborns and DAV Resolution 020, which calls on VA to enhance health services for service-disabled women veterans.

H.R. 2681, a bill to direct the Secretary of Veterans Affairs to submit to Congress a report on the availability of prosthetic items for women veterans from the Department of Veterans Affairs.

H.R. 2681 would require the VA Secretary to report on the availability of prosthetic items made for women veterans at all VA medical facilities.

Although the number of women with limb amputations who use VA is small (2%)⁵, across the lifespan, more than half of women (and men) in VHA care rely on VA prosthetic and sensory aids services for important devices and services. In fiscal year 2016, this encompassed 233,005 women veterans.⁶ VA provides a wide variety of medical devices to support or replace a body part or function, from hearing aids and glasses to walkers, wheelchairs, home oxygen and other durable medical equipment.⁷ Services also cover specialized needs for women, such as maternity items, including maternity support belts; breast pumps and nursing bras; post-mastectomy items such as a breast prosthesis; swimsuits and bras; and intrauterine devices or pelvic floor strengtheners.

Despite this progress, VA is still having difficulty sourcing prostheses that fit women due to a lack of prosthetic options for women in the wider marketplace. One avenue for alleviating this issue, 3D printing, is something both VA and DoD are actively researching through an interagency work group and ongoing collaboration with the Food and Drug Administration, and DoD at the Walter Reed National Medical Center Printing Lab. Walter Reed’s 3D Medical Application Center uses computer-aided design and manufacturing technologies to fabricate custom medical models, implants, prostheses and prosthetic parts. They have helped print custom prostheses for holding a fishing rod, wearing ice skates or getting around without strapping on full prosthetic legs.

The technology and lab has obvious applications for women veterans, who often have issues with prosthetic fit, function and appearance. At a VA Innovation Creation Challenge in 2015, a team worked on an idea from a veterans advocate for a socket that would allow veterans to use a single lower-leg prosthesis while swapping attachments for different uses. VA funding has also been received for a 2018 research project to develop a new system to 3D print custom energy-absorbing feet to fit any shoe size that would incorporate a quick disconnect system to change foot and shoe combinations. Until 3D printers are more widely available, women veterans with prosthetic needs should be made aware that the 3D Medical Application Center accepts referrals for custom prostheses or attachments from any VA or DoD provider.

VA also has plans to collect data on women who use a prosthesis, including funding prosthetic research that will help optimize women’s upper-limb prostheses. However, because VA has a very small population of women prostheses users, VA and DoD research communities would benefit from collaborating with industry and academia to expand the number of women in the eligible research population who can be recruited to participate in comprehensive research studies to advance prosthetic science for women. VHA established the Amputee Veterans Registry to help target care and has plans for a second phase to add outcome measures to help researchers identify best practices. In 2017, VA established the Prosthetic Women Emphasis Group to also determine best practices and appropriate prosthetic needs of women

⁴ Sourcebook: Women Veterans in the Veterans Health Administration. 2015, p. 35.

⁵ Meeting Minutes of the Advisory Committee on Women Veterans. 2017

⁶ Meeting Minutes of the Advisory Committee on Women Veterans. 2017

⁷ <https://www.va.gov/budget/docs/summary/fy2020VAbudgetVolume1MedicalProgramsAndInformationTechnology.pdf> p. 65.

veterans. Additionally, VA's Rehabilitation and Research Development Service was selected for and received funding for three studies focused on the needs of women veterans with limb loss.

Madam Chair, we believe that some of the initiatives we describe above will help women obtain more appropriate prosthetic items, but we also believe Congress could fulfill its oversight duties more successfully by broadening the approach of information collected. We believe every VA medical center will report that it makes prosthetics available to women and may also provide data on the number of women veterans the prosthetic service has served. Unfortunately, that information is not enough to answer questions about the delivery of high-quality prosthetic items that are satisfactory to veterans.

Instead, DAV recommends surveying a representative sample of the 50,000 veterans in the Amputee Care program to assess their satisfaction with prosthetics furnished or procured by VA that replace appendages (or their functions) to ensure that the approach each medical facility uses to fit, customize and train veterans in the use of their prosthetic device is satisfactory and results in a product that meets veterans' expectations in terms of appearance and usability. Because they are a small portion of the user population, women veterans should be oversampled to ensure their representation in the results. A broader representative survey would allow VA to identify specific problems within subpopulations such as women, service-connected veterans or combat-injured veterans. It might also allow VA to target specific medical centers or points within the process that are less satisfactory to veterans. We believe these findings would allow for better remedies to address any challenges within the system.

DAV supports the intent of H.R. 2681, but hopes that Representative Pappas and the Subcommittee would be amenable to broadening the scope of the survey and information collected about the availability of prosthetic items for women veterans in VA.

H.R. 2752, a bill authorizing VA to furnish medically necessary transportation for newborn children of certain women veterans

H.R. 2752 would authorize VA to reimburse expenses for medically necessary transportation for newborns of women veterans and allow the Secretary to waive a debt or reimburse a veteran previously billed for such service.

As we discussed in our justification for supporting H.R. 2645, women veterans in their childbearing years have many risk factors, including a high burden of service-connected conditions, which can endanger their pregnancies and negatively impact birth outcomes. This makes it more likely their newborn children might require more advanced care and require medical transport to a specialized pediatric medical facility. For these reasons, we strongly support this measure and urge its swift passage.

DAV supports H.R. 2752 as an important measure to enhance women veterans' health care as called for by DAV Resolution No. 020 by ensuring a robust maternity health care benefit.

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

Madam Chair, this bill would establish a permanent counseling program in retreat settings for women veterans newly separated from military service. We believe these programs can offer women veterans important opportunities to network with other women with shared experiences in an environment conducive to healing and recovery-based care.

DAV has supported the Boulder Crest program and stated our strong support for it and similar programs in our 2018 publication, *Women Veterans: The Journey Ahead*. These programs are born of the concept that post-traumatic stress can create opportunities for growth and a learning environment for veterans with similar experiences. The bill also requires that VA conduct an assessment to determine outcomes of these retreats and a biennial report. Preliminary data on these retreats thus far has shown significant improvements in participants' ability to better manage post-traumatic stress symptoms and maintain learned coping strategies.

DAV Resolution No. 020 supports improvements in programs and services for women veterans and allows us to strongly support H.R. 2798, the Building Supportive Networks for Women Veterans Act.

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

H.R. 2816, the Vietnam-Era Veterans Hepatitis C Testing Enhancement Act of 2019, would increase access to testing for Hepatitis C for Vietnam-era veterans. Specifically, the bill would establish a one-year pilot within five Veterans Integrated Service Networks to conduct such testing at outreach events coordinated by veterans service organizations such as national or regional conventions or other community events.

DAV recognizes the importance of spreading awareness of hepatitis C to this cohort of veterans, in addition to assuring that more veterans are aware of their status relative to this viral infection and their treatment options if they screen positive for the disease.

DAV has no specific resolution on this matter, but it is in line with providing comprehensive health care services to all eras of veterans; therefore, we have no objection to the bill's favorable consideration.

H.R. 2972, a bill to direct the Secretary of Veterans Affairs to improve the communications of the Department of Veterans Affairs relating to services available for women veterans, and for other purposes.

H.R. 2972 would ensure that the VA Women Veterans Call Center has text messaging capability. While we understand that the Women Veterans Call Center already has the capability of receiving and sending text messages through its central call number, 1-855-VAWOMEN or 1-855-829-6636, we appreciate the legislative assurance that the texting capacity will remain in place. The bill would also require VA to maintain a webpage with up-to-date listings of women veterans' coordinators and contact information for representatives assisting women in the Veterans Benefits, Health and National Cemetery Administrations. This resource would also list important health services provided within the network at each medical facility and community-based outpatient clinic to ensure women know what services are available in the location they are seeking care.

Madam Chairwoman, in accordance with DAV Resolution No. 020, we support having these resources available for women veterans to enhance VA's outreach efforts, and, thus we are pleased to support H.R. 2972.

H.R. 2982, Women Veterans Health Care Accountability Act

The Women Veterans Health Care Accountability Act seeks to identify and remedy barriers women veterans encounter in accessing VA health care. The legislation would require the VA Secretary to survey women veterans—both those who use VA health care as well as those who do not—to better understand their reasons for not using VA services. The survey will question women veterans about their perceptions of safety in VHA facilities, access to services, and stigmas or barriers they may express about seeking treatment for sensitive issues such as military sexual trauma, mental health conditions or substance abuse disorders. The legislation also requires VA to identify strategies and make recommendation for addressing any issues identified by the survey.

According to the VA, while there was a 175% increase in the number of women veterans using VA health care from 2000 to 2015, only 22% of women veterans, compared with 28% of men who are veterans, use VA health care.⁸ Over the past decade, VA has made many improvements in the way it manages the care of women using the system and launched several campaigns to increase awareness about women veterans' eligibility for VA benefits and services. VA has also sought to address long-standing cultural issues, including sexual harassment of women veterans seeking care at VA facilities by male veterans that prevent some women veterans from seeking the care they need, yet these problems persist.⁹

Findings from an independent detailed survey as proposed in the bill, that build upon barrier to care studies conducted in 2008 and 2015 may assist the VA in developing strategies to tackle some of the ongoing concerns and issues that prevent women veterans from accessing VA health care. Conducting research to examine women veterans perception of personal safety, gender sensitivity, comfort, sense of welcome, effectiveness of outreach efforts, access to child care and operating hours

⁸Sourcebook: Women Veterans in the Veterans Health Administration, Volume 4, p.18.

⁹Dyer KE, Potter SJ, Hamilton AB, Luger TM, Bergman AA, Yano EM, Klap R. Gender Differences in Veterans' Perceptions of Harassment on Veterans Health Administration Grounds. Women's health issues : official publication of the Jacobs Institute of Women's Health. 2019 Jun 25; 29 Suppl 1:S83–S93.

for VA services may also add value in better understanding the overall women veterans patient experience and help to improve services for this population.

DAV supports H.R. 2982 in accordance with DAV Resolution No. 020, calling for VA to enhance women veterans' health care programs and assist them in overcoming barriers that may affect their ability to obtain necessary medical care.

H.R. 3036, Breaking Barriers for Women Veterans Act

H.R. 3036, the Breaking Barriers for Women Veterans Act would correct environmental, structural, and staff deficiencies to ensure VA's delivery of high-quality health care to women veterans. The bill would authorize \$20 million to assist VA in addressing deficiencies it identifies in annual environment of care surveys to assure that the privacy, security and dignity of women patients is upheld at each VA medical center. It would also require VA to ensure it had at least one full-time or part-time women's health primary care provider at each facility and authorize \$1 million to develop more in-house expertise by offering mini-residency training to VA primary care and emergency physicians and other independent practitioners. The bill would also require VA to develop a training curriculum for community care providers treating women veterans and conduct a study to determine the staffing and training needs for Women Veterans' Program Managers and whether an ombudsman for women veterans at each VA facility is warranted.

By authorizing the resources necessary, the legislation will better ensure that women veterans have expert care for gender-related issues wherever they seek such care within the VA or in sponsored settings.

We strongly support H.R. 3036 in accordance with DAV Resolution No. 020, which supports enhancing women's health care programs to ensure equity for women veterans seeking VA health care.

H.R. 3224, to provide for increased access to Department of Veterans Affairs medical care for women veterans.

This measure seeks to ensure women veterans have access to comprehensive gender-specific VA medical services at all its clinical points of care. While we appreciate and concur with the general intent of this bill-the definition of gender-specific care and services is not included in the bill text. While current VHA directives (1330.01,02), outline what gender-specific services must be available in VA to the greatest extent possible-when such services are not available, VA is authorized to contract for such services in the community. Certain types of care, such as maternity and obstetric care (and newborn), is generally provided to women veterans in the community due to lack of volume and VA's lack of expertise in providing such care. Likewise, mammography services are not available at all VA locations due to low volume and frequently provided in the community. Without the gender-specific services definition, the bill's overall intent is unclear.

Additionally, H.R. 3224 calls for a study on extended care hours and the best practices and resources required to implement the use of extended hours at VA medical clinics and facilities.

Women veterans are, on average, younger than their male peers (48.4 v. 63 years old) and face a number of barriers when seeking care. Many women veterans struggle to maintain single-parent households, full-time employment or education track, or provide caregiving to an aging parent. Extended clinical hours at VA points of care may be an additional means of making services available to these women and we would be interested in the Committee's findings and recommendations based upon such a study.

While DAV is able to support the provisions in the bill related to a study on extended hours and best practices, we request the Subcommittee amend the bill to clarify the definition of gender-specific services prior to advancing H.R. 3224.

