

**LEGISLATIVE HEARING ON H.R. 1506, H.R. 2322,
H.R. 3832, H.R. 4334 AND H.R. 4635; VA Medic-
inal Cannabis Research Act of 2018 and a Draft
Bill To Make Certain Improvements in The Fam-
ily Caregiver Program**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED FIFTEENTH CONGRESS
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Tuesday, April 17, 2018

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

The Subcommittee met, pursuant to notice, at 3:35 p.m., in Room 334, Cannon House Office Building, Hon. Brad Wenstrup [Chairman of the Subcommittee] presiding.

Present: Representatives Bilirakis, Radewagen, Dunn, Rutherford, Higgins, Gonzalez-Colon, Roe, Coffman, Brownley, Takano, Kuster, O'Rourke, Correa, Walz.

OPENING STATEMENT OF BRAD WENSTRUP, CHAIRMAN

Mr. WENSTRUP. The Subcommittee will come to order. Before we begin, I would like to ask unanimous consent for our colleague and fellow Committee Member, Representative Coffman from Colorado, to sit on the dais and participate in today's proceedings. Without objections, so ordered.

Good afternoon, thank you all for joining us. Today we will be discussing a number of bills that have been referred to the Subcommittee on Health, as well as two draft proposals that are sponsored by Chairman Roe and Ranking Member Walz, respectively. These bills, which are sponsored by Committee Members and colleagues from both sides of the aisle, would address some of the most important health care issues facing our Nation's veterans and the Department of Veterans Affairs. H.R. 1506, sponsored by Congressman O'Rourke, would address VA's longstanding recruitment and retention challenges by increasing the caps for VA's Education Debt Reduction Program.

H.R. 2322, sponsored by Congressman Walberg, would improve care for injured and amputee veterans, and clarify what those in need of prosthetic and orthotic care are entitled to from VA, including access to timely and quality care, either in VA or in the community, that best meets their needs and goals.

H.R. 3832, sponsored by Dr. Dunn, would help prevent opioid abuse among veterans by allowing for the greater sharing of information between VA and state-based prescription drug monitoring programs.

H.R. 4334, sponsored by Congressman Correa, and H.R. 4635, sponsored by Congressman Coffman, would improve care for women veterans by collecting information regarding access to gender-specific care in the community and environment of care standards in VA medical facilities, and requiring a sufficient number of peer-to-peer counselors for women veterans respectively.

The draft bill, the VA Medicinal Cannabis Research Act of 2018, which is sponsored by Ranking Member Walz with Chairman Roe and Congressmen Correa as original co-sponsors, would authorize VA to conduct and support research on the efficacy and safety of medical marijuana for veterans with chronic pain, post-traumatic stress disorder, and other conditions.

Finally, the draft bill to make certain improvements in the Family Caregiver Support Program, which is sponsored by Chairman Roe, would require the implementation of an information technology system to support VA's Family Caregiver Support Program, and then reform and expand that program.

I look forward to learning more about each of these bills and draft proposals today. I am grateful to each of the bill sponsors for their leadership on these issues and for being here to testify on our first panel. I am also grateful to our veteran service organization partners for being here to provide their views on these bills on our second panel.

I now yield to Ranking Member Brownley for any opening statements she may have.

OPENING STATEMENT OF JULIA BROWNLEY, RANKING MEMBER

Ms. BROWNLEY. Thank you, Mr. Chairman and Ranking Member Walz, for being here and thank you to all of today's witnesses for participating in our legislative hearing.

I am excited to discuss the legislation on today's agenda. Each piece of legislation is in response to a serious issue or concern affecting our veterans' health care. I look forward to hearing from our witnesses addressing any concerns ahead of a future markup and moving these important reforms forward.

As a co-sponsor of several of the bills before the Subcommittee today, I am proud of the work being done within this Committee and throughout this congress to preserve and enhance the VA health care so that many veterans utilize, value, and recommend.

During my time on this Committee, I have made it a special priority to ensure women veterans have access to high-quality gender-specific care in a safe and welcoming environment. I believe that two of the bills on today's agenda will advance this goal.

The Improving Oversight of Women's Veterans Care Act requires the VA to practice oversight on the community care providers that the VA contracts with to provide gender-specific health care to women veterans. We need to do a better job tracking the quality of care provided to women veterans and conduct effective oversight to ensure that they are well served no matter where they get their care.

I am also excited to lend my support for Congressman Coffman's legislation to require the VA to ensure that veterans' peer counseling programs includes enough peer counselors for women vet-

erans. It is clear that peer-to-peer counseling is an effective way to reach veterans that may not be willing to submit to a formal mental health care treatment plan. Peer-to-peer counseling is meant to be sensitive to the specific culture of the military and how that culture affects a veteran's experience.

It is integral that veterans seeking peer-to-peer counseling are afforded an opportunity to speak with a peer that they can relate to, and for many women veterans their most relatable peer will be their fellow women. I appreciate Congressman Coffman's leadership on this issue and look forward to further discussions on the merits of his legislation.

Finally, I am eager to hear from the Ranking Member of the VA Medicinal Cannabis Research Act of 2018. I will leave it to the Ranking Member to discuss its merits, but I will say I am proud to co-sponsor the legislation because I believe the VA must continue to look at complementary and alternative treatments, such as cannabis, that can help veterans cope with the invisible wounds of war.

Thank you also to Congressman O'Rourke and all of our colleagues for your legislation and your work supporting veterans. I look forward to your input and recommendations of our VSO partners. And Mr. Chairman, thank you and I yield back.

Mr. WENSTRUP. Thank you, Ms. Brownley. We are honored today to be joined by Ranking Member Walz who will be speaking about his respective draft proposal, and I want to thank you for being here today, and we will recognize you for five minutes for any comments you may have before we begin.

OPENING STATEMENT OF TIM WALZ, RANKING MEMBER, FULL COMMITTEE ON VETERANS AFFAIRS

Mr. WALZ. Well, thank you Chairman and Ranking Member. Thank you both for your longstanding bipartisanship and your ability to bring good solid pieces of legislation forward that are able to be passed into law. I am grateful to be here with you.

As a point of personal privilege, I wanted to point out we are joined today by a non-profit from Minnesota, Wiggle Your Toes, folks we were just talking to, that mission statement is pretty clear that they are out here to make sure that folks who have lost a limb have the capacity to be able to get back the life that they want, working with our veterans as well as some of our hero's in the Boston Marathon bombing, appropriate this week, so thank you for being here. And I will note that at least one of the Members here today is a fellow alumni of Minnesota State University Mankato, which the Chairman knows as the Harvard of the Midwest in its more common name. So just so you know, but thank you for that.

I appreciate the opportunity to put this forward, and I want to thank the Chairman of the Full Committee, Dr. Roe, for working with us on this, and my friend and colleague from California, Mr. Correa, has been a champion of this. We all know that the issues that come with pain, whether they be physical or the mental injuries that come with serving this Nation, are great. We understand that there are incredibly powerful drugs that are able to help at times, but we also know the dangers of the abuses of opioids and other therapies that we want to try and move folks to.

The VA has always been, since the early 1920s, this Nation's premier research institution, and they have a cohort of folks that we owe it to, to get the best possible treatments to. And one of the things that we are seeing across the country is veterans understanding that the potential for medicinal cannabis is great. And what we need to know, and what this Act does, is very simple. It simply clarifies that the VA has the capacity and the authority to do research into medicinal cannabis, and then it asks them to update Congress on where they are at.

It doesn't mandate that they do it. It doesn't tell them to do it. It asks us to try and find the data to make sure it is there. And what this does is clarify because there have been some confusions, and the VA believes that because of being labeled a Schedule I drug, that they do not have the capacity to do this.

They have the largest cohort. We have veterans suffering. We have the opportunity to do the research, and then find out once and for all if we can put this in. We have a patchwork system right now. If you are a veteran in one state you have access to medicinal cannabis, in another you do not. We don't have the hard research to show that the best way that we can do this. I want to give a special thanks to some of the partners in this, The American Legion, who has come out and asked us to find out if this works, find out the research, the VFW, and others.

This is just one of the many things, and I am proud of all of you who have worked on here. It wasn't that many years ago when we were talking about acupuncture or yoga being alternative therapies that couldn't be embraced. Now, we have those things in the VA. This is the next step of ensuring that the VA has the best possible research, the best possible data. And if it is going to provide relief for our veterans, we should be looking into what is the next step in medicinal cannabis.

So Mr. Chairman, I thank you for that. I thank you for the opportunity for introducing this, and again, I want to give a big thank you to Chairman Roe. We have a lot of medical doctors on this Committee, and I truly look towards your judgment and your ability to understand what we need to do to make sure before we start prescribing these. So thank you.

Mr. WENSTRUP. Thank you very much. I now want to introduce our first panel. It is a pleasure to be joined today by several of our bill sponsors, and I appreciate you all taking the time out of your afternoon to be here. With us here today is Congressman Beto O'Rourke from Texas, Congressman Tim Walberg from Michigan, Congressman Neal Dunn from Florida, Congressman Louis Correa from California, and Congressman Mike Coffman from Colorado.

Mr. O'Rourke, if you are ready, you are now recognized for five minutes.

STATEMENT OF HONORABLE BETO O'ROURKE

Mr. O'ROURKE. Thank you, Mr. Chairman. I wanted to speak a little bit about H.R. 1506, the VA Healthcare Provider Education Debt Relief Act of 2017 which I think will help us to address the crisis and provider shortage that we have in the VA right now. I think by the last VA Secretary's estimate, we had at least 30,000 authorized funded, but unhired, clinical positions in the VA. Every

day that goes by without those positions being hired is another day that we fail to see veterans honor the commitment they have made with the care that they need, that they deserve, and that they have earned.

This bill would increase the debt reimbursement available to providers for their medical school education from \$120,000 to \$150,000. It would also provide the means in certain critical shortage areas to waive the cap altogether by working between the VA and the Department of Health and Human Services. This bill has support from a number of veteran service organizations. We have been working with the VA to improve the bill and I am grateful to have a chance to get feedback from Members of the Committee and veteran service organizations today about how we can get this done.

And with that, I yield back. Thanks.

[THE PREPARED STATEMENT OF BETO O'ROURKE APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you. Mr. Walberg, you are now recognized for five minutes.

STATEMENT OF HONORABLE TIM WALBERG

Mr. WALBERG. Thank you, Chairman Wenstrup and Ranking Member Brownley. Thank you as well for giving me the opportunity to be back in this very special room, dealing with a very special constituency, that being our veterans. And thank you for allowing me to be here today to testify on H.R. 2322, the Injured and Amputee Veterans Bill of Rights.

I would like to start off by thanking the Subcommittee Members and staff for their time and willingness to work with me on this very important issue.

I think we can all agree that our veterans have earned the highest quality possible health care. I understand there are problems at the Veterans Affairs and that this Committee is diligently working to address these concerns to ensure our veterans receive the benefits and care they deserve. I also know there are great doctors, nurses, and staff that work hard to make sure our veterans receive timely care.

With that being said, I believe a veteran's health care decisions are personal choices. We know all too well that the VA can be an intimidating and hard-to-navigate bureaucracy. There are layers of paperwork and red tape that can make these health care decisions daunting.

H.R. 2322 moves to empower veterans when it comes to making their own health care choices, and it does so by ensuring that injured and amputee veterans know their health care rights. Years on the battlefield has taken a toll on our war fighters. Our veterans are younger than before, and transitioning from active duty can be difficult. We need to ensure that amputee veterans have the best access to care and the ability to more easily transition into civilian life. The Injured and Amputee Veteran Bill of Rights is a bipartisan approach to empowering injured and amputee veterans in making their health care choices. This bill simply requires the VA

to prominently display a list of rights in a VA orthotic or prosthetic OMP clinics, as well as their Web site.

These rights include, and aren't limited to, the right to access the highest quality and most appropriate OMP care; the right to select the practitioner of their choice; the right to consistent and portable health care, including obtaining comparable services at any VA medical facility; the right to timely and efficient OMP care; the right to both a primary prosthesis and orthosis, and functional spare.

Additionally, the VA should be required to educate their staff, so VA employees can help veterans navigate this process to make sure veterans are receiving the care they deserve and need. Our bill also requires the VA to follow up and resolve any complaints by veterans who believe the VA is not meeting their OMP needs.

Mr. Chairman, at the end of the day, veterans should receive the best available and timely care they can get. I know this is something you and I, and your staff, have worked hard on and I applaud your unwavering commitment to our veterans. I am willing to work with you and your Committee in any way to better this legislation so that we can empower injured and amputee veterans when they are making their health care choices.

Thank you for your time today and for the work this Committee is doing to keep our promises to our Nation's heroes. Thank you.

[THE PREPARED STATEMENT OF TIM WALBERG APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Mr. Walberg. We are honored to have Chairman Roe here with us today, and Dr. Roe, if you would like to take five minutes to discuss your proposals for the Family Caregivers Support Program.

STATEMENT OF HONORABLE PHIL ROE, CHAIRMAN, FULL COMMITTEE ON VETERANS AFFAIRS

Mr. ROE. Thank you, Dr. Wenstrup. It is a pleasure to be here with the Subcommittee today, and there are a number of worthy pieces of legislation that we are going to discuss this afternoon, and I am particularly interested in

Dr. Dunn's bill, the Veterans Opioid Abuse Prevention Act which would give improvement—would improve the Department of Veterans Affairs Communication with a state-based prescription drug monitoring program to help identify and address opioid addiction among veteran patients.

I am also interested in Representative Walberg's just presented an Injured and Amputee Veteran Bill of Rights. That bill was discussed at the Committee's field hearing in Fayetteville, North Carolina a couple of weeks ago. And when clarified that those veterans were in need of prosthetic or orthotic services through VA are entitled to the very best care at the provider of their choice in light of the unique and highly individualized needs.

And I am grateful that my draft bill to make certain improvements in the Department of Veterans Affairs Family Caregiver Support Program is included on the agenda for today's hearing. My draft bill would require the VA to implement an IT system to support the Family Caregiver Program, to use the data that the sys-

tem collects to conduct an assessment of the program, and to use that assessment to identify and implement needed modifications, and to certify to Congress that the IT system and modified program are both working.

From there, it would expand eligibility for the program to pre-9/11 veterans; amend eligibility for the program to veterans in need of personal care services due to an inability to perform three or more activities of daily living, ADLs, rather than the one or more ADL; grant VA the flexibility to change how the monthly stipends are calculated by removing certain requirements from the current law and requiring VA to promulgate regulations regarding stipend determination; require a primary caregiver to reside or agree to reside in “close proximity” with the veteran he or she is caring for, and defined close proximity as one that allows regular in-home management care, supervision, or treatment; require VA to develop and publish in the Federal Register a plan to transition those currently approved for the program to the amended program.

This draft has been in development since the Full Committee hearing on the program in early February and has been the subject of multiple round table discussions with VA and veteran service organization since that time. While this bill remains a work in progress, I appreciate the thoughtful feedback provided in those conversations, and look forward to continuing to work with all interested stakeholders on moving this forward.

I know that there has been much published discussion recently about a compromise agreement between Senator Isakson, Senator Tester, and me that would expand eligibility to the Family Caregiver Program to pre-9/11 veterans without making any changes to the eligibility criteria or stipend calculations. Inclusion of that provision was one of the chief concessions that I made to achieve a compromise agreement. I am committed to that compromise agreement and hope to see movement on it in the coming weeks.

That said, negotiations are ongoing. I remain convinced that should negotiations prove unfruitful, we must have an honest conversation about the findings of right balance between clinical appropriateness and the costs within this program, and make needed changes to ensure it is working as intended for increasing its participants in such a dramatic fashion.

I also want to mention the draft bill offered by Ranking Member Walz and myself to authorize VA to conduct research on the efficacy and safety of medical cannabis. As a medical doctor, I have written countless prescriptions, but never once in my life have I prescribed a drug which has not been proven effective by the FDA. Allowing VA to research medical marijuana will finally allow us to separate fact from fiction, and provide a scientific footing on which sound policy may be built.

As you noted in your testimony, Mr. Celli, 92 percent of respondents in veteran households support researching the effort of medical cannabis for mental and physical conditions. That is a statistic that should not be ignored. I thank The American Legion for leading this effort, so we might, at last, find out if medical marijuana is a viable treatment option for our Nation’s veterans. I look forward to hearing everyone’s comments on legislation today.

With that, I thank you again for allowing me to be here today, Dr. Wenstrup, and I yield back the balance of my time.

Mr. WENSTRUP. Thank you, Dr. Roe. Dr. Dunn, you are now recognized for five minutes to discuss H.R. 3832.

STATEMENT OF HONORABLE NEAL DUNN

Mr. DUNN. Thank you very much, Chairman Wenstrup, and thank you, Chairman Roe, for your kind words. And I appreciate the opportunity today to speak on behalf of H.R. 3832, the Veterans Opioid Abuse Prevention Act.

According to the Centers for Disease Control, 249 million prescriptions were written by health care providers in 2013. The Department of Veterans Affairs Health Care System is the largest health care provider. Because of this, it is in a unique position to help curb the opioid epidemic by using every tool available when a veteran is prescribed an opioid. The Veterans Opioid Abuse Prevention Act gives the VA health care providers access to these valuable tools.

H.R. 3832 comes directly from recommendations from the Nation's top policymakers, the White House Commission on Combating Drug Addiction, and the Opioid Crisis recommended last July that the VA lead efforts to have all state and Federal prescribing drug—or prescription drug monitoring programs, known as PDMPs, share information.

The interim report cited multiple published best practices for PDMPs, and has identified interstate data sharing as among the top priorities to ensure that health care professionals have a better understanding for prescribing practices for their patients.

H.R. 3832 directs the VA to have health care providers participate in the sharing of prescribing data, across a network of interstate prescription drug monitoring programs. PDMPs are state-based networks which can access when—which providers can access when writing or filling prescriptions. And PDMP data includes the type of the medication, the fill dates, and the dosage amounts. PDMPs improve a clinician's ability to follow good prescribing practices for at-risk patients who may have a pattern of prescription opioid abuse.

In 2011, the National Board of Pharmacy created a national platform of prescription monitoring programs, PMPs, called PMP Interconnect, which allows the various states to share the PDMP data across state lines securely. Today, 44 states and Washington, D.C., participate in the PMP Interconnect and more states are adding all the time. My own state, Florida, is adding now.

I have veterans in my district who are desperate for opioids because well-meaning but underinformed physicians repeatedly overprescribed opioids for them. I can guarantee everyone sitting on this dais today has veterans back home suffering for the same reason, and let me be clear, this is not something that anyone up here on this dais or in this room should accept as good treatment for veterans. The tragedy in these situations is that so many of them are preventable just by giving doctors the right tools and the right information on how to prescribe these safely to which patients, and we want to make this a high priority.

H.R. 3832 implements the commission's recommendation by granting providers the ability to use an interstate PDMP platform for the betterment of our veterans who are at risk of opioid abuse. Every doctor has a duty to help the sick, and according to one's ability and judgment. So as a Committee, we have a duty to ensure the veterans have access to doctors who are enabled to make the best clinically informed decision for the veterans.

I encourage my colleagues to support H.R. 3832, and I yield my time back, Mr. Chairman.

[THE PREPARED STATEMENT OF NEAL DUNN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, Dr. Dunn. Mr. Correa, you are now recognized for five minutes.

STATEMENT OF HONORABLE LUIS CORREA

Mr. CORREA. Thank you, Mr. Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee for the opportunity to speak on my bipartisan bill H.R. 4334, the Improving Oversight of Women Veterans Care Act, and I want to thank my friend and colleague, Ranking Member Brownley, for her support of this legislation.

Women represent the fastest growing population of veterans in our society. In 2015, women represented 9.4 percent of the total veteran population. By 2045, this number is expected to go above 16 percent. Yet according to the GAO, the Veterans Health Administration does not have performance measures to determine women's veteran accessibility to gender-specific care.

My bill will enhance the monitoring needed for effective oversight of women's veteran's health by requiring the VA to submit an annual report on veteran access to gender-specific care under community care contracts, and quarterly reports on environment of care standards for women veterans. This will ensure that we understand women veterans' ability to access gender-specific health services.

I understand my bill may require technical edits, and I am open to working with the Committee and others to address those needed changes. Again, I thank you for the chance to speak before this Subcommittee.

I yield.

[THE PREPARED STATEMENT OF LUIS CORREA APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, thank you. And Mr. Coffman, you are now recognized for five minutes.

STATEMENT OF HONORABLE MIKE COFFMAN

Mr. COFFMAN. Thank you. Chairman Wenstrup and Ranking Member Brownley, thank you for allowing me to present H.R. 4635, the Peer-to-Peer Counseling Act that I introduce with Congressman Esty to improve VA counseling afforded to female veterans. I would also like to thank the Members of the Subcommittee who co-sponsored H.R. 4635, Ranking Member Congresswoman Brownley, Representative Bilirakis, Representative Kuster, Representative

Radewagen, Representative O'Rourke, Representative Rutherford, and Representative Gonzalez-Colon.

Currently, female veterans make up nearly 10 percent of our Nation's veteran population, and this population is expected to grow to 15 percent by 2030. Over the past ten years, the VA has seen a 45 percent increase in the number of female veterans using VA benefits, demonstrating that female veterans are relying more and more on VA services. And as the female veteran population increases it is critical for VA to meet future demand.

One area of need among female veterans that warrants our particular attention is peer-to-peer counseling. Unfortunately, many female veterans have experienced sexual trauma and PTSD while serving in the military, and are also suffering from other mental conditions that put them at risk for homelessness. Peer counseling can help female veterans who are facing these critical issues.

The VA's 2016 suicide data report found that the risk of suicide for female veterans was 2.4 times higher than non-female adult females, and the rates of suicide increases more among women than men. The data is disturbing. We owe it to our female veterans to ensure sufficient resources are available to assist with gender-specific needs, and that is why I introduce H.R. 4635, the Peer-to-Peer Counseling Act.

H.R. 4635 enhances the VA's existing peer-to-peer program which has been successful in providing peer counseling to all veterans by ensuring the current program has a sufficient quantity of female peer counselors for female veterans who are separating, or newly separated, from military service. Ideal counselors will have expertise in gender-specific issues, VA services, and benefits focused on women, as well as employment mentoring.

The Act also would emphasize counseling services for female veterans who have suffered sexual trauma while serving in the military, have PTSD, or any other mental health condition, for our female veterans who are at risk of homelessness.

To ensure these counseling services are not only available but also known throughout the veteran community, H.R. 4635 directs the VA Secretary to conduct outreach to inform female veterans about the peer-to-peer program and the services available to women.

H.R. 4635 authorizes the VA Secretary to facilitate engagement and coordination with community organizations, state and local governments, institutions of higher learning, and local business organizations. With the help from our communities, we can leverage resources and expertise that exist within these communities.

Peer-to-Peer counseling. The Peer-to-Peer Counseling Act ensures VA's peer-to-peer program is better postured to address the gender-specific needs of women veterans and updates this vitally important program to better represent the growing veteran population it serves.

Mr. Chairman, I encourage my colleagues to support this important legislation and I yield back the remainder of my time.

[THE PREPARED STATEMENT OF MIKE COFFMAN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, thank you, Mr. Coffman. I thank everyone from the first panel for being here today, and you are now excused. I will now welcome our second panel to the witness table.

Joining us on our second panel is Louis J. Celli, Director of the National Veterans Affairs and Rehabilitation Division of The American Legion; Adrian Atizado, the Deputy National Legislative Director for the Disabled American Veterans; Sarah S. Dean, Associate Legislative Director for the Paralyzed Veterans of America, and Kayda Keleher, Associate Director for the National Legislative Service of the Veterans of Foreign Wars of the United States.

While VA is unable to be here, I do look forward to receiving the Department's views for the record, and appreciate our veteran service organizations for their time and attendance this afternoon.

Mr. Celli, we will begin with you. If you are ready, you are recognized for five minutes.

STATEMENT OF LOUIS J. CELLI

Mr. CELLI. Tree bark, mold spores, poppy, cocoa, rhododendrons. There are more than a hundred distinct chemical substances that are derived from organic plants being used in pharmacology today. From these organic substances, we enjoy the benefit of aspirin, a tranquilizer called Rhomitoxin, codeine, and morphine, and in 1928, a petri dish contaminated with floating mold spores changed the course of human history by introducing the first antibiotic, penicillin.

General Wenstrup, Ranking Member Brownley, distinguished Members of the Subcommittee on Health, on behalf of National Commander Denise Rohan and The American Legion, I am honored to be able to testify on the following and pending draft legislation.

According to The National Institute of Health, cannabis is a complex plant with over 400 chemical entities, of which more than 60 of them are cannabinoid compounds. Today, 30 states have medical cannabis laws that allow patients to use cannabis for illnesses ranging from inflammation and pain to epilepsy and cancer, and all 50 states have legalized one of the chemical derivatives, cannabidiol or CBD, as it is more commonly known today.

And yet there isn't a single physician who has been formally trained by an accredited U.S. based medical school on what this plant can or can't do. There is no education that discusses medicinal use, drug interaction, placebo effect, dosage rates, strains, or anything else regarding this plant because the United States Drug Enforcement Agency continues to insist that cannabis has, and I quote, "No currently accepted medical use, and a high propensity for abuse," as opposed to Schedule IV drugs, like Xanax, Darvon, Valium, Ativan, Ambien, and Tramadol, which according to the DEA have a low propensity for abuse and low risk of dependence.

The National Academy of Medicine recently reviewed 10,000 scientific abstracts on the therapeutic value of cannabis and reached nearly a hundred conclusions in a 2017 report. And yet the United States continues to lag behind other developed Nations by restricting scientific research into this drug. The draft legislation will call on VA to conduct the research necessary to determine if the cannabis plant, marijuana, has medical value or not. Our veterans are

asking for this research, and our Nation has an obligation to provide it.

Next, I will address H.R. 1506, the Health Care Debt Reduction Act. The Department of Veteran Affairs went from 33,000 vacancies in 2016 to 43,000 vacancies today, a 30 percent increase. The Department has been the subject of intense scrutiny over the past several years, and rightfully so, but along with that scrutiny comes responsibility, the responsibility to be fair and balanced. The VA operates the largest health care network in the country, some say in all the world, and just like any large organization, VA has a board of directors, you.

We often compare VA to private industry. We hold them up against private metrics, quality standards, efficiencies, wait times, and cost benefit ratios, but we fall short when it comes time to argue that the employees' pay needs to be competitive to their non-government peers. H.R. 1506 can help fix that by making VA a more attractive employment option for our health care community by offering to pay some of their student debt. Will this solve the problem? Not entirely, but what it will do is prove that we are willing to invest in high quality professionals to care for our wounded and ill veterans.

The Veterans Opioid Abuse Prevention Act will bring VA online with state-based prescription monitoring programs. This is in the best interest of patients and helps doctors provide holistic quality medicine at the Federal level. Patients commonly have multiple doctors, and it is especially true for veterans who because of their combat related injuries commonly suffer more co-morbidities than their civilian counterparts.

In the absence of a single lifetime medical record that can be accessed and shared among all patients—medical professionals' participation in a unified database that helps guard against drug interaction and duplication of prescriptions is an important step in ensuring veterans receive proper and accurate care.

Next, peer-to-peer counseling has always been a preferred counseling medium, long supported by The American Legion. VA's hundreds of vet centers were built on this very premise, and The American Legion continues to support this reliable, individual, peer-to-peer counseling where veterans who have had similar experiences can share their stories and tactics for recovery. That said, we support H.R. 4635.

At this time, we are unable to support H.R. 2322, the Injured Amputee Veterans Bills of Rights Act because it appears to be missing some language which appears to be a very simple fix. The American Legion is committed to ensuring that all veterans, especially those with catastrophic injuries, receive expert care. We just have to be careful that we don't create a mechanism whereby VA has no control over how that care is delivered or how the government will pay for it. We wouldn't have an issue if the bill contained the passage that is reflected in the VA Handbook stating, "Or the veteran's preferred prosthetist who has agreed to accept the preferred provider rate," which unfortunately, this bill is missing.

Thank you and I look forward to your questions.

[THE PREPARED STATEMENT OF LUIS J. CELLI APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, thank you. Mr. Atizado, you are now recognized for five minutes.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, I want to thank you for inviting DAV to testify at this legislative hearing today. As you know, DAV is a non-profit service organization. We provide a lifetime of support to all generation of veterans, and we have been helping more than a million veterans each and every year to better their lives and empower them.

I am pleased to offer DAV's views for your consideration on the bills for today's hearing. I would like to start off with comments to H.R. 1506. DAV urges the Subcommittee to pass this bill, The VA Healthcare Provider Education Debt Relief Act of 2017, which would improve VA's ability to compete with other entities in recruiting and retaining high-quality clinicians to take care of our Nation's veterans and provide them comprehensive care.

In our testimony, we make recommendations to improve this critical piece of legislation and make it stronger. One, we would like to see the deadline for this program be extended beyond its current date. Two, we would like to make sure that there is increased funding for this program. And three, we would like just the Subcommittee to review the staffing for this program. According to VA, it requires one staff for any additional 1,000 participants in the program, and if we want to consider effective use of monies and keep VA accountable, I think that is something this Committee should be looking at.

As you are aware, the average debt that a medical student graduates in 2017 is about \$190,000, and the student loan, this debt, weighs heavily on them when they consider their employment. And I think EDRP is one of the most successfully utilized programs that VA has. Combined with the caps that this Committee had passed and agreed to in 2014, not only has the number of participants in this program increased, it has also increased the average amount of award, meaning for the same amount of money we are having to provide more and more.

Last year GAO found that local facilities depleted their EDRP budgets early in the physical year. They were not able to commit to provide debt reduction payments to incoming students and clinicians because they simply ran out of money. This bill would also amend the condition in which VA could waive these authority—these statutory caps. We do ask the Committee review that this does not—and we know this is not the intent, but we hope that it doesn't impinge on the ability for local facilities to use their current statutory authority in light of the ones that are being proposed now.

DAV strongly supports H.R. 4334, The Improving Oversight of the Women Veterans Care Act of 2017. This bill would improve current efforts to ensure access to quality gender-specific health services provided through community care contracts as well as highlight VA facilities' performance in meeting standard that they have agreed to meet with regard to environment of care.

As this committee knows, women veterans are about 10 percent of the veteran population in total, and it is growing. We have got

20 percent of new recruits are women veterans, 15 percent of active duty are women veterans, and 18 percent of Guard and Reserve are women—or are female servicemembers. The provisions in this bill, Mr. Chairman, are consistent with the recommendations of DAV's report. We issued that report in 2014. It is called *Women Veterans: A Long Journey Home*.

This report spans the breadth and depth of all Federal assistance that is available to women veterans, and we make recommendations in every single one of those. We are in the process of updating this report, and we would be so happy to brief the Subcommittee as well as the Full Committee on those findings.

DAV also is pleased to offer its support for H.R. 4635, which would increase the number of peer-to-peer specialists to provide women veteran support and counseling tailored to them and their needs. We recommend the Subcommittee consider adding funding for this program to ensure peer specialists are given priority among other critical clinical professional vacancies that VA has to fill.

Mr. Chairman, VA's existing peer support program has been shown to be effective in assisting patients to not only become more active and more engaged in their treatment, but to be empowered, to be able to advocate for themselves, and it improves patient satisfaction as well as their quality of life. Facilities such as West Palm Beach, Chillicothe, Cincinnati, they have shown that this program is quite effective for their patient population.

Women peer specialists are available to assist and guide other women veterans in accessing the services that they need, which is the bulk of the legislation for today's hearing.

This concludes my statement, Mr. Chairman. I would be happy and be pleased to answer any questions you or other Members on the Subcommittee, may have.

[THE PREPARED STATEMENT OF ADRIAN M. ATIZADO APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you, very much. Ms. Dean, you are now recognized for five minutes.

STATEMENT OF SARAH S. DEAN

Ms. DEAN. Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee, Paralyzed Veterans of America thanks you for the opportunity to present our views on the legislation before you today.

PVA supports H.R. 3832, the Veterans Opioid Abuse Prevention Act. Given the specialized needs of veterans, it is not uncommon for some to travel to different states to receive their care. And there is no assurance that the prescription data of a veteran who receives care at an SCI center in Minneapolis, but lives in Wyoming, can be shared. We urge the Subcommittee to ensure—to make sure these specialized patient populations are benefitting from the opioid safety measures in the same way as non-traveling veterans. H.R. 3832 is the means to do just that.

PVA strongly supports H.R. 1506, the VA Healthcare Provider Education Debt Reduction Act of 2017. We believe VA must be adequately resourced to attract the best and brightest medical professionals, and the Education Debt Reduction Program has been a

markedly successful means to do just that. As there is a current and worsening provider shortage in the United States, VA must be able to insulate, as best as possible, veterans' care from this trend.

That new residents are hesitant to take a post in an underserved community should come as no surprise. The cost burden of their education and training is an overwhelming prospect, and debt is all but guaranteed. No matter how eager to serve any resident may be, a career at an understaffed VA may not be a tenable choice, and loan assistance can cultivate a culture of commitment from those unburdened by their debt and revive areas too long stressed by continuous shortages.

PVA appreciates deeply the work of this Committee this year on behalf of the Caregiver Program. Your staffs have maintained a thoughtful and open dialogue on the issues of the draft before us and we thank them for that. The draft addresses, in part, the greatest malformation of the current program, the unequal treatment of veterans with the same service-connected needs. And for eight years, VSOs have asked Congress to reckon with this injustice, and we appreciate the Members' commitment to that goal.

This draft does address it, but does so in a way that creates a different imbalance. It strikes the date of injury requirement, but raises the clinical eligibility from one or more activity of daily living to three. And while this would make a still imperfect program, it is an imperfection that my members, veterans with spinal cord injuries, can endure a little easier knowing that they and their caregivers are finally receiving the clinical supports and services their injuries require.

Our support for this draft is not any statement on the work and sacrifices of those with one or two ADLs. Our position remains the full expansion of the current program, but my members can't unhear the ticking clock in their lives, not just the decades of work their caregivers have done unsupported and unacknowledged, but the very real sensitivity of the time they have left to them and their wish to spend that time at home.

We appreciate the cost and quality considerations of the draft, and while we support it, we do so as a first step because two activities of daily living due to injury or a disease are still activities of daily living that a veteran need someone else to do because they were injured in their service. PVA's organizational mandate is to expand and improve the current program to all veterans with catastrophic service-connected injuries or illnesses, and in this moment in time, the means to most closely accomplish that mandate is the negotiated package that was to be included in the omnibus last month.

That would see that the equal treatment of injured veterans is done by striking the 9/11 date. This issue is an urgent one, and aside from any consideration of cost savings, of institutional care, or the right way to do eligibility, the majority of veterans today are over 65. And those injured because they served are having conversations about what the rest of their lives will look like, and their caregivers are wondering if they can continue to do this alone. These families need the financial and clinical supports of this program right now. We ask the Subcommittee to see that some relief

in some form is finally provided to those who need it most as soon as possible.

Mr. Chairman, PVA thanks the Subcommittee and I am happy to answer any questions you may have.

[THE PREPARED STATEMENT OF SARA S. DEAN APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Thank you very much.

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

STATEMENT OF KAYDA KELEHER

Ms. KELEHER. Chairman Wenstrup, Ranking Member Brownley, Members of the Subcommittee, it is my honor to represent the 1.7 million members of the Veterans of Foreign Wars of the United States and its Auxiliary.

The VFW is pleased to support bills H.R. 4334 and 4635. As you all know, women veterans are the fastest growing demographic within the veteran population, and the VFW has worked hard alongside Congress and VA to make sure they are able to access the best health care possible. While a lot of progress has been made, there is still room for improvement.

H.R. 4635 would be an outstanding asset for VA to be able to increase the number of peer-to-peer counselors for women veterans who have survived sexual trauma, are diagnosed with post-traumatic stress disorder, struggle with other behavioral health conditions, or are deemed at risk for homelessness.

With the hardships faced by these women, including increased rates of suicide and homelessness, this legislation would be an invaluable benefit.

H.R. 4334 would be instrumental in providing oversight for Congress and VA. This bill would provide oversight for women who choose VA, but must still receive care in the community for sex-specific appointments. By doing this, we would be assuring that patients still receive the highest quality of care possible.

The VFW believes the expansion of VA's Program for Comprehensive Assistance for Family Caregivers is long overdue and agrees with the intent of this draft legislation, but has very serious concerns with it as currently written. The VFW would oppose setting arbitrary eligibility requirements, such as increasing the criteria to three activities of daily living and efforts to lower costs.

The VFW also has concerns with other aspects of this draft legislation, such as the lack of provisions addressing caregivers and veterans graduating out of the program. Currently, when and if a veteran improves and is slated to be removed from the program, there is a lump-sum totaling three months of their stipend paid from VA. This abrupt ending has resulted in financial, emotional, and medical distress of the veteran and their caregiver.

In addition to this, the VFW believes equity between DoD and CMS must be provided by including those who are made ill due to their service.

Moving ahead, the VFW looks forward to continuing to work with Congress in assuring the package of the Community Care Package from S. 2193 that includes the expansion of caregivers, which the VFW supports.

The VFW is happy to support H.R. 5520 for reiterating VA's current authority for research on medical cannabis. With over half of the country's states legalizing marijuana, along with the current opioid epidemic and ongoing Forever War, the VFW believes it is medically irresponsible for VA providers to be left in the dark, not knowing about health outcomes and pharmaceutical interactions associated with medical marijuana. With veteran patients able to easily access medical marijuana legally, VA providers must understand the effects associated with patient's marijuana use. Many states and academic entities have already conducted research and now is the time for the next episode of medical cannabis research at the Federal level.

Previous and current studies have found results showcasing how CBD helps patients with chronic pain and decreases opioid abuse relapses, an over-represented health struggle for veterans. While other studies show THC helps with varying symptoms associated with PTSD and cancer recovery — also health concerns either over-represented or of high prevalence within the veteran community.

This is all in addition to high prescription rates from VA, though better than those in the private sector, for opioids, benzodiazepines, and SSRIs, with little to no data showing how marijuana interacts with these FDA-approved drugs. This is particularly troubling as the only two drugs FDA approved for PTSD are SSRIs. Studies published by AMA show SSRIs are no more effective than placebos for most adult patients, and other medical research shows that SSRIs are only effective on less than half the adult population with depressive symptoms, all while medical providers and researchers scramble with addressing the highly-addictive negative outcomes that come with prescribing opioids, benzodiazepines, and other drugs.

The VFW knows VA is a leader in medical research. VA researchers have even won Nobel Peace Prizes in the past. This is why we believe that VA should lead the way in allowing our country to better understand medical marijuana for the safety of our Nation's veterans.

Chairman Wenstrup, thank you again for the opportunity to present to you today, and I look forward to questions you or the Subcommittee Members may have.

[THE PREPARED STATEMENT OF KAYDA KELEHER APPEARS IN THE APPENDIX]

Mr. WENSTRUP. Well, thank you all very much. I appreciate your testimony here today. True professionals, you all neatly stay right under 5 minutes, I appreciate that. But I yield myself 5 minutes for questions.

I want to start with you, Mr. Celli. You were talking about the draft bill to allow VA research on cannabis. You said in October 2017 there was a nationwide survey conducted The American Legion. Can you describe how the survey was conducted and what your findings were?

Mr. CELLI. I can. Thank you, Chairman Wenstrup.

We hired an independent research firm and gave them some really basic questions, Dear Veteran, and they were responsible for going out and finding veteran households. They didn't use our

members, some of them may have been coincidentally our members, but it was completely independent, it was hands-off, and we just waited for the results. And we asked them a series of different questions that gauged their interest in if cannabis should be legal medically, if the Federal Government should do research, if it should be rescheduled, and we have a complete printout of all of those results that we are happy to share with this Committee.

Mr. WENSTRUP. What was the response on the research part?

Mr. CELLI. The research was overwhelmingly positive in support of legislation that would allow for not only research, but also for medical use, overwhelmingly, it was over 90 percent.

Mr. WENSTRUP. So from that were you able to be guided in any way, shape, or form for what type of specific research that the American Legion may be interested in the VA doing?

Mr. CELLI. So there is a host of different illnesses that the cannabis has been—you know, that our veterans have told us that cannabis has been successful for. PTSD is certainly one of them, but so is inflammation, so is pain management, epilepsy. There is just a variety of different illnesses that this drug, which it is a drug, has been successful in patients with.

Mr. WENSTRUP. Why, thank you. And I appreciate if you would forward over the results.

Mr. CELLI. I am very much happy to do that.

Mr. WENSTRUP. That would be very helpful. Thank you for doing that.

Mr. Atizado, you talked about the family caregivers and the stipend involved. What do you think is a more appropriate stipend schedule, what would that look like?

Mr. ATIZADO. So, Mr. Chairman, before I answer that question, I just want to give a little bit of background about the discussion that took place that yielded what we have now.

At the time that the stipend schedule was being discussed from statute to be made into regulation and implemented as a program, the idea was the population being served was undergoing tremendous stress and strain, and the goal of having what is currently the current schedule is to give them a sense of stability, that they can count on whatever modest stipend that they would be receiving would offer them some financial stability and not add to the stress.

And so the idea that VA decided to use was specifically the BLS survey of homemaker/home health aide wages, which is referred to in the statute. Now, the statute and the law didn't specifically tell them to use that, that is just what the agency decided to use. And in its regulation, it had noted there was wide variation in the amount of homemaker/health wages from any geographic region from one to another and that has led to these wild deviations from the norm or for the mean.

And so we don't believe that the current issue with the stipend program being labor-intensive, as well as having such wide deviations in pay, is necessarily based on statute and we think VA could regulate themselves out of this mess in using what this Committee in holding its roundtable, there have been talk about maybe using a GS schedule which is both geographically reflective, as well as meeting the intent of the law of not being any less than what a homemaker/home health aide would receive pay for.

So there are a number of schedules that VA can use that meets the intent of the law that doesn't incur this labor-intensive and this wild deviation of stipends.

Mr. WENSTRUP. Thank you.

With that, I will now recognize Ms. Brownley for 5 minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

My first question is really to all four of you. And thank you all for being here, and your constant and steadfast counsel is very, very helpful. So the question is, how would the lack of a grandfather clause—this has to do with the caregiver bill—the lack of a grandfather clause allowing currently enrolled veterans to continue to participate in the revised program impact the veteran caregiver community?

In other words, we have got, you know, two different sets of standards and what do you think the impacts are going to be?

Ms. KELEHER. Thank you. The VFW, moving forward, we would not be in support of having two different standards between post-9/11 veterans and veterans who did serve beforehand. We do believe that including a grandfather clause if eligibility requirements are to change is absolutely necessary. It would provide clarity to not just the veteran, but to VA as well, for what the standard for those currently on it are.

If by any means that eligibility requirement did change, there needs to be something set in stone saying that individuals who are currently on the program, even if they are not at the same eligibility requirement or standard moving forward, saying that they are safe, and they are going to remain on the program, and continue getting the support and recognition from VA that they have been receiving.

Ms. BROWNLEY. Any other comments from anyone?

Mr. CELLI. The American Legion could never support a bill that reduces benefits for veterans, just as simple as that.

Ms. BROWNLEY. So PVA has recommended the use of multi-disciplinary teams in caregiver eligibility assessments in the past, Ms. Dean, so what disciplines would you like to see represented on the team?

Ms. DEAN. They already are being—that already is the way that the program is executed is to use multi-disciplinary teams as a way to sort of not allow for the whole decision to rest on one doctor at a facility, so that the pressure from the family or the veteran doesn't influence that one doctor's decision. So it is a team decision already and I think that should continue.

Ms. BROWNLEY. So, Ms. Keleher, on the medicinal cannabis issue you stated I think in your testimony it would be medically unethical for Congress to allow VA providers to stay in the dark on medicinal cannabis. Could you expand somewhat on that statement?

Ms. KELEHER. Yes. As a non-doctor, doctors are required to provide ethical treatment that is in the best interest of the patient. So particularly in the instance of VA, as a Federal entity and they are in states where it is medically legal, the VFW views it as being unethical for them not to understand the science and medical research behind the interactions, whether it be CBD or THC is actually more valuable than a pharmaceutical drug, or whether it is

that there is an interaction between one of the pharmaceuticals that they are taking with their recreational or medical use.

So we view it as being unethical that in a sense VA not having this research or the lack thereof with Federal research that these providers just they don't know, they are in the dark.

Ms. BROWNLEY. So, and to anyone who would like to answer, this particular legislation allows the VA to do research and I think that kind of codifies what the VA can already do, it is my understanding, but don't you believe that we should have a bill that says, you know, the VA should and must do the research in this area?

Mr. CELLI. Well, you know, I think that VA has really stepped up to the plate. Former Secretary David Shulkin had issued a memo stating that primary care physicians would have these conversations with their patients and in good faith, and would record that conversation in their medical records. Unfortunately, you know, to VFW's point, right now physicians don't have the clinical training because there is no research that the Federal Government supports that they can learn from. You know, it is a vicious cycle.

We definitely think that the VA should do the research, but we also understand, you know, VA's apprehension of wanting to be at cross purposes with Federal law and their boss. So, you know, legislation is what they need, I think that is what we are here for today, and we support that.

Ms. BROWNLEY. Thank you very much.

I have no more questions. I yield back.

Mr. WENSTRUP. Mr. Higgins, you are now recognized for 5 minutes.

Mr. HIGGINS. Thank you, Mr. Chairman.

Mr. Celli, regarding your organization's position on medical marijuana, cannabis research, there have been thousands of studies around the world on this subject already.

Mr. CELLI. There are and, you know, the nice thing about having those studies already at the Federal Government's disposal is that, once they make a decision to study cannabis and take it off of Schedule I, put it down into, you know, a schedule that will allow medical institutions, allow colleges, allow the Federal Government to study it, they can then absorb those existing research studies. So they wouldn't have to start from ground zero, so it is very beneficial.

Mr. HIGGINS. So isn't it, specifically regarding the VA, let's stay away from society in general for the moment, much to the chagrin of my friend at the rear of the room, let's focus on veterans, for a Federal program, wouldn't there have to be a federally mandated standard of THC within the cannabis?

And hasn't this always been the difficulty amongst the thousands of surveys and studies that have been done around the world is not the question of whether or not cannabis has medicinal value, certainly I don't question it and I support it, by the way, but our challenge, isn't it to actually introduce cannabis medicinally into the Federal system, the VHA system, doesn't that challenge come down to the THC content and how to regulate that? We are talking about growing a plant. Or does the Legion support synthetic production of a medicinal equivalent?

And just share with us what your thoughts are on that, please.

Mr. CELLI. Congressman Higgins, that is an excellent point, and what the Legion supports right now is research specifically to answer those very questions that you have. There is no standard dosage, there is no standard efficacy, there is no standard strength, and just like with an opiate, you wouldn't just randomly take a poppy plant, grind it up, and create your own opiates and decide that—

Mr. HIGGINS. Exactly.

Mr. CELLI [continued]. —you are going to self-medicate.

So the research absolutely needs to be done; it needs to be done professionally by scientists, it needs to be validated by the Federal Government, and then they can turn around and take this drug and they can distill it into whatever media or whatever delivery method that is appropriate for the patient based on the illness, and then they can deliver it that way.

Mr. HIGGINS. Thank you for your clarification and you have just very eloquently explained why I support this draft legislation.

Mr. Atizado, I believe we should support veterans if they would like to look outside the VA for their prosthetics. Reasonable accommodations should always be made to ensure that veterans receive the best care available according to that veteran's unique needs.

Is it your understanding that the VA's policy pertaining to prosthetic or orthotics and other rehabilitative services have effectively changed, and are veterans now experiencing more difficulty or less getting the authorizations they need for the life-changing items when they use providers outside of the VA? Just share with the Committee, please, your feelings on it.

Mr. ATIZADO. Thank you for that question, Congressman Higgins.