H.R. 3636, Caring for Our Women Veterans Act

The Caring for Our Women Veterans Act would require the VA Secretary to submit a report on the number of women veterans who reside in each state; the number of women veterans who are enrolled in VA care and have received care in the past year; the number of women veterans seen at each VA medical facility over the past year; VISNs with the largest increase of women veteran users; models of care used by VA to treat women veterans and how VA makes such determinations about the appropriate use of such models in each facility; and VA staffing available for the care and treatment of women veterans.

The measure also requires an assessment on strategic capital investment planning, including modifications and upgrades for women veterans and information on

staffing levels, including the number of full and part-time gynecologists within the Department, the number of patient-aligned care teams in women's clinics, and the number of providers who have completed a mini-residency and serve as a women's health provider.

DAV believes this information is essential to the development of Veterans Integrated Service Network marketing plans and any future modernization and capital restructuring efforts. While DAV believes much of this information is currently available through the Department, we agree a comprehensive assessment that provides all the required information in one report would be useful information for Congress and interested stakeholders. We therefore suggest the Subcommittee work closely with the Women's Health Program Office to determine any potential amendments to the bill regarding the collection of information needed to ensure the intent of the measure is fully realized. Fully understanding the impact of increasing use of VA services by women veterans and what resources and future plans are needed is essential to better serving this population.

DAV is pleased to support H.R. 3636, which comports with recommendations made in our report *Women Veterans: The Journey Ahead* and DAV Resolution No. 091, which calls upon VA to modernize its health care infrastructure.

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

H.R. 3798, the Equal Access to Contraception for Veterans Act, would limit charging veterans copayments for contraceptive items/medications furnished by the VA.

Access to contraception is part of providing comprehensive health services. However, cost sharing can be a barrier for some veterans who need health care services or treatment. Many private health plans have eliminated copayments for beneficiaries for preventative care, in part because it is often significantly less expensive than having to treat various health conditions or stabilize chronic diseases.

We are able to offer our support for H.R. 3798, as the measure is in accordance with DAV Resolution No. 365, which calls for the reduction or elimination of all copayments for health care for service-connected veterans obtaining care within VA and DoD medical facilities.

H.R. 3867, Violence Against Women Veterans Act

H.R. 3867, the Violence Against Women Veterans Act, would create a comprehensive new program to improve supportive services for women veterans who have experienced domestic violence or sexual abuse.

The measure calls for the establishment of a national task force (Task Force) on veterans experiencing domestic violence or sexual assault for the purpose of integrating VA programs with community agencies and resources such as housing and benefit programs, rape crisis centers, shelters for women who are fleeing abusive partners, and other appropriate state and community programs meeting the needs of these individuals. The Task Force would include the VA Secretary working in consultation with the Attorney General and the Secretary of Health and Human Services. In addition, the bill requires VA to conduct a baseline study of domestic violence and sexual assault among veterans and spouses of veterans and an assessment of effects of intimate partner violence and the Secretary could assist with establishing VA coordinators who would help train community providers to identify and connect veterans with needed VA services, care and benefits.

The DoD and VA continue to confront the worsening epidemic of military sexual trauma and its consequences. There are high rates of women who experience sexual trauma within the military (according to DoD's most recent survey of personnel, 6.2% of service women reported experiencing unwanted touching and many more (24.2%) report having experienced some form of harassment within the past 12 months.) A significant number of these women (1/5 of those assaulted) report having experienced both.¹⁰

VA does not have the authority to change the policy and culture within the military services, but it can and should make changes in its own culture to ensure that women are not re-traumatized in the process of obtaining care for the mental health challenges these all-too-common occurrences bring. According to a recent study, VA

¹⁰Department of Defense Annual Report on Sexual Assault in the Military Fiscal Year 2018. P. 9

found that many women veterans (about 20%) are experiencing sexual harassment from male patients while seeking care within its facilities.¹¹

VA reports also indicate a high burden of intimate partner violence experienced by women veterans using VA services that exceed those of civilian women. Specifically, about one-third of women veterans compared to one-fourth of civilian women experience intimate partner violence.¹²

Sexual trauma and domestic violence can lead to post-traumatic stress disorder, depression, anxiety, substance use disorders and other mental health conditions. Violent domestic attacks on women veterans have also been associated with traumatic brain injury (TBI) (about 25% of veterans experiencing intimate partner violence have a history of TBI and 12.5% have current symptoms).¹³ Any of these conditions can affect a survivor's ability to live healthy, productive and economically stable lives.

These findings indicate a compelling need for a comprehensive program for women veterans experiencing these types of violence. VA prescribes to a whole-health model of care that integrates supportive services and care coordination that allow them to address the array of issues that often accompany trauma, and require income assistance, housing, legal services and specialized medical and mental health care and substance-use treatment. VA's program for homeless veterans provides an excellent example of a successful collaborative model of VA and community providers.

While we support the provisions in this measure focused on ensuring veterans using VA services who have experienced sexual trauma or domestic violence have access to supportive services aimed at recovery, DAV does not have a resolution calling for formation of a National Task Force that would integrate VA assets into community-based networks of care for survivors of sexual and domestic abuse. We note however, that VA does not have the breadth and scope of services provided in the community for these veterans who would likely benefit from VA leveraging community resources from agencies and programs with expertise in these areas therefore, we have no objection to passage of the bill.

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

H.R. 4096, the Improving Oversight of Women Veterans' Care Act of 2019, requires an annual report to determine veteran access to gender-specific services such as mammograms, obstetric and gynecological care through VA's community care program.

As VA implements the Veterans Community Care Program (VCCP) as required under the VA MISSION Act of 2018, it is increasingly important that VA identify means of assuring that VA network community care providers are required to meet the same quality standards as VA providers are required to meet and that community care is commensurate with VA's whole health model of care. H.R. 4096 requires information on average wait times, drive times, and reasons why appointments could not be scheduled with a community provider.

H.R. 4096 would also require VA to standardize environment of care and VA's inspections and reporting procedures to align with VHA's women's health handbook. It would further disqualify high-performing VA medical centers (based upon Strategic Analytics for Improvement and Learning (SAIL) quality measures from being awarded a 5-star rating if they are not in compliance with environment of care standards for women veterans clinics outlined in the handbook.

Ensuring the appropriate facility design and staff composition is critical to easing women veterans concerns about their safety, privacy and dignity and will help to ensure comprehensive high quality care at all VA points of care. For these reasons, we strongly support H.R. 4096, in accordance with DAV Resolution No. 020.

Draft bill, to establish in the Department of Veterans Affairs, the Office of Women's Health and for other purposes

Chairwoman Brownley, DAV is happy to lend its support to your draft bill establishing an Office of Women's Health within the VHA. The Office would be respon-

¹¹ Dyer KE, Potter SJ, Hamilton AB, Luger TM, Bergman AA, Yano EM, Klap R. Gender Differences in Veterans' Perceptions of Harassment on Veterans Health Administration Grounds. *Women's health issues* : official publication of the Jacobs Institute of Women's Health. 2019 Jun 25; 29 Suppl 1:S83-S93.

¹² Dichter, M.E, et al. (2011). Intimate partner violence victimization among women veterans and associated heart health risks. *Womens health Issues*. 21 (suppl 4): S190-S194.

¹³ Iverson, KM, et al. (2017). Traumatic brain injury and PTSD symptoms as a consequence of intimate partner violence. *Comprehensive psychiatry* 74: 80-7.

sible for evaluation, oversight and improvement of women veterans' health services in VA and in the community; development and implementation of standards of care; and identifying and correcting deficiencies in standards of care for women. Additionally, the Office would oversee distribution of resources for these purposes and promote expansion and improvement of clinical, research and educational activities with respect to women's health services within the Department. We believe this change will significantly improve the tracking and use of centralized funding for women's programs ensuring resources are used for intended purposes, and specifically, allowing VA to address long-standing issues affecting women veterans' access to comprehensive gender-specific health care.

The current Women's Health Services office is understaffed and lacks control over resources to assure that administrative priorities of the office are implemented. Without control over resources, the director is beholden to other program offices and facility director's priorities that may not be in line with the women's health program office priorities. This hampers the full resourcing of the women's health centers which are widely regarded as the model that is most likely to ensure high-quality, comprehensive care and satisfaction for women veterans. It creates challenges in training and hiring designated women's health providers in facilities that lack them in order to ensure appropriate care for women veterans at all sites of care. It also hampers the ability to ensure that awareness campaigns and campaigns to address sexual harassment, and increase the awareness of women's special needs are given appropriate support.

While DAV does not have a resolution specifically calling for the establishment of an Office of Women's Health, we have addressed the need to elevate the program to that status in our report, *Women Veterans: The Journey Ahead*.¹⁴ Given existing and persistent challenges within the Department to address many issues related to women veterans, we support this draft measure as it may be a necessary prerequisite to establish such an office to ensure that women's health care programs can be enhanced in a manner that ensures the equity and availability in women's services as we call for under DAV Resolution No. 020.

Chairwoman Brownley, this concludes my testimony. Thank you for inviting DAV to testify at today's hearing. I would be pleased to address any questions related to the bills under consideration by the Subcommittee.

Prepared Statement of Roscoe Butler

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for this opportunity to provide our views on some of the pending legislation you will be reviewing today.

H.R. 3867, the "Violence Against Women Veterans Act"

PVA supports H.R. 3867, the "Violence Against Women Veterans Act." We believe that any veteran-male or female who experienced domestic violence or sexual assault while serving on active duty should have access to appropriate health care and services to help them overcome the trauma they encountered while serving our nation at home and abroad. When VA is not able to provide the needed care or services, this legislation would authorize the Secretary of Veterans Affairs (VA) to establish partnerships with domestic violence shelters and programs; rape crisis centers; state domestic violence and sexual assault coalitions; and such other health care or service providers. Partnerships like these could help veterans who experienced domestic violence receive the care and services they need and deserve.

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

PVA supports H.R. 4096, the "Improving Oversight of Women Veterans' Care Act of 2019." This legislation would require the Under Secretary for Health to submit to Congress an annual report on the ability of women veterans to access gender-specific care in the community, including the average waiting period between the veteran's preferred appointment date and the date on which the appointment is completed, reasons VA could not fulfill the appointment, and the driving time required for appointments. It would also require each medical facility to report to the Secretary, on a quarterly basis, the compliance and noncompliance of the facility with the environment care standards for women veterans, as defined in Veterans Health Administration (VHA) Directive 1330.01(1). Each report is to name the per-

¹⁴DAV. *Women Veterans: The Journey Ahead*. P. 3.

son at the facility who is responsible for compliance and provide the facility plan to strengthen the environment of care standards.

According to a December 2016 U.S. Government Accountability Office Report (17-52), VHA does not have data and performance measures for women veterans' access to gender-specific care delivered through the Veterans Choice Program. However, VHA does collect data to evaluate women veterans' access to gender-specific care received through PC3 - a different community care program. The report also found VHA does not have accurate or complete data regarding medical centers' compliance, or noncompliance with the environment of care standards for women veterans.

If VA cannot meet the needs of women veterans and refers them to providers in the community, then VA must still ensure that the care is quality, appropriate care that best meets the veterans' needs. Holding VA and community care providers to different standards is unacceptable. VA must be able to ensure the care a veteran receives, whether provided by VA or in the community, is the best clinical option available. As such, Congress must have the data to conduct the appropriate oversight on that care.

H.R. 1163, the "VA Hiring Enhancement Act"

PVA encourages many efforts to bolster staffing levels at VA facilities, particularly within the Spinal Cord Injury System of Care, which the historical data shows is one of the most difficult areas to recruit and retain physicians and nursing staff. We strongly support the "VA Hiring Enhancement Act," which seeks to release physicians from "non-compete agreements" for the purpose of serving at VA. It would also allow VA to begin recruiting and hiring physicians on a contingent basis up to two years before they complete their residency. These contingent-appointed physicians would still have to satisfy VA's requirements in order to receive a permanent appointment. Removing these barriers would help encourage more of the best and brightest doctors and nurse practitioners coming out of medical school to pursue a career with VA.

H.R. 2628, the "Veterans Early Treatment for Chronic Ailment Resurgence through Examinations Act of 2019" or the "VET CARE Act of 2019"

PVA supports H.R. 2628, which would expand eligibility for VA dental care to certain veterans. Studies show a person's oral health has a major impact on their physical health and gum disease is often associated with diabetes, heart disease, and many other serious medical conditions.

Even though dental benefits are the bridge to health and wellness, VA closely rations these services citing the severe underfunding of its dental departments. Currently, VA dental care is limited to a small number of veterans such as those who are 100 percent disabled or have a service-connected dental condition, former prisoners of war, and homeless veterans. Dental care may also be available if a dental condition is aggravating a service-connected condition or complicates treatment of that condition.