So we, a lot of our members use VA's prosthetics and sensory-aid service by virtue of who our organization representations and are trying to serve. So, over the years the program, the service has actually changed, and because fundamental aspects of that program has changed over years it has impacted service delivery, but there is a catch. The change is supposed to have yielded some positive results, which we are still trying to engage VA to make sure that has happened, because there has been some problems getting the care and services and the items in a timely manner.

We are very appreciative of VA actually creating my understanding is a complaint line that patients can actually call and get their attention, and get the leadership of the program's attention to address those situations in a more timely manner that has been occurring lately.

And so to your question, it has had some growing pains, that it has adversely impacted patients who need this service, but we are working very closely with VA to improve them, because we hear from our members and other patients about these programs and we can identify possibly policy issues or statutory limitations to just make it work better for veterans.

Mr. HIGGINS. Thank you for your answer, sir, very thorough.

Mr. Chairman, I yield back, my time has expired.

Mr. WENSTRUP. Mr. Takano, you are now recognized for 5 minutes.

Mr. TAKANO. Thank you, Mr. Chairman.

I want to just echo Ranking Member Brownley's comments about the Family Caregivers Program and I would like to back the sentiments of The American Legion that I would not support anything that would diminish the benefits for any veteran, and that I prefer what I see occurring with the Senate bill, which is to expand the current program to veterans to all eras is our best option. And so I just want to make sure we get that on the record now.

But I want to move on to H.R. 1506, which has been the VA Care Provider Education Debt Relief Act of 2017, which has been offered by my colleague Mr. O'Rourke. How can Congress ensure that the authority granted under this legislation to increase the caps for educational debt is properly implemented and utilized following enactment?

Mr. ATIZADO. Thank you for that question, Mr. Takano. I would have to direct you to VA and, unfortunately, they are not here to answer this question, but the EDRP program is well tracked by VA. They can project with a good amount of certainty the number of new applicants that will be coming into the program, as well as how many are currently in and how long they will be in.

And so I think if you work with the department, with that agency, in identifying what they believe will be the new demand because of these new caps, I think you will get a very respectful answer as far as funding levels moving forward.

Mr. TAKANO. Well, Mr. Atizado, in your written testimony you highlight the fact that the Education Debt Reduction Program is set to expire at the end of next year. What impact would that have on VA's ability to recruit and retain medical providers?

Mr. ATIZADO. Well, so it would be quite devastating for these medical graduates, these clinicians. The award under this program is usually a multi-year award, and so what you will get is a number of current participants who probably, you know, are serving as clinicians in the VA health care system with an agreement that VA may not need. And so they will be saddled with these student debts that they thought would otherwise be taken care of, at least in part or if not in whole by the VA, suddenly find themselves having to repay those because of the extinguishment of this program, not to mention the number, the thousands of vacancies that are out there that facilities won't be able to fill simply because they don't have this as a tool at their disposal.

Mr. TAKANO. So you are saying it is a very important tool to be able to bring medical professionals into our health care system, that without it these positions will continue to be vacant or we could see more vacancies occur as people leave the VA through separations or retirements.

Mr. ATIZADO. Well, yes, sir. So that is actually a very good point. If this were to expire and they have these loans that they need to pay, they are likely going to get released from the agreement and probably seek employment elsewhere where they can have those debts extinguished.

But to the point, you know, facilities use this program, the Education Debt Reduction Program, as well as another program called the Relocation, Recruitment, and Retention Program, the RRR Program. That program actually suffers from a cap as well, much like this. And so those two are actually very important tools that local

facilities use to recruit new medical graduates, as well as retain high quality health professionals within the health care system, and because those two are under stress now, to us, we understand why VA's vacancies remain as high as they are.

Mr. TAKANO. Well, I hadn't heard about the caps on this other program. What is the program called again, the RRR you said?

Mr. ATIZADO. So it stands for Recruitment, Relocation and Retention. It got swept into the VA Choice bill that was enacted back in 2014 and it was swept into the cap for bonuses being paid.

So we actually supported the idea of limiting bonuses being paid to clinicians because of poor performance, right? But the RRR is not a performance-based, it is actually a recruitment and retention instrument, but it somehow got pulled into those caps. And we have been working very closely with not only the Full Committee, but the Senate VA Committee to address that issue as well.

Mr. TAKANO. All right. Well, thank you very much.

My time is up. I'm sorry I went over, Mr. Chairman, and I yield back.

Mr. WENSTRUP. Mr. Rutherford, you are now recognized for 5 minutes.

Mr. RUTHERFORD. Thank you, Mr. Chairman.

First, I would like to say that I am a strong supporter of improving and expanding the loan-repayment program at VHA and that is why I offered my VA Physician Recruitment Act, which includes that loan repayment, as an amendment to the Choice legislation that the Committee agreed to and moved earlier last year.

Everything Mr. O'Rourke said highlights the fact that we have got to get this right and we have got to get it right soon, because half of all providers in VA are eligible for retirement within the next 10 years. That is a scary thought.

And what is even scarier is the Senate Choice Act, their proposal still extends the Graduate Medical Education Program as a way to bring more doctors into the system. However, in hearings that we have had with the previous Secretary and Dr. Clancy, we have learned that, number one, this is more expensive, less effective, and potentially brings in less qualified physicians to care for our veterans, where loan repayment provides VA with more flexibility to recruit the most qualified candidates.

And so, Mr. Atizado, can you give me your perspective on the GME versus the loan repayment? The GME as it still remains in the Senate Choice Act.

Mr. ATIZADO. So, Congressman Rutherford, I first have to let you know that I think we do support the GME proposal. We think VA frankly needs every tool in the bucket that they can have in there. Certainly, GME has its own purpose and it is successful in its own way, but I don't believe the two should be seen as a competition. I think they both work in different ways to enhance the local facility, fill a critical need.

I think GME works in areas where there are facilities who have very strong affiliate relationships where they have that pool of talent that comes in to help care for veterans, both in the academic institution as well as in the VA facilities, and I think that program works very well, but not all facilities have that kind of relationship

with an affiliate. And so these other tools, these financial-incentive tools, become more important for those other facilities.

So I think those two are good programs and each—

Mr. RUTHERFORD. Complementary?

Mr. ATIZADO. I believe so, yes, sir, for the whole system as a whole to address its workforce shortage issues.

Mr. RUTHERFORD. Okay. Anybody else want to comment on that, GME vs. loan repayment? Okay.

Let me share this experience too. Mr. Chairman, when I was sheriff in Florida, I had an opportunity, I was a legislative chairman for the Florida Sheriffs Association. When we actually as an association of 67 sheriffs advocated for Charlotte's Web, which is an extract of cannabis, very high in CBDs, but low in THC, and I have seen, I can tell you firsthand the results of Charlotte's Web on a little girl who was around eight or nine years old suffering a tremendous number of seizures every day. Her legs, she couldn't get out of bed, her legs had atrophied. With Charlotte's Web, a year later, that girl was up walking around.

That is why I support this idea that we have to look at this drug, see what we can do to help individuals with a drug that I think for too long we have just mischaracterized—well, I don't want to—I am not defending marijuana, but I am saying there is a medicinal purpose and efficacy there that I would like to see studied.

And so with that, Mr. Chairman, I will yield back.

Mr. WENSTRUP. Mr. O'Rourke, you are now recognized for 5 minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman.

Mr. Chairman, I have got to say I really appreciate the conversation today and the fact that on almost every one of these bills there seems to be bipartisan agreement on what it is we are trying to do here, and very helpful feedback from the panel, some constructive criticism that on at least the bill that we have authored, H.R. 1506, will incorporate into the changes that we will propose.

And I agree with some of the panelists that perhaps the only complaint I have is that some of these bills do not go far enough. And I love what the Chairman is doing on the Family Caregiver Program, but I want to make sure, as one of the panelists said, that this is just a first step, it doesn't get us to where we are.

And I think implied in some of the questions about medical cannabis is how much more study do we need to do for something that is legal in 29 states, that doctors are already prescribing. That veterans in Texas at least come up to me at town hall meetings and say this is the only thing that I can take that makes life livable for me, but I am treated as a criminal under the law in this state. How screwed up is that? And if we are going to wait for study upon study upon study for veterans to get the care they need, especially if it is an alternative to opioids, from which veterans are dying today.

I had a town hall meeting in El Paso, a veteran came forward and he said, listen, the VA cut off my opioid prescription and I understand why the VA is doing this, but they didn't provide an alternative in its place and I am—and he said this in front of 200 people at the town hall—I am buying heroin on the street right now because this is how I can take care of this issue.

I think we have got to go, you know, within the bounds of reason and medicine and science as quickly as we can to making sure that doctors can prescribe what they think is in the best interest of their patients, including cannabis or marijuana. I think we are there. And just given the number of states who are there, the number of countries who are there, the number of veterans who need it, I mean, let's get there.

On the debt repayment issue—and we authored it—I don't think it goes far enough. I mean, that is my complaint. We should be much more aggressive in raising the caps, and if we have got between 30 and 40,000 vacancies, let's be aggressive on that. I mean, there are people literally dying right now because they cannot get in to see an appointment. We still have a crisis in veteran suicide, though the last Secretary made it his number one clinical priority.

And so I think, especially in those under-served, in-demand professions I think of psychiatry, and the need for those who treat traumatic brain injury and post-traumatic stress disorder, let's make it as easy as possible to make the choice to practice medicine in the Veterans Health Administration or to stay there, if you are already there. And I think everyone is on the same page, it is just I want us to be as aggressive as possible. And so your comments about making sure that this is funded, that we get past the sunset, and that we do everything within our power to make this attractive hit home, and I will do everything that I can.

And I just, I think within the context of \$1.4 trillion in outstanding student loan debt, why do we make it so hard for people to better themselves, so that they can do better for their fellow Americans, especially in the VA. This is an investment this country absolutely should make. And so I hope there is bipartisan commitment to actually fund what we are proposing to authorize.

So I don't really have a question. I think you all did such a great job in providing your feedback and we are taking notes on all this, and just I want to tell you that we are grateful for that.

And I will yield back to the Chairman.

Mr. WENSTRUP. Thank you.

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

Mr. DUNN. Thank you, Chairman Wenstrup.

My principal interest today has been the Veterans Opioid Abuse Prevention Act, one of the bills we are considering here. I don't have the sense, as Mr. O'Rourke said, I don't have the sense of any pushback from anybody, but I want to poll you explicitly. Do you have the sense in any of the VSOs that there is opposition to this prescription database sharing plan? Any of you or all of you.

Mr. CELLI. So based on the feedback from our veterans, it is not that there would be opposition to it, it is that there has been such a pendulum swing of, you know, the opioid crisis with veterans who are in chronic pain and on systemic lifelong opioid prescriptions, they are very concerned that their prescriptions will be reduced and that they will not be able to perform the daily functions that they are currently able to enjoy now.

So any time there is legislation, legislative efforts, or efforts by our Federal Government to try to curtail the abuse, the patients who are taking this as prescribed get very nervous. So that would be the only thing.

And the only other thing that I would add to that is, if we had the lifetime electronic medical record, we wouldn't need additional legislation specifically to track prescriptions. So I think that we have work to do in both of those areas.

Mr. DUNN. So I appreciate that comment as a surgeon myself and I don't look forward to having my hands tied on how long I can prescribe a medicine for. I don't know that I can say that that won't happen, honestly, because as you have hinted at, you know, the Government tends to overreact when they react. So, you know, buckle up, it could be a bumpy ride, but I do agree with that.

I do also want to make one more comment about the cannabis research. You know, we have a form of legal cannabis now that really has no abuse history at all, very effective. It is actually tetrahydrocannabinol, the stuff that makes you high in cannabis. And I just looked it, because I want to be sure I was right, it is a Schedule III drug. So it should be very easy to do research on, at least that form or that cannabinoid, which is just one of dozens to hundreds of cannabinoids in a marijuana plant and it is different than the cannabinoid that Congressman Sheriff Rutherford mentioned, which I am familiar with and is effective against, you know, seizure disorders in some children, and certainly want to make that available, it is available in Florida to children. I don't see a lot of veterans with that particular affliction, because it affects infant children.

But, you know, I think we could study the THC in the Marinol, the generic name is Dronabinol and it is just tetrahydrocannabinol. So I don't know if you have any comment on that, but it is available, and it actually would be pretty easy to do research on a Schedule III drug, I think.

Any thoughts?

Mr. CELLI. Well, the only thing that I would add to that, and I am not a scientist, but I do know that there are components within that tetra cannabinol that are in the Schedule IV—or in Schedule I, rather, that prohibits the Federal Government from authorizing—

Mr. DUNN. Well, so that is a marijuana plant. So I am just saying—

Mr. CELLI. Correct, that is right.

Mr. DUNN [continued]. —if you want to do research on THC, tetrahydrocannabinol, you can go at it all day long and it is not even a particularly controlled drug. I have prescribed it and it is only used currently for anorexia, and for pain potentiation in typically terminal patients, but, you know, it is a very available drug and I have never seen it abused, I have never seen it stolen, I have never heard of it, you know, walking out of a pharmacy. I wish Buddy Carter were here. But I think it is a pretty, you know, available drug for study right now.

I have no other questions, Mr. Chairman, and I am happy to yield back.

Mr. WENSTRUP. Ms. Kuster, you are now recognized for 5 minutes.

Ms. KUSTER. Thank you very much, Mr. Chairman, and thank you to all of you for being with us. I just want to join my colleagues that these are predominantly bipartisan bills and it is great to

make progress here in the Veterans' Affairs Committee, and I have joined as a cosponsor on most of the bills.

I want to direct some of my concerns. I appreciate the efforts that Dr. Roe has made to come up with a bipartisan compromise on the benefits for family caregivers, but I still am concerned about the policy proposed and the fact that it doesn't really resolve the fundamental lack of fairness between our post-9/11 and pre-9/11 veterans.

This is just directed at any of the VSO witnesses. Besides increased cost to the VA, is there any other reason not to expand the program to include all veterans of all eras that require home caregivers?

Mr. CELLI. We believe it is only a cost issue.

Ms. KELEHER. Yes. The VFW doesn't see any reason to not expand to everybody as is. We do understand there is constant concern and some criticisms on VA for the way the current program has been implemented and road bumps that they have undoubtedly had along the way. But, again, VFW doesn't look at that as a reason to not expand for all eras of veterans.

Ms. KUSTER. I mean, sometimes, this is just my impression, I think we spend a whole lot of money trying to limit care and determine who is eligible for what, and I really like the way you said it that, you know, being unable to do two activities of daily living is a major constrain on someone's life that you need help with.

So could the VSOs explain some of the potential unintended consequences of expanding benefits to only those with three or more activities of daily living? So, just briefly, examples of how that would be a problem.

Ms. DEAN. I think we have seen it the last 8 years of the program as is. This inherent unfairness about people who need these services, but are not allowed because of an arbitrary date. We are picking a new lucky cohort, essentially.

Ms. KUSTER. Well, now we're not only having an arbitrary date, but now we're having an arbitrary number of issues that you might have, which I can't imagine medically that has any basis in reality.

And then could you give us some examples of veterans that would not qualify for expanded benefits, but reasonably might need additional help? Does anybody have an example of what this might look like?

Mr. ATIZADO. So, in the current program now, you would have a significant majority who would fall under the one and two ADL who would have to be transitioned out and I can't even imagine the impact on their lives, not only on the veteran's, but the caregiver's and their families as well if that were to happen.

I do want to make sure we understand, though, you know, the intent of the legislation is to operate to expand the program, within certain constraints, and so we appreciate that work. We very much appreciate the work that Congressman Roe has done, his staff has done to talk to us about how to do this within these constraints, and we appreciate that. But to echo my colleague's comments, we have an opportunity, we have an historic opportunity before us, before this Committee and the Senate and Congress, to actually not even have to talk about the proposed draft bill, because we are talking about actually expanding the current program to all eras.

And I really have been thankful of my colleagues' support and all the Members' support to try and make that a reality this year. And so I would prefer we actually focus on making that a reality and then pick up, if that in case doesn't happen, then perhaps take up this conversation after.

Ms. KUSTER. Well, I would love to work with you on that, and I certainly think that is the direction we want to go.

Otherwise, I just want to join my colleagues, anything that we can do to improve access to care for women veterans and also the veteran opioid abuse prevention, this is something that I have dedicated the past five years of my life. We have a bipartisan task force with 105 Members, Republicans and Democrats, trying to tackle the opioid epidemic all across our country. And I think the VA is where a lot of the innovative solutions will come from, both to lower the rate of opioid prescriptions by using alternative pain management, and also to help with this prescription monitoring program, and help with more efficient and effective methods for treatment and long-term recovery.

And I yield back.

Mr. WENSTRUP. I want to thank everyone once again. Thank you all for being here. I appreciate all the input you provided with us today and the second panel is now excused.

And I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material.

Without objection, so ordered.

I would like to once again thank all of you, our witnesses and audience members, for joining us this afternoon. The hearing is now adjourned.

[Whereupon, at 5:04 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Honorable Beto O'Rourke

Chairman Wenstrup, Ranking Member Brownley, honorable Members of the Committee it is my pleasure today to present to the House Committee on Veterans Affairs Subcommittee on Health H.R. 1506 -VA Health Care Provider Education Debt Relief Act of 2017. Thank you for this opportunity. I introduced H.R. 1506 on March 10, 2017 to address serious staffing shortages throughout the Department of Veterans Affairs (VA) and to increase the VA's recruitment and retention capacity for high need and difficult to fill medical provider positions. It is my hope we can work together to ensure talented medical professionals remain in the VA to deliver quality care to our veterans.

H.R. 1506 increases the maximum amount of education debt reduction available for health care professionals employed by the Veterans Health Administration (VHA) participating in certain education reimbursement programs. The bill also makes clear the definition of a provider shortage so that VA facilities can better address their efforts to fill the highest need provider positions.

Colleagues, you are well aware of the enduring provider shortage at the VA. When this bill was introduced, the VA reported a shortage of 43,000 medical providers nationally. This number remains in the tens of thousands. Last week, VA spokesman, Mark Cashour, reported, as of early March 2018, there are more than 33,000 full-time vacancies at the VA.¹ At the February 15th Full Committee VA budget hearing, we learned from then Secretary Shulkin that the VA has approximately 2,800 vacant mental health provider positions. These are positions critical for ensuring veterans get the care they need - care they have earned through their service - in a timely fashion.

In many cases, timely care can save lives. Currently, veterans are waiting approximately four days for primary care and mental health care appointment. In some regions, this can be upwards of 7–10 days.² A 2016 report from the RAND Corporation states “only about half of veterans reported getting care “as soon as needed.””³ Today, mental health care providers at the VA are doing their best to serve veterans, however, their case loads are much too large and they report “burn out” and frustration.

Staffing shortages also hurt retention. Medical providers, specifically, mental health care providers cite being overworked and underpaid as one of the top reasons they seek positions in the private sector. In February, I met with a nurse from the Houston VA who shared his experience in this kind of work environment; he also impressed upon me the importance of recruitment and retention efforts focused on specialty providers. This reinforces the importance of H.R. 1506. According to the 2016 Commission on Care Report, medical providers at the VA make an average \$74,631 less than those in the private sector, while the long-term earning potential differential at the top of the salary range can be as much as \$310,000. Furthermore, the report explains, “lower salaries reduce VHA’s competitive edge [...] when trying to attract top talent.”⁴

H.R. 1506 bill seeks to make the VA a more attractive employer by increasing the benefit available for a VA medical professional who is part of the Education Debt Reduction Program (EDRP). The EDRP is a student loan reimbursement program for employees with qualifying student loans in provider positions that are difficult to recruit and retain as determined by each VHA facility.⁵ The VA estimated there

¹ Washington Post, 10 April 2018.

² VA, Report: Pending Appointments as of 1 April 2018.

³ “Balancing Demand and Supply for Veterans’ Health Care,” RAND Corporation, 2016, pg. 9.

⁴ Commission on Care Report, 2016, VA.

⁵ VA, Education Debt Reduction Program (EDRP).

are about 3,000 medical professionals participating in this program. In accordance with 38 U.S. Code Section §7683(d) and under the EDRP, an employee with student loans for a degree program that qualified the individual for their position at the VA is eligible for a maximum benefit of \$120,000 over the course of five years as reimbursement for their proven student loan payments.

H.R. 1506 increases the total amount of reimbursement eligible from \$120,000 to \$150,000 keeping in place the five year time frame. Accordingly, the bill would increase the total amount of debt reduction possible per year from \$24,000 to \$30,000. Keeping in mind the average long-term earning difference between medical professional at the VHA and their counterparts in the private sector is estimated at \$74,631, this bill provides a modest increase in the benefit available for a VA professional by \$30,000.

H.R. 1506 is both relevant and important. At a time when the collective student debt held by Americans is around \$1.3 trillion dollars,⁶ making loan repayment possible for those who serve in high need and critical public service positions could not be more important. For the 2017–2018 academic year, the Association of American Medical Colleges (AAMC) reports the average cost of attendance (tuition fees, and health insurance) for an in-state student at a public medical school was \$53,327 per year, while the average cost per year for a private medical school (all nonresident) was about \$67,000 per year.⁷ The cost of attendance estimates show a 3.5% increase from 2016. At the least, H.R. 1506 will provide additional support for the rising cost of attendance for medical school. And, I hope this bill will help further recruitment and retention for critical medical professional and specialists at VA.

Finally, this bill more clearly defines what it means to have a provider shortage, thus allowing for the waiver of reimbursement caps for certain positions at VA facilities in Health Professional Shortage Areas (HPSA) set annually by the Department of Health and Human Services (HHS). This bill would encourage the Secretary of Veterans Affairs to exercise the authority to waive provider education debt reimbursement limits to fill provider vacancies with a focus on geographic locations as having shortage areas in primary care.

I remain dedicated to ensuring the brave men and women who have served this country receive excellent care. To do this, we must provide the VA resources necessary to recruit and retain the best and the brightest in the field of medicine. I look forward to working with my colleagues to ensure the VA is equipped with the resources needed to take care of our nation's heroes. Again, it is my pleasure to lead on this legislation and look forward to working with everyone here to close the provider gap, retain talented and motivated VA professions, and, most importantly, care for our veterans. Thank you to all Members of the Committee, Ranking Member Brownley, and Chairman Wenstrup for your time and attention.

Prepared Statement of Honorable Walberg

VA Committee Hearing on H.R. 2322 Testimony

Chairman Wenstrup and Ranking Member Brownley, thank you for allowing me to be here today to testify on H.R. 2322, The Injured and Amputee Veterans Bill of Rights. I would like to start off by thanking the Subcommittee members and staff for their time and willingness to work with me on this important topic.

I think we can all agree that our veterans have earned the highest quality possible health care. I understand there are problems at the Veterans Affairs and that this committee is diligently working to address these concerns to ensure our veterans receive the benefits and care they deserve. I also know there are great doctors, nurses and staff that work hard to make sure our veterans receive timely care.

With that being said, I believe a veteran's healthcare decisions are personal choices. We know all too well that the VA can be an intimidating and hard to navigate bureaucracy. There are layers of paperwork and red tape that can make these healthcare decisions daunting. H.R. 2322 moves to empower veterans when it comes to making their own healthcare choices and it does so by ensuring injured and amputee veterans know their healthcare rights.

Years on the battlefield has taken a toll on our war fighters. Our veterans are younger than before and transitioning from active duty can be difficult. We need to ensure that amputee veterans have the best access to care and ability to more easily transition into civilian life.

⁶“Student Loan Debt In 2017, A \$1.3 Trillion Crisis,” Forbes, 21 February 2017.

⁷Association of American Medical Colleges, “Tuition and Student Fees for First-Year Students,” 2017–2018.

The Injured and Amputee Veterans Bill of Rights is a bipartisan approach to empower injured and amputee veterans in making their healthcare choices. This bill simply requires the VA to prominently display a list of “rights” in VA Orthotic and Prosthetic (O&P) clinics as well as on their website.