Simply put, the VET CARE Act would require VA to establish a four-year pilot program for older veterans with type 2 diabetes. Since the VA spends most of its health care costs on treating veterans with chronic conditions like diabetes, expanding dental coverage to these individuals will help improve their overall health and may bring those costs down.

H.R. 2681, to direct the Secretary of Veterans Affairs to submit to Congress a report on the availability of prosthetic items for women veterans from the Department of Veterans Affairs

PVA supports H.R. 2681 which directs the VA Secretary to submit to Congress a report on the availability of prosthetic items for women veterans from VA. Female veterans are more likely than male veterans to receive a prosthesis that does not properly fit. This can cause these women additional medical problems, such as socket burn, and higher rates of hip and knee osteoarthritis. Women veterans in need of prosthetics appliances are on an increase, and VA must ensure prosthesis for women veterans meet all of their health and social needs.

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

PVA supports this legislation which directs VA to carry out a one-year pilot program making hepatitis C testing available to covered veterans at outreach events organized by veterans service organizations (VSOs). Veterans who have this disease need to be identified in order to receive treatment for it. We believe that increasing outreach through VSOs will facilitate these efforts.

H.R. 2982, the “Women Veterans Health Care Accountability Act”

PVA supports H.R. 2982, which directs the VA Secretary to conduct a study of the barriers for women veterans to health care from VA. Accessibility at VA facilities to gender-specific care has been an area of concern for many of our members.

Ingress/Egress

The first hurdle women veterans may encounter is the entrance to the woman’s health clinic. Many clinics were hastily established so they did not receive the careful level of planning necessary to ensure wheelchair users could enter the facility. For example, the entrance to a VA women’s health care clinic we recently visited did not have an automatic door for patients to use. To complicate matters further, the entrance was not visible to staff so they could not see if a patient outside required assistance, nor was there an external bell for the patient to alert someone. In this case, it was an outside entrance, so any patient needing assistance would be exposed to the elements until someone came along to help them.

Accessible Exam Rooms

Accessibility to doctors’ offices is essential in providing medical care to people with severe or catastrophically disabilities, but often this is the next hurdle a women veteran may encounter at VA. Some of VA’s exam rooms are too small to accommodate a women veteran in a wheelchair and a portable lift. Other rooms may not be big enough for a larger wheelchair to enter at all. A portable lift would be unnecessary if the examination rooms had a built-in lift to hoist a women veteran from her wheelchair to the examination table, but many women’s health clinics do not have these lifts installed.

Barriers like these tend to make individuals with severe disabilities less likely to get their routine preventative medical care. It is a major concern because wheelchair users face the insidious health threat of having to sit all day. Loss of muscle tone and diminished circulation cause pressure sores to develop, and it is very important that seemingly minor problems like these be detected and treated early before turning into major, and possibly life-threatening, problems. However, if the patient is unable to enter the exam room or be placed upon the exam table, the physician will be forced to examine the patient in her wheelchair, diminishing the quality of the exam and any care provided.

Mammography Examinations

Some VA medical centers do not have diagnostic equipment to conduct mammography examinations. For the facilities that do, wait times are excessively long (two months or longer), or the equipment is inaccessible for women veterans in wheelchairs, particularly quadriplegics. While there are mammography machines that allow women with physical disabilities to lay on an exam table, not every VA health care facility has this type of equipment.

In light of these concerns, we believe that H.R. 2982 should specifically address the need to evaluate the barriers faced by women veterans with spinal cord injuries and disorders in receiving proper gender-specific health care.

H.R. 3036, the “Breaking Barriers for Women Veterans Act”

Making VA facilities work for women veterans is the goal of H.R. 3036. This legislation directs VA to ensure each of its medical facilities has at least one full or part-time women’s health primary care provider; provides \$1 million in funding each fiscal year for a Women Veterans Health Care Mini-Residency Program; and ensures that providers in the community network are equipped with training modules specific to women veterans. To verify that these standards are being met, the bill also instructs VA to conduct a study to make sure that staffing levels specific to women veterans are appropriate. PVA supports H.R. 3036 because it will strengthen VA’s ability to deliver easily accessible, high quality care for women veterans at VA facilities.

Discussion Draft, to amend title 38, United States Code, to establish in the Department of Veterans Affairs the Office of Women’s Health, and for other purposes

VA’s Center for Women Veterans was established by Congress in November 1994 (P.L. 103-446) to monitor and coordinate VA’s administration of health care and benefits services, and programs for women veterans. It also serves as an advocate for a cultural transformation (both within VA and in the general public) in recognizing the service and contributions of women veterans and works to raise awareness of the responsibility to treat women veterans with dignity and respect. Estab-

lishing a separate Office of Women's Health would elevate the good work currently being done by the Women's Health Services Program Office; therefore, we support this proposed legislation.

H.R. 2645, the "Newborn Care Improvement Act of 2019"

PVA supports H.R. 2645 which would raise the number of days a newborn under VA care could stay in the hospital from 7 to 14. Most newborn births are without complications, but if problems develop, the infant may be required to remain in the hospital for an undetermined period. H.R. 2645 ensures the newborn is covered for a greater period of time so women veterans and their families can focus on their child's health rather than worrying about how to pay for the hospital bill.

H.R. 2752, the "VA Newborn Emergency Treatment Act"

VA's current newborn care authority provides hospital care but does not cover emergency transportation when medically necessary transportation is required. PVA supports H.R. 2752 which would authorize the VA Secretary to furnish medically necessary transportation for newborn children of certain women veterans. This common sense legislation will ensure that women veterans are not forced to think about the cost of such transportation when considering emergent care options for their newborns.

H.R. 2798, the "Building Supportive Networks for Women Veterans Act"

PVA supports H.R. 2798, the "Building Supportive Networks for Women Veterans Act," which would make the existing pilot on counseling in retreat settings for newly separated women veterans a permanent program. This legislation provides VA with the authority to extend the program using the same measurements and eligibility requirements. PVA supported the original program established by the "Caregivers and Veterans Omnibus Health Services Act of 2010" and has been pleased to see it continue.

In surveys conducted after the program, participants consistently showed better understanding of how to develop support systems and to access resources at VA and in their communities. The OEF/OIF women veterans at these retreats are most often coping with effects of severe Post-Traumatic Stress and Military Sexual Trauma. They work with counselors and peers, building on existing support. If needed, there is financial and occupational counseling. To be eligible, women veterans must have been deployed in OEF/OIF, and have completed at least three sessions of counseling in the past six months.

The program, managed by the Readjustment Counseling Service, has been a marked success since its inception in 2011. The results have been overwhelmingly positive for women veterans, who experience consistent reductions in stress symptoms as a result of their participation. Other long-lasting improvements included increased coping skills. It is essential for women veterans that Congress make this program permanent. We believe the value and efficacy of this program is undeniable.

H.R. 1527, the "Long-Term Care Veterans Choice Act"

PVA supports the "Long-Term Care Veterans Choice Act" which would authorize VA to enter into contracts or agreements for the transfer of veterans to non-VA adult foster homes for certain veterans who are unable to live independently. PVA believes that VA's primary obligation involving long-term support services is to provide veterans with quality medical care in a healthy and safe environment. This should include access to a medical foster home as desired by the veteran.

As it relates to veterans with a catastrophic injury or disability, it is PVA's position that adult foster homes are only appropriate for disabled veterans who do not require regular monitoring by licensed providers, but rather have a catastrophic injury or disability and can sustain a high level of independence. When these veterans are transferred to adult foster homes, care coordination with VA's specialized systems of care is vital to the veterans' overall health and well-being.

This bill requires the veteran to receive VA home health services as a condition to being transferred. As such, PVA believes that if a veteran with a spinal cord injury or disorder is eligible and willing to be transferred to an adult foster home, the VA must have an established system in place that requires the VA home-based primary care team to coordinate care with the VA Spinal Cord Injury (SCI) Center and the SCI primary care team that is in closest proximity to the adult foster home. When caring for a veteran with a catastrophic injury or disability this specialized expertise is extremely important to prevent and treat associated illnesses that can quickly manifest and jeopardize the health of the veteran. Thus, these veterans

must also be regularly evaluated by specialized providers who are trained to meet the needs of their specific conditions.

H.R. 2972, to direct the Secretary of Veterans Affairs to improve the communications of the Department of Veterans Affairs relating to services available for women veterans, and for other purposes

PVA supports H.R. 2972 which would expand the capabilities of VA's Women Veterans Call Center by including a text messaging capability and establishing a single website where women veterans can find information about the benefits and services available to them. The call center already has text messaging capability, but the benefit of having a one-stop resource for information on women veterans' health care and benefits cannot be overstated.

H.R. 3224, to amend title 38, United States Code, to provide for increased access to Department of Veterans Affairs medical care for women veterans

Without additional clarification, PVA cannot support H.R. 3224 as written. Subsection 1720J(a) would require that the Secretary ensure that gender-specific services are continuously available at every VA medical center and community-based outpatient clinic. However, H.R. 3224 does not define the type of "Gender-Specific Services" VA is required to provide. VHA Directive 1330.01(02), Health Care Services for Women Veterans breaks down gender-specific care into several categories, e.g., primary care and specialty care. It is gender-specific specialty care which concerns PVA. VHA Directive 1330.01(02), paragraph j, provides a list of gender-specific specialty services that must be available in-house to the greatest extent possible. If gender-specific specialty services are not available in-house, such services must be provided through non-VA medical care, contractual or sharing agreements, academic affiliates, or other VA medical facilities within a reasonable traveling distance (less than 50 miles).

Unless additional clarification is provided, VA could interpret Congress's intent with this legislation as a requirement to offer all gender-specific services in each VA medical center or community based outpatient clinic. There are a number of gender-specific specialty services listed in the directive that VA medical centers and community-based outpatient clinics are not capable of providing-particularly when it comes to maternity and newborn care.¹ PVA recommends that this legislation be amended to include language defining the types of gender-specific services that VA would be required to provide.

H.R. 3798, the "Equal Access to Contraception for Veterans Act"

The Affordable Care Act (ACA) prevents individuals with insurance from being charged pharmaceutical co-payments for all 11 categories of preventive medicine as determined by the U.S. Preventive Task Force and Centers for Disease Control and Prevention. Yet, with VA being exempt from the ACA, Section 1722A(a)(3) requires VA to charge for these categories with exemptions provided by the Secretary for immunizations and smoking cessation. Veterans are experiencing a disparity in co-payment requirements for the remaining nine categories including contraceptives women veterans receive from the pharmacy. PVA supports H.R. 3798 which eliminates this undue and unjust barrier to accessing birth control that only women veterans and the uninsured must face.

Again, PVA appreciates this opportunity to express our views on some of the many important pieces of legislation being examined today. We look forward to working with the Subcommittee to improve the quality and accessibility of health care for women veterans, and to enhance the quality of health care benefits for veterans in general.

footnotes (1)

STATEMENTS FOR THE RECORD

Honorable Max Rose

Thank you, Chairwoman Brownley, and Ranking Member Dunn, for having this forum to provide due attention to the pending legislation before us. We are faced here with an issue of persistent disparities of health care access between male and female veterans. The Department of Veterans' Affairs (VA) has an influx of women

¹ VHA DIRECTIVE 1330.01(2), "Health Care Services for Women Veterans"

veterans entering their systems but they have been unable to keep up with increased demand.

Funding for health services specifically for women in VA has increased about 16% over the last five years, totaling just over \$500 million in 2019. But that figure is less than 1% of overall veterans' health spending, even though women veterans represent one of the fastest growing populations using VA health care. The number of women using Veterans Health Administration services has also tripled since 2001, a group expected to grow much larger in the coming years.

However, as our women veterans seek health care, they are either faced with a lack of resources to meet their specific needs or they must jump through hoops due to administrative delays and short staffing. It is alarming to see that women make up both 10% of the veteran population, and nearly 16% of the active-duty military force, yet there are still major questions as to whether VA can effectively serve this large portion of current and future veterans.

There needs to be an increase in resources and H.R. 3036, The Breaking Barriers for Women Veterans Act, would be an important first step in bridging the gender health care gap. This bill would require the VA to implement improvements to better serve women veterans, including upgrading existing medical facilities. Additionally, the VA must ensure its medical facilities have at least one full-time or part-time women's health provider, and establish training modules for community providers that are specific to women veterans.

The VA needs to be able to properly serve these women and their health care needs. Women veterans shouldn't have their health put at risk because their local VA facility doesn't have the appropriate resources to take care of them or because they need to wait extended periods of time due to administrative delays.

I would like to thank Paralyzed Veterans of America, Iraq and Afghanistan Veterans of America, and Disabled American Veterans for their support of this legislation, along with the bipartisan group of colleagues currently co-sponsoring.

Thank you for your consideration, and I urge the passage of this legislation.

Honorable Gus M. Bilirakis

Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the Subcommittee, as a fellow member of the House Veterans Affairs Committee and former member of this Subcommittee, I would like to thank you all for the opportunity to present this statement regarding my bill, H.R. 2628, the Veterans Early Treatment for Chronic Ailment Resurgence through Examinations Act, or the VET CARE Act.

I have been proud to serve on this Committee during my entire tenure in Congress and have always said that caring for Veterans is one of my top priorities. I am also proud to represent Florida's 12th Congressional District, which is home to thousands of Veterans in the Tampa Bay area.

Many of my Veteran constituents have come to me over the years expressing their desire to add dental care to the VA's medical benefits package. Currently, the Department of Veterans Affairs (VA) provides outpatient dental care for a limited number of the Veteran population - specifically 100% rated service-connected disabled Veterans. It also provides dental services to Veterans who are disabled due to a specific debilitating dental condition. Otherwise, the access that many Veterans have to these services is limited. Some may be able to sign up for the VA Dental Insurance Program (VADIP), which provides a discounted, low-cost insurance plan provided by private insurers. But I believe we need to do more to move this issue forward.

The old saying goes an ounce of prevention is worth a pound of cure, and many small studies suggest that regular dental care equates to lower overall health care costs and better health outcomes. One such study published in the American Journal of Preventive Medicine, conducted by University of Pennsylvania professor Dr. Marjorie Jeffcoat, found that regular periodontal checkups lead to reduced hospitalizations and overall medical cost savings in care for chronic conditions such as cardiovascular disease, cerebral vascular disease, and diabetes. It is off this study that I based the VET CARE Act, which would expand this research to determine the potential health benefits to Veterans and the potential cost savings to the VA associated with periodontal care. My bill would require the VA to create a four-year pilot program to provide dental services to 1,500 Veterans diagnosed with type-2 diabetes, at five selected VA Medical Centers. To be eligible for the pilot, Veterans must not already be receiving regular periodontal care. Additionally, Veterans with service-connected disability ratings would receive preference for participation.

Each treated Veteran will receive appropriate periodontal evaluation and treatment on an annual basis during the pilot. Throughout and at the conclusion of the pilot, the overall health of the treated Veterans will be recorded. Those results will be compared to Veterans outside the pilot to determine if providing Veterans with dental care equates to fewer complications of chronic ailments. If so, an analysis can be done to determine if the lower costs of overall health care due to fewer chronic ailments saves the VA enough money to reallocate funds to provide more Veterans with dental care. The data recorded and collected by the VA would also be able to be distributed to the research community for further study.

Finally, at the end of the four-year pilot period, Veterans who participated in the program will receive information on how they may continue to obtain dental services and treatment in the community, including information about enrolling in VADIP. Currently, VA is prohibited from advising its patients to go to non-profits and other providers in the community for dental care. H.R. 2628 would amend section 1712 of Title 38 to enable VA providers to have that conversation with those Veterans who apply for the pilot program by giving them a list of those potential providers in the community and advising patients of opportunities for dental care through VADIP and other partners in the community for low to no cost dental care. One example of this is the “Stars, Stripes, and Smiles” event that my office has hosted annually with our local West Pasco Dental Association to provide oral health care for Veterans’ untreated dental pain and infections free of charge. In this way, we can ensure that we are providing the essential continuity of care for Veterans in need of further treatment.

I believe we must give Veterans the health care they have earned and deserve. If we can improve on this care by providing preventive dental services that leads to fewer complications of chronic ailments, it not only shows that we are looking at the long-term outlook of their health, it could also prove to be cost-effective. The VET CARE Act is a practical, common-sense way to demonstrate this approach for dental services, replicating already established research in the community.

To conclude, I am proud of the work that this Committee has consistently done over the years on a bipartisan basis for our nation’s Veterans, our true American heroes. I am grateful that the Subcommittee has continued this bipartisan tradition by bringing my bill up for further discussion, and I once again thank the Subcommittee for giving me the chance to express my support for this important legislation for the record. I welcome the opportunity to continue the conversation further, discuss any questions or concerns you may have, and to find common ground to advance policy solutions that help our Veterans and their families.

Honorable J. Luis Correa

Chairwoman Brownley, Ranking Member Dunn, and Members of the Subcommittee, I thank you for the opportunity to submit testimony in support of my bipartisan legislation: H.R. 4096, the “Improving Oversight of Women Veterans’ Care Act.”

According to the U.S. Department of Veterans Affairs (VA), there were over 2 million women veterans in 2016. Although women represent the fastest growing cohort of veterans, women veterans continue to face challenges in receiving health care services.

In 2016, the Government Accountability Office (GAO) reported that the Veterans Health Administration (VHA) had limited information on VA medical centers’ (VAMCs) compliance with environment of care standards for women veterans. VHA policies require that VA medical facilities meet certain privacy and safety factors, conduct regular inspections, and report instances of noncompliance. Yet, of the VAMCs inspected, GAO found that noncompliance, such as the lack of privacy curtains in examination and inpatient rooms, had not been reported. Additionally, GAO found that VHA did not have performance measures for monitoring women veterans’ access to gender-specific care provided by non-VA physicians under the then-Veterans Choice Program.

In response, the “Improving Oversight of Women Veterans’ Care Act” directs VA to establish and disseminate environment of care standards and inspection policies to VAMCs. To encourage compliance, VAMCs will be ineligible for a five-star end of year rating unless the facility meets the environment of care standards. Additionally, the bill requires VA to submit an annual report to Congress regarding women veterans’ accessibility via community care to gender-specific health care services, such as maternity care.

It is important that VA evolve and adapt to ensure that women veterans receive health care in a timely, dignified, and safe manner.

Chairwoman Brownley and Ranking Member Dunn, I want to thank you for the inclusion of my bipartisan bill on the agenda today. I appreciate the work that the Members of this Subcommittee do to ensure quality health care for our nation's veterans, and I look forward to working with you all to move this policy forward.

Honorable Vicky Hartzler

Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the Subcommittee, I want to applaud you for your commitment and dedication to improving outcomes for our veterans and for allowing me to share my views on the Department of Veterans Affairs' (VA) critical staffing issue that is impacting the care our veterans receive.

Our veterans deserve the best. Unfortunately, top-notch care is often hampered by a shortage of doctors at the VA. I believe that this bill, which I introduced along with Representatives Bost, Correa, Lesko, Mooney, Rouzer, and Wilson will help the VA fill some of these vacancies. Our bill has three main provisions.

First, it would allow physicians to be released from non-compete agreements only for the purpose of serving in the VA for at least one year. Non-compete agreements are supposed to prevent a physician from building up a patient base, and then taking those patients with them as they set up their own practice. A physician moving to the VA simply does not fit that description. This provision would ensure that a non-compete agreement is never used to keep a physician from serving veterans at a VA facility, and only applies to such a circumstance.

Second, our bill updates the minimum training requirements for VA physicians. Completion of a medical residency is widely accepted as standard comprehensive training for clinical physicians in the United States. However, current law only requires that a physician be licensed in order to treat veterans. In the case of some medical specialties, the difference between licensing and completing residency can represent six years of training. Some have suggested that this provision would exacerbate the shortage of physicians at the VA by shrinking the pool from which the VA can hire. However, the VA currently hires almost exclusively those physicians which have completed residency training, so this provision would not result in such an impact.

Others have rightly submitted that veterans are largely satisfied with the quality of care they receive at the VA. They, therefore, submit that we do not need to legislate a higher standard. I contend that as long as Congress sees fit to impose any standard on the VA regarding those caring for veterans, we have a duty to ensure that the standard is appropriate. Completion of residency training is the accepted standard in this nation, and we should never expect veterans to accept anything less. This is a common-sense update to something Federal law already addresses and ensures that only fully trained physicians care for those who have served our nation.

Finally, our bill would place veterans' hospitals on a level playing field with the private sector when it comes to recruiting timelines. Often, private sector health care providers begin recruiting medical residents as they begin their final year of residency, sometimes even earlier. Most residents have school debt they will need to start paying off—an average of \$190,000. During residency they treat patients and work upwards of 80 hours a week, sometimes with single shifts up to 28 hours. These residents—rightfully motivated to secure a post-residency job with better pay and better hours—often accept a solid job offer from the private sector before VA recruiters are able to get their recruiting process started.

Our bill authorizes VA recruiters to make job offers to physicians up to 2 years prior to fulfilling all of the VA's requirements, contingent on meeting all requirements before they begin treating veterans. It offers job security to medical residents who want to work at the VA when they complete their training and allows VA facilities and recruiters to shore up appointments further in advance, helping them to plan and forecast medical workforce needs. VA recruiters are already pitching a great opportunity for physicians, and we owe them policies that make them as competitive as possible with private sector recruiters. I believe that advancement of this legislation will help begin to fill the VA's many vacant health care positions.

We've worked closely with this Committee's staff, VA recruiters, and VSOs on this bill, and I'm pleased to report that it has garnered wide support and formal endorsement from 10 VSOs including the American Legion, Blinded Veterans Association, AMVETS, Disabled American Veterans and Paralyzed Veterans of America. We are

forever indebted to the brave men and women who serve in uniform and we owe them our continued support as veterans. It's my hope we can work together to move this bill to the House floor soon.

Thank you, again, for your time and consideration.

Honorable Susie Lee (NV-03)

September 9, 2019

Chairman Takano, Ranking Member Roe, Chairwoman Brownley, and Ranking Member Dunn, Today I speak to the importance of my legislation, the Newborn Care Improvement Act, to the needs of veterans - particularly women.

As you may know, currently, veterans are eligible to receive seven days of newborn care following the birth of their baby, after which they must find and sign up for health insurance for their newborn. Very often, the new mothers receiving medical care from the Department of Veterans Affairs (VA) face challenges with time, finances, and complicated insurance choices while adapting to the new challenges of parenthood. My bipartisan legislation would double the available time of newborn care to fourteen days, providing additional time for a veteran to find the best health coverage for the needs of their family and baby.

I am proud to have introduced this critical, bipartisan legislation and know that it is one piece of a pivotal movement in improving the care provided to our women veterans at the VA. As I have said before, and want to reaffirm, again, our women veterans deserve the best health care and maternal care available to them and their families. Starting a family can be an overwhelming time for any parent, making it even more important to ensure our veterans have the resources and time they need to get the best maternal care possible.

I ask my colleagues to join me in passing this legislation and help improve the lives of the veterans in my district and across our grateful nation.

Honorable Chris Pappas (NH-01)

Good morning to my esteemed colleagues and members of the House Veterans Affairs Subcommittee on Health. I appreciate the opportunity to submit my statement for the record in support of the passage of my bill, H.R. 2681, concerning the availability of prosthetics for women veterans.

Earlier this year, I was shocked to learn that many of our female veterans are forced to use prosthetic items that were originally designed for men. Prosthetics designed for a different gender are not just cosmetically different, but in practice they may have differences that make a difficult transition even more burdensome for our veterans. For instance, a prosthetic item designed for a man will likely be on a larger scale and proportion than one designed for a woman. So, while a female veteran may receive a prosthetic for a lower leg injury whose socket technically fits, the foot of the device is likely to be much larger than her own. This creates additional problems in her rehabilitation process and is very often emotionally difficult.

My bill, co-sponsored by Representative Elise Stefanik (NY-21), requires VA to assess the availability of prosthetic items made specifically for female veterans available at VA medical facilities and to present their findings to Congress. This will give us a better idea of what options currently exist and where we can work with VA to ensure that our female veterans have access to prosthetic items that enhance their quality of life.

Women represent roughly 16% of the United States active duty force, 18% of the officer corps, and the 2,000,000 female veterans in our country represent the fastest group of veterans. They serve honorably and openly alongside their male counterparts and return home from deployment with the same psychological and physical wounds. When they do, they deserve to know that they will receive the highest-quality, specialized care that we can provide - and that includes prosthetic items that are specifically designed for them.

I appreciate the Subcommittee's time and consideration and urge the passage of my bill.

Thank you.

Honorable Elise M. Stefanik

Good morning Chairman Takano, Ranking Member Roe, and members of the Committee. I am grateful for the opportunity to testify before the House Veterans' Affairs Committee and discuss issues very important to my district. I proudly represent New York's 21st Congressional District-where nearly one in ten adults is a veteran. That's what makes the work of this Committee deeply personal to me and my constituents.

Tomorrow the Subcommittee on Health will discuss and debate several important pieces of legislation concerning Veterans' health care, many of which have a special focus on improving the access and quality of care for women veterans. I applaud the Committee, as well as your staffs, for focusing on this ever-important topic.