These rights include:

1. The right to access the highest quality and most appropriate O&P care
2. The right to continuity of care during their transition
3. The right to select the practitioner of their choice
4. The right to consistent and portable healthcare, including obtaining comparable services at any VA medical facility
5. The right to timely and efficient O&P care
6. The right to play a meaningful role in their rehabilitation process and a second medical opinion
7. The right to both a primary prosthesis and orthosis and a functional spare
8. The right to be treated with respect and dignity during and after their rehabilitation
9. The right to transition and readjust to civilian life in an honorable manner

Additionally, the VA would be required to educate their staff so VA employees can help veterans navigate this process.

To make sure veterans are receiving the care they deserve and need, our bill also requires the VA to follow up and resolve any complaints by veterans who believe the VA is not meeting their O&P needs.

Mr. Chairman, at the end of the day, veterans should receive the best available and timely care they can get. I know this is something you and your staff have worked hard on and I applaud your unwavering commitment to our veterans.

I am willing to work with you and your committee in any way to better this legislation so that we can empower injured and amputee veterans when they are making their healthcare choices.

Thank you for your time today and for the work this committee is doing to keep our promise to our nation’s heroes.

Prepared Statement of Honorable Rep. Neal P Dunn, M.D.

Statement for the Record - H.R. 3832, “Veteran’s Opioid Abuse Prevention Act”

Mr. Chairman, thank you for the opportunity to speak today on behalf of H.R. 3832, the “Veterans Opioid Abuse Prevention Act.”

According to the Centers for Disease Control, 249 million prescriptions were written by healthcare providers in 2013. The Department of Veterans’ Affairs healthcare system is the nation’s largest healthcare provider, and because of this, is in a unique position to help curb the opioid epidemic by using every tool available when a veteran is prescribed an opioid. The “Veterans Opioid Abuse Prevention Act” gives VA health care providers access to these valuable tools.

H.R. 3832 comes directly from recommendations from the nation’s top policy makers. The White House’s Commission on Combatting Drug Addiction and the Opioid Crisis recommended last July that the VA lead efforts to have all state and Federal Prescription Drug Monitoring Programs - known as PDMPs - share information. The interim report cited multiple published best practices for PDMPs, and has identified interstate data sharing among PDMPs as a “top priority” to ensure that healthcare professionals have a better understanding for prescribing practices for their patients.

H.R. 3832 directs the VA to have healthcare providers participate in sharing prescribing data across a network of interstate prescription drug monitoring programs. PDMPs are state-based networks which healthcare providers and pharmacists can access when writing or filling a prescription. PDMP data includes types of medications dispensed, fill dates, and dosage amounts. PDMPs improve a clinician’s ability to follow good prescribing practices for at-risk patients who may have a pattern of prescription opioid abuse. In 2011, the National Board of Pharmacy created a national platform of Prescription Monitoring Programs - or PMPs - called “PMP Interconnect” - which allows states to share PDMP data across state lines securely.

Today, 44 states and Washington D.C. participate in PMP Interconnect, with more soon to follow suit.

I have veterans in my district who are desperate for opioids because well-meaning but underinformed doctors have time and time again have overprescribed opioids for them. I can guarantee everyone sitting on this dais today has veterans back home suffering for the same reason. And let me be clear - this is not something anyone up here on this dais or in this room should accept as good treatment for our veterans. The tragedy in these situations is that so many of them are preventable by just giving doctors the right tools to decide on how to prescribe an opioid safely. We must make sure this is a priority.

H.R. 3832 implements the Commission's recommendation by granting providers the ability to use an interstate PDMP platform for the betterment of our veterans who are at risk of opioid abuse. Every doctor has a duty to help the sick according to one's own ability and judgment, and we as a Committee have a duty to ensure veterans have access to doctors who are enabled to make the best clinically-informed judgments for veterans.

I encourage my colleagues to support H.R. 3832, and I yield my time back to the Chairman. Thank you.

Prepared Statement of Honorable Congressman J. Luis Correa

H.R. 4334 - Improving Oversight of Women Veterans' Care Act

Thank you, Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee. I appreciate the opportunity to speak on my bipartisan legislation today: H.R. 4334, the Improving Oversight of Women Veterans' Care Act. I am particularly grateful to my friend and colleague Ranking Member Brownley for her support of the bill.

Women represent the fastest growing population in the veteran community. According to the Department of Veterans Affairs, there are about two million women veterans today. That number is expected to increase at an average rate of about 18,000 women per year for the next ten years. It is important that we ensure that women veterans receive quality care in a safe and dignified environment, as well as in a timely manner.

According to the Government Accountability Office, the Veterans Health Administration does not have performance measures to determine women veterans' accessibility to gender-specific care delivered through certain community care programs despite having such metrics for Patient-Centered Community Care (PC3). Additionally, GAO reports that the Veterans Health Administration does not have accurate or complete data regarding VA medical centers' compliance with environment of care standards for women veterans. Currently, medical centers must conduct regular inspections and report instances of noncompliance, but sometimes these cases are not reported to VHA.

My legislation will enhance the monitoring needed for effective oversight of women veterans' by requiring VA to submit an annual report on veteran access to gender-specific care under community care contracts and quarterly reports on environment of care standards for women veterans. This will ensure we understand women veterans' ability to access gender-specific health services.

I understand the legislation may require technical edits and I am open to working together with my colleagues to address those needed changes. Again, thank you for the chance to speak before the Subcommittee.

Prepared Statement of Honorable Mike Coffman

Chairman Wenstrup and Ranking Member Brownley, thank you for allowing me to present H.R. 4635, The Peer-2-Peer Counseling Act that I introduced with Congresswoman Esty to improve VA counseling afforded to female veterans. I would also like to thank the members of the Subcommittee who co-sponsored H.R. 4635 - Rep Bilirakis, Rep Radewagen, Rep O'Rourke, Rep Rutherford, and Rep Gonzalez-Colon.

Currently, female Veterans make up 10% of our nation's veteran population and this population is expected to grow to 15% by 2030. Over the past 10 years, the VA has seen a 45% increase in the number of female veterans using VA benefits, demonstrating that female veterans are relying more and more on VA services. As the female veteran population increases, it is critical for VA to meet future demand.

One area of need among female veterans that warrants our particular attention is peer-to-peer counseling. Unfortunately, many female veterans have experienced sexual trauma and PTSD while serving in the military and are also suffering from other mental conditions that put them at risk for homelessness. Peer counseling can help female veterans who are facing these critical issues.

The VA's 2016 suicide data report found that the risk of suicide for female veterans was 2.4 times higher than non-veteran adult females and the rates of suicide increase more among women than men. This data is disturbing. We owe it to our female veterans to ensure sufficient resources are available to assist with gender-specific needs and that is why I introduced H.R. 4635, The Peer-2-Peer Counseling Act.

H.R. 4635 enhances the VA's existing Peer-to-Peer program, which has been successful in providing peer counseling to all veterans, by ensuring the current program has a sufficient quantity of female peer counselors for female veterans who are separating or newly separated from military service. Ideal counselors will have expertise in gender-specific issues, VA services and benefits focused on women, as well as employment mentoring.

The act would also emphasize counseling services for female veterans who have suffered sexual trauma while serving in the military, have PTSD or any other mental health condition, or female veterans who are at risk for homelessness.

To ensure these counseling services are not only available but also known throughout the veteran community, H.R. 4635 directs the VA Secretary to conduct outreach to inform female veterans about the peer-to-peer program and the services available to women.

Finally, H.R. 4635 authorizes the VA Secretary to facilitate engagement and coordination with community organizations, state and local governments, institutions of higher learning, and local business organizations. With the help from our communities, we can leverage resources and expertise that exists within our communities.

The Peer-2-Peer Counseling Act ensures VA's peer-to-peer program is better positioned to address the gender-specific needs of women veterans and updates this vitally important program to better represent the growing veteran population it serves.

Mr. Chairman, I encourage my colleagues to support this important legislation and I yield back the remainder of my time.

Prepared Statement of Louis J. Celli Jr.

Chairman Wenstrup, Ranking Member Brownley and distinguished members of the Subcommittee on Health; on behalf of National Commander Denise H. Rohan and The American Legion, the country's largest patriotic wartime veterans service organization, comprising over 2 million members and serving every man and woman who has worn the uniform for this country, we thank you for the opportunity to testify on behalf of The American Legion's positions on the following pending and draft legislation.

H.R. 1506 - VA Health Care Provider Education Debt Relief Act of 2017

To amend Title 38, United States Code, to increase the maximum amount of education debt reduction available for health care professionals employed by the Veterans Health Administration, and for other purposes

The American Legion is deeply troubled by the Department of Veterans Affairs (VA) leadership, physicians and medical specialist staffing shortages within the Veterans Health Administration (VHA). Since the inception of our System Worth Saving program in 2003, The American Legion has identified, and reported staffing shortages at every VA medical facility and reported these critical deficiencies to Congress, the VA Central Office (VACO), and the President of the United States.

Currently, there are 43,000 vacancies throughout the VA in primary care, mental health care and dental care providers. Moreover, the June 2016 Commission on Care report has concluded that, "in the area of educational debt repayment relief, VHA lags behind other federal and state agencies that use such programs to fill critical physician shortages in medically under-served areas."¹

This bill provides an incentive to attract qualified providers to fill the above noted vacancies by increasing total educational loan repayment amounts from \$120,000 to \$150,000 and annual debt repayment amounts from \$24,000 to \$30,000.

¹ Commission on Care Final Report, June 30, 2016, page 145

During testimony before the joint House and Senate Veterans' Affairs Committees this February, our National Commander called for raising the ceiling of the VA Debt Relief Reduction program to \$200,000 to increase VA probability of attracting high-quality talent in its recruitment efforts.²

In VA's Office of Inspector General (VAOIG) September 27, 2017 report entitled "Veterans Health Administration's Occupational Staffing Shortages," VAOIG determined based on data provided by VHA that the largest critical need occupations were Medical Officers, Nurses, Psychologists, Physician Assistants, and Medical Technologists.³

One medical center interviewed by VAOIG reported encountering recruitment challenges generally related to "extreme competition" for quality healthcare professionals. The facility further stated that it made use of multiple recruitment endeavors such as special salary rates, incentives (for recruitment, relocation, and retention), and an education debt reduction program.

During The American Legion May 2017 System Worth Saving site visit to the Alaska VA Healthcare System, medical center personnel voiced concerns that community hospitals are offering to repay a provider's debt in exchange for them coming to work at their hospital. While VA has a debt reduction program, VA does not forgive provider's debt in exchange for acceptance of a position at a particular VAMC.⁴

A common theme our System Worth Saving team hears from VHA medical center human resource staff and physicians is VA's debt reduction program is not adequately funded and the amount VA can offer to a VA provider is not in keeping with what local community hospitals can pay.

Under current law, the amount of education debt reduction payments made to or for a participant under VA's Education Debt Reduction Program may not exceed \$120,000 over a total of five years of participation in the Program, of which not more than \$24,000 of such payments may be made in each year of participation in the Program.

According to the Association of American Medical Colleges, the average medical school debt balance for graduating physicians in 2015 was \$183,000, and is no doubt higher today. Add that burden to their average undergraduate balance of \$24,000 and the total average student loan balance for a doctor is \$207,000.⁵ Once interest is factored in, repayment amounts can range from \$329,000 to \$480,000.⁶

Through The American Legion Resolution No. 377, Support for Veteran Quality of Life, we support any legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care, timely decisions on claims and receipt of earned benefits, and final resting places in national shrines and with lasting tributes that commemorates their service.⁷

The VA Health Care Provider Education Debt Relief Act will grant this nation's veterans better access to care by increasing the number of doctors available to be seen and will improve the overall quality of care that the VA is able to provide.

The American Legion supports H.R. 1506.

H.R. 2322 - Injured and Amputee Veterans Bill of Rights

To direct the Secretary of Veterans Affairs to educate certain staff of the Department of Veterans Affairs and to inform veterans about the Injured and Amputee Veterans Bill of Rights, and for other purposes

The American Legion has long opposed the privatization of the Department of Veterans Affairs (VA.) Though we understand the intention of HR 2322, which is to highlight and provide more and better benefits and educations as to the rights of those who have lost a limb in service of this nation, the VA in concert with the veteran patient, must determine when the veteran should seek and obtain care outside the community. In order for the VA to remain an organization that is there to serve the 9 million currently enrolled veterans, and those in the future, the VA must have the final approval on when a veteran is approved for outside care.

² <https://www.veterans.senate.gov/hearings/legislative-presentation-of-the-american-legion—02282018>

³ VAOIG Report 17-00936-835

⁴ 2017 Alaska VA Healthcare System Worth Saving Site visit

⁵ Gitlen, Jeff. Average Medical School Debt, LendEDU, Feb. 15, 2017, lendedu.com/blog/average-medical-school-debt/

⁶ Marquit, Miranda. Is Medical School Worth It? 4 Questions to Ask Before Deciding, Student Loan Hero, Feb. 9, 2018, studentloanhero.com/featured/cost-of-medical-school-worth-it/

⁷ The American Legion Resolution No. 377 (2016): Support for Veteran Quality of Life

Allowing veterans to elect when the VA pays more for outside care, especially when they may have the internal ability, will destroy the VA, leaving a dilapidated system.

H.R. 2322, calls for a veteran to have the right to select a practitioner that best meets their orthotic and prosthetic needs, whether or not that practitioner is an employee of the VA, a private practitioner who has entered into a contract with the VA, or even a private practitioner with specialized expertise. Allowing veterans to simply dictate when they government spends money is a dangerous slope that will turn the robust VA system into nothing more than an over-paying insurance system.

Through American Legion Resolution No. 372: Oppose Closing or Privatization of Department of Veterans Affairs Health Care System, passed in 2016, The American Legion opposes any legislation or effort to close or privatize the Department of Veterans Affairs healthcare system.

The American Legion Opposes H.R. 2322.

H.R 3832 - Veterans Opioid Abuse Prevention Act

To direct the Secretary of Veterans Affairs to enter into a memorandum of understanding with the executive director of a national network of State-based prescription monitoring programs under which Department of Veterans Affairs health care providers shall query such network, and for other purposes

America continues to be in the throes of an opioid addiction crisis, including an epidemic of overdose deaths, affecting veterans and non-veterans alike.⁸ H.R. 3832 directs the Department of Veterans Affairs (VA) to connect VA health care providers to a national network of state-based prescription drug monitoring programs (PDMPs), databases which track controlled substance prescriptions. PDMPs ensure health care providers do not accidentally prescribe dangerous and potentially lethal combinations of drugs to patients who also see other healthcare providers. These state programs also have been proven to curb “doctor shopping” whereby people visit multiple health care providers to solicit more prescription medications than their original doctor has agreed to prescribe.

Currently, VA doctors are required to consult state-based PDMPs before prescribing potentially dangerous pain medications to veterans. VA doctors, however, lack the ability to consult a national network of state-based PDMPs that can identify someone from another state who is at high risk for abuse, overdose, and death.

H.R. 3832 would help overcome this lack by directing VA to enter into a memorandum of understanding with the executive director of a national network of state-based prescription drug monitoring programs under which VA health care providers shall query such a network to support the safe and effective prescribing of controlled substances to covered patients. Under such memorandum of understanding:

(1) Department health care providers practicing in a state that participates in such network shall query such network in accordance with the agreement between that state’s prescription drug monitoring program and such network in accordance with applicable Veterans Health Administration policies; and

(2) Department health care providers practicing in states that do not participate in such network shall query such network through the drug monitoring program of the participating State that is in closest proximity to the State where the provider is practicing.

Because prescription abuse, misuse, and diversion is a nationwide issue, it is vital that VA and states work together to share PDMP data and provide a national solution to prescription abuse issues.⁹ The President’s Commission on Combating Drug Addiction and the Opioid Crisis issued a preliminary report in July 2017 that cited the lack of cross-state interoperability as one significant shortcoming of state PDMPs. The Commission recommended “enhancing interstate data sharing among state-based prescription drug monitoring programs.”¹⁰

Through The American Legion Resolution No. 83: Virtual Lifetime Electronic Record, we support the use of Electronic Health Records as a method of coordinating care provided to veterans inside and outside VA medical facilities and the controlled

⁸ <http://thehill.com/blogs/congress-blog/healthcare/241243-a-national-prescription-drug-data-base-to-combat-opioid>

⁹ <https://www.pharmacist.com/sites/default/files/files/Prescription%20Drug%20Monitoring%20Programs.pdf>

¹⁰ <https://www.whitehouse.gov/ondcp/presidents-commission/>

but widespread sharing of electronic medical records so that veterans can receive the highest possible quality healthcare available.¹¹

The American Legion supports H.R. 3832.

H.R. 4334 - Improving Oversight of Women Veterans' Care Act of 2017

To provide for certain reporting requirements relating to medical care for women veterans provided by the Department of Veterans Affairs and through contracts entered into by the Secretary of Veterans Affairs with non-Department medical providers, and for other purposes

H.R. 4334 would enhance the monitoring needed for effective oversight of women veterans' healthcare in the Department of Veterans' Affairs (VA) and community care programs.

According to a December 2016 Government Accountability Office (GAO) report, the Veterans Health Administration (VHA) does not have data and performance measures to determine women veterans' accessibility to gender-specific care delivered through the Veterans Choice Program, a community care program. VHA does, however, already collect data to evaluate women veterans' access to gender-specific care received through PC3 - a different community care program.¹²

The GAO report also found that VHA does not have accurate or complete data regarding medical centers' compliance with environment of care standards for women veterans. Medical centers must conduct regular inspections and report instances of noncompliance, however sometimes instances of noncompliance are not reported to VHA.

This legislation would require VA to report to Congress women veterans' accessibility to gender-specific healthcare in any community of care program. The report must include the average waiting period between the veteran's preferred appointment date and the date on which the appointment is completed, and driving time required for veterans to attend their appointments. The bill would also require VA medical facilities to report to the Secretary the compliance and noncompliance of the facility to ensure they meet quality care standards for women veterans. Evidence gathered from the reports could potentially help the VA enhance and preserve the benefits and the medical care for women veterans while providing timely access to care.

Through The American Legion Resolution No. 377, Support for Veteran Quality of Life, we support any legislation and programs within the VA that will enhance, promote, restore or preserve benefits for veterans and their dependents, including, but not limited to, the following: timely access to quality VA health care, timely decisions on claims and receipt of earned benefits, and final resting places in national shrines and with lasting tributes that commemorates their service.¹³

The American Legion supports H.R. 4334.

H.R. 4635

To direct the Secretary of Veterans Affairs to increase the number of peer-to-peer counselors providing counseling for women veterans, and for other purposes.

H.R. 4635 would help ensure that the Department of Veterans' Affairs (VA) existing peer-to-peer counseling program has sufficient female peer counselors for female veterans who are separating or newly separated from military service.

This bill, as written, would also emphasize counseling for women who suffered sexual trauma while serving, have PTSD or another mental health condition, or are at risk of becoming homeless. The American Legion supports the goal of this legislation recognizing the risk of suicide is 2.4 times higher among female veterans when compared to their civilian counterparts. The American Legions also recognizes existing peer-to-peer counseling programs have been successful and this bill creates a more representative program for the veteran population. Peer counselors are veterans themselves and can relate in profound ways to the mental health challenges facing fellow veterans. By connecting female veterans with one another, peer-to-peer assistance can empower female veterans to connect with each other and their communities.

Through The American Legion Resolution No. 364, Department of Veterans Affairs to Develop Outreach and Peer to Peer Programs for Rehabilitation, we continue to exert maximum effort to ensure that the Secretary of Veterans Affairs utilizes returning servicemembers for positions as peer support specialists in the effort

¹¹ American Legion Resolution No. 83 (Sept. 2106): Virtual Lifetime Electronic Record

¹² Improved Monitoring Needed for Effective Oversight of Care for Women Veterans. GAO-17-52; Published: Dec 2, 2016

¹³ The American Legion Resolution No. 377 (2016): Support for Veteran Quality of Life

to provide treatment, support services and readjustment counseling for those veterans requiring these services¹⁴.

The American Legion supports H.R. 4635.

Draft Bill

To authorize the Secretary of Veterans Affairs to use the authority of the Secretary to conduct and support research on the efficacy and safety of medicinal cannabis

The federal government continues to list cannabis as a Schedule I drug - the most addictive and dangerous - although its addiction rates are lower than alcohol, and the less-restrictive Schedule II classification that applies to opioids, which kill 91 Americans every day.

Medical schools offer limited formal education in the human endocannabinoid system, or the impact of cannabinoids on the human body. Every day, thousands of citizens ingest cannabis but have no federally certified doctor to turn to for accredited consultation. In response to this dire need, medical education must be updated, as well. By continuing to consider accumulating evidence of the efficacy of cannabis-based medicines, the federal schedule fails patients fighting debilitating conditions, including PTSD and potentially lethal opioid addiction. The American Legion fully supports research for potential medicinal use of cannabis and responsible action in the interest of advancing medicine, particularly for veterans who report relief from service-connected conditions, thanks to this important drug.

For over two years now, The American Legion has called on the federal government to support and enable scientific research to clinically confirm the medicinal value of cannabis. The National Academies of Science, Engineering, and Medicine recently reviewed 10,000 scientific abstracts on the therapeutic value of cannabis and reached nearly 100 conclusions in a 2017 report. As a two million member strong veteran service organization, our primary interest and advocacy is grounded in the wellbeing and improved health of our veterans, and specifically our service disabled veterans.

The American Legion is a strong, vocal proponent of the Department of Veterans Affairs (VA) and has published several books, pamphlets, and magazines that help showcase VA's value to The United States of America. Our members have long been ferocious advocates for evidence-based, complementary and alternative medicines and therapies. For decades, we have supported increased funding and research in such therapies as hyperbaric oxygen therapy, Quantitative Electroencephalography (QEEG), animal therapy, recreational therapy, meditation, and mindfulness therapies, just to name a few, to improve outcomes for veterans confronted with PTSD and other combat related illnesses and injuries.

The American Legion supports VA's statutory medical research mission and has donated millions of dollars toward expanding their scientific research. VA innovation is widely championed for their breakthrough discoveries in medicine and has been recognized over the years with several Nobel Prizes for scientific work that has benefited the world over.

The opioid crisis in America is having a disproportionate impact on our veterans, according to a 2011 study of the VA system, as they contend with the facts that poorly-treated chronic pain increases suicide risk, and veterans are twice as likely to succumb to accidental opioid overdoses. Traumatic brain injury and PTSD remain leading causes of death and disability within the veteran community.

VA officials report that about 60 percent of veterans returning from combat deployments and 50 percent of older veterans suffer from chronic pain compared to 30 percent of Americans nationwide. Many veterans suffering from post-traumatic stress disorder and chronic pain - especially those of the Iraq and Afghanistan generation - have told The American Legion that they have achieved improved health care outcomes by foregoing VA-prescribed opioids in favor of medical cannabis.

While the stories of these wartime veterans are compelling, more research must be done in order to enable lawmakers to have a fact-based debate on future drug policy. As a scientific research leader in this country with a statutory obligation to care for and improve the lives of our nation's veterans, The American Legion supports the draft bill "VA Medicinal Cannabis Research Act of 2018" co-sponsored by Chairman Roe and Ranking Member Walz, that will continue to put VA at the forefront of national cutting edge research.

The American Legion calls for immediate reclassification of cannabis from Schedule I to Schedule III on the DEA Controlled Substance Act Schedule to allow re-

¹⁴The American Legion Resolution No. 364 (2016) Department of Veterans Affairs to Develop Outreach and Peer to Peer Programs for Rehabilitation

search into its potential for medical application. We call on Congress to conduct oversight hearings and support legislation that enables research on cannabis, and the medical impact it could have for Americans suffering from; opioid over-prescription, pain, depression and a host of other known ailments, and direct departments and agencies within the administration to fully cooperate in all federally authorized scientific research and offer assistance as needed to authorize extensive research.

In October 2017, The American Legion conducted a nationwide survey of veterans.¹⁵ The results are significant and reinforce The American Legion's continued efforts, under Resolution 11, to urge Congress to amend legislation to remove marijuana from Schedule I of the Controlled Substances Act and reclassify it, at a minimum, as a drug with potential medical value.