Another topic that the Subcommittee will discuss tomorrow is H.R.2816, the Vietnam Era Veterans Hepatitis C Testing Enhancement Act. This is an incredibly important bill. To help my colleagues understand why, I would like to share a story with you:

In 1970, Danny Kaifetz, a young man from the North Country, volunteered to serve in the United States Marine Corps while the country was embroiled in the Vietnam War. Danny completed training at Parris Island, and went on to Jungle Warfare School and Combat Infantry Training at Camp Lejeune. At some point during training-as any one of my colleagues who has been through boot camp knows-all the recruits were lined up, like a factory assembly line, and were inoculated with the necessary vaccinations. Back then the Armed Forces, to include the Marine Corps, used the Ped-O-Jet air inoculation device, or "jet-gun," to quickly vaccinate one recruit to the next. And as difficult as it for us to imagine today, medics were not required to sterilize the devices in between the inoculations. In fact, page 38 of the operator's manual, explicitly states "sterilization not required between injections." As we now know, this practice exposed thousands of recruits to dangerous, and often deadly, blood-borne diseases. Contamination happened without discrimination-to volunteers and to those who were drafted. To those who went on to serve honorably for several years and those who didn't make it through training. To those who saw combat and bear the emotional burdens of a horrific war and those who, through some good fortune, were spared.

Danny Kaifetz thought he was one of the lucky ones who was able to serve his country and fellow Marines without going to combat. He proudly fulfilled his duty and was distinguished with the Meritorious Service Medal at the completion of his service contract. But, unbeknownst to him, Danny did not leave the military unharmed.

Nearly forty years later, in 2011, Danny was diagnosed with Hepatitis C. He sought and received treatment at the VA, and today Mr. Kaifetz will tell you with gratitude that he owes his life to the outstanding medical staff at New York VA.

As you all know, Congress dedicated significant resources to enable the VA to test and treat veterans for the hepatitis C virus, and VA has made significant progress to date. However, these efforts primarily focus on Veterans enrolled in the VA, testing only 78% of the two million Vietnam-era Veterans enrolled in VA care. Estimates indicate as many as 1 in 10 of the eight million surviving Vietnam Era servicemember may be infected with hepatitis C due to the cross-contamination. Of those who do not meet VA eligibility criteria, as many as seven million are considered at high-risk for hepatitis C infection and unaware of their status. Our veterans deserve better.

The Vietnam Era Veterans Hepatitis C Testing Enhancement Act focuses on Hepatitis C screening and does not take away from the VA's efforts, rather enhances them. Furthermore, the bill is budget neutral by utilizing resources previously allocated by Congress through the Honoring America's Veterans and Caring for Camp Lejeune Families Act (P.L.112-154). The concept has proven successful at a local level due to the extraordinary efforts led by my constituent, Danny Kaifetz, and American Legion Post 1619. We owe it to a generation of veterans to provide this valuable screening tool. I urge my colleagues to join the American Liver Foundation, the AIDS Institute, and Vietnam Veterans of America to support H.R.2816.

Mr. Chairman and Ranking Member, I thank you for the opportunity to speak with you today. And I thank the entire Committee and staff for the invaluable work you do to support our nation's heroes. I look forward to working with you. I yield back.

Honorable Nydia Velazquez

Mr. Chairman Takano, Ranking Member Roe, and members of the Committee, I submit this written statement today in support of H.R. 3867, the Violence Against Women's Veterans Act of 2019. Although military sexual trauma (MST) is not a new issue, it currently lacks resources to combat it effectively. Every sexual assault in the military is a failure to protect the men and women who have volunteered to defend us. Today I'd like to thank the Committee for considering my legislation that will better help our servicemembers who have been victims of domestic violence.

Based on a 2014 study examining prevalence of MST, it is estimated that one-third of females in the military screen positive for MST, and the rates are higher for younger veterans.¹ MST refers to sexual harassment or sexual assault that occur in military settings. MST is the leading cause of post-traumatic stress disorder among female veterans resulting in many other mental health issues surpassing combat trauma.²

The number of women servicemembers and veterans is at an all-time high, with continued growth expected. Yet women servicemembers continue to face serious challenges in service; approximately 1 in 4 experience sexual assault or sexual harassment. Women veterans who experienced MST are more likely to suffer adverse outcomes such as mental health conditions, substance use, discharge from the military, unemployment, and homelessness. Sadly, women veterans make up the fastest-growing segment of the homeless population.³

For many of our veterans, the biggest battle of their lives will not be fought during deployment, but with the difficult memory of their abusers replaying in their minds. It is heartbreaking to think that our veterans, individuals who have fought for our freedoms, would have to endure this hardship.

For these reasons we need to improve the services provided by the VA. The Violence Against Women Veterans Act seeks to accomplish this by requiring an integration of VA services with proven, existing community-based programs that serve domestic violence or sexual assault victims.

With the establishment of the National Task Force on Domestic Violence, H.R. 3867 enables us to gather information on how to best provide comprehensive support to our veterans and seeks to create a network of local coordinators that facilitate cooperation between the VA and social services and assist domestic violence shelters and rape crisis centers in providing services to veterans. This is a vital component considering the number of sexual assaults reported by members of the U.S. armed forces is about a third of the total reported in a confidential survey of servicemembers.

Currently the VA does not have a comprehensive national program to address intimate partner violence (IPV). Notably, H.R. 3867 requires the Advisory Committee on Women Veterans to conduct an assessment of the effects of IPV on women. This required assessment, jointly with the VA convened Domestic Violence Task Force will define the scope of and design a plan for evaluating domestic violence among Veterans.

We can and must play a role in helping women veterans understand symptoms that they experience, to recognize MST and IPV, to know where to seek help and directly connect our Veterans with the help they need to improve the quality of their lives.

Members of the U.S. Army, Navy, Air Force, Marines, and Coast Guard courageously take an oath of enlistment to support and defend the United States. It is our obligation to take care of those who serve.

Minority Veterans Of America (MVA)

Prepared by: Lindsay Church, Executive Director

with inputs from Katherine Pratt, Director of Advocacy, and Kiersten Down, Board of Directors

¹ Cichowski, Sara et al. "Female Veterans' Experiences with VHA Treatment for Military Sexual Trauma." *Federal practitioner: for the health care professionals of the VA, DoD, and PHS* vol. 36,1 (2019): 41-47.

² O'Brien BS, Sher L. "Military sexual trauma as a determinant in the development of mental and physical illness in male and female veterans." *International Journal of Adolescent Health and Medicine*. vol 25,3 (2013): 74-269

³ Hamilton AB, Poza I, Washington DL. "Homelessness and trauma go hand-in-hand": pathways to homelessness among women veterans. *Women's Health Issues: Official publication of the Jacob's Institute of Women's Health*. vol. 21 (2011): 9-203

Chairwoman Brownley, Ranking Member Dunn, and distinguished members of the House Veterans Affairs Committee, Subcommittee on Health; on behalf of the Minority Veterans of America, an organization dedicated to creating community belonging and advancing equity for minority and underrepresented veterans, we thank you for the invitation to submit a statement for the record today and to share our position regarding legislation to support women veterans at the Department of Veterans Affairs.

Summary

As an organization, Minority Veterans of America (MVA) is pleased to see that Congress is taking steps to address issues of disparate health care for women and pre-9/11 veterans in the Department of Veterans Affairs (VA). The recent attention to and support of women veterans that the House of Representatives has taken with the introduction of the Women Veterans Task Force has resulted in legislation that works to address the concerns that organizations who serve women veterans have been bringing forward for years.

We are disappointed that much of the proposed legislation has not taken an intersectional approach and seeks to address one subpopulation of veterans in a binary way that fails to understand how other identities such as race, gender orientation (i.e. transgender and gender non-conforming veterans), LGBTQ status, or religious identity factor into the lives of our women veterans. This is important, especially in the area of research surrounding the barriers that women veterans experience when accessing their VA benefits. While women veterans broadly are in need of unique and increased medical care, the same can be said for transgender veterans who continue to receive inadequate and incomplete care through the VA system.

Additionally, few of these bills include any reference to funding or allocation of money to complete the task addressed. We understand that many of these bills are requests for action, but in order for the legislation to be properly implemented, they should be supported with at least the promise of an increase in funds to ensure that the task is accomplished properly.

Finally, it would be worthwhile to see greater reference to collaboration with existing centers that can support the requisite changes to the VA system. Of note, the Center for Women Veterans should serve as an excellent resource to answer the questions asked in HR 3636 and for implementing a centralized website as proposed in HR 2972. It is telling that in 2019 we don't even know how many women veterans are in each state nor do we understand how or if they use their VA benefits for their health care. These pieces of legislation are an excellent first step at better serving and understanding women veterans, but we would like to see more intersectionality and consideration beyond the binary in these and future bills.

HR 2628

Veterans Early Treatment for Chronic Ailment Resurgence through Examination Act of 2019

We support the Department of Veterans Affairs enacting legislation and changes to expand access to dental coverage broadly. The current levels at which dental coverage is offered covers only a small portion of the veteran community. In the communities we serve, particularly veterans of color who face greater health disparities and student veterans who do not have access to dental coverage through other means, this coverage is desperately needed. Currently, many veterans struggle to find adequate access to dental insurance and for this reason, their oral health suffers greatly after service.

The greatest concerns we have regarding this legislation center on the limiting nature of the qualifications for the pilot. Of greatest concern is the age limitation which states that a veteran must be between the ages of 40 and 70 years old. As we struggle to find ways to better serve the youngest generation of our nation's veterans, this limitation effectively eliminates a large portion of the veterans who served after 9/11. Additionally, the disqualification of individuals who are in need of periodontal surgery limits access to care for those with the most severe dental needs.

The position of MVA is that dental care should be broadened to serve a greater portion of our community. The current level of care for most veterans is unacceptable as we recognize the link between better oral health and improved health outcomes. This pilot legislation seeks to prove what civilian institutions, such as the U.S. Department of Health and Human Services and the Mayo Clinic, have already proven - better oral health leads to improved health outcomes.

HR 2645**Newborn Care Improvement Act of 2019**

MVA supports the extension of the coverage for newborn care for women veterans from the current seven days to the 14 days. The issue with this legislation is that there is little known about maternity care or maternity benefits that the VA provides or can provide. Many women veterans are unaware of the benefits that are currently offered and the current materials available, even on the Center for Women Veterans' site are ambiguous and does not provide details on what, if any, care is provided.

For this legislation to be impactful, it will be important to understand how many veterans are currently using this benefit and how the outreach about these benefits can be expanded. It should not be the veterans responsibility to navigate a process that is convoluted, the information needs to be readily available and easily accessible. In addition, there is concern among providers that women veterans are not being admitted to community care within the window of 30 days that the VA holds as the standard. The next step to improving this benefit is to assess what the wait time is for expectant mothers between when the referral is issued by the provider and when they are admitted by the community based provider.

HR 2681

MVA supports seeking to better understand the availability of prosthetics available to women veterans. In order to be inclusive of all women veterans, this legislation will need to include prosthetic availability for transgender veterans. The prostheses necessary for transgender veterans are both medically necessary and, in the absence of the VA performing gender affirming surgeries, is the best that the VA currently offers to our transgender veterans. The availability of these devices should not be limited to specific hospitals or areas of the country.

HR 2752**VA Newborn Emergency Treatment Act**

MVA supports the expansion of newborn emergency treatment. This legislation to amend the current code to include transportation for newborn children in emergency situations will require further clarification as to who "certain women veterans" are. This legislation and outreach about the services available need to be targeted in nature to ensure that the communities of women veterans who experience the highest rates of premature birth and other complications, primarily women of color, have this information available to them. It is imperative now that marginalized populations gain access to pre- and post-natal care.

HR 2798**Building Supportive Networks for Women Veterans Act**

As an organization, MVA supports the reintegration of women veterans through means that support the holistic transition of the individual. It is our belief that alternative treatments create opportunities for veterans to choose the methods that work best for them in their process or journey. It is not, however, our position that the VA should be facilitating these retreat settings themselves. There are currently many retreat style programs that exist in the community that are doing excellent work. Rather than creating new programs, the VA should contract with or allocate funding to support programs with proven records of success. With the current lack of confidence of the women veteran community broadly, it is not prudent to create a program that requires more trust on the part of the veteran without a proven track record of supportive care.

Additionally, we would like to see that veterans of all genders have access to the same treatment setting to support better reintegration. Without offering this to the entire community, there is a chance of creating a greater stigma for women veterans as they take advantage of these programs.

Finally, the limitation of access to those who have returned from prolonged deployments severely limits the number of women veterans who can take advantage of a program designed to help them more successfully reintegrate. Women veterans encounter a range of traumas such as Post-Traumatic Stress, Traumatic Brain Injury, and rape and sexual assault, among others, while serving that could benefit from this type of program.

HR 2972

MVA supports the existence of a centralized website for women veterans though, the creation of a new site seems duplicative in nature. If the VA seeks to create this site to ensure that there is easily accessible information available to women veterans, it will be imperative to integrate this site with the current site administered by the Center for Women Veterans. Rather than creating anything new and causing confusion for the user, the current site should be overhauled and usability testing conducted to ensure it is accessible for individuals with differing abilities.

HR 2982**Women Veterans Health Care Accountability Act**

MVA supports the study of health barriers impacting women veterans' access to care. In order for this study to be comprehensive, it is imperative that it be extended in the following ways:

Expansion of questions surrounding the stigma of seeking mental health care services to include seeking mental and physical health care services at the VA specifically. While there is a stigma in the community of veterans broadly regarding receiving mental health treatment, there is also a stigma that is just as strong against using any form of VA care. It is important to note where women veterans feel most comfortable receiving their mental health care to expand services in this manner.

Expansion of questions surrounding the personal safety and comfort of patients as well as the gender sensitivity of staff and providers at VA facilities to include behavior carried out by patients. While it is extremely important to include questions regarding staff and providers at the VA, it is often not only the providers that are the perpetrators of behavior that makes women veterans feel unsafe or unwelcome in VA facilities. This will be important to developing solutions and strategies for addressing the concerns of women veterans.

Introduce a question about the VA's motto to gauge the impact to the community of women veterans. As it stands, the VA's motto is outdated and does not include women or gender diverse individuals. In this study of the barriers to access, this is an important topic to understand the feelings of the community and how the motto contributes to a culture that is exclusionary to women veterans.

Additionally, the results of this study should be mandatorily reviewed by each department of the VA that serves women veterans. This information is imperative to creating truly inclusive programs and should not be siloed within the Center for Women Veterans. To impact the necessary changes, all departments of the VA need to be involved in helping to create solutions to the issues that women veterans are experiencing across the organization.

HR 3036**Breaking Barriers for Women Veterans Act**

MVA supports facility upgrades to better serve women veterans across the VA health care system. The appropriation of \$20 million to support this legislation along with additional funding to provide training to providers of health care for women veterans in the community is important to ensuring this legislation is executed properly. We encourage the addition of greater oversight measures to this legislation to ensure that all monies are distributed to the necessary infrastructure upgrades and not reallocated to other projects and priorities in a flat funded organization.

HR 3224

As an organization, we are supportive of the expansion of the VA's hours to ensure that women veterans are able to access their care on schedules that work with their own. The issue with this legislation is that the VA is already struggling with being understaffed and is barely able to serve the veterans who are waiting for care within their normal hours. Should this legislation be enacted, especially without the promise of additional monetary support, it's unclear as to if this can be accomplished. As a whole, the VA needs to place an emphasis on filling the alarming number of vacancies system-wide and ensure that the veterans using the system, in its current iteration, are able to receive care as well as looking at extending the hours of operation.

HR 3636**Caring for Our Women Veterans Act**

MVA believes that it is imperative that the VA maintain accurate reporting regarding the number of women veterans using the VA for their care. It is telling that in 2019, the number of women veterans in each state using care is not readily available with the VA's Center for Women Veterans already in existence.

When these surveys are being conducted at VA facilities across the country, numbers should also be collected on other identities that can inform care and point to underserved populations. It is the recommendation of MVA that reporting also be conducted across identity groups such as race/ethnicity, gender orientation (i.e. cis-, trans-, and non-binary), sexual orientation (if disclosed), and religious identity. These identities can help to better assist the VA and Congress to identify underserved populations and more accurately prescribe actions that will address the department's deficiencies through providing culturally appropriate care.

Additionally, data should be collected regarding the number of patients who used the VA multiple times in the year and the number of patients that have only used their benefits once. These data sets will point to patient retention and attrition more accurately.

Lastly, in regards to the number of providers at each facility dedicated to the care of women veterans, it is important for the community to understand what the goal is in regards to the ratio of patients to providers is. In some cases, staff sizes are larger and more able to adequately support and serve the women veterans in that area or region but in smaller cities and rural areas, there are very few dedicated providers. What is the long-term goal or outcome?

HR 3867**Violence Against Women Veterans Act**

MVA opposes HR 3867 as it is written as the language of this bill is extremely problematic and has the potential to further stigmatize women veterans. While we recognize and support the need for expanded services for survivors of military sexual assault and sexual violence as well as survivors of domestic violence, this legislation further marginalizes women by identifying them as the primary community that experiences rape, sexual assault, and domestic violence. While women have higher instances of sexual assault and violence per capita, there is still a large population of male and gender diverse survivors that need access to this same level of care but may not feel included by the title of this bill and the binary gender references throughout.

This legislation also does not take into account that members of the LGBTQ community experience greater instances of sexual violence in the civilian population than their heterosexual counterparts in the general public. In the absence of the military collecting and reporting on the LGBTQ status of servicemembers, the assumption must be made that the military population is reflective of the general population. As we engage with and support the minority and underrepresented veteran community, we see a direct correlation between a history of sexual assault and violence and our members' LGBTQ status. Members who are LGBTQ are more likely to be survivors of rape or sexual assault while serving than their heterosexual counterparts.

Additionally, HR 3867 only accounts for veterans and the coordinated care network to serve them but does not account for or discuss collaboration with the Department of Defense where many instances of sexual assault and domestic violence begin. This bill, while intended to be holistic in nature, does nothing to move toward a culture of prevention.

Bill to establish in the Department of Veterans Affairs the Office of Women's Health

MVA supports Congresswoman Brownley's legislation proposing the creation of the Office of Women's Health as well as the Director of Women's Health in the VA. The creation of this office will allow for greater oversight of the overall care available to women veterans. As this legislation is introduced, it will be important to include a funding note that will allow for this legislation to be enacted and the office to be funded. The expansion of care and oversight of the offerings to women veterans is imperative to the overall success of the VA's women veteran program. Moving forward, we would like to see collaboration with the VA's current Center for Women Veterans to ensure that silos are not created within the system and that

both offices are able to work side-by-side to achieve better care for our women veterans. This legislation and the prioritization of women veterans in the VA system is long overdue.

Additionally, we recommend that this and all legislation intended to support women veterans explicitly note the support of transgender women veterans and veterans who do not identify as women but are in need of gynecological care. This will ensure equitable access for all women veterans in the VA system.

Military Women's Coalition (MWC)

Chairwoman Brownley, Ranking Member Dunn and members of the Committee, thank you for the opportunity for the Military Women's Coalition to provide a statement for the record on the health legislation before the Committee today.

Background: The MWC is a national coalition of formal and informal organizations who work collaboratively to serve and support US active duty, Guard, reserve, Veteran and retired service women by uniting and elevating their voices to influence policy and improve their well-being. Our vision is that someday military women are fully integrated, equally respected and equally supported members of the military and veteran community and their contributions are recognized as essential to national defense. Currently there are 18 organizations in the Coalition from across in the nation.

Better Health care for Women Veterans: Members of the MWC are particularly concerned about the health care provided to women veterans as good care has often been lacking in many areas. The MWC is encouraged to see so many efforts underway to rectify failures and shortcomings in the existing system. Although the MWC supports all of the legislation under consideration we strongly support the following legislation:

HR 3636
 HR 2972
 HR 2645
 HR 2681
 HR 3224
 HR 2752
 HR 2628
 HR 2816
 HR 1527
 HR 3798
 HR 3867
 HR 4096
 Draft Bill

A few members of the MWC expressed reservations about some of the proposed legislation. Their concerns had to do with vague language, costs and redundancy.

HR 3036 There were concerns about cost and therefore execution of this legislation.

HR 2798 There were concerns about cost and the vagueness of the language in this legislation.

HR 2982 Several organizations felt that another study is a waste of money because the needs have already been identified in other studies.

HR 1163 Several organizations abstained from providing support or opposition to this legislation.

This statement is submitted on behalf of the Military Women's Coalition by Ellen L. Haring, the Coalition Steering Committee Chair.

Sincerely,

Ellen L. Haring, PhD
 Steering Committee Chair
 Military Women's Coalition

MWC Steering Committee Organizations

Service Women's Action Network
 Women in Military Service For America
 Protect Our Defenders
 GA Military Women
 Service: Women Who Serve Pink Berets
 Red Feather Ranch
 WINC: For All Women Veterans

Northeast Florida Women Veterans
 Combat Female Veterans Families United
 Veteran Women Enterprise Center

Veterans Of Foreign Wars (VFW)

CARLOS FUENTES, DIRECTOR
 NATIONAL LEGISLATIVE SERVICE

Chairwoman Brownley, Ranking Member Dunn, and members of the Subcommittee, on behalf of the women and men of the Veterans of Foreign Wars of the United States (VFW) and its Auxiliary, thank you for the opportunity to provide our remarks on legislation pending before this Subcommittee.

H.R. 1163, VA Hiring Enhancement Act

Section 2

The VFW supports this section which would remove barriers for employment of health care providers who were required to sign a non-compete contract with previous employers. By removing this barrier more medical professionals who want to treat veterans would be able to pursue a career at the Department of Veterans Affairs (VA) medical facilities.

Section 3

This section is intended to authorize VA to hire physicians who are in the process of completing a residency and to codify training requirements for VA providers. The VFW is concerned that this section may unintentionally limit VA's authority to offer contingent employment offers to physicians who are completing a residency. Section 206 of Public Law 115-46, VA Choice and Quality Employment Act of 2017, authorized VA to hire students and recent graduates. This section may limit such authority to a two-year period for physicians. The VFW recommends removing such limitation.

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

The VFW supports this legislation which would authorize VA to enter into contract agreements for non-VA medical foster homes. By expanding this option of long-term care to veterans who are unable to live independently but do not want to be institutionalized, Congress would be providing veterans with the ability to receive the care they need while also maintaining their quality of life. The VFW urges Congress to pass this legislation, which would provide more options for veterans to decide what form of long-term care is right for them.

H.R. 2628, VET CARE Act of 2019

The VFW supports this legislation which would improve dental care provided to veterans by VA through a pilot program, and expand outreach regarding the VA Dental Insurance Program (VADIP). While the VFW would prefer to see legislation that would expand eligibility for VA dental care to all veterans who are eligible for VA health care, the VFW supports this bill.

For the past five years, the VFW has partnered with Student Veterans of America (SVA) to select ten student veterans from across the country to research and advocate for the improvement of an issue that is important to veterans. VFW-SVA fellow and George Washington University student Tammy Barlet focused her semester-long research project on dental health for veterans. In her research, Tammy found that four out of 10 veterans describe their oral health as poor to fair and that veterans are at higher risk of developing gingivitis compared to their civilian counterparts. Lifestyle behaviors such as poor eating habits, smoking, and chewing tobacco; mental illness, including depression, anxiety disorder, and post-traumatic stress disorder; toxic exposures; rural versus urban environments; gender; and polypharmacy are some of the factors that increase a veteran's risk of developing gingivitis. Tammy also found that a healthy smile is linked to job security. In fact, VA is currently authorized to extract teeth from veterans who are inpatients, but does not have the authority to replace such teeth with prosthetics or dentures unless the veterans is otherwise eligible for VA dental care. The VFW has heard from veterans who felt embarrassed to attend employment interviews or go back to work with missing teeth.

There is a large disparity between VA and Department of Defense (DoD) dental coverage, which can have a significant impact on the health and quality of life for

veterans. To this day, servicemembers are required to maintain a high level of dental readiness, to the extent that they are placed on a non-deployable status if they fail to receive a dental evaluation every year. However, only veterans who are 100 percent service-connected disabled, certain homeless veterans, and those who have a service-connected dental condition are eligible for VA dental care. The majority of veterans enrolled in VA health care are unjustly denied access to VA dental care. Instead, they are offered the ability to purchase dental insurance through VA, which has high costs and poor coverage. VFW members who are asked for feedback on VADIP report that it is better than nothing. Those who have worn our nation's uniform deserve the best, not "better than nothing."

However, it is important for veterans to know that VADIP is an option. For that reason, the VFW supports requiring VA to provide information on VADIP to veterans. The VFW would recommend that the Subcommittee expand the outreach requirement to include outreach at all VA medical centers and through the VA Welcome Kit. All VA health care enrolled veterans are sent a VA Welcome Kit which details their VA benefits. The only mention in the kit of dental care is in reference to a one-time appointment veterans are able to receive if they are within 180-days from their military service separation date.