According to the survey - which included more than 1,300 respondents and achieved a +/- 3.5 percent margin of error at a 95 percent confidence level - 92 percent of veteran households support research into the efficacy of medical cannabis for mental and physical conditions.

Eighty-three percent of veteran households surveyed indicated that they believe the federal government should legalize medical cannabis nationwide;¹⁶

- 82 percent said they wanted cannabis as a federally legal treatment option.
- Only 40 percent lived in states with medical marijuana laws.
- Over 60 percent were 60 and older, the largest cohort of veterans committing suicide.
- 22 percent of veterans are currently using cannabis to treat a medical condition.

And as former Speaker of the House John Boehner revealed in his official statement when he joined the Board of Advisors for one of the nation's largest, multi-state actively-managed cannabis corporations last week, "We need to look no further than our nation's 20 million veterans, 20 percent of whom, according to a 2017 American Legion survey, reportedly use cannabis to self-treat PTSD, chronic pain and other ailments."¹⁷

Based on The American Legions extensive advocacy, The Department of Veterans Affairs' recently issued updated guidance on medical marijuana that urges government doctors to discuss medical marijuana use with veterans, due to its clinical relevance to patient care, and discuss marijuana use with any veterans requesting information about marijuana. Because marijuana is a Schedule I controlled substance, VA doctors cannot prescribe, recommend, or assist patients with getting it.

Following the VA's announcement, American Legion National Commander Rohan issued the following statement, "I applaud the VA in taking this bold move toward treating veterans and also fulfilling resolutions passed by The American Legion. We do not support recreational use of drugs, but we do think the medicinal possibilities of cannabis should not be ignored by the VA. We are all about putting the health of veterans first."

Over the course of the past two years, The American Legion has passed two resolutions, testified on the necessity for additional research into the effectiveness of medical cannabis, and has held a press conference right here in this very room. We have received thousands of comments and interactions on this issue through our website, social media, as well as letters, phone calls, and personal interactions around the country, and the support we receive is overwhelmingly positive.

For more information on this research, please visit www.Legion.org/mmjresearch

American Legion Resolution No. 11, passed in 2016, titled, Medical Marijuana Research, The American Legion calls on the Drug Enforcement Agency to license privately funded medical marijuana production operations in the United States to enable safe and efficient cannabis drug development research; and urging Congress to remove marijuana from Schedule I and reclassify it in a category that, at a minimum, will recognize cannabis as a drug with potential medical value.¹⁸

The American Legion supports the Draft Bill.

Draft Bill

To make certain improvements in the family caregiver support program of the Department of Veterans Affairs

¹⁵ <https://www.legion.org/documents/legion/pdf/medical—cannabis—study.pdf>

¹⁶ <https://www.legion.org/sites/legion.org/files/legion/documents/Veterans%20and%20Medical%20Cannabis.pdf>

¹⁷ <https://www.acreageholdings.com/news-release-board-of-advisors-appointment>

¹⁸ <https://archive.legion.org/bitstream/handle/20.500.12203/5763/2016N011.pdf?sequence=4&isAllowed=y>

The American Legion advocates for equal benefits for all veterans regardless of period of service, and will never support a reduction in benefits. This bill reduces benefits to the existing caregiver program. The American Legion opposes this bill.

The American Legion Opposes this Draft Bill.

Conclusion

As always, The American Legion thanks this Subcommittee for the opportunity to elucidate the position of the over 2 million veteran members of this organization. For additional information regarding this testimony, please contact Assistant Director of the Legislative Division, Jeff Steele, at (202) 861-2700 or jsteele@legion.org.

Prepared Statement of Adrian M. Atizado

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the Subcommittee on Health of the House Veterans' Affairs Committee. 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 Committee.

H.R. 1506, the VA Health Care Provider Education Debt Relief Act of 2017

DAV supports passage of this important legislation based on DAV Resolution 128, calling for enabling the Department of Veterans Affairs (VA) to compete for, recruit and retain the types and quality of VA employees needed to provide comprehensive health care services to sick and disabled veterans.

We recommend the Education Debt Reduction Program be extended beyond the current December 31, 2019 deadline, the baseline funding be increased to achieve the intent of this measure, and that additional program staff may be needed for successful implementation.

To recruit and retain health professionals to work at VA to meet the health care needs of over 6 million ill and injured veterans, VA provides financial incentives under four broad categories to improve on the rigid government pay scales that has less room for growth than in private practice: market-based salaries, recruitment, retention, and relocation incentives (3Rs), Continuing Medical Education funds (CME), and Health Professionals Educational Assistance Program (HPEAP).

This bill seeks to improve HPEAP, which includes other critical recruitment and retention programs such as the Education Debt Reduction Program (EDRP). EDRP is one of the most utilized programs and allows the Veterans Health Administration (VHA) to reimburse qualifying education loan debt for employees, including physicians, in hard-to recruit positions. Physicians apply directly to the VA medical center, and applications are approved by VHA to repay student loans for up to five years.

Section 302 of Public Law 113-146, the Veterans' Access to Care through Choice, Accountability, and Transparency Act of 2014 (VACAA) made improvements to EDRP by increasing the monthly and annual caps on debt reduction payments to an individual participant from \$12,000 to \$24,000 and from \$60,000 to \$120,000, respectively. As a result, both the number of new EDRP awards are increasing, the current active participants increased by 45 percent and the current average award has increased by more than 40 percent.

This measure seeks to build on the success of EDRP due to the VACAA cap increases by increasing the current annual cap of \$24,000 and five-year cap of \$120,000 to \$30,000 and \$150,000 respectively.

As this Subcommittee is aware, the Government Accountability Office (GAO) October 19, 2017 reported, based on conversations with VA medical center officials, that their EDRP program funding was insufficient, given that both the number of applicants and the amount awarded to individual physicians increased significantly, and that they depleted their EDRP budgets early in the fiscal year. As a result, some facilities GAO reviewed would not commit to providing EDRP during the recruitment process. Instead, officials routinely told candidates that they would consider EDRP eligibility if funding was available.

The bill would also amend the conditions under which VA could waive such caps. Currently, the caps could be waived if the health professional is serving in a position for which there is a shortage of qualified employees, by reason of either location

or requirements of the position. If enacted, the bill would change the waiver criteria to apply to health professionals working in a geographical area designated by the Department of Health and Human Services as a health professional shortage area with respect to such participant's specialty or assignment. Because of the difference between these two definitions, we urge the Subcommittee to ensure this change does not adversely impact the ability for local VA medical centers to use EDRP in meeting their staffing needs.

H.R. 2322, the Injured and Amputee Veterans Bill of Rights

This bill would require the Secretary of Veterans Affairs to ensure that the "Injured and Amputee Veterans Bill of Rights" (hereafter referred to as the Amputee Bill of Rights) is posted on signage and displayed prominently in each prosthetics and orthotic clinic of the VA. The measure includes provisions for targeted outreach to notify veterans and veterans service organizations of the Amputee Bill of Rights, including placement on the Department's website. H.R. 2322 also requires VA employees working in prosthetic and orthotic clinics, federal recovery coordinators, case managers, and those working as patient advocates to receive training on the Amputee Bill of Rights.

The bill includes provisions mandating that each fiscal quarter patient advocates and veterans' liaisons collect information related to complaints and alleged mistreatment from veteran patients and report it to the VA's Chief Consultant of Prosthetics and Sensory Aids. The Chief Consultant would then be required to address and investigate allegations and complaints in accordance with the Amputee Bill of Rights.

Based on the bill, injured and amputee veterans would have the right to:

- access prosthetic and orthotic devices of the highest quality, and appropriate technology, while receiving care from the best qualified practitioners;
- continuity of care between VA and DoD by including comparable benefits relating to prosthetic and orthotic services;
- select the practitioner that best meets a veteran's needs regardless of the practitioner's Department affiliation (VA/DoD), to include private practitioners that have entered into contracts with the VA Secretary;
- comparable services and technology at any VA medical facility;
- timely and efficient orthotic care, including a speedy authorization process with expedited authorization for veterans visiting from another area of the country;
- be included in rehabilitation decisions and have the ability to get a second opinion regarding their prosthetic and orthotic treatment and needs;
- receive a primary and functional spare prosthetic or orthotic device;
- access to VA vocational rehabilitation, employment programs, and housing assistance; and
- be treated with respect and dignity.

DAV does not have a resolution that specifically calls for an Amputee Bill of Rights; however, DAV Resolution No. 178 calls for sufficient funding for the Prosthetic and Sensory Aid Service and timely delivery of prosthetic items. It also urges VA to rededicate itself to becoming a leader in prosthetic care by providing cutting-edge services and items to help injured, ill and wounded veterans fully regain mobility and achieve maximum independence in their activities of daily living, and in sports activities such as running, cycling, skiing, rock climbing and other physical exercises if they so choose. For the reasons mentioned above, we have no opposition to the enactment of this legislation.

H.R. 3832, the Veterans Opioid Abuse Prevention Act

The Veterans Opioid Abuse Prevention Act requires the Secretary of Veterans Affairs to enter into a memorandum of understanding with the executive director of the national network of state prescription drug monitoring programs. The purpose of this agreement would be to allow VA to submit queries on veterans who are longer-term users of controlled substances to such programs in the states in which the clinicians practice, or for non-participating states, the nearest state with a monitoring program. Submitting these veterans to these monitoring programs would enhance the safety and effectiveness of prescribing controlled substances to certain veterans who are prescribed such substances for more than 90 days by ensuring they are not receiving the same prescribed drugs from different clinicians.

DAV does not have a resolution calling for support of VA's participation in state prescription drug monitoring programs. However, we believe this enhances patient safety in prescribing controlled substances with many known adverse effects, including addiction and overdose, to veteran patients therefore; we have no objection to its enactment.

DAV also urges Congress to ensure that VA redoubles its efforts to conduct a uniform national pain management program to ensure that veterans with chronic pain who have been prescribed pain medications over long periods of time are managed in a patient-centered environment, with balanced regard for both patient safety and provided humane alternatives to the use of controlled substances. Additionally, while under VA care veterans should be confident they will receive their prescribed medications in a timely fashion to relieve unnecessary pain or anxiety. We urge VA to monitor pain management efforts and resolve any conflicts between the effects of the Controlled Substances Act of 1970 and its prescribing policies and procedures to ensure the Department is compliant with its own national pain management policy and guidelines and comport with its stated goals of patient-centered, safe care that offers appropriate alternatives and carefully monitors withdrawal from controlled substances for veterans who have been long-term users of such medications.

H.R. 4334, the Improving Oversight of Women Veterans' Care Act of 2017

DAV strongly supports H.R. 4334, in accordance with DAV Resolution No. 225, which calls for support for enhanced medical services and benefits for women veterans. This resolution seeks to ensure that health care services and specialized programs provided by VA to eligible women veterans are provided to the same degree and extent that services are provided to eligible male veterans, inclusive of counseling and/or psychological services incident to combat exposure or sexual trauma.

DAV urges VA to strictly adhere to stated policies regarding privacy and safety issues relating to the treatment of women veterans and to proactively conduct research and health studies as appropriate, periodically review, adjust and improve its women's health programs, and seek innovative methods to address barriers to care, thereby better ensuring women veterans receive the quality treatment and specialized services they so rightly deserve.

H.R. 4334, the Improving Oversight of Women Veterans' Care Act of 2017, would require the VA Secretary to submit an annual report to Congress on women veterans' access to covered sex-specific services under community care contracts including the average wait time for appointments, the veteran's driving time to the appointment and reasons why appointments could not be scheduled with non-Departmental medical providers.

The bill would also require each VA medical facility to submit quarterly reports on compliance with environment of care standards to the VA Secretary and to develop a plan within 180 days of enactment for strengthening the process to verify non-compliance data is accurate and complete; that all patient care areas are inspected; and to include the list of inspected items to align with those outlined in the Women Veterans Program Manager's Handbook.

The provisions in this bill are also consistent with recommendations in DAV's 2014 report, *Women Veterans: The Long Journey Home*. I am pleased to report that DAV will be releasing an update to that report in the near future and we look forward to sharing our findings and recommendations with the Subcommittee.

H.R. 4635, to increase the number of peer-to-peer counselors providing counseling for women veterans

DAV is pleased to offer its support for H.R. 4635, legislation calling for an increase in the number of peer-to-peer specialists to provide support and counseling specific to women veterans. This bill is consistent with DAV Resolution No. 225, calling for enhanced health care services and benefits to meet the unique needs of women veterans.

If enacted, this bill would require the Secretary of Veterans Affairs to ensure the Department has a sufficient number of peer counselors for women veterans. These counselors may be employees of VA and have expertise in gender-specific issues and services, employment mentoring, service and benefits provided by the Secretary. The bill would also require the Secretary to emphasize facilitation of peer-to-peer counseling for women veterans who have experienced military sexual trauma (MST), have post-traumatic stress disorder (PTSD), or other mental health conditions, or are at risk of becoming homeless.

The Secretary would be required to conduct outreach to inform women about the peer-to-peer program, and facilitate engagement and coordination with community organizations, state and local governments, institutions of higher education, chambers of commerce, local business organizations, and organizations that provide legal assistance to facilitate the transition of women veterans. The bill would require the Secretary to use existing funds to carry out the mandates and provisions in H.R. 4635.

Women comprise a small, but growing portion of the veteran population using VA services. Many service-disabled women veterans face challenges reintegrating into

their communities following military service. Researchers have found that women veterans often lack a supportive social network during the transition period and that they face a number of barriers to accessing the care and benefits they need. Women veterans often do not self-identify as veterans and seek benefits at lower rates than their male peers. Lack of child care services is frequently noted as a barrier to accessing post-deployment mental health readjustment counseling. Exposure to military sexual trauma and abuse of alcohol are complicating factors among this population that also make them more prone to homelessness and suicide.

Peer specialists have been shown to be especially effective in engaging VA users in accessing needed mental health services. Ensuring that women peer specialists are available to assist and guide other women veterans with accessing the services they need, such as mental health care, child care, legal assistance and assistance with job placement or training and in identifying appropriate resources within and outside of VA, will lead to a more successful transition and better health outcomes for this population.

DAV supports using peer specialists as a means of expanding VA's workforce and providing additional support to veterans with complex and comorbid conditions such as PTSD, substance-use disorders and traumatic brain injury. However, we are concerned that other priorities such as filling critical health occupation vacancies within the Veterans Health Administration (VHA) such as physicians, nurses, psychologists, and other credentialed professionals may hamper VHA's ability to hire more women peer specialists. For these reasons, we recommend the Subcommittee consider adding funding for this important program.

It is critical that these peer specialists are available to provide culturally competent and gender-sensitive assistance in navigating the many federal government programs available to meet women veterans' needs. VA's existing peer support program has been shown to enhance patient engagement, increase veterans self-advocacy skills, increase quality of life and patient satisfaction and ensure more appropriate use of services.

Draft Bill, the VA Medicinal Cannabis Research Act of 2018

The VA Medicinal Cannabis Research Act of 2018 would allow the Secretary of VA to engage in research on the safety and efficacy of medicinal cannabis use on health outcomes for veterans with chronic pain, post-traumatic stress disorder (PTSD) and other conditions the Secretary deems appropriate. The bill would require that VA include certain forms of cannabis in addition to different delivery methods for using cannabis products in its research and develop a means of preserving data for future studies. It further requires that VA develop a five-year implementation plan for conducting such research, including issuance of requests for proposal, within 180 days of enactment. Finally, the bill would require VA to submit progress reports to Congress not less frequently than annually.

DAV understands that use of cannabis for medicinal purposes is now legal in 29 States and the District of Columbia. However, we note there have been no changes made to federal law regarding use of these products for any purpose. We further understand that, while the medical literature has been inconclusive about the effectiveness of marijuana for improving symptoms of chronic pain and PTSD, noting both risks and, in some cases, benefits, many veterans report the use of cannabis for these purposes is beneficial.

While DAV has no specific resolution calling for VA to conduct research on the safety and efficacy of medicinal cannabis for veterans with chronic pain or PTSD, DAV Resolution No. 129 notes strong support for VA research on common conditions related to military service and effective treatments to help veterans recover, rehabilitate and improve the overall quality of their lives. We must ensure that any intervention for treatment of chronic pain and PTSD is both safe and effective for veteran patients especially veterans with clinically complex comorbid conditions such as traumatic brain injury, PTSD and chronic pain from amputations and other war-related injuries. For these reasons we have no objection to passage of this bill.

Discussion Draft, to make certain improvements in the family caregiver support program of the Department of Veterans Affairs

Public Law 111-163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," established the Program of General Caregiver Support Services and the Program of Comprehensive Assistance for Family Caregivers. The Program of Comprehensive Assistance for Family Caregivers (the Comprehensive Program) provides additional support services to caregivers beyond what is provided through the Program of General Caregiver Support Services, including a modest monthly financial stipend, health care coverage through CHAMPVA, counseling and mental health services, respite care, and technical assistance. However, the Program is only avail-

able to veterans who have serious injuries (including traumatic brain injury, psychological trauma, or other mental disorder) incurred or aggravated in the line of duty in the active military, naval, or air service on or after September 11, 2001 (post-9/11).

We are encouraged the program is working as intended based on comments from a qualitative online survey conducted by DAV, which received 1,833 validated responses from veterans and caregivers. This is described in greater detail in our testimony before the full Committee during its oversight hearing on February 6, 2018. But our members recognize there is always room for improvement.

Since the program's enactment, DAV has fought for legislation that improves the program and provides family caregivers and veterans severely ill and injured before September 11, 2001 (pre-9/11) equitable access to comprehensive caregiver support services.

During the February 6, 2018 oversight hearing, DAV, along with virtually all of our VSO colleagues, called on the full Committee to take bold and decisive actions, similar to what the Senate Veterans' Affairs Committee did last fall, and pass legislation extending eligibility for the full array of caregiver support services to veterans from all eras.

As such, we continue to advocate that the most equitable solution is for Congress to amend existing statute by removing "on or after September 11, 2001" so that all veterans and caregivers have equal access to the Program. Furthermore, Congress should amend the statute by including provisions allowing severely ill veterans and their family caregivers to be eligible for the Program.

DAV, along with our VSO colleagues, has been working with both the House and Senate Veterans' Affairs Committees to come to an agreement and pass a legislative package, which includes extending the current eligibility criteria for the Comprehensive Program to family caregivers of veterans severely injured pre-9/11; requires the implementation and certification of an information technology system to assess, support, and improve the family caregiver support program, and modifies the annual evaluation report of the program.

In light of current circumstances, DAV has grave concerns regarding Section 3 of this draft measure, which proposes to address the unfairness of excluding pre-9/11 veterans from the Comprehensive Program by raising the bar for eligibility on both pre- and post-9/11 veterans. We could not support limiting or restricting eligibility to the Comprehensive Program for family caregivers and veterans when a more supportive and equitable caregiver policy has already tentatively been agreed to and is under active consideration by Congress.

We urge the Subcommittee to amend and reconsider the provision in this draft bill that would amend paragraph (3)(C) of section 1720G(a). The original intent of this paragraph remains sound and is an important one, which is to mitigate the financial impact of caregiving, by providing caregivers a modest stipend that would not be less than the amount a commercial home health entity would pay an individual in the geographic area of the veteran to provide equivalent personal care services. We believe the source of the issues surrounding both the labor intensive process in calculating local stipend rates and the resulting outlier stipend rates are more the result of the Department's regulatory decision to calculate such rates by using the Bureau of Labor Statistics hourly wage for home health aides in a geographic area.¹

This draft measure could better address the disadvantages of this particular regulation by assisting VA in establishing a more appropriate stipend schedule that does not erode current benefits while addressing program inefficiencies. We urge the Subcommittee to work with VA in crafting more suitable language to accomplish the desired intent and for VA to make improvements through regulatory action.

There is also a conditional effective date for the sections in draft bill amending title 38, United States Code, section 1720G. Rather than leaving the effective date open ended, we recommend a date certain be included in Section 3 of this bill to ensure program improvements contemplated in such section is realized and not left to uncertainty.

Finally, we urge the Subcommittee to consider additional provisions such as integrating a research component to VA's caregiver support program, which could help find answers such as how to most effectively support family caregivers of severely ill and injured veterans in a cost-effective manner and could better inform program managers, policy makers and the public. In addition, because the success of the Program and the quality of life of severely ill and injured veterans relies heavily on the ability for VA to provide in-home assistance, and based on DAV's report "American's Unsung Heroes: Challenges and Inequities Facing Veteran Caregivers," which

¹ 38 C.F.R. § 17.40(c)(4)(v)

found that family caregivers of severely ill and injured veterans often do not get the support they need, such as financial assistance, respite care, medical training or home health aide services, we urge the Subcommittee to include a provision that would instruct the Government Accountability Office to update its 2003 report on veterans' access to non-institutional/home- and community-based care.

In reviewing Section 2 of this draft bill, we believe it is intended to address the recommendations in GAO's September 2014 report on VA's caregiver support program that VA "expedite the process for identifying and implementing an [IT] system that fully supports the program and will enable [VHA] program officials to comprehensively monitor the program's workload, including data on the status of applications, appeals, home visits, and the use of other support services, such as respite care," and that VA "use data from the IT system, once implemented, as well as other relevant data to formally reassess how key aspects of the program are structured and to identify and implement modifications as needed to ensure that the program is functioning as envisioned so that caregivers can receive the services they need in a timely manner."

DAV continues to press VA to ensure it meets the GAO's recommendations to implement an IT system that fully supports the program. We are encouraged that VA's long-term IT solution for the caregiver program is due to be delivered by the end of September. We urge this Subcommittee to use its oversight powers to ensure progress in its development is maintained to meet the delivery date.

This concludes my testimony, Mr. Chairman. DAV would be pleased to respond for the record to any questions from you or the Subcommittee Members concerning our views on these bills.

Prepared Statement of Sarah S. Dean

Chairman Wenstrup, Ranking Member Brownley, and members of the Subcommittee, Paralyzed Veterans of America (PVA) would like to thank you for the opportunity to present our views on the broad array of pending legislation impacting the Department of Veterans Affairs (VA) that is before the Subcommittee. No group of veterans understand the full scope of care provided by the VA better than PVA's members-veterans who have incurred a spinal cord injury or disease. Most PVA members depend on VA for 100 percent of their care and are the most vulnerable when access and quality of care is threatened. Several of these bills will help to ensure veterans receive timely, quality care and services.

H.R. 1506, the "VA Health Care Provider Education Debt Relief Act of 2017"

PVA supports H.R. 1506, the "VA Health Care Provider Education Debt Reduction Act of 2017." This legislation would increase the maximum amount of education debt reduction available for health care professionals employed by the Veterans Health Administration (VHA). Currently, the total amount VA may provide for debt reduction of a provider is \$120,000 over a five year period, provided the amount does not exceed more than \$24,000 per year. This legislation would increase the maximum amount to \$150,000 and \$30,000, respectively, in order to match education debt average.

If the Secretary determines there is a particular shortage in an area or specialty, VA currently has the authority to waive the maximum amount of debt, and pay the principal plus interest of a provider's loans. This proposal would specify shortages and adopt the Department of Health and Human Services' definition of Health Professional Shortage Areas.

PVA believes VA must be adequately resourced to attract the best and brightest medical professionals. The Education Debt Reduction program has been a markedly successful means to do just that. There is a current and worsening provider shortage in the United States. VA must be able to see that veterans are insulated from this trend. That new residents are hesitant to take a post in an underserved community, should come as no surprise. The cost burden of their education and training is an overwhelming prospect and debt is all but guaranteed. No matter how eager to serve, or desirous of giving back to veterans a new resident may be, a career at an understaffed VA may not be a tenable choice. Loan assistance can cultivate a culture of commitment from those unburdened by their debt and revive areas too long stressed by continuous shortages.