This draft legislation would create a pilot program to expand dental care services to veterans who are enrolled in VA at five locations across the country. The pilot is also limited to 1,500 veterans who are between 40 and 70 years of age, do not receive regular periodontal care, and have been diagnosed with type 2 diabetes. The VFW understands that veterans who need dental care access the most must be prioritized, but would urge the Subcommittee to expand the eligibility to include all veterans enrolled in VA health care.

H.R. 2645, Newborn Care Improvement Act of 2019

The VFW supports this legislation, which would expand VA's authority to provide health care to a newborn child, whose delivery is furnished by VA, from seven to 14 days post-birth.

My wife and I are expecting our first child this month and recently discussed our options for providing him with health care coverage. Before this month, VA was my only health care option. I am fortunate that the VFW's employee-sponsored health care plan open enrollment was this past month, so I was able to enroll in the VFW's employee-sponsored health insurance so my son can have health coverage after he is born. If he were born before the open enrollment period, I would have needed to wait months or up to a year to enroll him. Women veterans in my situation may not be so lucky. Women veterans who rely on VA health care for their maternity care have seven days to find health care coverage for their child. The time following the birth of a child is a hectic time for new parents. Whether their newborns have health care coverage is the last thing on their minds.

According to the Centers for Disease Control and Prevention, newborn screenings are vital to diagnosing and preventing certain health conditions that can affect a child's livelihood and long-term health. The VFW understands the importance of high-quality newborn health care and its long term impact on the lives of veterans and their families. To align this bill with common practice in the private sector, the VFW urges the Subcommittee to expand the time a newborn child is covered by VA to 30 days. Doing so would ensure newborns receive the proper post-natal health care they need.

H.R. 2681, to direct the Secretary of Veterans Affairs to submit to Congress a report on the availability of prosthetic items for women veterans from VA

The VFW supports this legislation, which would require VA to review whether VA provides prosthetics that meet the needs of women veterans. VFW members have reported being prescribed VA prosthetic items such as shoes and eyeglasses, but not being able to receive them because VA did not have women's shoes or frames they could use. The VFW supports an audit of availability of such items.

H.R. 2752, VA Newborn Emergency Treatment Act

The VFW supports this legislation which would expand VA's current authority to cover the cost of emergency transportation for eligible newborn babies. Under current law, VA is authorized to provide seven days of medical coverage for newborn children, but that coverage does not include emergency transportation if a newborn requires treatment that is not available at the medical facility where the child was born.

The VFW has long supported expanding the length of time a veteran's newborn child is provided medical coverage by VA, and believes also expanding current legis-

lation to include emergency transportation is common sense. If a veteran gives birth to a child who then has an emergency medical situation which the birthing facility is unable to address, VA must cover the cost of transporting such newborn to a facility that can provide the required care. Veterans in this situation are already under a great deal of stress, and it is unjust to then add the burden of emergency transportation costs.

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

This legislation would establish a permanent program of retreat counseling services for women veterans. The VA pilot counseling retreat program has served as an invaluable tool to help newly discharged veterans seamlessly transition back to civilian life. The VFW supports making this program permanent.

Another successful program created by the Caregivers and Omnibus Health Services Act of 2010 is the child care pilot program. This program has been well received by veterans at all four pilot sites and has also contributed to the success of the counseling retreat program. The VFW has heard from veterans who say they could not have completed their treatment programs if not for the services offered through VA's child care pilot program.

The VFW thanks the Subcommittee and Chairwoman Brownley for securing House passage of H.R. 840, the Veterans' Access to Child Care Act, which would make the child care pilot permanent. The VFW is hopeful that the Senate would follow your lead and pass it as well.

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

This legislation would require VA to host outreach events with veterans organizations to expand hepatitis C (HCV) testing. The VFW agrees with the intent of the bill, but does not believe it is needed.

The VFW lauds VA for its efforts to test for and cure HCV. It recently announced that the VA health care system has cured more than 100,000 veterans with HCV. In an effort to maximize outreach, VA has reached out to veterans organizations and made itself available for organizations that would like to host testing events, similar to what is required by this legislation. VA medical staff is present at the VFW National Convention every year and has conducted such testing.

The VFW does support the provision to require VA to report to Congress activities it conducts as part of the HCV campaign.

H.R. 2972, to improve the communications of VA relating to services available for women veterans

The VFW supports this legislation, which would rightfully expand the authority of the VA Women Veterans Call Center to communicate via text message, and ensure women veterans are able to easily connect with women's health coordinators at their VA medical facilities.

H.R. 2982, Women Veterans Health Care Accountability Act

This legislation would require VA to conduct a comprehensive study of women veterans health care. The VFW supports this bill and has a recommendation to improve it.

In 2016, the VFW conducted a survey of nearly 2,000 women veterans as a way to evaluate the performance of VA in caring for women veterans. Over the past three years, we have worked with VA and Congress to address health care, identity and outreach, and homelessness issues identified in the survey. We found that women veterans overwhelmingly prefer to receive their health care from women primary care providers, and are more likely to be satisfied with their VA health care experience when they receive care from female providers.

VFW members reported concerns regarding gender-specific competencies in specialty clinics. For example, veterans reported having problems finding prosthetic options suitable for women, leaving them with no choice but to use uncomfortable products that do not fit properly. In orthopedics, veterans reported that doctors fail to treat them with their gender in mind. VFW members have also voiced concerns about the lack of gender-specific training for mental health care providers. The VFW thanks the Subcommittee for considering this legislation which would commission a study to evaluate whether VA has been successful in addressing these issues, and require it to develop a plan to further improve health care for women veterans.

The VFW survey of women veterans also found that older women veterans were less likely to report receiving disability compensation, but equally as likely to have been injured or made ill as a result of their military service. Similarly, older veterans were less likely to report that they use VA health care, but equally as likely

to report being eligible for VA health care than their younger counterparts. We were also concerned that several respondents who reported being 55-years-old and older believed they did not rate the same benefits as their male counterparts, which is an egregious misperception that must be addressed. No veteran should be left to wonder what, if any, VA benefits she is eligible to receive. It must be clear that women veterans have earned the exact same benefits as male veterans. That is why the VFW urges the Subcommittee to expand the scope of the study to include an analysis of non-health care programs and benefits that serve women veterans.

H.R. 3036, Breaking Barriers for Women Veterans Act

The VFW support this legislation which would require VA to evaluate whether VA's infrastructure must be modified to meet the health care and privacy needs of women veterans, increase staffing, and establish women-centric training for community care providers.

Barriers to health care is a significant concern for VFW members. Particularly, VA must be more proactive than reactive when it comes to access to gender-specific care for women veterans. As the women veteran population continues to grow, VA must ensure it provides care and services tailored to their unique health care needs. Veterans deserve access to the best treatment and care this nation has to offer. That is why it is crucial for VA to outfit existing facilities with basic necessities, such as curtains for privacy in women's clinics. These clinics also need to maintain at least one primary care provider with expertise in women's health who is able to train others.

However, the VFW recommends removing the option of one part-time provider. A part-time provider would limit access to care for woman veterans and decrease the provider's ability to maintain gender-specific expertise. While we understand that not every VA medical facility can have a doctor who devotes 100 percent of clinical time exclusively to women veterans, it is unacceptable for veterans to wait for care simply because the provider at their facility is only there on certain days of the week. The primary duty of Designated Women's Health Primary Care Providers must be to care for women veterans, but some should have the ability to see male veterans to fill their schedules or panels. Regardless, the VFW believes that all VA medical facilities must have at least one full-time provider trained to care for the unique needs of women veterans.

H.R. 3224, to provide for increased access to VA medical care for women veterans

The VFW supports this legislation, which would require VA to continually make available gender-specific services. VFW members have reported facing delays or barriers to accessing gender-specific services at remote locations and at facilities that have the demand for gender-specific service, such as mammogram machines, but have failed to do so or have inaccessible services. The VFW does suggest, however, that the report required by this legislation include data on timeliness of gender-specific services. Some facilities may have gender-specific services available, but wait times prevent veterans from utilizing them.

H.R. 3636, Caring for Our Women Veterans Act

The VFW supports this legislation, which would require reports on staffing and locations that provide care to women veterans. All three reports required by this bill are due 90 days following enactment of the bill and annually thereafter. To ensure uniformity in reporting, the VFW recommends consolidating the three reports into one comprehensive report.

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

This legislation would require VA to provide veterans contraceptive items without copayments. The VFW cannot support this bill because it is too narrow. The VFW recommends the Subcommittee consider and advance H.R. 3932, Veterans Preventive Health Coverage Fairness Act. The VA formulary currently carries all categories of pharmaceuticals deemed preventive by the U.S. Preventive Services Task Force. However, VA is exempt from requirements to provide preventive care and services without cost-shares.

Cost is a significant barrier for veterans who use VA health care, whom have been found to have lower income on average than veterans who do not use VA health care. There are currently 11 categories of preventive medications found to be effective by the U.S. Preventive Services Task Force, which include contraceptives and aspirin to lower the risk of cardiovascular disease. Cardiovascular disease is the number one cause of death in the United States and is highly prevalent among the veteran population. Additionally, folic acid is recommended for pregnant women to

prevent neural tube defects. It is unjust to require women veterans to pay for the cost of medication to prevent such birth defects. Vitamin D is another preventive medicine which is often prescribed to prevent bone fractures, which benefits traumatic brain injury patients with hindbrain injuries. There is also breast cancer prevention medication which is useful not just for individuals with a family medical history of breast cancer, but for Camp Lejeune toxic water survivors who have been found to suffer from increased rates of breast cancer. These pharmaceuticals have been found to prevent possible deadly disease and to lower long-term health care costs.

This legislation would leave out veterans who are in need of other preventive medicines. That is why the VFW calls on the Subcommittee to consider and pass H.R. 3932, Veterans Preventive Health Coverage Fairness Act, which would eliminate this inequity and ensure veterans have access to lifesaving preventive medicine.

H.R. 3867, Violence Against Women Veterans Act

The VFW supports this legislation, which would enhance VA's efforts to address domestic violence and sexual assault. While the language of the bill does not explicitly limit the program, study, and taskforce created by this bill to women veterans, the VFW recommends the Subcommittee make clear that such provisions apply to all veterans.

Sexual assault continues to be a problem within DoD for all active, reserve, and guard components and for veterans of all backgrounds without regard to age, gender, or race. Most survivors of military sexual trauma (MST) are males, but women are disproportionately affected. While DoD continues to increase its efforts to reduce or eliminate sexual trauma within the military service, the number of servicemembers affected by MST is slow to decline. The VFW agrees that a collaborative effort in awareness, reporting, prevention, and response among all branches of the Federal and state governments is needed.

VA has a national MST screening program that screens all patients enrolled in VA for MST. National data from this program reveals that about one in four women, and one in 100 men, respond affirmatively to having experienced sexual trauma while serving their country. All veterans who screen positive are offered a referral for free MST-related treatment, but notably does not trigger the VA disability claims process. Previous years of VA data show growing numbers exceeding 100,000 veterans receive care for MST-related treatment.

In fiscal year 2017, 3,681 men and 8,080 women submitted claims to VBA for health problems related to MST. Of those claims, 55 percent of claims from males and 42 percent of claims from females were denied. This is why the VFW encourages Congress to continue its oversight efforts on VA care related to MST and VBA's process of handling MST claims. It can take many years for survivors to even acknowledge a trauma occurred, and sharing details with advocates and care providers can be extremely difficult. Survivors of sexual assault often report they feel re-traumatized when they have to recount their experiences to compensation and pension examiners. Therefore, we encourage VA to employ the clinical and counseling expertise of sexual trauma experts within the community to ensure VA can provide the care and benefits sexual assault survivors deserve.

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

The VFW supports this legislation which would require VA to report on gender-specific community care, and increase compliance of VA women veterans health care policies.

Due to a lack of capacity of gender-specific services at VA medical facilities, women veterans are often required to rely on community care for services such as mammography, obstetric care, and gynecological care. In the VFW's women veterans survey, nearly 40 percent of women who reported using VA community care said they did so for gender-specific services. This legislation would ensure veterans who rely on community care are provided the best possible care available and would ensure such care complies with best practices.

This legislation would also require increased compliance with VA's women veterans health care policy. However, it references a women's health handbook that the VFW was unable to find. VA has published Veterans Health Administration (VHA) Directive 1330.01, which establishes standards for the delivery of health care to women veterans and specifies the roles and responsibilities of staff. VA often issues directives and guidance to the field, but fails to conduct the appropriate quality assurance to verify compliance. The VFW supports requiring VA to enforce compliance with VHA Directive 1330.01.