H.R. 2322, the "Injured and Amputee Veterans Bill of Rights"

PVA supports H.R. 2322, the "Injured and Amputee Veterans Bill of Rights" to better educate injured and amputee veterans on their rights and the requirement

that VA staff who work at prosthetics and orthotics clinics or who work as patient advocates for veterans understand these rights as well. This bill would ensure that VA prosthetics clinics around the country prominently display the “Injured and Amputee Veterans Bill of Rights” and, ideally, that VA employees understand it. This reaffirms the idea that a veteran in need of an assistive device or prosthetic gets the highest quality item available and in a timely manner. PVA is concerned, however, that the language ignores veterans who are in need of special equipment because of a specific disease and not a physical injury. Further, we remain concerned VA is not sufficiently resourced to procure prosthetics for veterans in a manner that is timely and clinically precise.

H.R. 3832, the “Veterans Opioid Abuse Prevention Act”

PVA supports H.R. 3832, the “Veterans Opioid Abuse Prevention Act.” This legislation would direct the Secretary to enter into a memorandum of understanding with the executive director of a national network of state-based prescription drug monitoring programs (PDMP) in order to assess if opioids have been accessed in other states. Currently, VA doctors cannot consult a national network of state-based PDMPs in order to identify those at high risk for abuse. A July report from the President’s Commission on Combating Drug Addiction and the Opioid Crisis said the lack of cross-state interoperability is a shortcoming of state PDMPs and recommended “enhancing interstate data sharing among state-based prescription drug monitoring programs.”

In 2016, Public Law 114–198, the “Comprehensive Addiction and Recovery Act” (CARA), required providers at the VHA to participate in their respective state’s PDMP. Prescribers must check patient records in the state databases before prescribing pain killers. The pharmacists are responsible for recording when they fill those prescriptions.

The United States is in the midst of an opioid epidemic and PDMPs are a critical tool for safe prescribing practices by providers. VA has been authorized to share prescription data with PDMPs since 2011 and last year, CARA required VHA to participate. The effectiveness of Opioid Safety Initiatives is dependent on the availability of all prescription data and the ability to see it across state lines. This loophole allows for veterans to ‘doctor shop’ across states with neither entity the wiser. These veterans suffering from chemical dependency must have the safety protections we can reasonably provide. This bill ensures VA can better mitigate the potential consequences of opioid use.

Given the specialized needs of veterans, it is not uncommon for veterans to travel to different states to receive their care. Each VA Medical Center (VAMC) only shares prescription data to the state PDMP in which the VAMC is located. Some have established regional Memoranda of Understanding, communicating information only with neighboring states. But there are veterans, particularly veterans with a spinal cord injury or disease (SCI/D) who regularly travel across multiple state lines to one of the 24 SCI Centers across the country. There is no assurance that the prescription data of an SCI/D veteran who receives care at an SCI/D center in Minneapolis, but lives in Wyoming, can be shared. We urge the Committee to make sure these specialized patient populations are benefiting from the opioid safety measures in the same way as non-traveling veterans. H.R. 3832 is the means to do just that.

H.R. 4334, the “Improving Oversight of Women Veterans’ Care Act of 2017”

PVA supports H.R. 4334, the “Improving Oversight of Women Veterans’ Care Act of 2017.” This legislation would require the Undersecretary of VHA to submit to Congress an annual report on the ability of women veterans to access gender specific care in the community. 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 VHA Directive 1330.01(1). Each report is to name the person at each facility who is responsible for compliance and the facility plan to strengthen environment of care standards.

According to GAO report 17–52 from December 2016, VHA does not have data and performance measures for women veterans’ accessibility 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 with environment of care standards for women veterans, allowing for instances of noncompliance not reported to VHA.

H.R. 4334 would require VA to report to Congress accessibility to gender-specific health care in any community of care program; and include the average waiting pe-

riod between the veteran's preferred appointment date and the date on which the appointment is completed, reasons VA could not fulfill the appointment, and driving time required for appointments.

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

H.R. 4635, to direct the secretary of Veterans Affairs to increase the number of peer-to-peer counselors providing counseling for women veterans, and for other purposes.

PVA supports H.R. 4635, to "direct the secretary of Veterans Affairs to increase the number of peer-to-peer counselors providing counseling for women veterans, and for other purposes." This legislation would require VA to employ sufficient numbers of peer counselors to meet the needs of women veterans, particularly to address military sexual trauma, post-traumatic stress, and those at risk of homelessness.

For those veterans who have been able to access peer-to-peer counseling or retreats for women provided through VA, participants report a better understanding of how to develop support systems and to access resources at VA and in their communities. Peer counseling programs have been a marked success for most veterans who show consistent reductions in stress symptoms and increased coping skills. It is essential for the life and wellbeing of women veterans that Congress make their needs a priority. By hiring peer counselors familiar with issues specific to women veterans' experiences we can move a step closer to meeting those needs.

A draft bill to authorize VA to conduct and support research on the efficacy and safety on medicinal cannabis

PVA has no position on the drafted legislation at this time.

A draft bill to make certain improvements in the Family Caregiver Program

Established by Public Law 111-163, the "Caregivers and Veterans Omnibus Health Services Act of 2010," the Program of Comprehensive Assistance for Family Caregivers provides caregivers of post-9/11 service-connected, injured veterans with support services. These include a modest monthly financial stipend, health care through CHAMPVA, mental health services, and respite care.

For those PVA members able to access the program, it has made all the difference in their lives. For eight years, PVA, along with nearly all VSOs, has ardently advocated the program be made accessible to those injured before 9/11 and to those made ill as a result of service in any era.

During the February 6, 2018, full committee hearing, PVA, DAV, and the Elizabeth Dole Foundation asked the House Committee to be as bold as the Senate Committee was last November and pass an expansion effort that treats all veterans the same, regardless of date of injury. This remains our chief legislative priority for the 115th Congress.

PVA's organizational mandate is to expand and improve the Caregiver Program. In this moment in time, the means to most closely accomplish that mandate is the negotiated package that was to be included in the omnibus last month. This legislative package would eliminate the date of injury requirement for the Comprehensive Program; require the implementation and certification of an information technology system to assess, support, and improve the program; and modify the annual evaluation report. While this effort was not actualized in the omnibus, it is our intention to see such a deal, both bipartisan and bicameral, passed as soon as may be accomplished. It is with this in mind that we provide our views on the draft legislation.

As this proposal would make eligible veterans with catastrophic injuries of all eras, PVA would support it as a first step to full expansion. This proposal would achieve what former Secretary Shulkin desired; serve those with a particular high need, while at the same time, simplify the program structure to be more efficiently implemented. A clearly understood eligibility, and efficient assessment, implemented nationwide, would greatly enhance this vital program. In order to accomplish both aims, this draft adopts a restrictive criteria for all future participants to require assistance with three Activities of Daily Living (ADLs).

If the committee moves forward with this restricted eligibility, we strongly encourage VA be enabled to develop or adopt a validated instrument to measure needs and caregiver burden. The current clinical assessment tool of ADLs and tiers can be unnecessarily confusing and does not clearly capture need. Tightening eligibility under

the same structure ensures the same concerns of inconsistency, espoused over the years by this Committee, continue. Because the participation is dependent on ADLs and their ongoing clinical assessment, variability is innate to each clinical team's opinion. Using a standardized assessment tool, such as the United Kingdom's Functional Assessment Measurement and Functional Independence Measurement (FAM & FIM), may help to clearly delineate the level of care required to accomplish ADLs and Instrumental Activities of Daily Living (IADL). Such an approach could help to make clear to families the means by which their loved ones needs, both physical and psychological, are measured.

As expressed in the February hearing on caregivers, we encourage the Subcommittee to advance provisions that support research into how to best support family caregivers of veterans with catastrophic disabilities and how to delay the costs of institutional long term care. We also encourage the draft include a GAO report on VA's Home and Community Based Services. It has been nearly a decade since such a study was conducted and would illustrate the needs of pre-9/11 caregivers today.

PVA would once again like to thank the Subcommittee for the opportunity to submit our views on the programs affecting veterans and their caregivers. We look forward to working with you to ensure our catastrophically disabled veterans and their families receive the medical services and supports they need.

Prepared Statement of Kayda Keleher

Chairman Wenstrup, Ranking Member Brownley 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. 1506, VA Health Care Provider Education Debt Relief Act of 2017

The VFW supports this legislation which would increase the maximum amount of education debt reduction available for health care professionals who work at the Department of Veterans Affairs (VA) Veterans Health Administration (VHA).

With over 35,000 current job vacancies, VA must be provided all tools necessary to address personnel shortages. This is particularly worrisome for VHA, where provider shortages result in access issues and insufficient wait times for veterans needing to receive treatments they have earned.

To address these personnel shortages, this legislation would authorize VA to work alongside the Department of Health and Human Services to identify areas with increased health professional shortages. Where these shortages are found to exist, VA would then be able to aggressively use their authority to provide new hires with educational debt reduction at increased cap rates.

Congress and VA must assure that funding appropriated for educational debt reduction is properly disbursed. The VFW has received feedback from multiple locations that VA facilities are only receiving the capped rate equivalent to what the maximum would be for one employee. For this authority to be effective in recruiting and retaining employees at VA, it must be properly implemented and utilized.

H.R. 2322, Injured and Amputee Veterans Bill of Rights

The VFW believes this legislation would unintentionally establish an unattainable expectation for VA. Therefore, the VFW cannot support this bill.

This legislation would require VA to display what would become the "Veterans Bill of Rights" throughout all VA prosthetics and orthotics clinics as a means of outreach for education. The VFW fully supports VA outreach campaigns to educate and connect with veterans, and believes that this legislation would be better routed as an outreach campaign to veterans who were injured and/or are amputees.

With this said, the VFW has concerns with some of the verbiage used in what would be the Bill of Rights. In the third subparagraph of these rights, it would be publicly shared and expressed that a veteran would have the right to see a private practitioner entered into a community care contract with VA, or the veteran would be able to access a practitioner with specialized expertise. This language may stand to be interpreted that if a veteran opts to see a specialized practitioner who has not entered into contract with VA, that the veteran would still have the right to see the practitioner. The VFW opposes veterans having the ability to see any provider outside VA of their choosing and VA then paying for the appointment without coordinating the care. Keeping VA as the coordinator of care not only provides assurance that patients are seeing quality doctors for appointments they need, but it also

provides quality assurance and oversight for the patient as well as VA appropriations. It is also worth noting that this legislation would build expectations going beyond current law, without amending what is currently in statute. For example, the Bill of Rights would establish that all amputees are eligible for a backup prosthetic, but that would not align with current eligibility requirements.

The VFW also believes the quarterly reporting requirement would be over legislating. This report would require every medical center within VA to submit a report for each fiscal quarter containing all information related to alleged mistreatment of injured and amputee veterans. Each of these allegations would then receive a full investigation. The VFW believes this is something VA already does and should be doing, making these provisions unnecessary.

H.R. 3832, Veterans Opioid Abuse Prevention Act

The VFW supports this legislation which would direct VA to enter into a memorandum of understanding (MOU) with the executive director of a national network of state-based prescription monitoring programs. By entering into this MOU, providers within VA will be able to access data regarding controlled substance prescriptions for patients regardless of which state they are in, so long as that state has entered into an MOU as well.

There are currently 43 states and the District of Columbia that have entered into an MOU with the National Association of Boards of Pharmacy for the association's prescription monitoring program (PMP) InterConnect. This allows participating states' PMPs across the entire country to be linked regardless of state lines, and provides an effective means of combating drug diversion and/or abuse. Data is shared and collected through a secure communications platform that transmits PMP data to authorized requestors, while the state's individual data access rules and laws are enforced. PMP InterConnect also does not house any data itself.

Having access to this data and being able to share with the states already entered into an MOU would benefit VA. VA would be more easily able to access prescription data for patients across state lines, such as winter snowbirds, while also making sure patients' information is shared with the private sector—providing great potential to identify and prevent prescription drug abuse and fraud.

H.R. 4334, Improving Oversight of Women Veterans' Care Act of 2017

The VFW supports this legislation which would require reporting associated with medical care for women veterans provided by VA and through non-VA providers entered into contract agreements with VA. Assuring veterans who receive care from non-VA providers receive the same high-quality standard of care, or above, that they would receive at VA is critical.

Not all appointments can be fulfilled by VA, and this is especially true for certain specialized services such as sex-specific treatments. Whether there is a shortage of gynecologists, or not enough women veteran patients to meet annual certification requirements for mammogram technicians, there is the need at times for women veterans to receive sex-specific health care in the community. For this reason, the VFW is pleased to see the reporting requirements this legislation would put into law.

To improve women veterans' health care within VA, it is also important for VA to keep up to date on where facilities need to improve, as well as for Congress to be aware of these needs. This is why the VFW is pleased to see the reporting requirements for the environment of care standards within VA facilities.

H.R. 4635, to direct the Secretary of Veterans Affairs to increase the number of peer-to-peer counselors providing counseling for women veterans

The VFW supports this legislation which would increase the number of peer-to-peer counselors for women veterans within VA. This legislation would also emphasize the demand for peer-to-peer support specialists for women veterans who have survived sexual trauma during their time in service, have post-traumatic stress disorder (PTSD), any other mental health condition, or are in other ways at risk of becoming homeless. This would be particularly useful as >>>40 percent of women veterans who participated in the VFW's women veterans' survey either currently use or have previously used VA for mental health services.

This legislation would also coordinate assistance for women veterans under the Department of Defense's employment, job training and transitional assistance programs with the Department of Labor to help women veterans identify employment and training opportunities, as well as how to obtain these necessities and other related information and services. The VFW is pleased to see this in the legislation, as addressing mental health care needs and avoiding homelessness must be addressed with a holistic approach. To do this, veterans must have assurance and a

sense of self-worth and meaningfulness through their work, as well as a means to provide food and shelter for themselves and their families.

Draft legislation, VA Medicinal Cannabis Research Act of 2018

The VFW supports this draft legislation which would direct VA to use its authority to conduct and support medical research on the effects and safety of medicinal cannabis.

The VFW supports expanding research of non-traditional medical treatments for alternative therapies and less harmful ways of addressing health care issues for veterans within VA. With the ongoing opioid epidemic, an increase in veterans who suffer from chronic pain, the constant co-morbidity of chronic pain with PTSD and a continuing list of other health ailments—all while VA is under constant scrutiny for over-prescribing pharmaceuticals, while still managing to prescribe opioids at nearly half the rate of the private sector, VA must be proactive in finding solutions to responsibly treat veterans.

There are currently 30 states and the District of Columbia that have passed legislation legalizing medical or recreational marijuana. This means veterans are able to legally obtain marijuana for medical purposes in over half the country. Some may see a private sector provider about using medical marijuana, while others may self-prescribe without a health care provider's guidance. Regardless of how veterans in the majority of the country choose to obtain medical marijuana, they are doing this without the medical understanding or proper guidance from their coordinators of care at VA. This is not to say VA providers are opting to ignore this medical treatment, but that there is currently a lack of federal research and understanding of how medical marijuana may or may not treat certain illnesses, injuries, and the way it interacts with other drugs. Due to this, the VFW believes it is medically unethical for Congress to allow VA providers to stay in the dark. VA must conduct research on medical marijuana to determine what is in the best interest of veteran patients.

This draft legislation would reiterate VA's current authority to conduct schedule one research for ailments ranging from physical injury to behavioral health. Three different strain variants consisting of differing ranges of phenotypical traits as well as ratios of tetrahydrocannabinol (THC) and cannabidiol (CBD) compositions must be researched in the study. The VFW believes it is important to test at minimum three strains, which can vary in strength such as when pharmaceuticals study dosing variations of both major chemical components found in marijuana. It is also important to test varying ratios of THC and CBD, as scientists know these chemicals affect different receptors in the human body. For example, in some studies, patients with PTSD or who are recovering from cancer have been found to benefit from THC. Meanwhile, other studies have found that patients struggling with chronic pain have been found to benefit from CBD. Participants in the study would use the marijuana in varying ways, subject to VA's decision on how to break up participant groups.

To assure the research study would be implemented as intended, VA would report to Congress 180 days from the date of enactment with a plan moving forward. At this time VA would then also make requests for anything needed to carry on with the study. After this initial report, VA would then be required over a five-year period to submit a report at a minimum of once per year to Congress.

The VFW is pleased to see bipartisan support for this very important issue for our nation's veterans, and looks forward to continuing to work on medical cannabis research with Congress and VA.

Draft legislation, to make certain improvements in the Family Caregiver Program

The VFW agrees with the intent of this draft legislation but has serious concerns with it as written. Since the Program for Comprehensive Assistance for Family Caregivers was first discussed, the VFW has urged Congress to expand eligibility to those caring for veterans who served before Sept. 11, 2001. The VFW strongly believes the contributions of family caregivers cannot be overstated, and our nation owes them the support they need and deserve. Regrettably, the program is unjustly limited to caregivers of severely wounded post-9/11 veterans. Severely wounded and ill veterans of all conflicts have made incredible sacrifices, and all family members who care for them are equally deserving of our recognition and support. The fact that caregivers of previous era veterans are currently barred from the program implies that their service and sacrifices are not as significant, and we believe this is wrong.

The VFW currently supports H.R. 1472 and S. 591, as well as S. 2193, which includes the expansion of VA's caregiver program. The VFW has been pleased to see

the committee's willingness to evaluate and advance a bill to expand this important program.

As currently written, this draft would increase the eligibility requirements from the current requisite of assistance for one or more activities of daily living (ADL) to a minimum of three ADLs. The VFW opposes setting arbitrary eligibility requirements and urges the committee to evaluate other means of accurately determining who should and should not be in the program. The VFW believes that eligibility determination must be clinically made by VA, and not restricted by arbitrary thresholds. There must also be an inclusion of instrumental activities of daily living (IADL), so the program does not disregard those in need for cognitive purposes. Moving forward, discussions of eligibility for the program should focus around accountability and rehabilitation, rather than limiting the program in efforts to save money as well as prevent fraud and abuse. This is particularly pertinent as VA has consistently provided feedback that less than one percent of those who have been removed from the program were removed for reasons at cause, which includes fraud. The VFW would also oppose any restrictive changes in program eligibility that does not provide a grandfather clause for current program recipients. This current draft would not only restrict eligibility, but would not offer a grandfather clause for those currently in the program. To draft a grandfather clause, technical assistance must be given by VA.

The VFW also believes that moving forward with new legislation, there must be an inclusion of veterans who were made ill. This would provide equity between caregivers to align more with caregiver programs in Titles 10 and 42, as well as assure equity between service members and veterans. For a veteran who is ill and unable to take care of herself or himself without the assistance of a caregiver, the VFW finds no just reason to continue not defining them as eligible for VA's caregiver program. This is particularly true for veterans who are ill from diseases undoubtedly linked to their service, such as non-Hodgkin's lymphoma.

Caregivers must be capable of providing care that is in the best interest of the veteran, and in a clinically timely manner determined by the veteran's VA provider in accordance with their treatment plan. The VFW believes the language within the draft for caregiver criteria living proximity requirements is moving in the right direction, but must be better defined to avoid inconsistent implementation.

Finally, the VFW believes any legislation amending the caregiver program must include provisions for caregivers and veterans who are graduating out of the program. Currently, when a veteran improves and is slated to be removed from the program, a lump sum of three months stipend is paid out for financial assistance. This has resulted in financial, emotional, and health distress of the veterans and their caregivers. The VFW urges this Subcommittee to amend this legislation to establish new off-ramp requirements which would remove the lump sum payment, continue a monthly stipend and insurance coverage for a reasonable amount of time, and provide employment training and assistance to the caregiver from the caregiver program coordinator they have worked with through their time in the program. This is imperative to the veteran and caregiver's success out of the program, as well as the well-being both physically and mentally of these highly regarded patriots.

In conclusion, the VFW supports expanding the caregiver program to veterans who served before 9/11, but opposes reducing eligibility requirements simply to lower cost.

Mr. Chairman, this concludes my testimony. I am prepared to take any questions you or the Subcommittee members may have.

Statements For The Record

STEVE SCHWAB

UNITED STATES HOUSE OF REPRESENTATIVES ON "A DRAFT BILL TO MAKE CERTAIN IMPROVEMENTS IN THE FAMILY CAREGIVER PROGRAM"

Chairman Roe, Ranking Member Walz, and Members of the Committee, the Elizabeth Dole Foundation is pleased to present its views on the House Committee on Veteran Affairs' draft legislation, which makes modifications to the Program of Comprehensive Assistance for Family Caregivers (PCAFC).

We thank the Committee for its continued leadership to support more than 5.5 million military and veteran caregivers serving across the nation. The PCAFC is a critical program that provides comprehensive caregiver support, helps offset the cost

of income lost from caregiving responsibilities, and recognizes the service they provide to our nation's wounded warriors. As the preeminent organization empowering, supporting, and honoring our nation's military caregivers, the Elizabeth Dole Foundation seeks to strengthen and empower American military and veteran caregivers and their families by raising public awareness, driving research, championing policy, and leading collaborations that make a significant impact on their lives. We appreciate that the Committee has made this legislation a priority and has conducted an open process by convening focused discussions on this draft legislation with VSOs and caregiver support organizations and incorporating feedback into modifications to the draft legislation.

Expanding the Program to Pre-9/11 Veterans

We are pleased that the Committee has put forward legislation that addresses what the Foundation has felt is the most significant deficit in the PCAFC; that only a limited scope of veterans and their caregivers are eligible under the current law. It is unfair that since the Program's enactment, pre-9/11 caregivers - who make up 80 percent of our nation's 5.5 million veteran and military caregivers - are arbitrarily barred from accessing the PCAFC because of their veterans' era of service or diagnosis with a service-connected illness. We appreciate that the Committee has demonstrated its intent to correct this injustice, and we are wholly supportive of expansion.

While the expansion of the program in the draft legislation represents a momentous victory for the caregiver community, it comes with some significant trade-offs. The Committee's bill proposes more restrictive thresholds for eligibility to the program, including that a caregiver provide support with an increased number of activities of daily living. This provision will drastically reduce the number of eligible veterans and demonstrate a considerable tightening of the Program's criteria. We understand that the Committee has proposed this provision to reduce the overall cost of the program and ensure that the program is in place to serve those who need it most. However, the Foundation strongly recommends that the Committee eliminate, make modifications to, or adjust this eligibility-reducing provision - as it may be detrimental to current and future generations of veteran caregivers.

Activities of Daily Living

The Foundation is a strong proponent of expansion with unaltered eligibility requirements, as proposed in the Senate's Caring for Our Veterans Act, which passed the Senate Veterans Affairs Committee with overwhelming bipartisan support in November 2017. However, we recognize that the Committee would like to explore different options related to eligibility and standardization of the program.

Under current law, participants must be in need of personal care services due to - among other criteria - the inability to perform one or more activities of daily living (ADLs). The Committee's draft increases the threshold to three or more ADLs. In 2012, the Foundation commissioned the RAND Corporation to conduct a study on military and veteran caregiving; the findings of which are detailed in a 2014 report "Hidden Heroes: America's Military Caregivers." The report found that, on average, post-9/11 caregivers help with 1.0 ADL, while pre-9/11 caregivers help with 1.3 ADLs (and instead help with an increased level of safety and supervisory assistance). The research did not provide analysis as to how many caregivers help with three or more ADLs. We believe that the proposed increased threshold may be too high and would severely limit the effectiveness of the PCAFC in supporting those who need the program most.

There is a lack of available information on the number of veterans potentially affected by the proposed increase to the activities of daily living. Therefore, the Foundation recommends that the Committee either consider eliminating this provision entirely or allow the Secretary of Veterans Affairs to make any eligibility-restricting determination only after conducting a comprehensive impact analysis and following the appropriate rule-making process.

Addition of Service-Connected Illnesses

The Foundation urges the Committee to consider expansion of the program to service-connected illnesses, not just injuries from all eras of service. The way the bill is written today, it still does not include service-connected illnesses, such as ALS or the hundreds of other illnesses included in the VA's Presumptive Disease List. That is unjust. We believe for this program to be genuinely inclusive of our nation's veterans and their caregivers, it must not exclude those with service-connected illnesses.

The Inclusion of the Financial Planning Services

The 2014 RAND report examined characteristics of military and veteran caregivers and services available to them. The report indicated that, of the military caregiver-specific programs, few provide long-term planning assistance, including financial planning, for military caregivers.