Draft bill to establish in VA the Office of Women's Health

The VFW support this legislation, which would establish an officer of Women's Health to provide centralized monitoring and standardized implementation of VA women veterans health care policy and programs. The VFW has enjoyed a great partnership with the VHA Patient Care Services Women's Health Services office. This office has been integral in ensuring VA is ready and able to provide high-quality care for women veterans. Elevating this important office would ensure more can be done for the brave women who have worn our nation's uniform.

National Association Of State Women Veteran Coordinators (NASWVC)

Chairwoman Julia Brownley, Ranking Member Dr. Neal Dunn, and members of the Subcommittee on Health, on behalf of the National Association of State Women Veteran Coordinators thank you for this opportunity to share support for Women Veterans nationwide.

Today is a small but vital step toward progressing the quality of life for Women Veterans across the country. The National Association of State Women Veteran Coordinators (NASWVC) has worked tirelessly to ensure that our voices do not go unheard. We are an alliance which represents Women Veterans from all of America and her territories, from the sandy beaches of Florida, to the snow-capped mountains of Alaska and into the proud territories of Puerto Rico and Guam. On this day, we are proud to stand as one in such a venue.

Women Veterans are the fastest growing Veteran group. We total approximately 2 million and account for over 9% of the U.S. Veteran population but are projected to account for 15% by the year 2025. Currently, women account for 22% of enrollees in military academies - a sharp increase in only a few decades. Their graduation rates are currently on par with their male counterparts.¹

The National Association of State Women Veteran Coordinators recognizes that there are four pressing issues facing Women Veterans today: 1) Military sexual trauma (MST) 2) Homelessness 3) Suicide and 4) Access to health care. Because these issues are all linked together as both negative outcomes and risk factors, NASWVC has made them priority issues, or pillars, upon which we will base our education, policy, and outreach for the next year. While each of the bills before the Committee are important, NASWVC has chosen seven to overwhelmingly endorse, as they are each tied intrinsically to one or more of our stated priority areas.

HR2681: While in service, Women Veterans experienced the problems that are associated with wearing gear designed for men (for example, flak vests, which can leave permanent scarring on the hips), and once discharged report to the VA for care only to find that the same conditions exist. While a woman is pregnant her center of gravity and balance will be greatly different. Wearing a prosthetic designed for a man will indeed hinder her mobility during much of her pregnancy. Properly fitted prosthetics, from insoles to artificial limbs, are important for both physical and mental health and can define for a Woman Veteran not only how she feels about herself but the importance she sees the VA placing on her as a Veteran. It can go so far as to determine whether she returns to the VA for care. This is why NASWVC is happy to support HR2681.

HR2982, HR3036, and HR3636: Substance use, mental health disorders, eating disorders, and MST are all risk factors associated with suicide and homelessness. The VA offers care specific to each of these issues for Women Veterans, yet not enough Women Veterans are using these services because of barriers to care or accessibility issues. Barriers to care for Women Veterans in many ways look different than they do for men. Aside from commonalities such as wait times, Women Veterans also report that safety, child care, comfort, and appropriate, and properly trained providers can all be barriers to obtaining care at the VA. Additionally, one in three Women Veterans experienced some form of military sexual trauma while on active duty², which has been associated with increased physical health symptoms, impaired health status, and more chronic health problems in veterans³. Obtaining physical and mental health care can mitigate the symptoms and reduce the

¹ <https://www.rand.org/pubs/research—briefs/RB9496/index1.html>

² Iovine-Wong, P.E., C. Nichols-Hadeed, J. T. Stone, et al. 2019. Intimate partner violence, suicide, and their overlapping risk in women veterans: a review of the literature. *Military Medicine*.

³ Suris, A. Lind, L. 2008. *Military Sexual Trauma : A Review of Prevalence and Associated Health Consequences in Veterans, Trauma Violence Abuse* DOI: 10.1177/1524838008324419

negative outcomes of MST and the other risk factors, making early and ongoing access to health care vital. In 2015, 22% (or approximately 456,000) Women Veterans, used VA health care. What's more notable, however, is the difference in use among those who are enrolled and not using VA health care (13.5%) or are not enrolled (64.1%)⁴

The Department of Veterans Affairs has found that among Veterans with suicide ideation, there is a substantial decrease in risk between those who use and those who do not use the VA. Since 2001, the rate of suicide among Veterans who use the VA increased by 8%, while among those who did not use the VA it increased by 38.6%. However, when examining that difference through a gender lens, the rate difference for Women Veterans is more obvious, at 4.6% increase for women who use the VA vs 98% those who do not⁵. Analyzing the data in this way, becomes more apparent that reducing barriers and connecting women to services is a vital step in helping to reduce suicide attempts.

Environmental factors are indeed often listed by Women Veterans as a barrier to care at the VA. While steps have been made to reduce these factors within Women's Health Clinics, departments outside Women's Health Clinics where women must receive services that extend beyond their reproductive and breast health (e.g. lab, internal medicine, oncology, etc.) are too often unfriendly environments for Women Veterans in the VA. Environmental factors could run the gamut from the arrangement of chairs in waiting rooms to an exam room with no curtain, which leaves the veteran exposed when the door opens.

Truly integrated care is a consideration that is also a challenge outside Women's Health Clinics. It means not receiving a letter addressed to "Mr." (or not being called Mr. when in the waiting room); not having the option of a female provider - especially when you have MST or another form of personal trauma; not having to wear "one size fits all" drawstring pants that are four sizes too big; or not being forced to wear pajamas cut for a man's body yet being disallowed to wear a bra-siere or undershirt and feeling exposed. While those who have not experienced such trauma may consider these small things, they can mean the difference between feeling comfortable and safe enough to get the needed care versus resorting to detrimental self-help practices. These small examples are easy to remedy but such simple things can be important. Ensuring that these changes happen not just in larger medical facilities but are also examined and changed in Community Based Out-patient Clinics will be a critical to step to removing barriers for women veterans.

Supporting Women Veterans in the U.S. and territories and serving all Women Veterans regardless of status for over 20 years, the NASWVC offers its full support for HB2982, HR3036, and HR3636. We recommend that throughout the nation the NASWVC along with the state level Women Veteran coordinators be involved as partners throughout each of the survey processes.

HR 2798: The National Association of State Women Veteran Coordinators acknowledge that one-third of women in the military screen positive for MST⁶, and some surveys have shown this number to be as high as 59% (2016 Oregon survey of women veterans⁷). PTSD is one of the three most prevalent diagnostic issues Women Veterans face⁸; and sexual assault is more likely to result in symptoms of PTSD than are most other types of trauma, including combat⁹, yet there remains a scarcity of retreat centers for Women Veterans in the United States that address MST, and for many women this is not something they seek care for until decades after separation. There are large sections of the country where there are no retreat options available. Recent research by the Department of Defense has found that the rate of sexual assault, rape, and harassment during active duty increased 30% from 2016 to 2018. While women are 20% of the military, they are 63% of assault victims¹⁰. Given the overwhelming number of Women Veterans who live with military sexual trauma, NASWVC recommends that Military Sexual Trauma be listed specifically as one of the Covered Services for retreat settings for Women Veterans

⁴ The Past, Present and Future of Women Veterans, Department of Veterans Affairs, National Center for Veterans Analysis and Statistics, February 2017

⁵ <https://www.va.gov/opa/publications/factsheets/Suicide-Prevention-FactSheet-New-VA-Stats-070616-1400.pdf>

⁶ Klingensmith K, Tsai J, Mota N, et al. Military sexual trauma in US veterans: results from the national health and resilience in veterans study. *J Clin Psychiatry*. 2014;75(10):e1133-e1139.

⁷ <https://www.oregon.gov/odva/Connect/Documents/FinancialReports/2016%20ODVA%20Women%20Veterans%20Health%20Care%20Study.pdf>

⁸ <https://www.womenshealth.va.gov/WOMENSHEALTH/latestinformation/facts.asp>

⁹ <https://www.mentalhealth.va.gov/docs/top-10-public.pdf>

¹⁰ <https://www.sapr.mil/sites/default/files/DoD-Annual-Report-on-Sexual-Assault-in-the-Military.pdf>

newly separated. Given the importance of early intervention and treatment that can help ameliorate risk factors for homelessness, suicide, and substance abuse, NASWVC wholeheartedly supports HR2798.

HR 3867: Women Veterans are at a higher risk (approximately 33%) than civilian women (24%) for experiencing intimate partner violence during their lifetime¹¹. Although the VA does offer IPV services, the survivors may not use the VA for a variety of reasons. For a variety of reasons, however, including accessibility, but they may be willing to utilize their community crisis intervention services. These community services can be the first line of defense for women seeking safety and shelter and to help prevent survivors and their families from having to choose between becoming homeless and having to remain with their abuser. Partnering with community crisis centers and state coalitions offers the Department of Veterans Affairs another opportunity to provide partner training on serving women veterans, and it provides increased opportunities to enroll women in VA for benefits and services vital to their well-being. Like MST, IPV is also a risk factor for homelessness. NASWVC supports the passage of HR3867.

HR4096: State Women Veteran Coordinators work one-on-one with Women Veterans and frequently hear that there are insufficient gender-specific or gender-inclusive services at the VA. Moreover, Women Veterans speak to this as a barrier, citing this as a reason for not returning. It is not unusual for Women Veterans, especially those who have MST, to prefer women providers. Too often, however, the VA's answer to a request for a female provider is "if there is one available." It is not unusual for the Woman Veteran to not know until she shows up that the provider is a male, which can cause her to feel as though she has no choice but to submit to the uncomfortable experience. This experience may drive her decision to not return to the VA for care. Having staff that is sensitive to the unique experiences, challenges and issues faced by Women Veterans instead of seeing them as problematic or inconvenient will go far in enhancing the environment of care for Women Veterans at the Department of Veterans Affairs. NASWVC members are in nearly every state and are happy to partner with their local VA medical facilities as women's health team members and participate in inspection and improvement teams. NASWVC strongly supports HR4096

Thank you for the opportunity to provide a platform for the voices that often go unheard. Any progress that can be made toward providing a better quality of life for women veterans is paramount. Legislation is a major step in the right direction.

On behalf of the National Associate of State Women Veterans Coordinators, again, we thank you.

Service Women's Action Network (SWAN)

Chairman Takano, Ranking Member Poe and members of the Committee, thank you for the opportunity for the Service Women's Action Network to provide a statement for the record on the health legislation before the Committee today.

Background: SWAN members have consistently expressed dissatisfaction with the quality, completeness and ease of access to health care provided to women veterans by the Department of Veterans Affairs. Their view is that the great disproportion between the percentage of male and female veterans who access VA health care steers VA to health care policies, practices and allocations of fiscal and personnel resources to the needs of men.'

Better Health care for Women Veterans: Both the Department of Veterans Affairs and Congress have taken actions over the years to safeguard women veterans' access to quality health care, but too often these efforts have fallen short both with respect to ease of access and to quality and completeness of the care given to women. Women will soon constitute 20% of the veterans' population. SWAN is pleased to see that the House Veterans Affairs Committee is considering the following legislation which should bring women veterans closer to receiving their earned health care with the same ease, quality and completeness as their brother veterans. SWAN, therefore, supports all of the bills under consideration by the Committee today.

We put particular importance on, and, therefore, strongly support the following:

¹¹ Iovine-Wong, P.E., C. Nichols-Hadeed, J. T. Stone, et al. 2019. Intimate partner violence, suicide, and their overlapping risk in women veterans: a review of the literature. *Military Medicine*.

- H.R. 2645** which raises to 14 days the emergency care that newborns can receive when necessary.
- H.R. 2681** which requires a report on the availability of prosthetic items tailored to women's needs and bodies.
- H.R. 2752** which provides medically necessary transport for newborns.
- H.R. 2972** which directs the Secretary of Veterans Affairs to improve communications to women veterans about the VA services available to them.
- H.R. 2982** which directs the Secretary of Veterans Affairs to conduct a study on the barriers women veterans face when trying to access VA health care.
- H.R. 3036** which directs the Secretary of Veterans Affairs to provide a plan on the requirements to retrofit VA facilities and staffing to better support women veterans' health care.
- H.R. 3224** which requires VA to conduct a study on extending the hours during which women veterans can obtain routine health care at VA medical facilities.
- H.R. 3798** which limits co-pays for contraceptives.
- H.R. 4096** which requires an annual report to Congress on veterans' access to gender-specific services under the newly let Community Care contracts.
Thank you for the opportunity to comment on this legislation.¹

Sincerely,

Ellen L. Haring, PhD
Colonel, US Army retire
CEO, Service Women's Action Network



¹Disabled Veterans of America, February 2017, "The Past, Present and Future of Women Veterans" states that 92.5% percent of users are men while only 7.5 percent are women—