The Senate's Caring for Our Veterans Act includes a provision which would require the VA to include financial planning and legal services related to the needs of injured veterans and their caregivers as a service provided to caregivers. The bill language makes clear that VA should provide these services through the use of contracts with or the provision of grants to public or private entities. The Senate Committee intends that VA and VA employees not provide these services, but instead partner with public or private entities.

We believe the financial planning services would be a critical improvement to the PCAFC program. We are also supportive of offering legal services to caregivers, but sympathetic to the VA's concerns that this might pose a conflict of interest. We urge the Committee to consider the inclusion of financial planning services to caregivers in the PCAFC.

Grandfathering Current Program Participants

The Foundation appreciates that Committee has added additional language to its current draft legislation to address what happens to current program participants who will be no longer eligible under the new criteria. However, we are concerned that the language allowing the Secretary of Veterans Affairs to develop a transition plan is too broad, creates further program uncertainty, and places the thousands of current program participants at potential risk of losing their caregiver benefits. The Foundation believes the legislation should explicitly protect current program participants from losing support as a result of these legislative changes.

Thank you again for this opportunity to submit our comments on the Committee's draft legislation. We look forward to continuing to work with the Committee to ensure support for our nation's military and veteran caregivers.

TOM PORTER

Chairman Wenstrup, Ranking Member Brownley, and Members of the Subcommittee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA) and our more than 425,000 members and supporters, thank you for the opportunity to share our views on the legislation being discussed today.

VA Medicinal Cannabis Research Act of 2018

IAVA is proud to express our support for the VA Medicinal Cannabis Research Act of 2018 and I would like to commend Chairman Roe and Ranking Member Walz for working in a bipartisan manner to develop the measure and hold this hearing to underscore the importance of getting this research right for our veterans at the VA.

IAVA veterans have made it clear that 2018 is the year we will be heard on the important and emerging health issue of utilizing cannabis to treat injuries of war. Veterans consistently and passionately have communicated that cannabis offers effective help in tackling some of the most pressing injuries we face when returning from war.

In our latest Member Survey, 63% supported and only 15% opposed legalization for the medical use of cannabis. The youngest of the Post-9/11 generation are most supportive; with about three-fourths of IAVA members under 35 supporting the allowance of medical cannabis.

Medical cannabis is rapidly gaining support across party lines in Congress and across the country. Yet our national policies are outdated, research is lacking, and stigma persists. In 2018, IAVA members will set out to change that and launch a national conversation underscoring the need for bipartisan, data-based, common-sense solutions that can bring relief to millions, save taxpayers billions, and create thousands of jobs for veterans nationwide. Those solutions must include the approval of medical cannabis for every veteran in America who needs it.

Our nation is rapidly moving toward legalizing cannabis, and twenty nine states plus the District of Columbia now permit medical cannabis. Yet, as with many innovative solutions to veteran needs, progress on this issue within the VA has been slow and incremental—and lags behind the needs of veterans and the changing reality of state-level laws.

There has been marginal progress, as in late 2017, when the Veterans Health Administration issued a policy change which urged patients to discuss medical cannabis use with their doctors. This policy change alleviates previous concern that admitting to cannabis use could jeopardize VA benefits, a policy recommendation noted in IAVA's Policy Agenda. But VA physicians still cannot refer patients to legally sanctioned state medical cannabis programs because of the federal prohibition. Moreover, patients are not allowed to have any cannabis on VA property, even if it is medically recommended to them and the state they are living in allows it. And VA employees are still barred from using any form of cannabis, including medical cannabis, while roughly one-third of VA employees are veterans and may want access to cannabis as a treatment option.

Further, in opposition to strong and rising popular opinion across the veterans community, the VA Secretary announced in early 2018 that the VA will not conduct research into whether medical cannabis could help veterans suffering from PTSD and chronic pain. This is despite protest from many in the VSO community who posit medical cannabis could serve as an alternative to opioids and antidepressants. A January 2017 National Academy of Sciences study that stated: there was "conclusive or substantial" evidence that cannabis is effective in treating chronic pain, moderate evidence that cannabis helps with sleep (which may impact other mental and physical health conditions), limited evidence in improving anxiety symptoms, and limited evidence in improving PTSD symptoms.

It is important to note that in our most recent member survey, 46% report suffering from PTSD, 38% report suffering from chronic pain, and almost 40% report depression and anxiety. These service-connected injuries are hard to treat, and if there is any possibility that cannabis can be used as an effective treatment, we should be willing to do the research to explore that opportunity.

Again, thank you for allowing IAVA to share our views. We thank Chairman Roe and Ranking Member Walz for taking this valuable step in moving forward with such a significant piece of legislation. We need the definitive research to be conducted on the efficacy and safety of medical cannabis use by veterans - and it is long past the time for the VA to have taken this up.

Congress must prioritize passage of this legislation this year.

Discussion Draft, to make certain improvements in the family caregiver support program of the Department of Veterans Affairs

IAVA opposes this draft bill as it raises the bar of eligibility for the post-9/11 veterans currently eligible for the Caregiver Program, as well as for pre-9/11 veterans that would gain eligibility under this draft.

IAVA has consistently supported expanding the Caregiver Program to all generations of veterans, but we cannot support legislation that reduces benefits by raising the eligibility bar for program beneficiaries.

The Improving Oversight of Women Veterans' Care Act of 2017 (H.R. 4334) and Legislation (H.R. 4635) to "direct the secretary of Veterans Affairs to increase the number of peer-to-peer counselors providing counseling for women veterans, and for other purposes."

IAVA thanks the sponsors for putting forth H.R. 4334 and H.R. 4635, as they are consistent with our She Who Borne The Battle campaign in the 115th Congress to close gaps in care for women veterans.

H.R. 4334 would require the Undersecretary of the Veterans Health Administration to submit to Congress an annual report on the ability of women veterans to access gender specific non-VA medical care in the community, including the average wait time between the veteran's preferred appointment date and the date on which the appointment is completed, driving time required for veterans to attend appointments, and reasons why appointments could not be scheduled. The bill would also require each VA medical facility to submit a quarterly report to the VA Secretary on the compliance and noncompliance of the facility with the environment of care standards for women veterans.

H.R. 4635 would increase number of peer-to-peer counselors providing counseling for women veterans, with an emphasis on treating women veterans who suffered military sexual trauma, suffer from PTSD or other mental health conditions, or are at risk of becoming homeless.

IAVA remains focused on the centerpiece of our She Who Borne The Battle campaign, the bipartisan Deborah Sampson Act (H.R. 2452), the most comprehensive legislation this Congress that addresses shortages in care for female veterans. H.R. 2452 establishes peer-to-peer assistance, makes permanent programs to provide counseling in retreat settings, provides legal and support services, doubles the newborn care at the VA, funds retrofits at VA facilities to improve privacy, requires the

VA to collect gender-specific data on all veterans programs, and expresses a sense of Congress that the VA motto should be more inclusive, among other initiatives.

On this last provision, our campaign has had an impact, as we know that VA leadership had taken recent, concrete steps to make motto changes more welcoming to our transitioning women warriors, but partisan infighting at the VA derailed those steps from moving forward.

IAVA encourages this committee to support a greater level of progress on making VA care more reflective of the growing numbers of women serving in uniform and move to enact the Deborah Sampson Act and other legislation that shares this spirit.

Thank you for allowing IAVA to share our views.

CARRIE STEAD

Chairwoman Dole, Members of the Committee, thank you for the opportunity to comment on the future of the Program of Comprehensive Assistance for Family Caregivers (PCAFC). I am Carrie Stead, Director of Programs for The Independence Fund, and am a caregiver myself.

The Independence Fund, founded 10 years ago, has provided more than \$50 million in adaptive equipment and support services for catastrophically wounded and seriously disabled Veterans, as well as Caregiver support services for the Caregivers of those wounded and disabled veterans.

Overall, The Independence Fund's greatest concern with the PCAFC program is the apparent lack of standardization throughout the program. We see wide variation not only across Veterans Integrated Service Networks (VISNs), but even across VA facilities within a VISN, or even a single VA facility itself.

This lack of standardization leads to wide variation in tier classification for similar cases; for what services and support individual Veterans and Caregivers are eligible; and even whether the Caregiver will be allowed to stay in the program or be "graduated."

Because of that lack of standardization, we see VA officials improperly apply the Caregiver eligibility standards, such as they exist, especially in cases of spouse or other family caregivers. VA officials apply improper "rules" in ways like telling Caregivers they cannot have outside employment. We also see it where individual veterans are forced by reviewing VA officials, without warning, to prove they cannot do certain activities, even where an occupational therapy order has not been issued.

The result is a pervasive and underlying presumption on the part of the medical administrators that Veterans or Caregivers are frauds, and need to be "tricked" into displaying their actual, greater, capabilities. Shame on the VA for such tactics.

While not the topic of today's hearing, this Committee is charged with making recommendations on other VA benefits and services that impact families and caregivers. Given that, the single biggest issue raised by the severely disabled Veterans and Caregivers we serve is the lack of access to timely and quality medical care. While we are uniformly told the clinicians that serve our clients, especially the doctors, are first rate, the medical administration staff that is supposed to support the Veteran in gaining access to that medical care, instead seem to consistently and uniformly act to block timely access.

We've received hundreds of complaints from our clients detailing the bureaucratic roadblocks; local "policies" and "guidance" not based on law, regulation, or printed VA directive; or simply what appears to be simple indifference on the part of the medical administration staff; which hinder, if not stop, Veteran access to the care they need. We've received numerous reports of medical providers repeatedly directing care outside the VA, or not in accordance with current standards of care or formularies, only to be repeatedly denied by the medical administration staff, often without justification or explanation.

Ultimately, this comes down to who is in charge of a Veteran's medical care decisions: the Veteran and his family, or the VA bureaucracy? Our experience is that the individual Veteran and his or her family are consistently denied the opportunity to make that choice themselves. In fact, we often experience an underlying, if unspoken, attitude the Veteran is incompetent to make such medical care decisions. This condescension towards the Veteran is unfortunately shared by many of the largest, and oldest, Veteran service organizations.

We believe the vast majority of Veterans are competent to make medical care decisions, just as they would if they were being served by Medicare or Tricare instead of the VA. We are heartened by the commitment President Trump made to that Veteran empowerment in the campaign. Therefore, we implore this Committee to rec-

ommend to the Secretary that he fully support a Veteran's ability to choose his or her health care provider, whether within the VA or in the community. Of note, in the current debate underway in Congress, neither the House or the Senate Veterans Affairs Committee passed bills come close to providing the real healthcare choice the President promised.

Finally, the VA issued a Request for Comments on the Caregiver program, with those comments due last month. The Independence Fund responded to that Request with its own recommendations for further refining the Caregiver program. In the interest of time, I request the attached copy of that Response be included in the record today.

Thank you for the opportunity to discuss this with you today.

MARGARET KABAT

Margaret Kabat
National Director
Caregiver Support Program (10P4C)
Veterans Health Administration
Department of Veterans Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Ms. Kabat:

Thank you for the opportunity to comment on the future of the Program of Comprehensive Assistance for Family Caregivers (PCAFC). The Independence Fund, founded 10 years ago, has provided more than \$40 million in adaptive equipment and support services for catastrophically wounded and seriously disabled veterans, as well as caregiver support services for the caregivers of those wounded and disabled veterans. Our Executive Director and our Director of Programs are both caregivers to catastrophically wounded veterans. As well, most of our employees are either disabled Veterans or Caregivers themselves.

Overall, The Independence Fund's greatest concern with the PCAFC program is the apparent lack of standardization for large segments of the program, from initial eligibility to program execution and classification standards, not only across Veterans Integrated Service Networks (VISNs), but even across VA facilities within a VISN, and even a single VA facility itself. While we understand the need for a clinical determination to establish individualized eligibility based on the need for assistance with activities of daily living, such clinical determination appears to justify not pursuing any type of national standardization for assessment or continuing eligibility standards for the program, essentially leaving those decisions to be implemented arbitrarily by the personal fiat of individual clinicians and VA medical administrators throughout the country.

Because of that, The Independence Fund regularly sees wide variation in the Caregiver tier classification determined for individually similar cases, for what services and support individual Veterans and Caregivers are eligible, and even whether the Caregiver will be allowed to stay in the program or be "graduated." Given the close similarities we see in these underlying cases with vastly different results, this broad variation across regions and even facilities appears to be an arbitrary execution of the law within the Department.

Further The Independence Fund receives numerous anecdotal complaints of VA officials improperly applying the Caregiver eligibility standards, such as they exist, especially with spouse or other family caregivers. One of the most commonly heard improper "rules" is that Caregiver cannot have outside employment besides serving as a Caregiver. Considering the Caregiver stipend is based upon 40 hours per week of Caregiver assistance (even for the most catastrophically wounded, or the barely conscious Veterans), those Administrators who do try to tell Caregivers that they cannot work outside their Caregiver assistance must believe these Caregivers do not provide any additional Caregiver assistance outside normal working hours. That's outrageous, as is VA officials wrongly telling Caregivers they cannot work outside the caregiving assistance they provide. The regulations regarding PCAFC should specifically state Caregivers can have outside employment beyond the Caregiver assistance they provide.

Within that framework, below are our answers to the specific Request for Comments.

1. Should VA change how "serious injury" is defined for the purpose of eligibility?

Yes.

Per the authorizing legislation, the Secretary is authorized to expand eligibility for PCAFC to an individual's need for personal care services of, "such matters as the Secretary considers appropriate (38 USC 1720G(a)(2)(A)-(B)). While there are obviously 100% disabled veterans who do not need and should not qualify for Caregiver support (which would seem to call into question why such a Veteran would be awarded a 100% disability rating), we do believe certain disability ratings, such as Special Medical Compensation rating R1 or R2, should carry with it a presumption of eligibility for the PCAFC program. We believe the Secretary should use that special authority referenced above to establish such a presumption.

A: Should the severity of injury be considered in determining eligibility to ensure VA is supporting family caregivers of Veterans most in need? If so, how should the level of severity be determined?

This question is confusing in its sentence structure. The program was, in our estimation, established on a clear standard of the Veteran not being able to complete activities of daily living. Congressional intent would appear clear that those Veterans are already considered most in need of Caregiver support?

If the Department is asking whether it should further limit access to the Caregiver program beyond the standard already established by Congress, then the answer is categorically no.

The question appears to imply the Department wishes to prioritize eligibility in order to ration access, something which The Independence Fund categorically rejects. The PCAFC program should be administered in a way that any Veteran qualified for the program gains immediate access to it.

However, establishing national eligibility standards would, in our estimation, reduce much of the variability across Caregiver eligibility described above, and would, in our opinion, reduce the need to even conduct such prioritization by providing bright line standards for clinicians and administrators to follow.

C. Should eligibility be limited to only those Veterans who without a family caregiver providing personal care services would otherwise require institutionalization?

Absolutely not.

The paltry stipend paid to current caregivers, and the presumption apparently applied by many of the VA eligibility gatekeepers that family caregivers should automatically be assisting Veterans with activities of daily living (including eating, mobility, hygiene and toileting) without compensation is insulting and atrocious. Essentially, considering to limit the Caregiver program to only those Veterans without a family caregiver available is to leverage the love families have for their disabled Veterans to provide the care the Department would otherwise provide, but at a far cheaper rate. Essentially, the US Government is leveraging that familial love for the Veteran against the family in order to save the US Government money. Considering to further limit eligibility to only those without a family caregiver available is, in our opinion, unconscionable.

2. To be eligible for the program, participation must be determined to be 'in the best interest' of the Veteran. How should 'best interest' be defined.

The way "best interest" is currently implemented perpetuates a paternalistic and condescending approach of how the Department should provide care to Veterans, assuming a Veteran is incapable of understanding what health care is and is not in their best interest. Such a "Big Brother" approach to health care decisions implies that the Veteran is incapable of making his or her own health care decisions.

Instead, The Independence Fund believes if a Veteran applies for Caregiver assistance, it should automatically be presumed that such assistance is in the best interest of the Veteran. Given the law requires a "Best Interest" determination by the Secretary, The Independence Fund recommends the "Best Interest" determination be changed to a negative only determination: Unless the Department specifically determines it is not in the best interest of the Veteran to participate in the program, the "Best Interest" test should be presumed to be met by the Veteran's application.

A. How can VA improve consistency in 'best interest' determinations for participation in the program?

By changing the "Best Interest" determination into a negative determination: Unless the Department specifically determines it is not in the best interest of the Veteran to participate in the program, the "Best Interest" test should be presumed to be met by the Veteran's application.

B. Are there any conditions under which participation would not be in a Veterans best interest?

The Independence Fund cannot think of any except where the Caregiver is abusing or taking financial advantage the Veteran, and where ending eligibility is the only way the Department would have to end the abuse.

4. Once approved for the PCAFC should the Veterans eligibility be reassessed at specific time intervals or based on clinical indicators?

Many Veterans assisted by PCAFC are catastrophically, permanently and totally disabled, and as such, their disability ratings are set at that minimum level with no future downgrading allowed. Similarly, The Independence Fund points out the Caregivers for these permanently and totally disabled veterans are, absent a miracle, going to be Caregivers for the rest of that Veteran's life. Requiring periodic re-evaluations, especially at the current 90 day interval, is insulting to the Veteran, introduces unnecessary stress and disruption for both the Veteran and the Caregiver, and completely unnecessary. The Independence Fund recommends reassessment be eliminated for the Caregivers of permanently and totally disabled Veterans enrolled in the program, who are also rated R1 or R2 under the Special Medical Compensation program.

b.1. Should reassessments be standard for every participant?

No.

The Independence Fund recommends reassessment be eliminated for the Caregivers of permanently and totally disabled Veterans enrolled in the program, who are also rated R1 or R2 under the Special Medical Compensation program.

b.2. Are there conditions under which continued eligibility should be presumed and a reassessment not needed?

Yes.

b.3. If so, what would these conditions be?

For the Permanently and Totally Disabled, who are also rated R1 or R2 under the Special Medical Compensation program.

6.b. Under what circumstances should the family caregiver benefits be continued after revocation?...How long should the benefits be continued under such circumstances?

Many caregivers give up careers and all outside employment to care for wounded and disabled veterans. The Caregiver stipend, completely insufficient though it is, is often the only income that Caregiver family has outside the Veteran's VA compensation. When the Veteran dies, that family loses a huge portion of their income, compounded by the fact the Veteran's Caregiver could very well have been out of the workforce for years. Further, the Caregiver loses health insurance coverage they receive under CHAMPVA.

Therefore, The Independence Fund recommends Caregiver stipends and CHAMPVA coverage be continued for at least a year after the death of the enrolled Veteran.

7. How should VA calculate stipends?

The Caregiver stipend rate is an embarrassment for our country. With a maximum weekly stipend of 40 times the rate for personal care assistance in that geographical region, for the most catastrophically wounded veteran who nevertheless provide round the clock care, such a paltry sum is an insult to the care Veterans' Caregivers provide. If that family caregiver were not available, the institutionalization of the Veteran would cost the Department far more, likely somewhere in the \$7,500 to \$10,000 per month range, under the best of circumstances. Further, basing the stipend on the presumption the family Caregiver will only provide 40 hours per week for the Veteran is fanciful, and seems to be chosen to save the government money, not properly compensate the Caregiver for his or her services.

Therefore, The Independence Fund recommends the stipend be calculated by what home care licensed vocational nurse care of that Veteran would cost the US Government, times 80 hours per week.

a. Should VA use one BLS rate per state?

No. Costs of living can vary greatly within a State, and varying stipends based on those costs of living is reasonable.

8.b. A Veteran is assigned a stipend tier based on the amount and degree of personal care services provided. How should VA assess and determine the amount and degree of personal care services provided to the Veteran by the family caregiver?

While much of the PCAFC program eligibility is related to needs regarding activities of daily living, given the well established disability rating program the Department already executes, both with the standard disability rating system and the Special Medical Compensation ratings, it should rely upon those standards to the extent that it can, regardless of the underlying activities of daily living standard, as there is likely a strong correlation between the two, and using such ratings would bring much greater transparency and uniformity to the Caregiver tier and compensation systems.

Thank you for the opportunity to submit these comments. If you need further clarification or if you wish to discuss further, I can be reached at B.Carey@IndependenceFund.org or 202-779-1598.

Very Respectfully,

Bob Carey
Director, Policy & Advocacy

BOB CAREY

Dear Chairman Wenstrup, Representative Brownley, and Members of the Subcommittee, thank you very much for inviting The Independence Fund to testify before your Subcommittee today. I am Bob Carey, Director of Policy & Advocacy of The Independence Fund, headquartered in Charlotte, North Carolina, with additional offices in Washington, DC and San Antonio, TX.

Only 10 years old, we were founded in 2007 with the very specific purpose of assisting the most catastrophically wounded veterans from the Iraq and Afghanistan with adaptive mobility devices, and returning to them, at least in part, their independence. Since those humble beginnings, The Independence Fund's grown to also provide assistance for the caregivers of the catastrophically wounded and disabled, assistance to adaptive athletes and teams, wellness programs to combat the scourge of veteran suicide and post-traumatic stress disorder, veteran service programs to navigate the overly complex VA health care and benefit systems, advocacy programs to change the laws and regulations that unnecessarily limit veterans access to their earned benefits, and our newest program, Heroes at Home, which will assist the children of the catastrophically wounded and disabled.

To date, The Independence Fund's provided more than \$50 million in assistance to the catastrophically wounded and disabled and their Caregivers. This includes more than 2,200 motorized cross-country wheelchairs, 1,500 adaptive bicycles, and more than 150 Caregiver support retreats.

Overall Issues and Compromise Legislation

Mr. Chairman, we would be remiss if we did not discuss the failed opportunity to bring widespread reform to the VA system with the recently considered compromise VA Choice, Caregiver expansion, and capital asset review legislation that was proposed to include on the Comprehensive Appropriations Act for FY 2018, recently passed by Congress. The Independence Fund supported this compromise legislation, as we believe most every other major veteran service organization did. We do not believe a single veteran service organization opposed the compromise legislation. That is why we joined our VSO colleagues in our disappointment it was not included in the final omnibus legislative package.

That said, it is not too late to enact this groundbreaking legislation. With the VA Choice program projected to run out of money by late May or early June, some type of legislative action will be needed very soon. The Independence Fund believes that original compromise legislation, without amendment, is our best chance to break ourselves from this endless cycle of budgetary brinksmanship with the VA Choice program, to bring meaningful and real choice to the VA health care system, to expand the caregiver program, and to analyze deliberatively and rigorously the real capital asset requirements of the VA.

While we share the Chairman's and the prior Secretary's concerns expanding the VA Caregiver program without revising the eligibility criteria may swamp the program so completely that current caregivers are denied the support they need, the need for expanding choice in the VA health care system is so severe, we are willing

to take that risk with the Caregiver program as part of a broad legislative compromise proposal.

Therefore, Mr. Chairman and members of the Subcommittee, The Independence Fund strongly recommends the proposed omnibus legislative compromise language, with all three pieces major reform - VA health care choice expansion and community care consolidation; VA Caregiver expansion, and the capital asset review - be pursued in their entirety, and without further amendment, before alternative texts are considered. It is in this compromise language that our community finds its best hope for passage. With the universal VSO support, if any part of the original omnibus language were reopened, we would demand, as we believe many other VSOs would demand, for additional reforms of other parts of that omnibus package. In our case, it would be further expansion of access to non-VA care and refinement and national standardization of the Caregiver program. But such renegotiation of the language would likely delay consideration to after the deadline for funding VA Choice, and with that, the best legislative vehicle for enacting such laws.

HR 2322

Mr. Chairman, with The Independence Fund's focus on reforming VA health care, especially for the catastrophically disabled, and for supporting the caregivers and families of those catastrophically disabled, we will only comment on HR 2322, HR 4334, and the Revised Draft to Make Certain Improvements in the Family Caregiver Support Program.

Which brings us to the specific issue of wheelchairs and prosthetics. Our Executive Director, Sarah Verardo, is Caregiver to her husband SGT Michael Verardo, USA (Ret), catastrophically wounded in Southern Afghanistan in 2010. Mike regularly talks about how his biggest battle was not on the battlefield, nor in the immediate recovery before his medical retirement from the military in 2013. Mike and Sarah's biggest battle is with a VA health care system unresponsive to their unique health care needs, and apparently either unwilling or unable to make the changes necessary to optimize the care for the catastrophically disabled. Their personal experience, and the experience of hundreds of our clients served through the years, is that the VA cannot deliver wheelchair and prosthetic repairs and replacements in a timely manner.

For example, when Mike was retired from the military and we moved back to Rhode Island, his prosthetic leg was damaged, but we had to wait 57 days for a VA medical administrator to sign a form authorizing the repair of the prosthetic. Eventually, the prosthetic vendor grew disgusted with the VA and provided a new prosthetic without authorization, risking non-payment. In the meantime, Sarah was forced to duct tape Mike's leg to keep it even somewhat operational. More recently when Sarah requested a wheelchair repair or replacement from VA, sheI was told that the VA needed to evaluate if Mike still had injuries that required wheelchair use. Apparently the VA did not realized limb loss is permanent.

The Independence Fund's made eliminating the requirement to see a Primary Care Physician first when seeking prosthetics or wheelchair repairs one of its type priorities, meeting with the White House, the prior Secretary, Congress (including this Subcommittee), and the leadership of the Rehabilitation, Wheelchair, and Prosthetics departments at the VA. And that is why we are so encouraged by VA's announcement week before last eliminating that requirement, allowing the Veteran to go directly to the wheelchair and prosthetics offices to seek assistance.

But that, Mr. Chairman, is not enough. The VA Inspector General released a report last month detailing the myriad problems with wheelchair and prosthetic repairs in VISN 7, which we believe apply nationwide. The first remarkable item in this report is that the VA apparently has no standard for how long it should take to repair wheelchairs and scooters. Second, the VA IG found the average wait time was 99 days. Some of the Veterans researched in this study were bedridden for more than 100 days while their wheelchairs were being repaired. We believe such wait times are similar for prosthetics as well.

Lastly, the VA IG detailed the repair administrative process. That process seems incredibly complex and unnecessarily duplicative. A simple process review would likely be able to trim substantial time and steps from this process. The Independence Fund recently met with the Central Office Prosthetics and Wheelchairs Department, and we are hoping to enter some Memorandum of Understanding with the VA to help them improve those processes. We request your support with the VA to enter into such an agreement with us.

But again, Mr. Chairman, we do not believe there are any circumstances where the VA will be able to adequately respond to Veterans' prosthetic and wheelchair repair and replacement needs. Having to wait until the point of failure for the VA to even initiate repair or replacement action and having no spares available for the

Veteran to use in the interim, highlights a system unresponsive to the basic needs of disabled Veterans. Even the 30-day repair standard the VA IG arbitrarily applied in their report (since the VA does not have its own repair/replacement standard), is unacceptably long. Therefore, we recommend Veterans be allowed immediate access to non-VA care for the repair or replacement of prosthetics, wheelchairs, and scooters.

With regards to HR 2322, we believe additions and revisions to the bill will help address these problems, and we look forward to working with the sponsors of the legislation and the Subcommittee to revise it. But specifically, we believe the following recommendations will help improve the legislation:

- Specifically add language for wheelchairs. While many amputees are able to use their prosthetics for many hours throughout the day, many others are more limited in that use, relying on wheelchairs for the other times. Further, administratively, the wheelchair programs and prosthetic programs are run by the same offices in the VA, and the procedures are developed by the same personnel.

- Required the VA to develop realistic repair and replacement timelines. As the VA IG report highlighted, the VA currently has not standards for how long it can take to repair or replace a wheelchair or prosthetic device. The VA IG used 30 days as an arbitrary standard, but even then, we believe that is unreasonably long. Further, the VA has no preventive maintenance programs, or backup/loaner programs, even for manual wheelchairs. We believe the Bill of Rights must include timely access to repairs and replacements, loaners and backups provided by the VA within days of the Veteran contacting VA, and immediate direct access to the vendor by the Veteran, rather than having to go through the Byzantine VA bureaucracy.

HR 4334

Mr. Chairman, The Independence Fund salutes the Subcommittee's commitment to serving our female Veterans and specifically addressing their unique needs. We also believe the bill's focus on exploring non-VA care options is wise. While female veterans make up an increasing portion of the VA health care population, they are still a significant minority. We are concerned, at least in some regions, there will never be enough of a female patient density to justify unique female programs at local VA facilities, and that the unique needs of female Veterans are such that the VA will never be able to recruit enough specialists to provide adequate VA care to that population at the local level.

Further, we do not believe regional or national specialist clinics, to which female Veterans would travel, are a reasonable way to provide the care. It forces sick Veterans to travel long distances, forces them inappropriately into inpatient care settings, and takes them away from their primary family and local support systems. Therefore, Mr. Chairman, The Independence Fund recommends the language regarding female Veteran access to non-VA care by strengthened and expanded. We look forward to working with the bill sponsors and the Subcommittee on those recommendations.

Caregiver Support Programs

Mr. Chairman, as The Independence Fund's noted many times in the past, we share your concern expanding the Caregiver program without also refining it may so swamp the VA Caregiver infrastructure that current Caregivers are denied the support they need. And in another time and another place, we would be excited to help the Subcommittee with such refinements. However, our fellow VSOs have made it clear, in no uncertain terms, that only absolute expansion of the program, under current eligibility rules, to pre-9/11 Veterans, is acceptable to them as part of the broader omnibus appropriations compromise legislation. Any change to that current language will trigger their opposition to the entire package. Therefore, we are concerned consideration of this legislation at today's hearing may endanger Congress' ability to get not only VA Caregiver expansion enacted, but VA Choice expansion as well.

The Independence Fund's attached it's response to the February 2018 Federal Register request for comments on the current Caregiver program, as well as our testimony before the VA's Caregiver and Military Family Advisory Committee, in order to provide the Subcommittee with the background on our overall concerns with the program.

If Congress is unable to pass the omnibus appropriations compromise VA reform legislation, and the entire gamut of issues is reopened for legislative consideration, The Independence Fund looks forward to working with the Subcommittee then on the new Caregiver expansion and reform legislation.

Thank you again, Mr. Chairman, for the opportunity to appear before this Subcommittee today. I look forward to answering any questions you may have.

THE VETERANS CANNABIS COALITION

Chairman Wenstrup, Ranking Member Brownley, Members of the Subcommittee, on behalf of the Veterans Cannabis Coalition (VCC), we thank you for the invitation to submit our remarks to authorize the U.S. Department of Veterans Affairs (VA) to conduct and support research of medicinal cannabis. We believe that the VA Medicinal Cannabis Act of 2018 is a positive first step toward putting the incredible research capacity of the Department of Veteran Affairs to work investigating the medical value of cannabis.

The Veterans Cannabis Coalition appreciates the Committee for having listened to the concerns of millions of veterans and identified the immediate need for more high-quality research into the efficacy of cannabis through the Department of Veteran Affairs. The untold number of veterans, whom are suffering from a lack of effective treatments for their service-connected injuries, need options. Based on current and existing research and anecdotal testimonies, we recognize the immense potential of cannabis to treat some of the most persistent health issues facing veterans today, particularly traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), and the pernicious effect of chronic pain.

The comorbidity of these conditions in many veterans returning home from Iraq and Afghanistan over the last 17 years has led to a modality within the Veterans Health Administration to focus on pharmacology. Doctors throughout the VA health system have consistently prescribed risky combinations of incredibly powerful drugs in order to manage the symptoms of the veterans under their care. These drugs include opioids, benzodiazepines, stimulants, sedatives, anti-depressants, anti-psychotics, and more, and are often taken in conjunction.

Veterans report that this commonly prescribed drug regimen, nicknamed the ‘combat cocktail’, negatively impacts their interpersonal relationships and employment, destroys their quality of life, and has led many to unsuccessfully attempting to take their own life while under the influence of the very same medications prescribed by the VA. There are thousands of others, driven by desperation and unable to find relief through the only treatments offered, who were successful. The veteran suicide and overdose rates reflect this reality.

As Congress and the public have begun to grapple with the fact that millions of Americans—from valedictorians to professional athletes to service members—struggle with opioid use disorders, the reaction from health systems has been to taper or cut opioid prescriptions for patients. The VA has touted their reduction and shift toward other therapies and holistic treatments like acupuncture and yoga. Scaling such therapies, however, presents massive challenges, while using non-narcotic medications like non-steroidal anti-inflammatory drugs (NSAIDs) carries other long-term risks such as kidney damage. Cannabis has no known toxicity, low rates of misuse and abuse, and its use as a medication is associated with marked improvements in dozens of different conditions, ranging from insomnia to anxiety, PTSD to pain management.

The Veterans Cannabis Coalition recognizes the VA Medicinal Cannabis Research Act of 2018 as an opportunity for Congress to decidedly address this crisis. Establishing the medical merit of cannabis through Department of Veterans Affairs guided and funded research will provide immeasurable public good, one that we hope both parties will fully support. We look forward to working with your offices and Committee staff as we aim to educate and build support for this effort in the weeks and months ahead.

For additional information, please contact Eric Goepel, Founder & CEO of the Veterans Cannabis Coalition at (213) 986-8139 or eric@veteranscannacoalition.org.

THE VETERANS CANNABIS PROJECT

“TO AUTHORIZE THE DEPARTMENT OF VETERANS AFFAIRS TO CONDUCT AND SUPPORT RESEARCH ON THE EFFICACY AND SAFETY OF MEDICINAL CANNABIS”

APRIL 17, 2018

Chairman Wenstrup, Ranking Member Brownley, Members of the Subcommittee, on behalf of the Veterans Cannabis Project (VCP), we thank you for the invitation to submit our remarks to authorize the U.S. Department of Veterans Affairs (VA) to conduct and support research of medicinal cannabis. It is imperative that Congress pass the VA Medicinal Cannabis Research Act of 2018 to provide the VA the

resources to effectively and comprehensively treat the complexity of every veteran's mental and physical wounds.

The internal wounds of military veterans have become a costly nationwide epidemic. Upwards of 20 percent of the 2.7 million Iraq and Afghanistan veterans will experience post-traumatic stress or depression, according to the VA.

Veterans are often placated with "cocktails" of prescription drugs, including powerful and addictive opiates. The current arrangement is not meeting veterans' healthcare needs. Recent research at the VA indicates a link between increased opioid dosages and suicide among veterans. Federal data shows veterans are twice as likely as non-veterans to die from an accidental overdose of highly addictive prescription drugs.

Medical cannabis is a proven, safe and common-sense personal health management option, free of the devastating side effects of opiate-based drugs. It is now legal in 30 states and is recognized by experts such as the American College of Physicians, the American Public Health Association and the American Nurses Association as a safer alternative to many legal treatments. Medicinal cannabis is an incredibly effective tool for veterans challenged with managing the symptoms of their wounds.

Furthermore, in states where medical cannabis is now legal, veterans are stuck in a "catch-22" situation if they elect to obtain a medical cannabis recommendation: the VA is a federal healthcare system, which ignores state cannabis laws, leaving veterans unable to openly discuss the issue with their primary care providers and at risk of losing hard-earned benefits. Regardless of the legal status of cannabis in a state, Veterans Health Administration physicians are prohibited from recommending cannabis as a treatment option for their Veteran patients.

The VA Medicinal Cannabis Research Act of 2018 will elevate cannabis as a health policy issue and lay the foundation for veterans to legally access an effective healthcare treatment. While data already exists proving medical cannabis' positive effects, federal research is needed to afford the VA the ability to treat cannabis as medicine. We owe those who served, currently serve, and will serve our nation access to every medically proven healthcare treatment, including medical cannabis.

The Veterans Cannabis Project was founded by veterans, for veterans, to create an improved quality of life through the opportunity of cannabis. The Veterans Cannabis Project team is comprised of veteran leaders and their families through meaningful career progression after the military. We thank the Subcommittee for holding this important hearing and for the opportunity to explain the views of the Veterans Cannabis Project.

For additional information, please contact Nick Etten, Founder & CEO of the Veterans Cannabis Project at (512) 992-7567 or nick@vetscp.org.

WOUNDED WARRIOR PROJECT

Chairman Wenstrup, Ranking Member Brownley, and distinguished members of the Subcommittee on Health - thank you for inviting Wounded Warrior Project (WWP) to provide this statement for the record for today's legislative hearing on pending health legislation. More than 113,000 wounded warriors are registered to receive WWP's free direct programs and services, and thus far in Fiscal Year 2018, WWP is registering an average of more than 1,200 new warriors per month.

Based on these figures and our own observations and experiences working with wounded warriors and their families around the country, we believe that the need for strong, sensible, and sustainable veteran-centric health care laws is great and growing. We are pleased to provide the following positions on legislation before the Subcommittee.

H.R.—: A draft bill to make certain improvements in the Family Caregiver Program

As a crucial component of delivering on our mission to honor and empower wounded warriors, WWP has been proud to advocate for benefits for seriously injured post-9/11 veterans' caregivers. In addition to organizing in support of enacting the Caregivers and Veterans Omnibus Health Services Act of 2010, WWP has worked closely with the Department of Veterans Affairs (VA) to ensure that the Program of Comprehensive Assistance for Family Caregivers (the Program) is carried out as effectively as possible.

Wounded Warrior Project believes the Program should be available to all generations with appropriate funding and without a reduction in benefits for post-9/11 warriors. While WWP's mission focuses on family caregivers of veterans and service members who have been wounded, ill, or injured since September 11, 2001, we ap-

precipitate that the Subcommittee has acknowledged that all generations should receive the benefits that have been such a crucial resource for post-9/11 caregivers over the last seven years.

In this context, WWP does not support the current draft legislation because its proposed improvements do not outweigh the associated detriments to the current program. WWP supports the information technology provisions in Section 1; however Section 2 creates concerns that overshadow the desired goal of expanding the Program to all generations. Specifically, raising the threshold for eligibility based on activities of daily living would result in the ability to serve fewer veterans whose best clinical interest can and should be served by participating in the Program.

Section 2 also proposes to “transition” current program participants - whose current eligibility may not be sufficient for participation under new criteria - to the new program. While WWP has concerns about the VA’s ability to administer a bifurcated Program with different eligibility standards, WWP is strongly opposed to implementing a new, single program that holds potential to remove current, deserving beneficiaries to accommodate new participants.

Moreover, it has been approximately one year since VA froze Program revocations due, in part, to complaints from veterans who lost access to the Program even though their conditions had not improved¹. Anecdotally, WWP has seen such revocations from veterans utilizing our Benefits Services program, and in our experience, successful appeals are extremely rare. By ordaining a transition process that could potentially remove thousands of veterans from the Program, this draft bill would amplify these issues even further. Removing current participants who have been clinically approved to participate and who maintain a severe level of disability is an unacceptable approach to realizing the greater community’s dream of bringing the Program within the reach of other veteran caregivers who are no more or less deserving of its critical resources.

In sum, WWP believes that those who cannot participate in the Program now (and all who could potentially participate in the future) should have access to the same benefits offered to those currently in the Program. Such an expansion can and should be achieved with careful management and appropriate funding, and without diminishing the quality of the Program for those currently-eligible or those who may become eligible in the future. As the current draft proposal does not meet these criteria, WWP respectfully opposes the current draft proposal. WWP also fully supports S. 2193 Caring for our Veterans Act of 2017, which offers full expansion of the Caregiver Program to all generations without diminishing the quality of the Program, and WWP will aggressively pursue its passage through the House and Senate.

H.R.—: A draft bill to authorize VA to conduct and support research on the efficacy and safety of medicinal cannabis

Wounded Warrior Project’s mission to honor and empower wounded warriors drives us to foster the most successful, well-adjusted generation of injured veterans in our nation’s history. The warriors, caregivers, and family members we serve are at the center of every decision we make. Several emerging and alternative therapies have demonstrated some initial promising results for the management and treatment of the invisible wounds of war, including post-traumatic stress disorder (PTSD) and traumatic brain injury (TBI). Lately, there has been much debate surrounding veterans’ rights to access medical cannabis as an alternative therapy.

At WWP, we believe that choosing a treatment method, whether alternative or empirically supported, is a personal decision that should be made between each warrior, his or her family, and his or her medical team. WWP encourages warriors to make informed decisions in pursuing the treatment options that are most relevant to their circumstances with the guidance of their health care providers. While WWP does not have an official stance on the use of medical cannabis, WWP is supportive of evidence-based and evidence-informed therapies, as well as complementary and alternative therapies that have been empirically demonstrated and validated through research to be successful in rehabilitation and recovery.

For these reasons, Wounded Warrior Project supports research and investments with potential to expand the number of evidence-based and evidence-informed therapies available to treat both the visible and invisible wounds of war affecting post-9/11 veterans. As any research plan developed by VA to investigate potential uses of medical cannabis under this proposal would be subject to additional review by Congress, this proposal permits future oversight of potential concerns regarding em-

¹Quil Lawrence, Some VAs are Dropping Veteran Caregivers from their Rolls, NPR (April 5, 2017) (available at <https://www.npr.org/2017/04/05/522690583/caregivers-for-veterans-dropped-from-va-plan>).

ployment constraints and other ramifications of those selected to participate. In this context, WWP is pleased to support this draft proposal.

H.R. 1506: VA Health Care Provider Education Debt Relief Act of 2017

Recent work to improve and consolidate VA's community care programs has provided an opportunity for WWP and others in the veterans policy community to highlight a corresponding need to ensure that VA is given the tools and resources necessary to grow and strengthen as it struggles to meet the increased demand for services for our nation's heroes. Of particular note, VA must be able to recruit, hire, and retain high-quality medical professionals.

WWP views the Health Care Provider Education Debt Relief Act of 2017 as a way to attract quality personnel to the VA, and with the rise of education debt, an opportunity to give VA a competitive advantage to hire and retain those best qualified to deliver care to veterans. In its Determination of VHA Occupational Staffing Shortages FY 2017 report, VA's Office of Inspector General found that the largest critical need occupations were Medical Officers, Nurses, Psychologist, Physician Assistants, and Medical Technologists². In the past four years, Medical Officers and Nurses have been the top two critical need occupations. Given the amount of cost it requires to obtain a degree in one of these two fields, H.R. 1506 would constitute an effective tool to attract these critically needed specialists to VHA. For these reasons, WWP is pleased to support the Health Care Provider Education Debt Relief Act of 2017.

H.R. 2322: Injured and Amputee Veterans Bill of Rights

While the past several years have seen increased focus on the mental health needs of post-9/11 veterans, WWP remains vigilant in addressing the needs of those with severe physical injuries. From January 1, 2001, through December 31, 2016, 1,710 service members sustained at least one conflict-related amputation (excluding fingers, thumbs, or toes)³. This group is just a small segment of a larger population. The total number of Veterans with amputations being seen at VA facilities increased 325 percent, from 25,000 in FY 2000 to almost 90,000 in FY 2016⁴. These figures reflect the need to help ensure veterans with injuries and amputations have access to high quality prosthetic limb and orthotic care.

Although not all amputees elect to wear a prosthesis, the vast majority do. The ultimate goal for a prosthesis is to achieve the most function and mobility possible, leading to an active and fulfilling lifestyle. To achieve that goal, an amputee must work closely with a prosthetist who understands their unique needs, such as residual limb size, type of amputation, gender- and age-related issues, and activity levels.

The proposed Injured and Amputee Veterans Bill of Rights would affirm a commitment to ensuring these veterans have access to timely, high quality, and patient-centered care. WWP believes the nine-line Bill of Rights in Section 2(d) are all reasonable and non-controversial policy statements, including the right to have access to high-quality care, the most appropriate prosthesis and orthosis, the most appropriate technology, and the best-qualified practitioners, whether or not that practitioner is an employee of the VA. A requirement to prominently post these rights at each VA prosthetics and orthotics clinic, as well as on the VA website, would help ensure they are known and understood by both veterans and health practitioners.

Additionally, with the increasing number of amputees relying on the VA for prostheses, WWP supports the reporting requirements for the VA to establish transparency of allegations of mistreatment of injured and amputee veterans. The educational component of this legislation would ensure that VA employees who work at prosthetics and orthotics clinics or as a patient advocate for amputees, receive training on such Bill of Rights.

For these reasons, WWP is pleased to support the Injured and Amputee Veterans Bill of Rights.

H.R. 4334: Improving Oversight of Women Veterans' Care Act of 2017

H.R. 4635: To direct the Secretary of Veterans Affairs to increase the number of peer-to-peer counselors providing counseling for women veterans, and for other purposes

² <https://www.va.gov/oig/pubs/VAOIG-17-00936-385.pdf>

³ VA/DoD Clinical Practice Guidelines for Rehabilitation of Individuals with Lower Limb Amputation. The Rehabilitation of Individuals with Lower Amputation Working group; Version 2.0 - 2017; pg. 10.

⁴ Id. at 10.

Women comprise 8.7 percent of the veteran population and are the fastest-growing demographic in the military⁵. At WWP, nearly 16 percent of our registered alumni are women and as an organization dedicated to honoring and empowering wounded veterans and service members who have been injured in both mind and body since 9/11, we are particularly aware of the growing contributions of women in our armed services - and the need for programs and services tailored to their needs.

The Department of Veterans Affairs has expanded its care options and outreach to women veterans, but there is still room for improvement. VA offers primary and specialty care to support women at every stage of their life - including women's services such as family planning, infertility services, menstrual and menopausal management - but accessibility in a community-based settings is not fully captured and compliance with environment of care standards for women in VA-based settings is not fully monitored. The Improving Oversight of Women Veterans' Care Act of 2017 aims to correct these deficiencies, and women veterans stand to benefit.

One particular area where women veterans are finding satisfaction is peer support. In our experience, peer-to-peer support is critical to recovery for many warriors. According to the 2017 Wounded Warrior Project Survey, more than half of those surveyed, or 51.6 percent, used talking with another Operation Enduring Freedom, Operation Iraqi Freedom, or Operation New Dawn veteran as a resource to address mental health issues. The only more frequently utilized resource was VA Medical Centers.

Within the context of female veterans, peer-to-peer support is a particularly important tool to break through seclusion and isolation. As the Subcommittee is aware, shifts in perception of military demographics are slow-moving, and many on either side of the civilian-military divide still think of members of the Armed Forces as male. Particularly when combined with injuries to mental health sustained in service, these preconceived notions can be harmful to reintegration and recovery. VA's 2016 suicide data report found that the risk of suicide was 2.5 times higher among female veterans when compared with civilian adult females⁶. By connecting female veterans with one another, peer-to-peer assistance can empower female veterans to connect with each other and their communities. At WWP, we've increased our commitment to offering more all-female peer support groups and all-female alumni workshops based on demand and overall satisfaction.

Wounded Warrior Project is committed to improving health options and outcomes for women veterans as both a program provider and an advocate for those receiving care and services through VA. Both H.R. 4334 and H.R. 4635 are consistent with our commitment to achieving these goals, and WWP is pleased to provide its support for both proposals.

H.R. 3832: Veterans Opioid Abuse Prevention Act

Wounded Warrior Project does not take a position on this bill at this time.

CONCLUSION:

Wounded Warrior Project thanks the Subcommittee on Health, its distinguished members, and all who have contributed to the policy discussions surrounding the bills under consideration at today's hearing. We share a sacred obligation to serve our nation's veterans, and WWP appreciates the Subcommittee's effort to identify and address the issues that challenge our ability to carry out that obligation as effectively as possible. We are thankful for the invitation to submit this statement for record and stand ready to assist when needed on these issues and any others that may arise.

Sincerely,

Rene C. Bardorf

Senior Vice President of Government and Community Relations



⁵Source: National Center for Veterans Analysis and Statistics: Profile of Veterans: 2016: Data from the American Community Survey, 2016.

⁶Source: Office of Suicide Prevention, Department of Veterans Affairs, Suicide Among Veterans and Other Americans 2001–2014, 4 (August 2016).